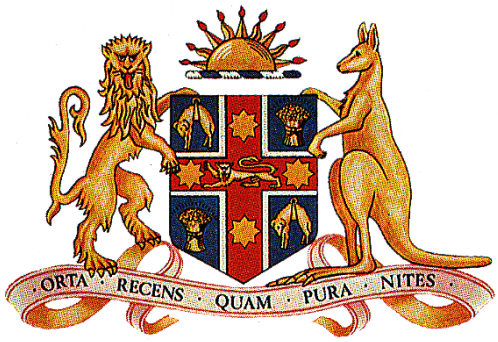

Government Gazette

of the State of

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The *New South Wales Government Gazette* is the permanent public record of official notices issued by the New South Wales Government. It also contains local council and other notices and private advertisements.

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To submit a notice for gazettal – see Gazette Information.

PARLIAMENT

ACTS OF PARLIAMENT ASSENTED TO

Legislative Assembly Office, Sydney 2 November 2015

It is hereby notified, for general information, that His Excellency the Lieutenant-Governor, has, in the name and on behalf of Her Majesty, this day assented to the under mentioned Acts passed by the Legislative Assembly and Legislative Council of New South Wales in Parliament assembled, viz.:

Act No 35 — An Act to amend the *Electricity Supply Act 1995* to make changes to the energy savings scheme; and for other purposes. **[Electricity Supply Amendment (Energy Savings Scheme) Bill]**

Act No 36 — An Act to amend energy legislation with respect to retail energy pricing; and for other purposes. **[Energy Legislation Amendment (Retail Electricity and Gas Pricing) Bill]**

Act No 37 — An Act to amend the *Local Government Act 1993* to modify the legislative scheme for dealing with councillor misconduct and poor performance and council maladministration, and for law revision purposes; and to make consequential amendments to the *Local Government (General) Regulation 2005*. **[Local Government Amendment (Councillor Misconduct and Poor Performance) Bill]**

Act No 38 — An Act to make miscellaneous amendments to various Acts that relate to health and associated matters. **[Health Legislation Amendment Bill]**

Act No 39 — An Act to amend the *Mining Act 1992* and the *Petroleum (Onshore) Act 1991* to make provision for competitive selection for prospecting titles for coal and petroleum. **[Mining and Petroleum Legislation Amendment (Grant of Coal and Petroleum Prospecting Titles) Bill]**

Act No 40 — An Act to amend the *Mining Act 1992* and *Petroleum (Onshore) Act 1991* to make further provision with respect to prospecting for and mining minerals and petroleum, including by harmonising certain provisions of those Acts. **[Mining and Petroleum Legislation Amendment (Harmonisation) Bill]**

Act No 41 — An Act to amend the *Mining Act 1992* and the *Petroleum (Onshore) Act 1991* in relation to land access mediation and arbitration processes; and for related purposes. **[Mining and Petroleum Legislation Amendment (Land Access Arbitration) Bill]**

Act No 42 — An Act to amend the *Protection of the Environment Operations Act 1997* in relation to the enforcement of requirements for gas and other petroleum exploration and production authorities and of the conditions of those authorities. **[Protection of the Environment Operations Amendment (Enforcement of Gas and Other Petroleum Legislation) Bill]**

Act No 43 — An Act to amend the *Work Health and Safety (Mines) Act 2013* to extend that Act to work health and safety at petroleum sites; to clarify how that Act interacts with the *Work Health and Safety Act 2011*; to make related and consequential amendments to other Acts; and for other purposes. **[Work Health and Safety (Mines and Petroleum) Legislation Amendment (Harmonisation) Bill]**

RONDA MILLER
Clerk of the Legislative Assembly

GOVERNMENT NOTICES

Appointments

FISHERIES MANAGEMENT ACT 1994

Instrument of Appointment

Industry Representative Members and Independent Chair to the Aquaculture Research Advisory Committee

I, Niall Blair, MLC, Minister for Primary Industries, pursuant to section 157 (4) of the *Fisheries Management Act 1994* and clause 16 of Schedule 1 to the *Fisheries Management (Aquaculture) Regulation 2012*, appoint each person named in the Schedule as an industry representative member of the Aquaculture Research Advisory Committee for a term commencing 27 September 2015 and expiring 27 September 2018.

Schedule

Name of member

Anthony TROUP

Jessica ZEALAND

Matthew WASSNIG

Anne LOFTUS

Milada SAFARIK

Russell SYDENHAM

Name of Chair

Ian WHITE

Dated this 5th day of November 2015.

NIALL BLAIR, MLC
Minister for Primary Industries

Planning and Environment Notices

NATIONAL PARKS AND WILDLIFE ACT 1974

Gunning Reserves Plan of Management

A plan of management for the Gunning Reserves, incorporating Bango Nature Reserve, Oakdale Nature Reserve, Mcleods Creek Nature Reserve and Belmount State Conservation Area was adopted by the Minister for the Environment on 5 May 2013.

Roads and Maritime Notices

ROADS ACT 1993

LAND ACQUISITION (JUST TERMS COMPENSATION) ACT 1991

Notice of Compulsory Acquisition of Land at North Strathfield in the City of Canada Bay Council Area and at Homebush in the Strathfield Municipal Council Area

Roads and Maritime Services by its delegate declares, with the approval of His Excellency the Governor, that the land described in the schedule below is acquired by compulsory process under the provisions of the *Land Acquisition (Just Terms Compensation) Act 1991* for the purposes of the *Roads Act 1993*.

K DURIE
Manager, Compulsory Acquisition & Road Dedication
Roads and Maritime Services

Schedule

All those pieces or parcels of land situated in the City of Canada Bay Council area, Parish of Concord and County of Cumberland, shown as:

Lot 1 Deposited Plan 115469, being the whole of the land in Certificate of Title 1/115469 and said to be in the possession of Kim Sun; and

Lot 2 Deposited Plan 115469, being the whole of the land in Certificate of Title 2/115469 and said to be in the possession of George Akkary and Sonia Akkary (registered proprietors), National Australia Bank Limited (mortgagee), NSW Land and Housing Corporation (lessee) and tenants.

And also all that piece or parcel of land situated in the Strathfield Municipal Council area, Parish of Concord and County of Cumberland, shown as:

Lot 6 Deposited Plan 15561, being the whole of the land in Certificate of Title 6/15561 and said to be in the possession of Peter Mansour.

(RMS Papers: SF2015/89062)

Primary Industries Notices

ANIMAL RESEARCH ACT 1985

Appointment of Inspector under Section 49

I, Simon A Y Smith, Secretary, NSW Department of Industry, Skills and Regional Development, pursuant to section 49 (1) of the *Animal Research Act 1985* ("the Act"), hereby appoint as an inspector for the purposes of the Act the person named in the Schedule below.

Dated this 30th day of October 2015.

SIMON A Y SMITH
Secretary
Department of Industry, Skills and Regional Development

Schedule

Catherine SAVAGE

FISHERIES MANAGEMENT ACT 1994

FISHERIES MANAGEMENT (AQUACULTURE) REGULATION 2012

Section 177 (1) – Notice of Aquaculture Lease Cancellation

OL77/184 within the estuary of Port Stephens, having an area of 2.1716 hectares, formerly leased by John Gordon COLLIE.

OL86/186 within the estuary of Port Stephens, having an area of 0.4751 hectares, formerly leased by John Gordon COLLIE.

OL94/009 within the estuary of Port Stephens, having an area of 7.1317 hectares, formerly leased by John Gordon COLLIE.

TIM GIPPEL
A/Manager Aquaculture
Fisheries Division
Department of Primary Industries

FISHERIES MANAGEMENT ACT 1994

FISHERIES MANAGEMENT (AQUACULTURE) REGULATION 2012

Clause 31 (3) – Notice of Granting of Class 1 Aquaculture Lease

The Minister has granted the following Class 1 Aquaculture Lease:

OL64/030 within the estuary of the Hawkesbury River, having an area of 0.3224 hectares to Adam MILLWARD of Brooklyn, NSW, for a term of 15 years expiring on 3 September 2030.

AL14/020 within the estuary of the Hastings River, having an area of 0.8450 hectares to Rodnie John AUSTIN & Kerry Lorraine AUSTIN of Lake Innes, NSW, for a term of 15 years expiring on 3 September 2030.

TIM GIPPEL
A/Manager Aquaculture
Fisheries Division
NSW Department of Primary Industries

FISHERIES MANAGEMENT ACT 1994

FISHERIES MANAGEMENT (AQUACULTURE) REGULATION 2012

Clause 33 (4) – Notice of Aquaculture Lease Renewal

The Minister has renewed the following class 1 Aquaculture Leases:

AL08/007 within the estuary of Wallis Lake, having an area of 1.0262 hectares to M S VERDICH & SONS PTY LTD of Forster, NSW, for a term of 15 years expiring on 31 May 2030.

OL99/025 within the estuary of Wallis Lake, having an area of 1.0462 hectares to M S VERDICH & SONS PTY LTD of Forster, NSW, for a term of 15 years expiring on 14 June 2030.

OL70/435 within the estuary of the Manning River, having an area of 0.8648 hectares to M S VERDICH & SONS PTY LTD of Forster, NSW, for a term of 15 years expiring on 19 July 2030.

OL70/116 within the estuary of the Manning River, having an area of 0.4072 hectares to M S VERDICH & SONS PTY LTD of Forster, NSW, for a term of 15 years expiring on 1 September 2030.

OL85/030 within the estuary of the Manning River, having an area of 0.0723 hectares to M S VERDICH & SONS PTY LTD of Forster, NSW, for a term of 15 years expiring on 11 September 2030.

OL96/047 within the estuary of Port Stephens, having an area of 0.6634 hectares to Graham Edward DESSENT & Lynette DESSENT of Soldiers Point, NSW, for a term of 15 years expiring on 6 August 2030.

OL66/308 within the estuary of Wallis Lake, having an area of 0.2289 hectares to POLSON OYSTERS PTY LTD of Old Bar, NSW, for a term of 15 years expiring on 15 April 2029.

OL83/192 within the estuary of the Manning River, having an area of 1.3893 hectares to POLSON OYSTERS PTY LTD of Old Bar, NSW, for a term of 15 years expiring on 17 February 2029.

OL69/463 within the estuary of Wagonga Inlet, having an area of 0.9209 hectares to Charles HAGENBACH of Narooma, NSW, for a term of 15 years expiring on 26 May 2030.

OL70/209 within the estuary of Wagonga Inlet, having an area of 0.4680 hectares to Charles HAGENBACH of Narooma, NSW, for a term of 15 years expiring on 24 March 2030.

OL88/104 within the estuary of Port Stephens, having an area of 1.3200 hectares to H R BROWNE & SONS PTY LTD of Salt Ash, NSW, for a term of 15 years expiring on 22 September 2030.

OL88/105 within the estuary of Port Stephens, having an area of 8.6073 hectares to H R BROWNE & SONS PTY LTD of Salt Ash, NSW, for a term of 15 years expiring on 22 September 2030.

OL85/009 within the estuary of Port Stephens, having an area of 0.3438 hectares to Dean COLE and Stephen COLE of Karuah, NSW, for a term of 15 years expiring on 9 September 2030.

OL70/336 within the estuary of Port Stephens, having an area of 1.1401 hectares to Kenneth Brian LILLEY of Swan Bay, NSW, for a term of 15 years expiring on 29 April 2030.

TIM GIPPEL
A/Manager Aquaculture
Fisheries Division
NSW Department of Primary Industries

Crown Lands Notices

1300 886 235 www.crownland.nsw.gov.au

ARMIDALE OFFICE

REVOCATION OF RESERVATION OF CROWN LAND

Pursuant to section 90 of the *Crown Lands Act 1989*, the reservation of Crown land specified in Column 1 of the Schedule hereunder is revoked to the extent specified opposite thereto in Column 2 of the Schedule.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2
Land District: Armidale Local Government Area: Armidale Dumaresq Council Locality: Armidale, Sandon (Parish, County) Reserve No 755808 Public Purpose: Future Public Requirements Notified: 29 June 2007	The part being Lot 1 DP No 728596 Parish Armidale County Sandon of an area of 1.007ha

DUBBO OFFICE

ADDITION TO RESERVED CROWN LAND

Pursuant to section 88 of the *Crown Lands Act 1989*, the Crown land specified in Column 1 of the Schedule hereunder is added to the reserved land specified opposite thereto in Column 2 of the Schedule.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2
Land District: Dubbo Local Government Area: Warren Shire Council Locality: Collie, Ewenmar (Parish, County) Lot 3 DP No 1196057 Parish Collie County Ewenmar Area: 2.226ha File Reference: 09/15461	Reserve No. 752570 Public Purpose: Future Public Requirements Notified: 29 June 2007 New Area: 10.82ha

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APPOINTMENT OF TRUST BOARD MEMBERS

Pursuant to section 93 of the *Crown Lands Act 1989*, the persons whose names are specified in Column 1 of the Schedule hereunder are appointed, for the terms of office specified in that Column, as members of the trust board for the reserve trust specified opposite thereto in Column 2, which has been established and appointed as trustee of the reserve referred to opposite thereto in Column 3 of the Schedule.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2	Column 3
The person for the time being holding the office of Manager, City Presentation, Orange City Council (ex-officio member) The person for the time being holding the office of Chairman, Friends Of Burrendong Arboretum Inc (ex-officio member) The person for the time being holding the office of Representative, Australian Plants Society (ex-officio member) The person for the time being holding the office of Councillor, Wellington Council (ex-officio member) Michael John ANLEZARK (new member) Helen Margaret SWAN (new member) Harold Robert HARRIS (re-appointment) Helen Mary O'BRIEN (re-appointment)	Burrendong Arboretum Trust	Reserve No 120082 Public Purpose: Arboretum Notified: 22 June 1990 File Reference: 08/1264

Column 1	Column 2	Column 3
Michael L AUGEE (new member) Anthony O'HALLORAN (re-appointment)		For a term commencing the date of this notice and expiring 12 November 2020.

NOTICE OF PURPOSE OTHER THAN THE DECLARED PURPOSE PURSUANT TO SECTION 34A (2) (b) OF THE CROWN LANDS ACT 1989

Pursuant to section 34A (2) (b) of the *Crown Lands Act 1989*, the Crown reserve(s) specified in Column 2 of the Schedule is to be used or occupied under a relevant interest granted for the purpose(s) specified in Column 1 of the Schedule where such use or occupation is other than the declared purpose of the reserve

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2
Grazing	Reserve No 91697 Public Purpose: Future Public Requirements Notified: 25 January 1980 File Reference: 15/07189

GRAFTON OFFICE

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Urotah; County – Sandon
Land District – Armidale; LGA – Armidale Dumaresq

Road Closed: Lot 1 DP 1212924
File No: AE07H98

Schedule

On closing, the land within Lot 1 DP 1212924 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Dinoga; County – Murchison
Land District – Bingara; LGA – Gwydir

Road Closed: Lot 2 DP 1208938
File No: ME06H22

Schedule

On closing, the land within Lot 2 DP 1208938 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Careunga; County – Stapylton
Land District – Moree; LGA – Moree Plains

Road Closed: Lots 1–2 DP 1211608
File No: ME06H97

Schedule

On closing, the land within Lots 1–2 DP 1211608 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Terranora; County – Rous
Land District – Murwillumbah; LGA – Tweed

Road Closed: Lot 1 DP 1212374
File No: 07/1577

Schedule

On closing, the land within Lot 1 DP 1212374 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Bluff Land; County – Clive
Land District – Tenterfield; LGA – Tenterfield

Road Closed: Lot 2 DP 1204330

File No: AE07H139

Schedule

On closing, the land within Lot 2 DP 1204330 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Bluff Land; County – Clive
Land District – Tenterfield; LGA – Tenterfield

Road Closed: Lot 3 DP 1204330

File No: AE07H139

Schedule

On closing, the land within Lot 3 DP 1204330 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Boyd; County – Gough
Land District – Glen Innes
LGA – Glen Innes Severn Shire

Road Closed: Lot 1 DP 1202821

File No: 07/2453

Schedule

On closing, the land within Lot 1 DP 1202821 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Kentucky; County – Hume
Land District – Corowa; LGA – Corowa

Road Closed: Lot 2 DP 1211574

File No: 15/03741

Schedule

On closing, the land within Lot 2 DP 1211574 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Bligh; County – Fitzroy
Land District – Bellingen; LGA – Bellingen

Road Closed: Lot 1 DP 1204426

File No: GF05H49

Schedule

On closing, the land within Lot 1 DP 1204426 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished.

Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Fairy Mount; County – Rous
Land District – Casino; LGA – Kyogle

Road Closed: Lot 3 DP 1212260

File No: 15/05857

Schedule

On closing, the land within Lot 3 DP 1212260 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parishes – West Coraki, Tatham; County – Richmond
Land District – Casino; LGA – Richmond Valley

Road Closed: Lots 1–2 DP 1212918

File No: 15/05723

Schedule

On closing, the land within Lots 1–2 DP 1212918 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Hume; County – Goulburn
Land District – Albury; LGA – Greater Hume

Road Closed: Lot 2 DP 1210357

File No: 15/00887

Schedule

On closing, the land within Lot 2 DP 1210357 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Brangalgan; County – Bourke
Land District – Wagga Wagga; LGA – Coolamon

Road Closed: Lot 1 DP 1212618

File No: 15/02724

Schedule

On closing, the land within Lot 1 DP 1212618 remains vested in the State of New South Wales as Crown land.

ROADS ACT 1993

ORDER

Correction of Defective Instrument

As per the notification of **Notification of Closing of a Road** which appeared in *Government Gazette* dated 6 November 2015, folio 3559, part of the description is hereby amended. Under heading of "Description" the words "Road Closed: Lot 2, DP 1121180, Lot 1 DP 1211800"; are deleted and replaced with "Road Closed: Lot 2 DP 1211800, Lot 1 DP 1211800". Under heading of "Schedule" the words "On closing, the land within Lot 2, DP 1121180, Lot 1 DP 1211800"; are deleted and replaced with "On closing, the land within Lot 2 DP 1211800, Lot 1 DP 1211800".

Ref: 15/05732

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Batlow; County – Wynyard
Land District – Tumut; LGA – Tumut

Road Closed: Lot 1 DP 1212375

File No: 15/01481

Schedule

On closing, the land within Lot 1 DP 1212375 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Baan Baa; County – Pottinger
Land District – Narrabri; LGA – Narrabri

Road Closed: Lot 1 DP 1212549

File No: 14/01823

Schedule

On closing, the land within Lot 1 DP 1212549 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parishes – Long Point, Merrywinebone
County – Denham
Land District – Moree; LGA – Walgett

Road Closed: Lot 13 DP 1199226

File No: 12/03601

Schedule

On closing, the land within Lot 13 DP 1199226 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Whalan; County – Benarba
Land District – Moree; LGA – Moree Plains

Road Closed: Lot 1 DP 1211720

File No: 15/04815

Schedule

On closing, the land within Lot 1 DP 1211720 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Gurley; County – Courallie
Land District – Moree; LGA – Moree Plains

Road Closed: Lot 1 DP 1212464

File No: 15/03998

Schedule

On closing, the land within Lot 1 DP 1212464 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parishes – Cooloobong, Tyrrell; County – Benarba
Land District – Moree; LGA – Moree Plains

Road Closed: Lots 1–3 DP 1211721

File No: 15/04818

Schedule

On closing, the land within Lots 1–3 DP 1211721 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Tomki; County – Rous
Land District – Casino; LGA – Lismore

Road Closed: Lot 1 DP 1211011

File No: 15/01449

Schedule

On closing, the land within Lot 1 DP 1211011 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – South Bellingen; County – Raleigh
Land District – Bellingen; LGA – Bellingen

Road Closed: Lot 1 DP 1211780

File No: 15/05352

Schedule

On closing, the land within Lot 1 DP 1211780 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Warrazambil; County – Rous
Land District – Casino; LGA – Kyogle

Road Closed: Lot 1 DP 1213650

File No: 15/08125

Schedule

On closing, the land within Lot 1 DP 1213650 remains vested in the State of New South Wales as Crown land.

GRIFFITH OFFICE

ORDER

Authorisation of Additional Purpose under s121A

Pursuant to s121A of the *Crown Lands Act 1989*, I authorise by this Order, the purpose specified in Column 1 to be an additional purpose to the declared purpose of the reserves specified opposite thereto in Column 2 of the Schedule.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2
Community Purposes; Government Purposes	Reserve No 73115 Public Purpose: Baby Clinic Notified: 25 March 1949 File Reference: 10/14219

APPOINTMENT OF TRUST BOARD MEMBERS

Pursuant to section 93 of the *Crown Lands Act 1989*, the persons whose names are specified in Column 1 of the Schedule hereunder are appointed, for the terms of office specified in that Column, as members of the trust board for the reserve trust specified opposite thereto in Column 2, which has been established and appointed as trustee of the reserve referred to opposite thereto in Column 3 of the Schedule.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2	Column 3
Vince CAMPISI (re-appointment) Barry Ian PITT (re-appointment) Timothy James CARROLL (re-appointment) Gary Kevin PUNCH (re-appointment) For a term commencing the date of this notice and expiring 12 November 2020.	Leeton Showground Trustees	Dedication No 559040 Public Purpose: Public Recreation; Showground Notified: 6 July 1934 File Reference: LN87R7-04

HAY OFFICE

APPOINTMENT OF TRUST BOARD MEMBERS

Pursuant to section 93 of the *Crown Lands Act 1989*, the persons whose names are specified in Column 1 of the Schedule hereunder are appointed, for the terms of office specified in that Column, as members of the trust board for the reserve trust specified opposite thereto in Column 2, which has been established and appointed as trustee of the reserve referred to opposite thereto in Column 3 of the Schedule.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2	Column 3
Ruth Elaine EVANS (re-appointment) Marcia NOLAN (new member) Jason Gary BROOKS (new member) Hugh Ross STEWART (re-appointment) Margaret Ellen WATSON (new member) Barry BENNETT (re-appointment) Robert Bruce WATSON (re-appointment) For a term commencing the date of this notice and expiring 12 November 2020.	Lalalty Hall Trust	Reserve No 86704 Public Purpose: Public Hall Notified: 26 April 1968 File Reference: HY81R91

MAITLAND OFFICE

ADDITION TO RESERVED CROWN LAND

Pursuant to section 88 of the *Crown Lands Act 1989*, the Crown land specified in Column 1 of the Schedule hereunder is added to the reserved land specified opposite thereto in Column 2 of the Schedule.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2
Land District: Newcastle Local Government Area: Newcastle City Council Locality: Broadmeadow	Reserve No 170178 Public Purpose:Community Purposes Notified: 25 October 1996
Lot 1 DP No 1151421 Parish Newcastle County Northumberland Area: 320m^2 File Reference: MD82R9	Lot 2692 DP No 755247 Parish Newcastle County Northumberland Lot 3285 DP No 1049501 Parish Newcastle County Northumberland New Area: 6216m^2

ROADS ACT 1993

ORDER

Transfer of a Crown Road to a Council

In pursuance of the provisions of section 151, *Roads Act 1993*, the Crown road specified in Schedule 1 is transferred to the Roads Authority specified in Schedule 2, hereunder, as from the date of publication of this notice and as from that date, the road specified in Schedule 1 ceases to be a Crown road.

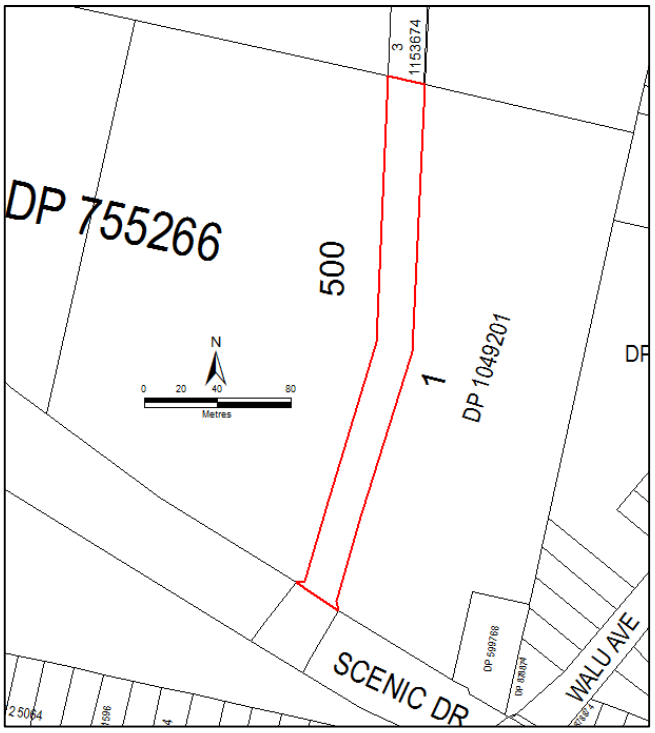
The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule 1

Parish – Wallarah; County – Northumberland
Land District – Gosford; Local Government Area – Wyong

Crown road extending north from Scenic Drive, adjacent to Lot 500 DP 755266 and terminating at Lot 3 DP 1153674 (as highlighted in red in the diagram below).

Schedule 2



Roads Authority: Wyong Shire Council
Council's Reference: F2014/00474
Lands File Reference: 15/09486

ROADS ACT 1993

ORDER

Transfer of a Crown Road to a Council

In pursuance of the provisions of Section 151, *Roads Act 1993*, the Crown road specified in Schedule 1 is transferred to the Roads Authority specified in Schedule 2, hereunder, as from the date of publication of this notice and as from that date, the road specified in Schedule 1 ceases to be a Crown road.

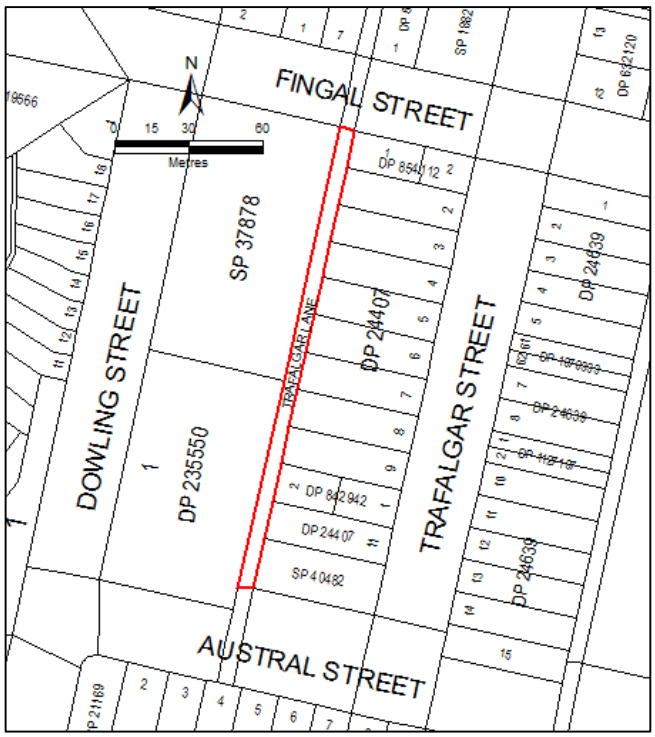
The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule 1

Parish – Tomaree; County – Gloucester
Land District – Newcastle
Local Government Area – Port Stephens

Crown public road extending north from the intersection with Austral street and terminating at the intersection with Fingal street (as highlighted in red in the diagram below).

Schedule 2



Roads Authority: Port Stephens Council

Council's Reference: A2004-0742

Lands File Reference: 15/09452

NEWCASTLE OFFICE

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Thompson; County – Georgiana
Land District – Blayney; LGA – Oberon

Road Closed: Lot 1 DP 1211546

File No: 09/04128

Schedule

On closing, the land within Lot 1 DP 1211546 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parishes – Oxley, Lorimer; Counties – Brisbane, Bligh
Land District – Mudgee, Muswellbrook
LGA – Upper Hunter

Road Closed: Lots 1–4 DP 1186916 (subject to easement for access created by Deposited Plan 1186916)

File No: 08/6594

Schedule

On closing, the land within Lots 1–4 DP 1186916 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Timor; County – Gowen
Land District – Coonabarabran; LGA – Warrumbungle

Road Closed: Lot 1 DP 1167196

File No: 10/09862

Schedule

On closing, the land within Lot 1 DP 1167196 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished.

Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Thugga; County – Hume
Land District – Albury; LGA – Greater Hume

Road Closed: Lot 1 DP 1181464

File No: 11/03078

Schedule

On closing, the land within Lot 1 DP 1181464 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Lewis; County – Macquarie
Land District – Taree; LGA – Greater Taree

Road Closed: Lot 1 DP 1211182

File No: 10/04817

Schedule

On closing, the land within Lot 1 DP 1211182 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Bumble; County – Courallie
Land District – Moree; LGA – Moree Plains

Road Closed: Lot 2 DP 1198381

File No: ME03H128

Schedule

On closing, the land within Lot 2 DP 1198381 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Carrabear; County – Leichhardt
Land District – Coonamble; LGA – Coonamble

Road Closed: Lots 1–3 DP 1213125

File No: 09/02117 CM

Schedule

On closing, the land within Lots 1–3 DP 1213125 remains vested in the State of New South Wales as Crown land.

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – St Luke; County – Cumberland
Land District – Metropolitan; LGA – Liverpool

Road Closed: Lot 82 DP 790072

File No: 15/06171

Schedule

On closing, the land within Lot 82 DP 790072 remains vested in Liverpool City Council as operational land for the purposes of the *Local Government Act 1993*.

Council Reference: 2015/0645

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Nubrigyn; County – Wellington
Land District – Wellington; LGA – Wellington

Road Closed: Lot 1 DP 1181792

File No: 09/19064 RS

Schedule

On closing, the land within Lot 1 DP 1181792 remains vested in the State of New South Wales as Crown land.

NOWRA OFFICE

NOTIFICATION OF CLOSING OF A ROAD

In pursuance of the provisions of the *Roads Act 1993*, the road hereunder described is closed and the lands comprised therein cease to be public road and the rights of passage and access that previously existed in relation to the road is extinguished. Upon closing, title to the land, comprising the former public road, vests in the body specified in the Schedule hereunder.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Description

Parish – Kember; County – King
Land District – Boorowa; LGA – Boorowa

Road Closed: Lot 1 DP 1180253

File No: 11/07376

Schedule

On closing, the land within Lot 1 DP 1180253 remains vested in the State of New South Wales as Crown land.

NOTICE OF PURPOSE OTHER THAN THE DECLARED PURPOSE PURSUANT TO SECTION 34A (2) (b) OF THE CROWN LANDS ACT 1989

Pursuant to section 34A (2) (b) of the *Crown Lands Act 1989*, the Crown reserve(s) specified in Column 2 of the Schedule is to be used or occupied under a relevant interest granted for the purpose(s) specified in Column 1 of the Schedule where such use or occupation is other than the declared purpose of the reserve

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2
Site Investigation	Reserve No 1012388 Public Purpose: Regional Requirements Notified: 15 September 2006 File Reference: 12/04080 Reserve No 56146 Public Purpose: Generally Notified: 11 May 1923 File Reference: 12/04080 Reserve No 1011268 Public Purpose: Future Public Requirements Notified: 3 February 2006 File Reference: 12/04080

ORANGE OFFICE

NOTICE OF PURPOSE OTHER THAN THE DECLARED PURPOSE PURSUANT TO SECTION 34A (2) (b) OF THE CROWN LANDS ACT 1989

Pursuant to section 34A (2) (b) of the *Crown Lands Act 1989*, the Crown reserve(s) specified in Column 2 of the Schedule is to be used or occupied under a relevant interest granted for the purpose(s) specified in Column 1 of the Schedule where such use or occupation is other than the declared purpose of the reserve

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2
Monitoring Gauges	Reserve No 3291 Public Purpose: Camping Notified: 16 April 1887 File Reference: 15/06325

Schedule

Column 1	Column 2
Grazing	Reserve No 96971 Public Purpose: Access Notified: 30 September 1983 File Reference: 15/04049

SYDNEY METROPOLITAN OFFICE

ASSIGNMENT OF NAME TO A RESERVE TRUST

Pursuant to clause 4 (3) of Schedule 8 of the *Crown Lands Act 1989*, the name specified in Column 1 of the Schedule hereunder is assigned to the reserve trust constituted as trustee of the reserve specified opposite thereto in Column 2 of the Schedule.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2
Helensburgh West (D1000263) Reserve Trust	Dedication No 1000263 Public Purpose: Baby Clinic Notified: 11 January 1946 File Reference: 15/08524

TAMWORTH OFFICE

REVOCATION OF RESERVATION OF CROWN LAND

Pursuant to section 90 of the *Crown Lands Act 1989*, the reservation of Crown land specified in Column 1 of the Schedule hereunder is revoked to the extent specified opposite thereto in Column 2 of the Schedule.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2
Land District: Gunnedah Local Government Area: Gunnedah Shire Council Locality: Gunnedah Reserve No 755503 Public Purpose: Future Public Requirements Notified: 29 June 2007 File Reference: TH00H154	The part being Lot 2 DP No 1212392 Parish Gunnedah County Pottinger

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NOTICE OF PURPOSE OTHER THAN THE DECLARED PURPOSE PURSUANT TO SECTION 34A (2) (b) OF THE CROWN LANDS ACT 1989

Pursuant to section 34A (2) (b) of the *Crown Lands Act 1989*, the Crown reserve(s) specified in Column 2 of the Schedule is to be used or occupied under a relevant interest granted for the purpose(s) specified in Column 1 of the Schedule where such use or occupation is other than the declared purpose of the reserve.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2
Encroachments	Reserve No 82555 Public Purpose: Public Recreation Notified: 13 May 1960 File Reference: 15/05585

Schedule

Column 1	Column 2
Pontoon; Walkway	Reserve No 56146 Public Purpose: Generally Notified: 11 May 1923 File Reference: 14/05386 Reserve No 1011268 Public Purpose: Future Public Requirements Notified: 3 February 2006 File Reference: 14/05386

WESTERN REGION OFFICE

ADDITION TO RESERVED CROWN LAND

Pursuant to section 88 of the *Crown Lands Act 1989*, the Crown land specified in Column 1 of the Schedule hereunder is added to the reserved land specified opposite thereto in Column 2 of the Schedule.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2
Land District: Walgett North Local Government Area: Walgett Shire Council Locality: Lightning Ridge Lot 33 DP No 1063047 Parish Wallangulla County Finch Area: 2594m^2 File Reference: 09/18582-02	Reserve No 1024168 Public Purpose: Opal Mining and Exploration and Public Access Notified: 4 December 2009 Lot 128 DP No 1118679 Parish Wallangulla County Finch Lot 1952 DP No 763834 Parish Kigwigil County Finch Lot 3 DP No 1158025 Parish Wallangulla County Finch Lot 4 DP No 1163616 Parish Wallangulla County Finch Lot 1 DP No 1167811 Parish Wallangulla County Finch Lot 433 DP No 1076808 Parish Wallangulla County Finch Lot 2 DP No 1164755 Parish Wallangulla County Finch Lot 8001 DP No 1169647 Parish Wallangulla County Finch Lot 2 DP No 1153975 Parish Wallangulla County Finch Lot 226 DP No 1076808 Parish Wallangulla County Finch Lot 511 DP No 1201786 Parish Wallangulla County Finch Lot 74 DP No 1120765 Parish Wallangulla County Finch Lot 1 DP No 1145840 Parish Blackwood County Finch Lot 1000 DP No 1117849 Parish Wallangulla County Finch Lot 1003 DP No 1117849 Parish Wallangulla County Finch Lot 2 DP No 1194722 Parish Mebea County Finch Lot 182 DP No 1076808 Parish Wallangulla County Finch

Column 1	Column 2
	Lot 312 DP No 1076808 Parish Wallangulla County Finch Lot 394 DP No 1076808 Parish Wallangulla County Finch Lot 81 DP No 1057617 Parish Wallangulla County Finch New Area: 5170ha

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APPOINTMENT OF TRUST BOARD MEMBERS

Pursuant to section 93 of the *Crown Lands Act 1989*, the persons whose names are specified in Column 1 of the Schedule hereunder are appointed, for the terms of office specified in that Column, as members of the trust board for the reserve trust specified opposite thereto in Column 2, which has been established and appointed as trustee of the reserve referred to opposite thereto in Column 3 of the Schedule.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2	Column 3
The person for the time being holding the office of Area Manager, National Parks & Wildlife Services (ex-officio member) Sally Jean TORR (new member) The person for the time being holding the office of Manager Of Environmental Services, Bourke Shire Council (ex-officio member) Jennifer Leigh BLOOMER (new member) The person for the time being holding the office of Founder, Gunni Thakun Cultural Association Inc. (ex-officio member) Cecily Joan HAMPTON (new member)	Byrock Rock Holes Reserve Trust	Reserve No 1004509 Public Purpose: Public Recreation Notified: 11 April 2003 File Reference: WL05R10

Column 1	Column 2	Column 3
Colm James DEMPSEY (new member) For a term commencing the date of this notice and expiring 12 November 2020.		

NOTICE OF PURPOSE OTHER THAN THE DECLARED PURPOSE PURSUANT TO SECTION 34A (2) (b) OF THE CROWN LANDS ACT 1989

Pursuant to section 34A (2) (b) of the *Crown Lands Act 1989*, the Crown reserve(s) specified in Column 2 of the Schedule is to be used or occupied under a relevant interest granted for the purpose(s) specified in Column 1 of the Schedule where such use or occupation is other than the declared purpose of the reserve.

The Hon NIALL BLAIR, MLC
Minister for Lands and Water

Schedule

Column 1	Column 2
Power/Transmission Line	Reserve No 2378 Public Purpose: Travelling Stock Notified: 25 September 1886 File Reference: 10/16858

Schedule

Column 1	Column 2
Site Investigation	Reserve No 61777 Public Purpose: Public Pound Notified: 28 March 1930 File Reference: 15/08539 Reserve No 71505 Public Purpose: Travelling Stock; Camping Notified: 18 May 1945 File Reference: 15/08539 Reserve No 84334 Public Purpose: Generally Notified: 22 March 1963 File Reference: 15/08539 Reserve No 4 Public Purpose: Common Notified: 16 January 1886 File Reference: 15/08539 Reserve No 1548 Public Purpose: Water Supply; Camping Notified: 24 February 1879 File Reference: 15/08539

Column 1	Column 2
	Reserve No 56146 Public Purpose: Generally Notified: 11 May 1923 File Reference: 15/08539
	Reserve No 1011268 Public Purpose: Future Public Requirements Notified: 3 February 2006 File Reference: 15/08539
	Reserve No 11545 Public Purpose: Access Notified: 31 May 1890 File Reference: 15/08539
	Reserve No 57069 Public Purpose: Public Sheep Dip Notified: 16 May 1924 File Reference: 15/08539
	Reserve No 57071 Public Purpose: Travelling Stock; Camping Notified: 16 May 1924 File Reference: 15/08539
	Reserve No 63557 Public Purpose: Access Notified: 14 October 1932 File Reference: 15/08539
	Reserve No 88353 Public Purpose: Public Recreation Notified: 10 September 1971 File Reference: 15/08539

Water Notices

WATER ACT 1912

An application under Part 5 of the *Water Act 1912* for a bore licence has been received as follows:

SCARRABELOTTI HOLDINGS PTY LTD for an existing bore on Lot 1 DP 837015 for water supply for commercial purposes and irrigation of 50ha on Lot 1 DP 837015, Lot 257 DP 755742 and Lot 10 DP 1065523.

Any inquiries should be directed to (02) 6676 7881. Written objections, from any local occupier or statutory authority, specifying grounds and how their interests are affected, must be lodged with DPI Water, PO Box 796, Murwillumbah NSW 2484 within 28 days of this publication.

MELISSA HUNDY
Water Regulation Officer
Department of Primary Industries (DPI) Water

WATER ACT 1912

An application for a controlled work approval under Part 8 of the *Water Act 1912* has been received as follows:

BORAL RESOURCES (COUNTRY) PTY. LIMITED for a new levee bank on Lot 10 DP 754303 and Lot 12 DP 731005 Parish of Coolbaggie County of Lincoln for prevention of inundation of land by flood waters (REF: 80CW809684).

Any inquiries should be directed to (02) 6841 7469. Written objections from any local occupier or statutory authority, specifying grounds and how their interests are affected, must be lodged with DPI Water, PO Box 717, DUBBO NSW 2830, within 28 days of this publication.

ALICE CLIFTON
Water Regulation Officer
Department of Primary Industries (DPI) Water

WATER MANAGEMENT ACT 2000

Order under Section 130 (2)

Inclusion of Land in Coleambally Irrigation Corporation Limited's Area of Operations

Pursuant to section 130 (2) of the Water Management Act, I, Andrew Windever, having delegated authority from the Minister for Primary Industries, do, by this Order, include the land listed in Schedule 1 within the area of operations of Coleambally Irrigation Corporation Limited.

This Order takes effect on the date that the Order is published in the *NSW Government Gazette*.

Signed at Parramatta this 10th day of November 2015.

ANDREW WINDEVER
Deputy Commissioner Water Regulation
Department of Primary Industries Water
Signed for the Minister for Primary Industries
(by delegation)

Schedule 1

Lot 1 DP 1084881, Parish of Howell, County of Boyd.
Lot 2 DP 1084881, Parish of Howell, County of Boyd.
Lot 3 DP 1084881, Parish of Howell, County of Boyd.
Lot 4 DP 1084881, Parish of Howell, County of Boyd.
Lot 1 DP 1094666, Parish of Howell, County of Boyd.
Lot 2 DP 1094666, Parish of Howell, County of Boyd.
Lot 3 DP 1094666, Parish of Howell, County of Boyd.
Lot 4 DP 1094666, Parish of Howell, County of Boyd.
Lot 6 DP 1185251, Parish of Banandra, County of Boyd.
Lot 1 DP 33222, Parish of Howell, County of Boyd.
Lot 2 DP 33222, Parish of Howell, County of Boyd.
Lot 5 DP 33222, Parish of Howell, County of Boyd.
Lot 11 DP 33222, Parish of Howell, County of Boyd.
Lot 12 DP 33222, Parish of Howell, County of Boyd.
Lot 1 DP 506424, Parish of Howell, County of Boyd.
Lot 104 DP 750885, Parish of Gidgell, County of Boyd.
Lot 106 DP 750885, Parish of Gidgell, County of Boyd.
Lot 107 DP 750885, Parish of Gidgell, County of Boyd.
Lot 108 DP 750885, Parish of Gidgell, County of Boyd.
Lot 109 DP 750885, Parish of Gidgell, County of Boyd.
Lot 22 DP 750885, Parish of Gidgell, County of Boyd.
Lot 25 DP 750885, Parish of Gidgell, County of Boyd.
Lot 1 DP 750889, Parish of Howell, County of Boyd.
Lot 2 DP 750889, Parish of Howell, County of Boyd.
Lot 3 DP 750889, Parish of Howell, County of Boyd.
Lot 4 DP 750889, Parish of Howell, County of Boyd.
Lot 5 DP 750889, Parish of Howell, County of Boyd.
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Lot 10 DP 750889, Parish of Howell, County of Boyd.
Lot 100 DP 750889, Parish of Howell, County of Boyd.
Lot 101 DP 750889, Parish of Howell, County of Boyd.
Lot 102 DP 750889, Parish of Howell, County of Boyd.
Lot 103 DP 750889, Parish of Howell, County of Boyd.
Lot 104 DP 750889, Parish of Howell, County of Boyd.
Lot 105 DP 750889, Parish of Howell, County of Boyd.
Lot 106 DP 750889, Parish of Howell, County of Boyd.
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Lot 116 DP 750889, Parish of Howell, County of Boyd.
Lot 117 DP 750889, Parish of Howell, County of Boyd.
Lot 118 DP 750889, Parish of Howell, County of Boyd.
Lot 12 DP 750889, Parish of Howell, County of Boyd.
Lot 121 DP 750889, Parish of Howell, County of Boyd.

Lot 123 DP 750889, Parish of Howell, County of Boyd.
Lot 13 DP 750889, Parish of Howell, County of Boyd.
Lot 14 DP 750889, Parish of Howell, County of Boyd.
Lot 15 DP 750889, Parish of Howell, County of Boyd.
Lot 153 DP 750889, Parish of Howell, County of Boyd.
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Lot 169 DP 750889, Parish of Howell, County of Boyd.
Lot 170 DP 750889, Parish of Howell, County of Boyd.
Lot 171 DP 750889, Parish of Howell, County of Boyd.
Lot 172 DP 750889, Parish of Howell, County of Boyd.
Lot 173 DP 750889, Parish of Howell, County of Boyd.
Lot 174 DP 750889, Parish of Howell, County of Boyd.
Lot 175 DP 750889, Parish of Howell, County of Boyd.
Lot 182 DP 750889, Parish of Howell, County of Boyd.
Lot 77 DP 750889, Parish of Howell, County of Boyd.
Lot 90 DP 750889, Parish of Howell, County of Boyd.
Lot 91 DP 750889, Parish of Howell, County of Boyd.
Lot 92 DP 750889, Parish of Howell, County of Boyd.
Lot 93 DP 750889, Parish of Howell, County of Boyd.
Lot 94 DP 750889, Parish of Howell, County of Boyd.
Lot 95 DP 750889, Parish of Howell, County of Boyd.
Lot 96 DP 750889, Parish of Howell, County of Boyd.
Lot 97 DP 750889, Parish of Howell, County of Boyd.
Lot 98 DP 750889, Parish of Howell, County of Boyd.
Lot 99 DP 750889, Parish of Howell, County of Boyd.
Lot 100 DP 754546, Parish of Corobimilla, County of Mitchell.
Lot 101 DP 754546, Parish of Corobimilla, County of Mitchell.
Lot 201 DP 754546, Parish of Corobimilla, County of Mitchell.

Other Government Notices

ASSOCIATIONS INCORPORATION ACT 2009

Cancellation of Registration Pursuant to Section 76

Take notice that the registration of the following associations is cancelled by this notice pursuant to section 76 of the *Associations Incorporation Act 2009*.

ASSOCIATION OF RUSSIAN SPEAKING AUTHORS OF AUSTRALIA AND NEW ZEALAND INCORPORATED	INC9893218
BARRINGTON LANDCARE INCORPORATED	Y2118639
BRIBBAREE & DISTRICT FISHING CLUB INCORPORATED	INC9877764
EARTHWISE ENVIRONMENTAL EDUCATION INCORPORATED	INC9878255
E-SAN THAI ASSOCIATION OF AUSTRALIA INCORPORATED	INC9888575
FRIENDS OF WARRINGAH INC	INC9877744
GRAFTON AND DISTRICT HEREFORD AND POLL HEREFORD PROMOTION GROUP INCORPORATED	INC9878341
GREEN LEAF INCORPORATED	INC9889761
GRETA LANDCARE INCORPORATED	Y2448906
HELLENIC TRIBUTE INCORPORATED	Y2945841
INTERNATIONAL SHORT FILM CONFERENCE INCORPORATED	INC9881369
MARULAN HERITAGE FAIR INCORPORATED	Y2582903
MONUMENT HILL PARKLANDS INCORPORATED	Y2210805
MOREE AGRICULTURAL TRADERS EXHIBITION INC	Y1209347
PARKVILLE SOCIAL CLUB INCORPORATED	Y1679103
QANTAS SQUASH CLUB INCORPORATED	INC9878442
RIVERINA ENDURANCE RIDERS ZONE INCORPORATED	INC9880147
ROYALLA-WILLIAMSDALE LANDCARE GROUP INCORPORATED	Y2723130
SCARBOROUGH WOMBARRA COLEDALE LANDCARE GROUP INCORPORATED	Y2040019
SYDNEY CYPRUS TURKISH ISLAMIC CULTURE & MOSQUE ASSOCIATION INC	INC9879973

Cancellation is effective as at the date of gazettal.

Dated this 13th day of November 2015

CHRISTINE GOWLAND
Delegate of the Commissioner
NSW Fair Trading

ASSOCIATIONS INCORPORATION ACT 2009

ERRATUM

Cancellation of Association Pursuant to Section 76

The notice that appeared in the *New South Wales Government Gazette* No 72 of 28 August 2015, folio 2730, cancelling the CITADEL WORLD MISSIONS INCORPORATED, INC9891995 was published in error.

The above association remains an Incorporated Association under the *Associations Incorporation Act 2009*.

This notice corrects that error.

Dated this 11th day of November 2015

CHRISTINE GOWLAND
Delegate of the Commissioner
NSW Fair Trading

ASSOCIATIONS INCORPORATION ACT 2009

Cancellation of Registration Pursuant to Section 80

Take notice that SOUTHERN YOUTH AND FAMILY SERVICES ASSOCIATION INCORPORATED (Y0210425) became registered under the *Corporations Act 2001* as SOUTHERN YOUTH AND FAMILY SERVICES LIMITED – ACN 606 896 217 a public company limited by guarantee on the third day of August 2015 and accordingly its registration under the *Associations Incorporation Act 2009* is cancelled as of that date.

Date: 9 November 2015

ROBYNE LUNNEY
Delegate of the Commissioner
NSW Fair Trading

CHARITABLE TRUSTS ACT 1993

Section 12

ORDER

Administrative Scheme Relating to the Thelma Afford Theatre, Stage, TV or Film Costume Design Award

In accordance with section 12 of the *Charitable Trusts Act 1993*, the Attorney General may, by order, establish a scheme for the administration of any charitable trust. This may be done on the application of any or all of the trustees where the value of the funds is less than $500,000 and is relatively uncomplicated (section 14 (1) (a) and (b)).

Ms Thelma Afford was a former actress who also designed stage costumes. By her will dated 29 July 1994, Ms Afford bequeathed the residue of her estate for the establishment of two Awards. Clause 10 (a) bequeathed 70% of the residue to establish the Max Afford Playwrights Award for the writing of three act plays for theatre or television. Clause 10 (b) bequeathed 30% of the residue to establish an Award 'to be known as the Thelma Afford Theatre, Stage, TV or Film Costume Designs Award'. The trustee was directed in clause 10 (c) to invest the capital from the residue and apply the net income therefrom to the two awards. The current value of the trust fund is approximately $400,000.00.

Since the Award was instituted in 2004, there have been very few applicants, of whom only two have been considered to be of a quality worth the Award.

The trustee proposed an administrative scheme that would alter the application process for the Award, which currently requires applicants to submit six original theatre, film, TV or stage costume designs that should be no smaller than fourteen inches high. The proposed scheme would require applications for the Award to include six original theatre, film, or TV costume designs suitable for the visual dramatisation of any existing play, opera, ballet, musical, pageant or other visual dramatic work that the application shall specify by name.

The terms of the administrative scheme are that the costume design must (a) have been created no earlier than 2 years prior to the closing date for entries; (b) may be drafted/ illustrated by hand or created/illustrated digitally or a mixture of the two; (c) may be submitted electronically in a suitable file format to be specified by the trustee when calling for applications; or (d) may be submitted in hard copy in a suitable size.

The trustee contends that the changes will make the selection process more efficient and reflective of modern times, and that the changes will attract a greater number of applications of a quality worthy of the Award.

As delegate of the Attorney General in *Charitable Trusts Act 1993* matters, I have determined that this is an appropriate matter in which the Attorney General should approve an administrative scheme under section 12 (1) (a) of the *Charitable Trusts Act 1993*.

Under section 12 (1) (a) of the *Charitable Trusts Act 1993* I hereby order an administrative scheme that will enable the designs (created no earlier than 2 years prior to the closing date for entries) submitted for the Thelma Afford Theatre, Stage, TV or Film Costume Design Award to be created/ illustrated digitally, and or/by hand, and allow for them to be submitted electronically or in hard copy.

This Order will take effect 21 days after its publication in the *New South Wales Government Gazette*, in accordance with section 16 (2) of the *Charitable Trusts Act 1993*.

Date of Order: 11 November 2015

Signed:
M G SEXTON, SC
Solicitor General (under delegation from the Attorney General)

CHILDREN'S COURT ACT 1987

The Children's Court of New South Wales

Practice Note No 3

Alternative Dispute Resolution Procedures in the Children's Court

First issued 7 February 2011
Last Amended 11 November 2015

1. Commencement

1.1 This amended Practice Note commences on 13 November 2015.

2. Preamble

2.1 Section 65 of the *Children and Young Persons (Care and Protection) Act 1998* (the Care Act) provides for a Children's Registrar to arrange and conduct a dispute resolution conference (a DRC) between the parties.

2.2 Section 65A of the Care Act empowers the Children's Court to make an order that the parties to a care application participate in an alternative dispute resolution process (external ADR) in relation to the proceedings before the Court or any aspect of those proceedings.

Dispute Resolution Conferences conducted under s65

3. Purposes and aims of a DRC

3.1 The purpose of a DRC is to provide a secure and confidential environment that promotes frank and open discussion between the parties to a care application in a structured forum and to encourage them to agree on action that should be taken in the best interests of the child or young person concerned.

3.2 A DRC is intended to facilitate the early resolution of care applications through an informal and non-adversarial process designed to include the parties and others who may make a contribution to the resolution of the issues.

3.3 A DRC should aim to:

- identify the risks and safety concerns that have led to the intervention or involvement of Community Services;
- identify and clarify the strengths within the family, including any progress made by family members in addressing those concerns;
- hear from the children's legal representative/s of any views expressed by the child(ren);
- focus the parties' attention on the child's best interests;
- identify and clarify the issues in dispute;
- identify and clarify areas of agreement;
- develop options for ensuring the safety and welfare of the child or young person and consider alternatives to the outcome sought in the Care Application;
- enhance communication between the parties;
- reach agreement between the parties to avoid, or limit the scope of any hearing;
- formulate final or interim orders that may be made by consent.

4. Attendees

4.1 A DRC is to be attended in person by:

- the parties to the proceedings and, if represented, their legal representatives, including any child representative appointed by the Court;
- a guardian ad litem, if appointed by the Court;
- the relevant caseworker/s delegated by the Secretary;
- the legal representative for the Secretary;

4.2 A DRC may, upon request and at the discretion of the Children's Registrar, be attended by:

- a support person;
- a member of a relevant kinship group;
- an interpreter and/or a non-legal advocate where a party requires such assistance to communicate effectively;
- a person who is, is proposed to be or wishes to be considered as a carer for a child or young person;
- any non-party upon whom an order might have a significant impact;
- in appropriate cases and if available, the authorised clinician of the Children's Court Clinic where the clinician has carried out an assessment prior to the DRC;
- an expert witness, other than an authorised clinician, where the expert witness has carried out an assessment prior to the DRC;
- a representative of a non-government organisation (NGO) authorised by the Secretary to case manage the placement of the child/ young person;
- any other person with the consent of all parties

4.3 If a party or their legal representative wishes a person specified in 4.2 to attend the DRC the party must give reasonable notice to the Children's Registrar and to the other parties.

4.4 Paragraphs 4.1,4.2 and 4.3 apply subject to paragraphs 6.2 and 6.3 of Practice Note 10 (Parent Capacity Orders) in so far as it relates to the attendance of persons at a DRC conducted under s 91D of the Care Act.

5. Personal Attendance

5.1 With the exception of an authorised clinician or other expert witness, attendance is to be in person. Attendance by telephone or audiovisual link can only occur in exceptional circumstances at the discretion of the Children's Registrar.

5.2 A party or legal representative seeking to appear by telephone must give the Registrar reasonable notice.

6. Attendance of child/young person at the DRC

6.1 Personal attendance of a child or young person is not required. However, the child or young person may attend, if the child or young person so wishes, with advance notice to the Children's Registrar and the parties, so that any concerns about the appropriateness of the child or young person's attendance can be addressed.

7. Responsibilities of all attendees at a DRC

7.1 All persons attending a DRC are required to:

- actively participate to promote the aims of the DRC as set out at 3.1 to 3.3;
- act in good faith and to be open and frank in all aspects of their participation in the DRC;
- conduct themselves in a courteous and considerate manner and
- act in a non-adversarial manner.

8. Responsibilities of all legal representatives at a DRC

8.1 All legal representatives at a DRC are required to:

- meet with their client and obtain updated instructions **before** the DRC;
- comply with all filing directions **before** the DRC;
- read and be familiar with all of the material filed in proceedings and any relevant subpoenaed material;
- actively participate and encourage their client to actively participate in discussion and decision making during the DRC;
- fully instruct any agent including providing them with authority to settle the matter;
- ensure arrangements have been made for the Authorised Clinician to attend (if applicable see PN 5);

9. Responsibilities of parties at a DRC

9.1 All parties at a DRC are required to:

- meet with their legal representative and confirm or update their instructions **before** the DRC;
- comply with any filing instructions **before** the DRC;
- read and be familiar with all material filed in the proceedings including any relevant subpoenaed material;
- actively participate in the DRC as best they can;
- state their point of view as best they can;
- listen to and discuss the views of others;
- genuinely consider all options for resolving the care and protection concerns including the arrangements that are in the best interests of the child.

10. Role of support persons

10.1 A member of the extended family or kinship group may act as a support to the child or family. In appropriate situations they may also provide a constructive and impartial contribution to the resolution of the care and protection concerns relating to the child or young person. A member of the extended family or kinship group is not to act as an advocate for one party against another.

10.2 Support persons, other than a member of the extended family or kinship group, will not take an active role in the DRC.

11. Timing of DRC

11.1 A DRC should as far as practicable be held as early as possible in the proceedings in order to facilitate the early resolution of a care application.

11.2 Once a care application has been filed in the Children's Court, the Magistrate or Children's Registrar responsible for the management of the case will, in consultation with the parties, determine if and when a DRC should take place.

11.3 If appropriate, more than one DRC may be held at different stages of the proceedings.

12. Listing of DRCs and hearing dates

12.1 In the usual course DRCs will be listed by the Magistrate or Children's Registrar during a mention of a matter in Court in accordance with the arrangements established by the Magistrate for that location and the Senior Children's Registrar. In locations where this is not practicable, arrangements will be made by the Senior Children's Registrar to allocate a conference date as soon as practicable.

12.2 Hearing dates will ordinarily only be allocated after the DRC has failed to settle the matter.

13. Duration and location of DRC

13.1 A DRC can be expected to run for two to three hours and should take place in courthouse accommodation.

14. Pre-DRC preparation

14.1 Prior to a DRC, a Children's Registrar will make contact with the parties or their legal representatives to establish who will be in attendance, to consider any issues that may affect the manner in which the conference is conducted and to resolve issues and answer any questions relating to the conference process.

15. DRC process

15.1 DRCs are to be conducted by using a conciliation model of alternative dispute resolution (ADR). As a conciliator the Children's Registrar has an advisory role, but not a determinative one.

15.2 The Children's Registrar is responsible for managing the dispute resolution process, including setting the ground rules, managing any apparent power imbalances between the participants and ensuring the participants conduct themselves appropriately.

15.3 In the ordinary course a DRC will be conducted in the following format;

- opening by the Children's Registrar
- parties' opening comments
- reflection and summary by the Children's Registrar
- identification of the relevant issues
- exploration of the relevant issues
- private sessions involving the Children's Registrar, a party and the party's legal representative
- negotiation
- further private sessions where appropriate
- agreement and closure

15.4 At the conclusion of a DRC a Children's Registrar may make directions for the further case management of the matter.

15.5 At the conclusion of a DRC the Children's Registrar will provide a report to the Court indicating whether or not an agreement has been reached by all the parties and, if an agreement has not been reached, the Children's Registrar will, with the consent of the parties, identify the issues remaining in dispute to allow the Court to allocate hearing time.

16. Conference outcomes

16.1 Where an agreement has been reached by all the parties, proposed consent orders will be prepared by one of the parties and presented at the next mention date of the matter before the Children's Court.

17. Alternative Dispute Resolution referred by the Court under s 65A

17.1 Approval is to be obtained from the President of the Children's Court before an order is made for the parties to attend external mediation unless the order is to be made under s 86 (1D) (b) of the Care Act.

17.2 Where the Court makes an order that the parties to a care application attend external ADR under s 65A of the Care Act, the Court expects that all attendees at that service will comply with the responsibilities and obligations that apply in a DRC as required by this Practice Note.

17.3 Wherever possible, an external ADR must be organised between two to four weeks following referral. All parties and their legal representatives should ensure that they are available to attend the external ADR conference.

17.4 At the conclusion of an external ADR conference, the convenor will provide a report to the Court stating whether or not an agreement has been reached by the parties and, if an agreement has not been reached, the convenor will, with the consent of the parties, identify the issues remaining in dispute.

18. Confidentiality

18.1 The confidentiality and admissibility of information disclosed in DRCs and external ADR conducted under s 65A of the Care Act is protected under Chapter 15A of the Care Act.

18.2 The fact that agreement could or could not be reached at a DRC or external ADR is not subject to confidentiality.

18.3 Directions made by a Children's Registrar after the conclusion of a DRC, are not subject to confidentiality.

Date: 11 November 2015

PETER JOHNSTONE
President of the Children's Court of NSW

CO-OPERATIVES NATIONAL LAW (NSW)

Section 601AA (4) of the Corporations Act 2001
as Applied by Section 453 of the
Co-operatives National Law (NSW)

Notice of Proposed Deregistration - Voluntary

Co-operative Details

Co-operative:	South East & South West Sydney Co-operative Alliance of Parents and Citizens Limited
Co-operative Number:	NSWC31894

Notice

The Registrar has received an application to deregister the Co-operative under section 601AA of the *Corporations Act 2001* as applied by section 453 of the *Co-operatives National Law* (NSW).

The Registrar may deregister the Co-operative when two months have passed since publication of this Notice in the *NSW Government Gazette*.

Dated this 6th day of November 2015 at Bathurst.

CHRISTINE GOWLAND
General Manager, Registry Services
Delegate of the Registrar of Co-operatives

CO-OPERATIVES NATIONAL LAW (NSW)

Section 601AA (4) of the Corporations Act 2001
as Applied by Section 453 of the
Co-operatives National Law (NSW)

Notice of Proposed Deregistration - Voluntary

Co-operative Details

Co-operative:	TFP Co-operative Limited
Co-operative Number:	NSWC28445

Notice

The Registrar has received an application to deregister the Co-operative under section 601AA of the *Corporations Act 2001* as applied by section 453 of the *Co-operatives National Law* (NSW).

The Registrar may deregister the Co-operative when two months have passed since publication of this Notice in the *NSW Government Gazette*.

Dated this 6th day of November 2015 at Bathurst.

CHRISTINE GOWLAND
General Manager, Registry Services
Delegate of the Registrar of Co-operatives

DISTRICT COURT ACT 1973

District Court of New South Wales

DIRECTION

Pursuant to section 32 of the *District Court Act 1973*, I direct that the District Court shall sit in its civil jurisdiction at the place and time shown as follows:

Armidale	10.00am	30 November 2015 (1 week) **Sittings Cancelled**

Dated this 9th day of November 2015.

Justice D PRICE AM
Chief Judge

MENTAL HEALTH ACT 2007

Section 109

Amendment to the Declaration of a Mental Health Facility

I, Dr Mary Foley, Secretary of the NSW Ministry of Health, pursuant to section 43 of the *Interpretation Act 1987*, DO HEREBY:

VARY the Order made pursuant to section 109 of the *Mental Health Act 2007*, published in the *NSW Government Gazette* No 169 of 16 November 2007, page 8561, declaring certain premises to be declared mental health facilities, by amending the name of "Hornsby Ku-ring-gai Hospital and Community Mental Health Service" in Column 1 of the Order to be "Hornsby Ku-ring-gai Community Mental Health Service" and amending the corresponding address in Column 2 of the Order to be "Level 2, Palmerston Centre, Gate 6A Derby Rd, Hornsby NSW 2077".

Signed, this 5th day of November 2015.

Dr MARY FOLEY
Secretary
Ministry of Health

TRANSPORT ADMINISTRATION ACT 1988

LAND ACQUISITION (JUST TERMS COMPENSATION) ACT 1991

Notice of Compulsory Acquisition of Land for the Purposes of Transport for NSW

Transport for NSW, with the approval of His Excellency the Governor with the advice of the Executive Council, declares that the land described in Schedule 1 hereto is acquired by compulsory process under the provisions of the *Land Acquisition (Just Terms Compensation) Act 1991* for the purposes of Transport for NSW, as authorised by the *Transport Administration Act 1988*.

Dated this Eleventh day of November 2015

WES HERON
Executive Director Program Delivery
Transport for NSW

Schedule 1

All that piece or parcel of land situated at Leppington, in the Local Government Area of Liverpool, Parish of Cook, County of Cumberland and State of New South Wales, being that part of Lot 1 in Deposited Plan 725231 shown as Lot 21 in Deposited Plan 1199761 and said to be in the possession of Water NSW.

Reference: 4595899_1

Strengthening local government

Office of Local Government

MODEL CODE OF CONDUCT FOR LOCAL COUNCILS IN NSW

NOVEMBER 2015

ACCESS TO SERVICES
The Office of Local Government is located at:

Levels 1 & 2
5 O'Keefe Avenue
NOWRA NSW 2541

Locked Bag 3015
NOWRA NSW 2541

Phone 02 4428 4100
Fax 02 4428 4199
TTY 02 4428 4209

Level 9, 6 – 10 O'Connell Street
SYDNEY NSW 2000

PO Box R1772
ROYAL EXCHANGE NSW 1225

Phone 02 9289 4000
Fax 02 9289 4099

Email olg@olg.nsw.gov.au
Website www.olg.nsw.gov.au

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NSW GOVERNMENT Office of Local Government

www.olg.nsw.gov.au

CONTENTS

PART 1 INTRODUCTION

This Model Code of Conduct for Local Councils in NSW ("the Model Code of Conduct") is made for the purposes of section 440 of the *Local Government Act 1993* ("the Act"). Section 440 of the Act requires every council to adopt a code of conduct that incorporates the provisions of the Model Code. For the purposes of section 440 of the Act, the Model Code of Conduct comprises all parts of this document.

Councillors, administrators, members of staff of council, independent conduct reviewers, members of council committees including a conduct review committee and delegates of the council must comply with the applicable provisions of council's code of conduct in carrying out their functions as council officials. It is the personal responsibility of council officials to comply with the standards in the code and regularly review their personal circumstances with this in mind.

Failure by a councillor to comply with the standards of conduct prescribed under this code constitutes misconduct for the purposes of the Act. The Act provides for a range of penalties that may be imposed on councillors for misconduct, including suspension or disqualification from civic office. A councillor who has been suspended on three or more occasions for misconduct is automatically disqualified from holding civic office for five years.

Failure by a member of staff to comply with council's code of conduct may give rise to disciplinary action.

PART 2 PURPOSE OF THE CODE OF CONDUCT

The Model Code of Conduct sets the minimum requirements of conduct for council officials in carrying out their functions. The Model Code is prescribed by regulation.

The Model Code of Conduct has been developed to assist council officials to:

- understand the standards of conduct that are expected of them
- enable them to fulfil their statutory duty to act honestly and exercise a reasonable degree of care and diligence (section 439)
- act in a way that enhances public confidence in the integrity of local government.

PART 3 GENERAL CONDUCT OBLIGATIONS

General conduct

3.1 You must not conduct yourself in carrying out your functions in a manner that is likely to bring the council or holders of civic office into disrepute. Specifically, you must not act in a way that:

a) contravenes the Act, associated regulations, council's relevant administrative requirements and policies
b) is detrimental to the pursuit of the charter of a council
c) is improper or unethical
d) is an abuse of power or otherwise amounts to misconduct
e) causes, comprises or involves intimidation, harassment or verbal abuse
f) causes, comprises or involves discrimination, disadvantage or adverse treatment in relation to employment
g) causes, comprises or involves prejudice in the provision of a service to the community. *(Schedule 6A)*

3.2 You must act lawfully, honestly and exercise a reasonable degree of care and diligence in carrying out your functions under the Act or any other Act. *(section 439)*

3.3 You must treat others with respect at all times.

Fairness and equity

3.4 You must consider issues consistently, promptly and fairly. You must deal with matters in accordance with established procedures, in a non-discriminatory manner.

3.5 You must take all relevant facts known to you, or that you should be reasonably aware of, into consideration and have regard to the particular merits of each case. You must not take irrelevant matters or circumstances into consideration when making decisions.

Harassment and discrimination

3.6 You must not harass, discriminate against, or support others who harass and discriminate against colleagues or members of the public. This includes, but is not limited to harassment and discrimination on the grounds of sex, pregnancy, age, race, responsibilities as a carer, marital status, disability, homosexuality, transgender grounds or if a person has an infectious disease.

Development decisions

3.7 You must ensure that development decisions are properly made and that parties involved in the development process are dealt with fairly. You must avoid any occasion for suspicion of improper conduct in the development assessment process.

3.8 In determining development applications, you must ensure that no action, statement or communication between yourself and applicants or objectors

conveys any suggestion of willingness to provide improper concessions or preferential treatment.

Binding caucus votes

3.9 You must not participate in binding caucus votes in relation to matters to be considered at a council or committee meeting.

3.10 For the purposes of clause 3.9, a binding caucus vote is a process whereby a group of councillors are compelled by a threat of disciplinary or other adverse action to comply with a predetermined position on a matter before the council or committee irrespective of the personal views of individual members of the group on the merits of the matter before the council or committee.

3.11 Clause 3.9 does not prohibit councillors from discussing a matter before the council or committee prior to considering the matter in question at a council or committee meeting or from voluntarily holding a shared view with other councillors on the merits of a matter.

3.12 Clause 3.9 does not apply to a decision to elect the Mayor or Deputy Mayor or to nominate a person to be a member of a council committee.

PART 4 CONFLICT OF INTERESTS

4.1 A conflict of interests exists where a reasonable and informed person would perceive that you could be influenced by a private interest when carrying out your public duty.

4.2 You must avoid or appropriately manage any conflict of interests. The onus is on you to identify a conflict of interests and take the appropriate action to manage the conflict in favour of your public duty.

4.3 Any conflict of interests must be managed to uphold the probity of council decision-making. When considering whether or not you have a conflict of interests, it is always important to think about how others would view your situation.

4.4 Private interests can be of two types: pecuniary or non-pecuniary.

What is a pecuniary interest?

4.5 A pecuniary interest is an interest that a person has in a matter because of a reasonable likelihood or expectation of appreciable financial gain or loss to the person. *(section 442)*

4.6 A person will also be taken to have a pecuniary interest in a matter if that person's spouse or de facto partner or a relative of the person or a partner or employer of the person, or a company or other body of which the person, or a nominee, partner or employer of the person is a member, has a pecuniary interest in the matter. *(section 443)*

4.7 Pecuniary interests are regulated by Chapter 14, Part 2 of the Act. The Act requires that:

a) councillors and designated persons lodge an initial and an annual written disclosure of interests that could potentially be in conflict with their public or professional duties *(section 449)*
b) councillors and members of council committees disclose an interest and the nature of that interest at a meeting, leave the meeting and be out of sight of the meeting and not participate in discussions or voting on the matter *(section 451)*
c) designated persons immediately declare, in writing, any pecuniary interest. *(section 459)*

4.8 Designated persons are defined at section 441 of the Act, and include, but are not limited to, the general manager and other senior staff of the council.

4.9 Where you are a member of staff of council, other than a designated person (as defined by section 441), you must disclose in writing to your supervisor or the general manager, the nature of any pecuniary interest you have in a matter you are dealing with as soon as practicable.

What are non-pecuniary interests?

4.10 Non-pecuniary interests are private or personal interests the council official has that do not amount to a pecuniary interest as defined in the Act. These commonly arise out of family, or personal relationships, or involvement in sporting, social or other cultural groups and associations and may include an interest of a financial nature.

4.11 The political views of a councillor do not constitute a private interest.

Managing non-pecuniary conflict of interests

4.12 Where you have a non-pecuniary interest that conflicts with your public duty, you must disclose the interest fully and in writing, even if the conflict is not significant. You must do this as soon as practicable.

4.13 If a disclosure is made at a council or committee meeting, both the disclosure and the nature of the interest must be recorded in the minutes. This disclosure constitutes disclosure in writing for the purposes of clause 4.12.

4.14 How you manage a non-pecuniary conflict of interests will depend on whether or not it is significant.

4.15 As a general rule, a non-pecuniary conflict of interests will be significant where a matter does not raise a pecuniary interest but it involves:

a) a relationship between a council official and another person that is particularly close, for example, parent, grandparent, brother, sister, uncle, aunt, nephew, niece, lineal descendant or adopted child of the person or of the person's spouse, current or former spouse or partner, de facto or other person living in the same household
b) other relationships that are particularly close, such as friendships and business relationships. Closeness is defined by the nature of the friendship or business relationship, the frequency of contact and the duration of the friendship or relationship
c) an affiliation between the council official and an organisation, sporting body, club, corporation or association that is particularly strong.

4.16 If you are a council official, other than a member of staff of council, and you have disclosed that a significant non-pecuniary conflict of interests exists, you must manage it in one of two ways:

a) remove the source of the conflict, by relinquishing or divesting the interest that creates the conflict, or reallocating the conflicting duties to another council official
b) have no involvement in the matter, by absenting yourself from and not taking part in any debate or voting on the issue as if the provisions in section 451(2) of the Act apply.

4.17 If you determine that a non-pecuniary conflict of interests is less than significant and does not require further action, you must provide an explanation of why you consider that the conflict does not require further action in the circumstances.

4.18 If you are a member of staff of council, the decision on which option should be taken to manage a non-pecuniary conflict of interests must be made in consultation with your manager.

4.19 Despite clause 4.16(b), a councillor who has disclosed that a significant non-pecuniary conflict of interests exists may participate in a decision to delegate council's decision-making role to council staff through the general manager, or appoint another person or body to make the decision in accordance with the law. This applies whether or not council would be deprived of a quorum if one or more councillors were to manage their conflict of interests by not voting on a matter in accordance with clause 4.16(b) above.

Reportable political donations

4.20 Councillors should note that matters before council involving political or campaign donors may give rise to a non-pecuniary conflict of interests.

4.21 Where a councillor has received or knowingly benefitted from a reportable political donation:

a) made by a major political donor in the previous four years, and
b) where the major political donor has a matter before council,

then the councillor must declare a non-pecuniary conflict of interests, disclose the nature of the interest, and manage the conflict of interests in accordance with clause 4.16(b).

4.22 For the purposes of this Part:

a) a "reportable political donation" is a "reportable political donation" for the purposes of section 86 of the *Election Funding, Expenditure and Disclosures Act 1981,*
b) a "major political donor" is a "major political donor" for the purposes of section 84 of the *Election Funding, Expenditure and Disclosures Act 1981.*

4.23 Councillors should note that political donations below $1,000, or political donations to a registered political party or group by which a councillor is endorsed, may still give rise to a non-pecuniary conflict of interests. Councillors should determine whether or not such conflicts are significant and take the appropriate action to manage them.

4.24 If a councillor has received or knowingly benefitted from a reportable political donation of the kind referred to in clause 4.21, that councillor is not prevented from participating in a decision to delegate council's decision-making role to council staff through the general manager or appointing another person or body to make the decision in accordance with the law (see clause 4.19 above).

Loss of quorum as a result of compliance with this Part

4.25 Where a majority of councillors are precluded under this Part from consideration of a matter the council or committee must resolve to delegate consideration of the matter in question to another person.

4.26 Where a majority of councillors are precluded under this Part from consideration of a matter and the matter in question concerns the exercise of a function that may not be delegated under section 377 of the Act, the councillors may apply in writing to the Chief Executive to be exempted from complying with a requirement under this Part relating to the management of a non-pecuniary conflict of interests.

4.27 The Chief Executive will only exempt a councillor from complying with a requirement under this Part where:

a) compliance by councillors with a requirement under the Part in relation to a matter will result in the loss of a quorum, and
b) the matter relates to the exercise of a function of the council that may not be delegated under section 377 of the Act.

4.28 Where the Chief Executive exempts a councillor from complying with a requirement under this Part, the councillor must still disclose any interests they have in the matter the exemption applies to in accordance with the requirements of this Part.

4.29 A councillor, who would otherwise be precluded from participating in the consideration of a matter under this Part because they have a non-pecuniary conflict of interests in the matter, is permitted to participate in consideration of the matter, if:

a) the matter is a proposal relating to
    i) the making of a principal environmental planning instrument applying to the whole or a significant part of the council's area, or
    ii) the amendment, alteration or repeal of an environmental planning instrument where the amendment, alteration or repeal applies to the whole or a significant part of the council's area, and
b) the non-pecuniary conflict of interests arises only because of an interest that a person has in that person's principal place of residence, and
c) the councillor declares the interest they have in the matter that would otherwise have precluded their participation in consideration of the matter under this Part.

<u>Other business or employment</u>

4.30 If you are a member of staff of council considering outside employment or contract work that relates to the business of the council or that might conflict with your council duties, you must notify and seek the approval of the general manager in writing. *(section 353)*

4.31 As a member of staff, you must ensure that any outside employment or business you engage in will not:

a) conflict with your official duties
b) involve using confidential information or council resources obtained through your work with the council
c) require you to work while on council duty

d) discredit or disadvantage the council.

Personal dealings with council

4.32 You may have reason to deal with your council in your personal capacity (for example, as a ratepayer, recipient of a council service or applicant for a consent granted by council). You must not expect or request preferential treatment in relation to any matter in which you have a private interest because of your position. You must avoid any action that could lead members of the public to believe that you are seeking preferential treatment.

PART 5 PERSONAL BENEFIT

For the purposes of this section, a reference to a gift or benefit does not include a political donation or contribution to an election fund that is subject to the provisions of the relevant election funding legislation.

Gifts and benefits

5.1 You must avoid situations giving rise to the appearance that a person or body, through the provision of gifts, benefits or hospitality of any kind, is attempting to secure favourable treatment from you or from the council.

5.2 You must take all reasonable steps to ensure that your immediate family members do not receive gifts or benefits that give rise to the appearance of being an attempt to secure favourable treatment. Immediate family members ordinarily include parents, spouses, children and siblings.

Token gifts and benefits

5.3 Generally speaking, token gifts and benefits include:

a) free or subsidised meals, beverages or refreshments provided in conjunction with:
   i) the discussion of official business
   ii) council work related events such as training, education sessions, workshops
   iii) conferences
   iv) council functions or events
   v) social functions organised by groups, such as council committees and community organisations
b) invitations to and attendance at local social, cultural or sporting events
c) gifts of single bottles of reasonably priced alcohol to individual council officials at end of year functions, public occasions or in recognition of work done (such as providing a lecture/training session/address)
d) ties, scarves, coasters, tie pins, diaries, chocolates or flowers
e) prizes of token value.

Gifts and benefits of value

5.4 Notwithstanding clause 5.3, gifts and benefits that have more than a token value include, but are not limited to, tickets to major sporting events (such as state or international cricket matches or matches in other national sporting codes (including the NRL, AFL, FFA, NBL)), corporate hospitality at a corporate facility at major sporting events, discounted products for personal use, the frequent use of facilities such as gyms, use of holiday homes, free or discounted travel.

How are offers of gifts and benefits to be dealt with?

5.5 You must not:

a) seek or accept a bribe or other improper inducement
b) seek gifts or benefits of any kind
c) accept any gift or benefit that may create a sense of obligation on your part or may be perceived to be intended or likely to influence you in carrying out your public duty

d) accept any gift or benefit of more than token value
e) accept an offer of cash or a cash-like gift, regardless of the amount.

5.6 For the purposes of clause 5.5(e), a "cash-like gift" includes but is not limited to gift vouchers, credit cards, debit cards with credit on them, prepayments such as phone or internal credit, memberships or entitlements to discounts.

5.7 Where you receive a gift or benefit of more than token value that cannot reasonably be refused or returned, this must be disclosed promptly to your supervisor, the Mayor or the general manager. The recipient, supervisor, Mayor or general manager must ensure that any gifts or benefits of more than token value that are received are recorded in a Gifts Register. The gift or benefit must be surrendered to council, unless the nature of the gift or benefit makes this impractical.

Improper and undue influence

5.8 You must not use your position to influence other council officials in the performance of their public or professional duties to obtain a private benefit for yourself or for somebody else. A councillor will not be in breach of this clause where they seek to influence other council officials through the appropriate exercise of their representative functions.

5.9 You must not take advantage (or seek to take advantage) of your status or position with or of functions you perform for council in order to obtain a private benefit for yourself or for any other person or body.

PART 6 RELATIONSHIP BETWEEN COUNCIL OFFICIALS

Obligations of councillors and administrators

6.1 Each council is a body politic. The councillors or administrator/s are the governing body of the council. The governing body has the responsibility of directing and controlling the affairs of the council in accordance with the Act and is responsible for policy determinations, for example, those relating to workforce policy.

6.2 Councillors or administrators must not:

a) direct council staff other than by giving appropriate direction to the general manager in the performance of council's functions by way of council or committee resolution, or by the Mayor or administrator exercising their power under section 226 of the Act *(section 352)*
b) in any public or private forum, direct or influence or attempt to direct or influence, any other member of the staff of the council or a delegate of the council in the exercise of the functions of the member or delegate *(Schedule 6A of the Act)*
c) contact a member of the staff of the council on council related business unless in accordance with the policy and procedures governing the interaction of councillors and council staff that have been authorised by the council and the general manager
d) contact or issue instructions to any of council's contractors or tenderers, including council's legal advisers, unless by the Mayor or administrator exercising their power under section 226 of the Act. This does not apply to council's external auditors or the Chair of council's audit committee who may be provided with any information by individual councillors reasonably necessary for the external auditor or audit committee to effectively perform their functions.

Obligations of staff

6.3 The general manager is responsible for the efficient and effective operation of the council's organisation and for ensuring the implementation of the decisions of the council without delay.

6.4 Members of staff of council must:

a) give their attention to the business of council while on duty
b) ensure that their work is carried out efficiently, economically and effectively
c) carry out lawful directions given by any person having authority to give such directions
d) give effect to the lawful decisions, policies, and procedures of the council, whether or not the staff member agrees with or approves of them
e) ensure that any participation in political activities outside the service of the council does not conflict with the performance of their official duties.

Obligations during meetings

6.5 You must act in accordance with council's Code of Meeting Practice, if council has adopted one, and the *Local Government (General) Regulation 2005* during council and committee meetings.

6.6 You must show respect to the chair, other council officials and any members of the public present during council and committee meetings or other formal proceedings of the council.

Inappropriate interactions

6.7 You must not engage in any of the following inappropriate interactions:

a) Councillors and administrators approaching staff and staff organisations to discuss individual or operational staff matters other than broader workforce policy issues.
b) Council staff approaching councillors and administrators to discuss individual or operational staff matters other than broader workforce policy issues.
c) Council staff refusing to give information that is available to other councillors to a particular councillor.
d) Councillors and administrators who have lodged a development application with council, discussing the matter with council staff in staff-only areas of the council.
e) Councillors and administrators being overbearing or threatening to council staff.
f) Councillors and administrators making personal attacks on council staff in a public forum.
g) Councillors and administrators directing or pressuring council staff in the performance of their work, or recommendations they should make.
h) Council staff providing ad hoc advice to councillors and administrators without recording or documenting the interaction as they would if the advice was provided to a member of the community.
i) Council staff meeting with applicants or objectors alone AND outside office hours to discuss applications or proposals.
j) Councillors attending on-site inspection meetings with lawyers and/or consultants engaged by council associated with current or proposed legal proceedings unless permitted to do so by council's general manager or, in the case of the Mayor or administrator, exercising their power under section 226 of the Act.

PART 7 ACCESS TO INFORMATION AND COUNCIL RESOURCES

Councillor and administrator access to information

7.1 The general manager and public officer are responsible for ensuring that members of the public, councillors and administrators can gain access to the documents available under the *Government Information (Public Access) Act 2009*.

7.2 The general manager must provide councillors and administrators with information sufficient to enable them to carry out their civic office functions.

7.3 Members of staff of council must provide full and timely information to councillors and administrators sufficient to enable them to carry out their civic office functions and in accordance with council procedures.

7.4 Members of staff of council who provide any information to a particular councillor in the performance of their civic duties must also make it available to any other councillor who requests it and in accordance with council procedures.

7.5 Councillors and administrators who have a private (as distinct from civic) interest in a document of council have the same rights of access as any member of the public.

Councillors and administrators to properly examine and consider information

7.6 Councillors and administrators must properly examine and consider all the information provided to them relating to matters that they are dealing with to enable them to make a decision on the matter in accordance with council's charter.

Refusal of access to documents

7.7 Where the general manager and public officer determine to refuse access to a document sought by a councillor or administrator they must act reasonably. In reaching this decision they must take into account whether or not the document sought is required for the councillor or administrator to perform their civic duty (see clause 7.2). The general manager or public officer must state the reasons for the decision if access is refused.

Use of certain council information

7.8 In regard to information obtained in your capacity as a council official, you must:

a) only access council information needed for council business
b) not use that council information for private purposes
c) not seek or obtain, either directly or indirectly, any financial benefit or other improper advantage for yourself, or any other person or body, from any information to which you have by virtue of your office or position with council
d) only release council information in accordance with established council policies and procedures and in compliance with relevant legislation.

Use and security of confidential information

7.9 You must maintain the integrity and security of confidential documents or information in your possession, or for which you are responsible.

7.10 In addition to your general obligations relating to the use of council information, you must:

a) protect confidential information
b) only release confidential information if you have authority to do so
c) only use confidential information for the purpose it is intended to be used
d) not use confidential information gained through your official position for the purpose of securing a private benefit for yourself or for any other person
e) not use confidential information with the intention to cause harm or detriment to your council or any other person or body
f) not disclose any information discussed during a confidential session of a council meeting.

Personal information

7.11 When dealing with personal information you must comply with:

a) the *Privacy and Personal Information Protection Act 1998*
b) the *Health Records and Information Privacy Act 2002*
c) the Information Protection Principles and Health Privacy Principles
d) council's privacy management plan
e) the Privacy Code of Practice for Local Government

Use of council resources

7.12 You must use council resources ethically, effectively, efficiently and carefully in the course of your official duties, and must not use them for private purposes (except when supplied as part of a contract of employment) unless this use is lawfully authorised and proper payment is made where appropriate.

7.13 Union delegates and consultative committee members may have reasonable access to council resources for the purposes of carrying out their industrial responsibilities, including but not limited to:

a) the representation of members with respect to disciplinary matters
b) the representation of employees with respect to grievances and disputes
c) functions associated with the role of the local consultative committee.

7.14 You must be scrupulous in your use of council property, including intellectual property, official services and facilities, and must not permit their misuse by any other person or body.

7.15 You must avoid any action or situation that could create the appearance that council property, official services or public facilities are being improperly used for your benefit or the benefit of any other person or body.

7.16 You must not use council resources, property or facilities for the purpose of assisting your election campaign or the election campaign of others unless the resources, property or facilities are otherwise available for use or hire by the public and any publicly advertised fee is paid for use of the resources, property or facility.

7.17 You must not use council letterhead, council crests and other information that could give the appearance it is official council material for:

a) the purpose of assisting your election campaign or the election campaign of others, or
b) for other non-official purposes.

7.18 You must not convert any property of the council to your own use unless properly authorised.

7.19 You must not use council's computer resources to search for, access, download or communicate any material of an offensive, obscene, pornographic, threatening, abusive or defamatory nature.

Councillor access to council buildings

7.20 Councillors and administrators are entitled to have access to the council chamber, committee room, Mayor's office (subject to availability), councillors' rooms, and public areas of council's buildings during normal business hours and for meetings. Councillors and administrators needing access to these facilities at other times must obtain authority from the general manager.

7.21 Councillors and administrators must not enter staff-only areas of council buildings without the approval of the general manager (or delegate) or as provided in the procedures governing the interaction of councillors and council staff.

7.22 Councillors and administrators must ensure that when they are within a staff area they avoid giving rise to the appearance that they may improperly influence council staff decisions.

PART 8 MAINTAINING THE INTEGRITY OF THIS CODE

8.1 You must not conduct yourself in a manner that is likely to undermine confidence in the integrity of this code or its administration.

Complaints made for an improper purpose

8.2 You must not make a complaint or cause a complaint to be made under this code for an improper purpose.

8.3 For the purposes of clause 8.2, a complaint is made for an improper purpose where it is trivial, frivolous, vexatious or not made in good faith, or where it otherwise lacks merit and has been made substantially for one or more of the following purposes:

a) to intimidate or harass another council official
b) to damage another council official's reputation
c) to obtain a political advantage
d) to influence a council official in the exercise of their official functions or to prevent or disrupt the exercise of those functions
e) to influence the council in the exercise of its functions or to prevent or disrupt the exercise of those functions
f) to avoid disciplinary action under this code
g) to take reprisal action against a person for making a complaint under this code except as may be otherwise specifically permitted under this code
h) to take reprisal action against a person for exercising a function prescribed under the procedures for the administration of this code except as may be otherwise specifically permitted under this code
i) to prevent or disrupt the effective administration of this code.

Detrimental action

8.4 You must not take detrimental action or cause detrimental action to be taken against a person substantially in reprisal for a complaint they have made under this code except as may be otherwise specifically permitted under this code.

8.5 You must not take detrimental action or cause detrimental action to be taken against a person substantially in reprisal for any function they have exercised under this code except as may be otherwise specifically permitted under this code.

8.6 For the purposes of clauses 8.4 and 8.5 detrimental action is an action causing, comprising or involving any of the following:

a) injury, damage or loss
b) intimidation or harassment
c) discrimination, disadvantage or adverse treatment in relation to employment
d) dismissal from, or prejudice in, employment
e) disciplinary proceedings.

Compliance with requirements under this code

8.7 You must not engage in conduct that is calculated to impede or disrupt the consideration of a matter under this code.

8.8 You must comply with a reasonable and lawful request made by a person exercising a function under this code.

8.9 You must comply with a practice ruling made by the Office of Local Government.

8.10 Where you are a councillor or the general manager, you must comply with any council resolution requiring you to take action as a result of a breach of this code.

Disclosure of information about the consideration of a matter under this code

8.11 You must report breaches of this code in accordance with the reporting requirements under this code.

8.12 You must not make allegations of suspected breaches of this code at council meetings or in other public forums.

8.13 You must not disclose information about the consideration of a matter under this code except for the purposes of seeking legal advice unless the disclosure is otherwise permitted under this code.

Complaints alleging a breach of this part

8.14 Complaints alleging a breach of this Part (Part 8) by a councillor, the general manager or an administrator are to be made to the Office of Local Government.

8.15 Complaints alleging a breach of this Part by other council officials are to be made to the general manager.

PART 9 DEFINITIONS

In the Model Code of Conduct the following definitions apply:

the Act	the *Local Government Act 1993*
act of disorder	see the definition in clause 256 of the Local Government (General) Regulation 2005
administrator	an administrator of a council appointed under the Act other than an administrator appointed under section 66
Chief Executive	Chief Executive of the Office of Local Government
committee	a council committee
conflict of interests	a conflict of interests exists where a reasonable and informed person would perceive that you could be influenced by a private interest when carrying out your public duty
council committee	a committee established by resolution of council
"council committee member"	a person other than a councillor or member of staff of a council who is a member of a council committee
council official	includes councillors, members of staff of council, administrators, council committee members, conduct reviewers and delegates of council
councillor	a person elected or appointed to civic office and includes a Mayor
delegate of council	a person (other than a councillor or member of staff of a council) or body, and the individual members of that body, to whom a function of the council is delegated
designated person	see the definition in section 441 of the Act
election campaign	includes council, State and Federal election campaigns
personal information	information or an opinion about a person whose identity is apparent, or can be ascertained from the information or opinion

the Regulation	the Local Government (General) Regulation 2005

The term “you” used in the Model Code of Conduct refers to council officials.

The phrase “this code” used in the Model Code of Conduct refers also to the procedures for the administration of the Model Code of Conduct prescribed under the Local Government (General) Regulation 2005.

Food Instrument of Delegation 2015

under the

Food Act 2003

I, ELIZABETH ANN SZABO, Chief Executive Officer of the Food Authority, in pursuance of section 109E of the *Food Act 2003*, make the following Instrument of Delegation.

Dated this 29th day of October 2015.

ELIZABETH ANN SZABO
Chief Executive Officer of the Food Authority

Explanatory note

This Instrument is made under section 109E of the *Food Act 2003*. The object of this Instrument is to delegate functions conferred or imposed on the Food Authority by or under the *Food Act 2003*.

Food Instrument of Delegation 2015

Made under the *Food Act 2003*

1 Name

This Instrument is the *Food Instrument of Delegation 2015*.

2 Commencement

This Instrument commences on 30th October 2015.

3 Interpretation

(1) In this Instrument:
function includes a power, authority or duty, and ***exercise*** a function includes perform a duty.
role includes office.
role title includes title of an office.
the Act means the *Food Act 2003*.
the Code means the Food Standards Code.
the Department means the Department of Industry, Skills and Regional Development.
the Regulation means the Food Regulation 2015.

(2) Unless otherwise defined in this Instrument, words and expressions that are defined in the Act or Regulation have the same meaning in this Instrument.

(3) Unless otherwise specified, references to a role or role title in this Instrument are references to a role or role title within the Department.

(4) The summary of a function delegated in Column 2 of Schedules 1, 2 and 3 is only for general explanation and does not limit the delegation of functions under the sections and clauses identified in Column 1 of the Schedules.

4 Delegation of functions

(1) Subject to clause 4(4) below, all of the functions conferred or imposed on the Food Authority under the Act, except those listed in section 109E(2), are delegated to the person assigned to the role having the title Group Director, Food Safety and Chief Executive Officer Food Authority.

(2) Subject to clause 4(4) below, the functions conferred or imposed on the Food Authority under the Act or Regulation in Column 1 of Schedules 1, 2 and 3 are delegated to any person assigned to the role having the title specified in Column 3 of the Schedules.

(3) Any limitation on a delegation is specified in Column 2 of the Schedules.

(4) The person assigned to the role having the title Group Director, Food Safety and Chief Executive Officer Food Authority or the role having the title specified in Column 3 of Schedules 1, 2 and 3 includes any person who is for the time being acting in that role or performing the duties and responsibilities of that role.

5 Revocation

All delegations previously made in pursuance of section 109E of the Act are revoked.

Schedule 1 – the Act

Column 1 Part and Section of the Act	**Column 2** Summary of functions delegated and limitations (if any)	**Column 3** Role Title
Part 4, Inspection and seizure powers		
47	Return of seized item if Authority becomes satisfied that there has been no contravention of the Act or Regulations	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations Manager, Food Incident Response & Complaints
48	Destruction, sale or disposal of seized item as Authority directs	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations Manager, Food Incident Response & Complaints
49	Certificate for the recovery of a debt	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations Manager, Food Incident Response & Complaints
50	Return of seized item after forfeiture to Crown if Authority becomes satisfied that there has been no contravention of the Act or Regulations	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations Manager, Food Incident Response & Complaints
51	Determination and payment of compensation in relation to seized item(s)	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations Manager, Food Incident Response & Complaints
Part 5, Improvement Notices and Prohibition Orders for premises or equipment		
60(1)	Prohibition Orders	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations Manager, Food Incident Response & Complaints
60(4)	Certificate of Clearance	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations Manager, Food Incident Response & Complaints
66	Determination and payment of compensation in relation to prohibition orders	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations Manager, Food Incident Response & Complaints
66AA(2)	Time extension and waiver of payment of improvement notice fee	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations

Column 1 Part and Section of the Act	**Column 2** Summary of functions delegated and limitations (if any)	**Column 3** Role Title
Part 6, Taking and analysis of samples		
75	Approval Of Laboratories	Director Biosecurity & Food Safety Compliance Director, Food Science & Strategy
78	Variation of conditions or suspension or cancellation of approval of laboratory	Director Biosecurity & Food Safety Compliance Director, Food Science & Strategy
81	Approval of Analysts	Director Biosecurity & Food Safety Compliance Director, Food Science & Strategy Manager, Science and Technical Services
84	Variation of conditions or suspension or cancellation of approval of analyst	Director Biosecurity & Food Safety Compliance Director, Food Science & Strategy Manager, Science and Technical Services
Part 7, Auditing		
87	Authorisation of food safety auditors	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
87A	Appointment of beef labelling auditors	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
90	Variation of conditions or suspension or cancellation of approval of auditor	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
93	Auditing and reporting requirements - priority classification system and frequency of auditing	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
97	Certificates of authority of food safety auditors	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
Part 8, Regulation of Food businesses		
101A	List of food businesses to be maintained and fees for inspections and copies	Director Biosecurity & Food Safety Compliance Director, Strategic Policy & Partnerships
105(1)	Industry consultation for food safety schemes	Director Biosecurity & Food Safety Compliance Director, Strategic Policy & Partnerships Director, Food Science & Strategy
106H(1)	Approval of registered training organisations for the purposes of issuing food safety supervisor certificates	Director, Strategic Policy & Partnerships Manager, Strategic Policy & Projects

Column 1 Part and Section of the Act	**Column 2** Summary of functions delegated and limitations (if any)	**Column 3** Role Title
Part 9, Administration		
109B	NSW Food Authority - use of consultants and contractors **Limitation:** This delegation is subject to the same limits, in terms of amount concerned, as apply under general financial delegations.	Director Biosecurity & Food Safety Compliance Director, Stakeholder Engagement & Customer Service Director, Food Science & Strategy Director, Strategic Policy & Partnerships
111C	Issue of guidelines relating to the appointment of enforcement agencies	Director Biosecurity & Food Safety Compliance Director, Strategic Policy & Partnerships
112	Adoption of national guidelines	Director Biosecurity & Food Safety Compliance Director, Strategic Policy & Partnerships Director, Food Science and Strategy
113	Reports by enforcement agencies – protocols and intervals of reporting	Director Biosecurity & Food Safety Compliance Director, Strategic Policy & Partnerships Manager, Local Government Unit
114	Appointment of authorised officers	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations
115	Certificates of Authority	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations
Part 10, Disclosure of information about offences and alleged offences		
133	Register of Offences and form of the Register	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations
133A	Register of information about penalty notices and form of the Register	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations
133B	Provision of information to the public and publication of information on registers	Director Biosecurity & Food Safety Compliance Director, Strategic Policy & Partnerships Director, Stakeholder Engagement & Customer Service
133C	Correction of register	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Director, Strategic Policy & Partnerships
133D	Removal of information from register	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Director, Strategic Policy & Partnerships
133E	Addition of information to register	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Director, Strategic Policy & Partnerships

Column 1 Part and Section of the Act	**Column 2** Summary of functions delegated and limitations (if any)	**Column 3** Role Title
133F(4)	Reduction, waiver or remission of application fee for changes to register	Director Biosecurity & Food Safety Compliance
Part 11, Miscellaneous		
136A	Providing information to another enforcement agency and relevant authority	Director Biosecurity & Food Safety Compliance Director, Strategic Policy & Partnerships Manager, Food Incident Response & Complaints Manager, Compliance Investigations

SCHEDULE 2 – the Regulation

Column 1 Part and Clause of the Regulation	**Column 2** Summary of functions delegated and limitations (if any)	**Column 3** Role Title
Part 3, Fees and Charges		
14	Increase, reduce or waiver of charges for inspections of non-licenced businesses	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
15	Annual administration charge	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
Part 4, Food Safety Supervisors		
19	Issue of a food safety supervisor certificate	Director, Strategic Policy & Partnerships Manager, Strategic Policy And Projects Manager, Licencing & Accreditation Services
20	Determination of required units of competency	Director, Strategic Policy & Partnerships Manager, Strategic Policy And Projects Manager, Licencing & Accreditation Services
21	Form of food safety supervisor certificate	Director, Strategic Policy & Partnerships Manager, Strategic Policy And Projects
22	Charges for issue of food safety supervisor certificates	Director, Strategic Policy & Partnerships Manager, Strategic Policy And Projects
23	Approval of registered training organisations to issue food safety supervisor certificates	Director, Strategic Policy & Partnerships Manager, Strategic Policy And Projects
24	Condition of approval and written agreement of Authority	Director, Strategic Policy & Partnerships Manager, Strategic Policy And Projects
25	Training qualifications	Director, Strategic Policy & Partnerships Manager, Strategic Policy And Projects
27	Variation, suspension and cancellation of approvals	Director, Strategic Policy & Partnerships Manager, Strategic Policy And Projects
Part 7, Food Safety Schemes – General provisions		
42	Information in relation to an application for a licence and waiver of application fee for licence	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations Manager, Licencing & Accreditation Services
43	Determination of Licence applications	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations Manager, Licencing & Accreditation Services Manager, Shellfish Programs

Column 1 Part and Clause of the Regulation	**Column 2** Summary of functions delegated and limitations (if any)	**Column 3** Role Title
46	Variation of terms and conditions of licence	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations Manager, Licencing & Accreditation Services
47	Suspension or cancellation of licence	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Licencing & Accreditation Services
49	Determination of licence renewals	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Licencing & Accreditation Services Manager, Compliance Investigations
50	Calculation, notification, approval to pay by instalments, waiver and reduction of licence fees and levies	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Licencing & Accreditation Services Manager, Compliance Investigations
51	Inspection of vehicles	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Licencing & Accreditation Services Manager, Compliance Investigations
52	Issue of vehicle labels	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Licencing & Accreditation Services Manager, Compliance Investigations
Part 7, Inspections and Audits		
55	Inspections and audits of food businesses	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations Manager, Licensing & Accreditation Services
56	Approval for a food business to retain food safety auditor	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Licensing & Accreditation Services
57	Increase, reduce or waiver of charges for inspections and audits	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Licensing & Accreditation Services
Part 8, Dairy Food Safety Scheme		
70	Frequency and standards of analysis	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification

Column 1 Part and Clause of the Regulation	**Column 2** Summary of functions delegated and limitations (if any)	**Column 3** Role Title
74	Establishment of Dairy Consultative Committee	Director Biosecurity & Food Safety Compliance Director, Strategic Policy & Partnerships
75	Increase of licence fees for licences in respect of dairy businesses	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Licensing & Accreditation Services
Part 9, Meat Food Safety Scheme		
100	Satisfaction, approval and variation of identification systems for lamb and hogget meat	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
108	Application and issue of brands for meat	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
110	Replacement of lost, stolen or damaged brands for meat	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
111	Approval of similar brands to prescribed brands for meat	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
112	Authorised use of brands similar to prescribed brands	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
113	Appointment of meat safety inspectors	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
115	Revocation of approval of appointment of meat safety inspector	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
116	Frequency and standards of analysis	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
118	Establishment and conduct of Meat Industry Consultative Council	Director Biosecurity & Food Safety Compliance Director, Strategic Policy & Partnerships
119	Increases to licence fees for licences in respect of meat businesses	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Licensing & Accreditation Services

Column 1 Part and Clause of the Regulation	**Column 2** Summary of functions delegated and limitations (if any)	**Column 3** Role Title
Part 10, Plant Products Food Safety Scheme		
123	Declarations that the plant products food safety scheme does not apply to certain plant products businesses and revocations of such declarations	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
125	Frequency and standards of analysis	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
127	Industry consultation	Director Biosecurity & Food Safety Compliance Director, Strategic Policy & Partnerships Manager, Compliance Investigations Manager, Audit Systems & Verification
128	Increases to licence fees for licences in respect of plant products businesses	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Licensing & Accreditation Services
Part 11, Seafood Safety Scheme		
137	Additional licence requirements - Applications	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Shellfish Program
139	Frequency and standards of analysis	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Shellfish Program
140	Exemption of analysis in a particular case or class of cases	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Shellfish Program
144	Establishment of NSW Shellfish Program and setting of procedures for calling and holding meetings	Director Biosecurity & Food Safety Compliance Director, Food Science & Strategy Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Shellfish Program
145	Establishment and conduct of NSW Shellfish Committee	Director Biosecurity & Food Safety Compliance Director, Food Science & Strategy Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Shellfish Program

Column 1 Part and Clause of the Regulation	**Column 2** Summary of functions delegated and limitations (if any)	**Column 3** Role Title
147	Appointment of local shellfish committees	Director Biosecurity & Food Safety Compliance Director, Food Science & Strategy Manager, Shellfish Program
148	Directions of the Food Authority in administering the local program	Director Biosecurity & Food Safety Compliance Director, Food Science & Strategy Manager, Shellfish Program
150	Funding of Committees	Director Biosecurity & Food Safety Compliance Director, Food Science & Strategy Manager, Shellfish Program
151	Increases to the annual general licence fees for seafood businesses	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Licensing & Accreditation Services Manager, Shellfish Program
152	Determination of licence fees for shellfish harvesting, cultivating of shellfish, cultivating of spat or operation of duration plant	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Licensing & Accreditation Services
156	Calculation of annual local shellfish program levy	Director Biosecurity & Food Safety Compliance Director, Food Science and Strategy Manager, Shellfish Program Manager, Licensing & Accreditation Services
157	Establishment and conduct of NSW Seafood Industry Forum	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Shellfish Program
Part 12, Vulnerable Persons Food Safety Scheme		
161	Frequency and standards of analysis	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
163	Establishment and conduct of NSW Vulnerable Persons Food Safety Scheme Consultative Committee	Director Biosecurity & Food Safety Compliance Director, Strategic Policy & Partnerships Manager, Compliance Investigations Manager, Audit Systems & Verification
164	Increases to license Fees for licences in respect of vulnerable persons food businesses	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Licensing & Accreditation Services

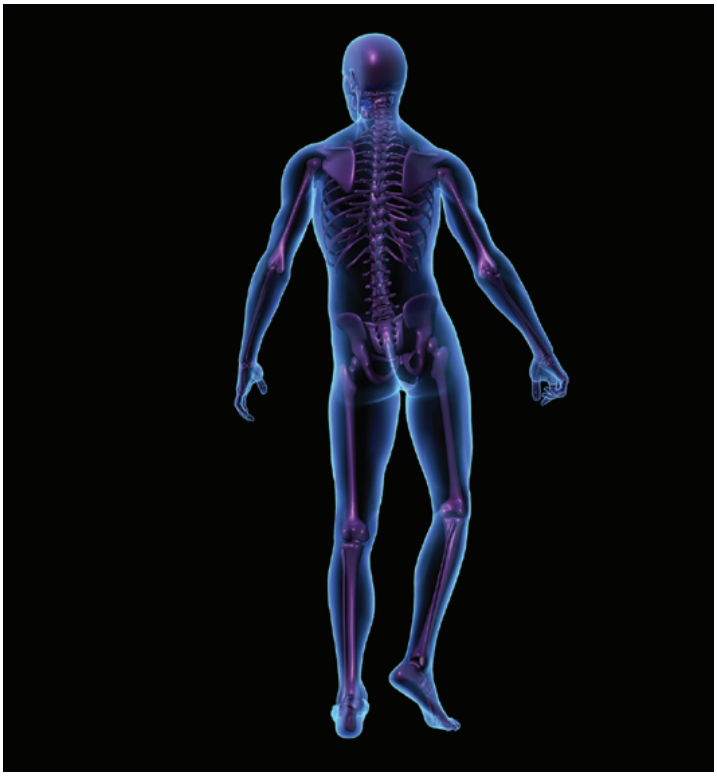
Column 1 Part and Clause of the Regulation	**Column 2** Summary of functions delegated and limitations (if any)	**Column 3** Role Title
Part 13, Egg Food Safety Scheme		
176	Written approval in relation to eggs for sale administered with a veterinary product	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
179	Frequency and standards of analysis	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification
182	Establishment of NSW Egg Industry Consultative Committee and setting of procedures for calling and holding meetings	Director Biosecurity & Food Safety Compliance Director, Strategic Policy & Partnerships Manager, Compliance Investigations Manager, Audit Systems & Verification
183	Increases to license Fees for licences in respect of egg businesses	Director Biosecurity & Food Safety Compliance Manager, Compliance Investigations Manager, Audit Systems & Verification Manager, Licensing & Accreditation Services
Schedule 4 Standards for animal food processing plants		
Cl 6 of Schedule 4	Provision of amenities during processing	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations Manager, Food Incident Response & Complaints
Schedule 5 Prescribed brands for abattoir meat		
Cls 2, 6 and 9 of Schedule 5	Approve the varying of the dimensions of the brand	Director Biosecurity & Food Safety Compliance
Schedule 6 Prescribed brands for game meat		
Clause 2 of Schedule 6	Approve the varying of the dimensions of the brand	Director Biosecurity & Food Safety Compliance
Schedule 7 Provisions relating to members and procedure of local shellfish committees		
Cl 3 of Schedule 7	Appointment of deputy for member	Director, Food Science & Strategy Manager, Shellfish Program

Schedule 3 – the Code

Column 1 Part and Section of the Act	**Column 2** Summary of functions delegated and limitations (if any)	**Column 3** Role Title
The Code		
The entire Code	All powers or functions of a relevant authority or the appropriate enforcement agency in the Code	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations
The entire Code	Any requirement in the Code to demonstrate that a requirement in the Code can be met by an alternative method	Director Biosecurity & Food Safety Compliance Manager, Audit Systems & Verification Manager, Compliance Investigations
Chapters 3.2.2 and 3.2.3 of the Code	All powers or functions of a relevant authority or the appropriate enforcement agency in the Code	The holder of the office of general manager of a local council

Note: Clause 38 of the *Food Regulation 2015* provides that a reference in the Code to relevant authority or appropriate enforcement agency are to be read as a reference to the Food Authority. It also provides that a reference to "demonstrate" is to be read to demonstrate to the satisfaction of the Food Authority.

State Insurance Regulatory Authority



NSW workers compensation guidelines for the evaluation of permanent impairment

Fourth edition – 1 April 2016

Foreword

The State Insurance Regulatory Authority has issued the 4th edition of the *NSW workers compensation guidelines for the evaluation of permanent impairment* (catalogue no. WC00970) (the Guidelines) for assessing the degree of permanent impairment arising from an injury or disease within the context of workers' compensation. When a person sustains a permanent impairment, trained medical assessors must use the Guidelines to ensure an objective, fair and consistent method of evaluating the degree of permanent impairment.

The Guidelines are based on a template that was developed through a national process facilitated by Safe Work Australia. They were initially developed for use in the NSW system and incorporate numerous improvements identified by the then WorkCover NSW Whole Person Impairment Coordinating Committee over 13 years of continuous use. Members of this committee and of the South Australia Permanent Impairment Committee (see list in Appendix 2) dedicated many hours to thoughtfully reviewing and improving the Guidelines. This work is acknowledged and greatly appreciated.

The methodology in the Guidelines is largely based on the American Medical Association's *Guides to the Evaluation of Permanent Impairment,* 5th Edition (AMA5). The AMA guides are the most authoritative and widely used in evaluating permanent impairment around the world. Australian medical specialists representing Australian medical associations and colleges have extensively reviewed AMA5 to ensure it aligns with clinical practice in Australia.

The Guidelines consist of an introductory chapter followed by chapters dedicated to each body system.

The Introduction is divided into three parts. The first outlines the background and development of the Guidelines, including reference to the relevant legislative instrument that gives effect to the Guidelines. The second covers general assessment principles for medical practitioners applying the Guidelines in assessing permanent impairment resulting from work-related injury or disease. The third addresses administrative issues relating to the use of the Guidelines.

As the template national guideline has been progressively adapted from the NSW Guideline and is to be adopted by other jurisdictions, some aspects have been necessarily modified and generalised. Some provisions may differ between different jurisdictions. For further information, please see the *Comparison of Workers' Compensation Arrangements in Australia and New Zealand report*, which is available on Safe Work Australia's website at safeworkaustralia.gov.au.

Publications such as this only remain useful to the extent that they meet the needs of users and those who sustain a permanent impairment. It is, therefore, important that the protocols set out in the Guidelines are applied consistently and methodically. Any difficulties or anomalies need to be addressed through modification of the publication and not by idiosyncratic reinterpretation of any part. All queries on the Guidelines or suggestions for improvement should be addressed to the State Insurance Regulatory Authority at contact@workcover.nsw.gov.au.

Contents

1. Introduction

PART 1 – INTENT AND LEGISLATIVE BASIS FOR THESE GUIDELINES

1.1 For the purposes of the WorkCover Authority of NSW*, the 4th edition of the *NSW workers compensation guidelines for the evaluation of permanent impairment* (catalogue no. WC00970) (the Guidelines) are made under s376 of the *Workplace Injury Management and Workers Compensation Act 1998* (WIMWC Act). The Guidelines are to be used within the NSW workers compensation system to evaluate permanent impairment arising from work-related injuries and diseases.

The Guidelines adopt the 5th edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (AMA5) in most cases. Where there is any deviation, the difference is defined in the Guidelines and the procedures detailed in each section are to prevail.

Date of effect

1.2 The Guidelines replace the *WorkCover Guides for the evaluation of permanent impairment,* 3rd edition, which was issued in February 2009, and apply to assessments of permanent impairment conducted on or after 1 April 2016.

When conducting a permanent impairment assessment in accordance with the Guidelines, assessors are required to use the version current at the time of the assessment.

Development of the Guidelines

1.3 The Guidelines are based on a template that was developed through a national process facilitated by Safe Work Australia. The template national guideline is based on similar guidelines developed and used extensively in the NSW workers compensation system. Consequently, provisions in the Guidelines are the result of extensive and in-depth deliberations by groups of medical specialists convened to review AMA5 in the Australian workers compensation context. In NSW it is a requirement under s377(2) of the WIMWC Act that the guidelines are developed in consultation with relevant medical colleges. The groups that contributed to the development of the Guidelines is acknowledged and recorded at Appendix 2. The template national guideline has been adopted for use in multiple Australian jurisdictions.

1.4 Use of the Guidelines is monitored by the jurisdictions that have adopted it. The Guidelines may be reviewed if significant anomalies or insurmountable difficulties in their use become apparent.

1.5 The Guidelines are intended to assist a suitably qualified and experienced medical practitioner in assessing a claimant's degree of permanent impairment.

PART 2 – PRINCIPLES OF ASSESSMENT

1.6 The following is a basic summary of some key principles of permanent impairment assessments:

a. Assessing permanent impairment involves clinical assessment of the claimant as they present on the day of assessment taking account the claimant's relevant medical history and all available relevant medical information to determine:

- whether the condition has reached Maximum Medical Improvement (MMI)
- whether the claimant's compensable injury/condition has resulted in an impairment
- whether the resultant impairment is permanent
- the degree of permanent impairment that results from the injury
- the proportion of permanent impairment due to any previous injury, pre-existing condition or abnormality, if any, in accordance with diagnostic and other objective criteria as outlined in these Guidelines.

* As of 1 September 2015, the workers compensation insurance regulatory functions of WorkCover NSW have been assumed by the State Insurance Regulatory Authority.

b. Assessors are required to exercise their clinical judgement in determining a diagnosis when assessing permanent impairment and making deductions for pre-existing injuries/conditions.

c. In calculating the final level of impairment, the assessor needs to clarify the degree of impairment that results from the compensable injury/condition. Any deductions for pre-existing injuries/conditions are to be clearly identified in the report and calculated. If, in an unusual situation, a related injury/condition has not previously been identified, an assessor should record the nature of any previously unidentified injury/condition in their report and specify the causal connection to the relevant compensable injury or medical condition.

d. The referral for an assessment of permanent impairment is to make clear to the assessor the injury or medical condition for which an assessment is sought – see also paragraphs 1.43 and 1.44 in the Guidelines.

1.7 Medical assessors are expected to be familiar with chapters 1 and 2 of AMA5, in addition to the information in this introduction.

1.8 The degree of permanent impairment that results from the injury/condition must be determined using the tables, graphs and methodology given in the Guidelines and the AMA5, where appropriate.

1.9 The Guidelines may specify more than one method that assessors can use to establish the degree of a claimant's permanent impairment. In that case, assessors should use the method that yields the highest degree of permanent impairment. (This does not apply to gait derangement – see paragraphs 3.5 and 3.10 in the Guidelines).

Body systems covered by the Guidelines

1.10 AMA5 is used for most body systems, with the exception of psychiatric and psychological disorders, chronic pain, and visual and hearing injuries.

1.11 AMA5 Chapter 14, on mental and behavioural disorders, has been omitted. The Guidelines contain a substitute chapter on the assessment of psychiatric and psychological disorders (Chapter 11) which was written by a group of Australian psychiatrists.

1.12 AMA5 Chapter 18, on pain, is excluded entirely at the present time. Conditions associated with chronic pain should be assessed on the basis of the underlying diagnosed condition, and not on the basis of the chronic pain. Where pain is commonly associated with a condition, an allowance is made in the degree of impairment assigned in the Guidelines. Complex regional pain syndrome should be assessed in accordance with Chapter 17 of the Guidelines.

1.13 On the advice of medical specialists (ophthalmologists), assessments of visual injuries are conducted according to the American Medical Association's *Guides to the Evaluation of Permanent Impairment,* 4th Edition (AMA4).

1.14 The methodology for evaluating permanent impairment due to hearing loss is in Chapter 9 of the Guidelines, with some reference to AMA5 Chapter 11 (pp 245–251) and also the tables in the National Acoustic Laboratories (NAL) Report No. 118, *Improved Procedure for Determining Percentage Loss of Hearing,* January 1988.

Maximum medical improvement

1.15 Assessments are only to be conducted when the medical assessor considers that the degree of permanent impairment of the claimant is unlikely to improve further and has attained maximum medical improvement. This is considered to occur when the worker's condition is well stabilised and is unlikely to change substantially in the next year with or without medical treatment.

1.16 If the medical assessor considers that the claimant's treatment has been inadequate and maximum medical improvement has not been achieved, the assessment should be deferred and comment made on the value of additional or different treatment and/or rehabilitation – subject to paragraph 1.34 in the Guidelines.

Multiple impairments

1.17 Impairments arising from the same injury are to be assessed together. Impairments resulting from more than one injury arising out of the same incident are to be assessed together to calculate the degree of permanent impairment of the claimant.

1.18 The Combined Values Chart in AMA5 (pp 604–06) is used to derive a percentage of whole person impairment (WPI) that arises from multiple impairments. An explanation of the chart's use is found on pp 9–10 of AMA5. When combining more than two impairments, the assessor should commence with the highest impairment and combine with the next highest and so on.

1.19 The exception to this rule is in the case of psychiatric or psychological injuries. Where applicable, impairments arising from primary psychological and psychiatric injuries are to be assessed separately from the degree of impairment that results from any physical injuries arising out of the same incident. The results of the two assessments cannot be combined.

1.20 In the case of a complex injury, where different medical assessors are required to assess different body systems, a 'lead assessor' should be nominated to coordinate and calculate the final degree of permanent impairment as a percentage of WPI resulting from the individual assessments.

Psychiatric and psychological injuries

1.21 Psychiatric and psychological injuries in the NSW workers compensation system are defined as primary psychological and psychiatric injuries in which work was found to be a substantial contributing factor.

1.22 A primary psychiatric condition is distinguished from a secondary psychiatric or psychological condition, which arises as a consequence of, or secondary to, another work related condition (eg depression associated with a back injury). No permanent impairment assessment is to be made of secondary psychiatric and psychological impairments. As referenced in paragraph 1.19, impairments arising from primary psychological and psychiatric injuries are to be assessed separately from the degree of impairment that results from physical injuries arising out of the same incident. The results of the two assessments cannot be combined.

Conditions that are not covered in the Guidelines – equivalent or analogous conditions

1.23 AMA5 (p 11) states: 'Given the range, evolution and discovery of new medical conditions, these Guidelines cannot provide an impairment rating for all impairments… In situations where impairment ratings are not provided, these Guidelines suggest that medical practitioners use clinical judgment, comparing measurable impairment resulting from the unlisted condition to measurable impairment resulting from similar conditions with similar impairment of function in performing activities of daily living.' The assessor must stay within the body part/region when using analogy.

'The assessor's judgment, based upon experience, training, skill, thoroughness in clinical evaluation, and ability to apply the Guidelines criteria as intended, will enable an appropriate and reproducible assessment to be made of clinical impairment.'

Activities of daily living

1.24 Many tables in AMA5 (eg in the spine section) give class values for particular impairments, with a range of possible impairment values in each class. Commonly, the tables require the assessor to consider the impact of the injury or illness on activities of daily living (ADL) in determining the precise impairment value. The ADL which should be considered, if relevant, are listed in AMA5 Table 1–2 (p 4). The impact of the injury on ADL is not considered in assessments of the upper or lower extremities.

1.25 The assessment of the impact of the injury or condition on ADL should be verified, wherever possible, by reference to objective assessments – for example, physiotherapist or occupational therapist functional assessments and other medical reports.

Rounding

1.26 Occasionally the methods of the Guidelines will result in an impairment value which is not a whole number (eg an assessment of peripheral nerve impairment in the upper extremity). All such values must be rounded to the nearest whole number before moving from one degree of impairment to the next (eg from finger impairment to hand impairment, or from hand impairment to upper extremity impairment) or from a regional impairment to a WPI. Figures should also be rounded before using the combination tables. This will ensure that the final WPI will always be a whole number. The usual mathematical convention is followed where rounding occurs – values less than 0.5 are rounded down to the nearest whole number and values of 0.5 and above are rounded up to the next whole number. The method of calculating levels of binaural hearing loss is shown in Chapter 9, paragraph 9.15, in the Guidelines.

Deductions for pre-existing condition or injuries

1.27 The degree of permanent impairment resulting from pre-existing impairments should not be included in the final calculation of permanent impairment if those impairments are not related to the compensable injury. The assessor needs to take account of all available evidence to calculate the degree of permanent impairment that pre-existed the injury.

1.28 In assessing the degree of permanent impairment resulting from the compensable injury/condition, the assessor is to indicate the degree of impairment due to any previous injury, pre-existing condition or abnormality. This proportion is known as 'the deductible proportion' and should be deducted from the degree of permanent impairment determined by the assessor. For the injury being assessed, the deduction is 1/10th of the assessed impairment, unless that is at odds with the available evidence.

Adjustment for the effects of orthoses and prostheses

1.29 Assessments of permanent impairment are to be conducted without assistive devices, except where these cannot be removed. The assessor will need to make an estimate as to what is the degree of impairment without such a device, if it cannot be removed for examination purposes. Further details may be obtained in the relevant chapters of the Guidelines.

1.30 Impairment of vision should be measured with the claimant wearing their prescribed corrective spectacles and/or contact lenses, if this was usual for them before the injury. If, as a result of the injury, the claimant has been prescribed corrective spectacles and/or contact lenses for the first time, or different spectacles and/or contact lenses than those prescribed pre-injury, the difference should be accounted for in the assessment of permanent impairment.

Adjustment for the effects of treatment

1.31 In circumstances where the treatment of a condition leads to a further, secondary impairment, other than a secondary psychological impairment, the assessor should use the appropriate parts of the Guidelines to evaluate the effects of treatment, and use the Combined Values Chart (AMA5, pp 604–06) to arrive at a final percentage of WPI.

1.32 Where the effective long-term treatment of an illness or injury results in apparent substantial or total elimination of the claimant's permanent impairment, but the claimant is likely to revert to the original degree of impairment if treatment is withdrawn, the assessor may increase the percentage of WPI by 1%, 2% or 3%. This percentage should be combined with any other impairment percentage, using the Combined Values Chart. This paragraph does not apply to the use of analgesics or anti-inflammatory medication for pain relief.

1.33 Where a claimant has declined treatment which the assessor believes would be beneficial, the impairment rating should be neither increased nor decreased – see paragraph 1.35 for further details.

Refusal of treatment

1.34 If the claimant has been offered, but has refused, additional or alternative medical treatment that the assessor considers likely to improve the claimant's condition, the medical assessor should evaluate the current condition without consideration of potential changes associated with the proposed treatment. The assessor may note the potential for improvement in the claimant's condition in the evaluation report, and the reasons for refusal by the claimant, but should not adjust the level of impairment on the basis of the claimant's decision.

Future deterioration of a condition

1.35 Similarly, if a medical assessor forms the opinion that the claimant's condition is stable for the next year, but that it may deteriorate in the long term, the assessor should make no allowance for this deterioration.

Inconsistent presentation

1.36 AMA5 (p 19) states: 'Consistency tests are designed to ensure reproducibility and greater accuracy. These measurements, such as one that checks the individual's range of motion are good but imperfect indicators of people's efforts. The assessor must use their entire range of clinical skill and judgment when assessing whether or not the measurements or test results are plausible and consistent with the impairment being evaluated. If, in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the assessor may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing.' This paragraph applies to inconsistent presentation only.

Ordering of additional investigations

1.37 As a general principle, the assessor should not order additional radiographic or other investigations purely for the purpose of conducting an assessment of permanent impairment.

1.38 However, if the investigations previously undertaken are not as required by the Guidelines, or are inadequate for a proper assessment to be made, the medical assessor should consider the value of proceeding with the evaluation of permanent impairment without adequate investigations.

1.39 In circumstances where the assessor considers that further investigation is essential for a comprehensive evaluation to be undertaken, and deferral of the evaluation would considerably inconvenience the claimant (eg when the claimant has travelled from a country region specifically for the assessment), the assessor may proceed to order the appropriate investigations provided that there is no undue risk to the claimant. The approval of the referring body for the additional investigation will be required to ensure that the costs of the test are met promptly.

PART 3 – ADMINISTRATIVE PROCESS

Medical assessors

1.40 An assessor will be a registered medical practitioner recognised as a medical specialist.

- 'Medical practitioner' means a person registered in the medical profession under the *Health Practitioner Regulation National Law (NSW)* No. 86a, or equivalent Health Practitioner Regulation National Law in their jurisdiction with the Australian Health Practitioner Regulation Agency.
- 'Medical specialist' means a medical practitioner recognised as a specialist in accordance with the *Health Insurance Regulations 1975,* Schedule 4, Part 1, who is remunerated at specialist rates under Medicare.

The assessor will have qualifications, training and experience relevant to the body system being assessed. The assessor will have successfully completed requisite training in using the Guidelines for each body system they intend on assessing. They will be listed as a trained assessor of permanent impairment for each relevant body system(s) on the State Insurance Regulatory Authority website at sira.nsw.gov.au.

1.41 An assessor may be one of the claimant's treating practitioners or an assessor engaged to conduct an assessment for the purposes of determining the degree of permanent impairment.

Information required for assessments

1.42 Information for claimants regarding independent medical examinations and assessments of permanent impairment should be supplied by the referring body when advising of the appointment details.

1.43 On referral, the medical assessor should be provided with all relevant medical and allied health information, including results of all clinical investigations related to the injury/condition in question.

1.44 Most importantly, assessors must have available to them all information about the onset, subsequent treatment, relevant diagnostic tests, and functional assessments of the person claiming a permanent impairment. The absence of required information could result in an assessment being discontinued or deferred. AMA5 Chapter 1, Section 1.5 (p 10) applies to the conduct of assessments and expands on this concept.

1.45 The Guidelines and AMA5 indicate the information and investigations required to arrive at a diagnosis and to measure permanent impairment. Assessors must apply the approach outlined in the Guidelines.

Referrers must consult this publication to gain an understanding of the information that should be provided to the assessor in order to conduct a comprehensive evaluation of impairment.

Reports

1.46 A report of the evaluation of permanent impairment should be accurate, comprehensive and fair. It should clearly address the question(s) being asked of the assessor. In general, the assessor will be requested to address issues of:

- current clinical status, including the basis for determining maximum medical improvement
- the degree of permanent impairment that results from the injury/condition, and
- the proportion of permanent impairment due to any previous injury, pre-existing condition or abnormality, if applicable.

1.47 The report should contain factual information based on all available medical information and results of investigations, the assessor's own history-taking and clinical examination. The other reports or investigations that are relied upon in arriving at an opinion should be appropriately referenced in the assessor's report.

1.48 As the Guidelines are to be used to assess permanent impairment, the report of the evaluation should provide a rationale consistent with the methodology and content of the Guidelines. It should include a comparison of the key findings of the evaluation with the impairment criteria in the Guidelines. If the evaluation was conducted in the absence of any pertinent data or information, the assessor should indicate how the impairment rating was determined with limited data.

1.49 The assessed degree of impairment is to be expressed as a percentage of WPI.

1.50 The report should include a conclusion of the assessor, including the final percentage of WPI. This is to be included as the final paragraph in the body of the report, and not as a separate report or appendix. The report must include a copy of all calculations and a summary table. A template reporting format is provided in the *WorkCover Guidelines on independent medical examinations and reports* at sira.nsw.gov.au.

1.51 Reports are to be provided within 10 working days of the assessment being completed, or as agreed between the referrer and the assessor.

Quality assurance

1.52 The degree of permanent impairment that results from the injury must be determined using the tables, graphs and methodology given in the Guidelines, as presented in the training in the use of the Guidelines and the applicable legislation. If it is not clear that a report has been completed in accordance with the Guidelines, clarification may be sought from the assessor who prepared the report.

1.53 An assessor who is identified as frequently providing reports that are not in accord with the Guidelines, or not complying with other service standards as set by the State Insurance Regulatory Authority, may be subject to State Insurance Regulatory Authority performance monitoring procedures and be asked to show cause as to why their name should not be removed from the list of trained assessors on the State Insurance Regulatory Authority website.

Code of conduct

1.54 Assessors are referred to the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia, 8.7 Medico-legal, insurance and other assessments*.

1.55 Assessors are reminded that they have an obligation to act in an ethical, professional and considerate manner when examining a claimant for the determination of permanent impairment.

1.56 Effective communication is vital to ensure that the claimant is well informed and able to maximally cooperate in the process. Assessors should:

- ensure that the claimant understands who the assessor is and the assessor's role in the evaluation
- ensure that the claimant understands how the evaluation will proceed
- take reasonable steps to preserve the privacy and modesty of the claimant during the evaluation
- not provide any opinion to the claimant about their claim.

1.57 Complaints received in relation to the behaviour of an assessor during an evaluation will be managed in accordance with the process outlined in the *WorkCover Guidelines on independent medical examinations and reports* at sira.nsw.gov.au and State Insurance Regulatory Authority performance monitoring procedures.

Disputes over the assessed degree of permanent impairment

1.58 Where there is a discrepancy or inconsistency between medical reports that cannot be resolved between the parties, the Workers Compensation Commission has the jurisdiction to determine disputes about assessed degree of permanent impairment.

2. Upper extremity

AMA5 Chapter 16 (p 433) applies to the assessment of permanent impairment of the upper extremities, subject to the modifications set out below. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing
- the appropriate chapter(s) of AMA5 for the body system they are assessing.

The Guidelines take precedence over AMA5.

Introduction

2.1 The upper extremities are discussed in AMA5 Chapter 16 (pp 433–521). This chapter provides guidelines on methods of assessing permanent impairment involving these structures. It is a complex chapter that requires an organised approach with careful documentation of findings.

2.2 Evaluation of anatomical impairment forms the basis for upper extremity impairment (UEI) assessment. The rating reflects the degree of impairment and its impact on the ability of the person to perform ADL. There can be clinical conditions where evaluation of impairment may be difficult. Such conditions are evaluated by their effect on function of the upper extremity, or, if all else fails, by analogy with other impairments that have similar effects on upper limb function.

The approach to assessment of the upper extremity and hand

2.3 Assessment of the upper extremity mainly involves clinical evaluation. Cosmetic and functional evaluations are performed in some situations. The impairment must be permanent and stable. The claimant will have a defined diagnosis that can be confirmed by examination.

2.4 The assessed impairment of a part or region can never exceed the impairment due to amputation of that part or region. For an upper limb, therefore, the maximum evaluation is 60% whole person impairment (WPI), the value for amputation through the shoulder.

2.5 Range of motion (ROM) is assessed as follows:

- A goniometer or inclinometer must be used, where clinically indicated.
- Passive ROM may form part of the clinical examination to ascertain clinical status of the joint, but impairment should only be calculated using active ROM measurements. Impairment values for degree measurements falling between those listed must be adjusted or interpolated.
- If the assessor is not satisfied that the results of a measurement are reliable, repeated testing may be helpful in this situation.
- If there is inconsistency in ROM, then it should not be used as a valid parameter of impairment evaluation. Refer to paragraph 1.36 in the Guidelines.
- If ROM measurements at examination cannot be used as a valid parameter of impairment evaluation, the assessor should then use discretion in considering what weight to give other available evidence to determine if an impairment is present.

2.6 To achieve an accurate and comprehensive assessment of the upper extremity, findings should be documented on a standard form. AMA5 Figures 16-1a and 16-1b (pp 436–37) are extremely useful both to document findings and to guide the assessment process.

2.7 The hand and upper extremity are divided into regions: thumb, fingers, wrist, elbow and shoulder. Close attention needs to be paid to the instructions in AMA5 Figures 16-1a and 16-1b (pp 436–37) regarding adding or combining impairments.

2.8 AMA5 Table 16-3 (p 439) is used to convert upper extremity impairment to WPI. When the Combined Values Chart is used, the assessor must ensure that all values combined are in the same category of impairment (that is WPI, upper extremity impairment percentage, hand impairment percentage and so on). Regional impairments of the same limb (eg several upper extremity impairments) should be combined before converting to percentage WPI. (Note that impairments relating to the joints of the thumb are added rather than combined – AMA5 Section 16.4d 'Thumb ray motion impairment', p 454.)

Specific interpretation of AMA5 – the hand and upper extremity impairment of the upper extremity due to peripheral nerve disorders

2.9 If an upper extremity impairment results solely from a peripheral nerve injury, the assessor should not also evaluate impairment(s) from AMA5 Section 16.4 'Abnormal motion' (pp 450–79) for that upper extremity. AMA5 Section 16.5 should be used for evaluating such impairments.

For evaluating peripheral nerve lesions, use AMA5 Table 16-15 (p 492) together with AMA5 tables 16-10 and 16-11 (pp 482 and 484).

The assessment of carpal tunnel syndrome post-operatively is undertaken in the same way as assessment without operation.

2.10 When applying AMA5 tables 16-10 (p 482) and 16-11 (pp 482 and 484) the examiner must use clinical judgement to estimate the appropriate percentage within the range of values shown for each severity grade. The maximum value is not applied automatically.

Impairment due to other disorders of the upper extremity

2.11 AMA5 Section 16.7 'Impairment of the upper extremity due to other disorders' (pp 498–507) should be used only when other criteria (as presented in AMA5 sections 16.2–16.6, pp 441–98) have not adequately encompassed the extent of the impairments. Impairments from the disorders considered in AMA5 Section 16.7 are usually estimated using other criteria. The assessor must take care to avoid duplication of impairments.

2.12 AMA5 Section 16.7 (impairment of the upper extremities due to other disorders) notes 'the severity of impairment due to these disorders is rated separately according to Table 16-19 through 16-30 and then multiplied by the relative maximum value of the unit involved, as specified in Table 16-18'. This statement should not include tables 16-25 (carpal instability), 16-26 (shoulder instability) and 16-27 (arthroplasty), noting that the information in these tables is already expressed in terms of upper extremity impairment.

2.13 Strength evaluation, as a method of upper extremity impairment assessment, should only be used in rare cases and its use justified when loss of strength represents an impairing factor not adequately considered by more objective rating methods. If chosen as a method, the caveats detailed on AMA5 p 508 under the heading '16.8a Principles' need to be observed – ie decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities and absence of parts (eg thumb amputation).

Conditions affecting the shoulder region

2.14 Most shoulder disorders with an abnormal range of movement are assessed according to AMA5 Section 16.4 'Evaluating abnormal motion'. (Please note that AMA5 indicates that internal and external rotation of the shoulder are to be measured with the arm abducted in the coronal plane to 90 degrees, and with the elbow flexed to 90 degrees. In those situations where abduction to 90 degrees is not possible, symmetrical measurement of rotation is to be carried out at the point of maximal abduction).

Rare cases of rotator cuff injury, where the loss of shoulder motion does not reflect the severity of the tear, and there is **no associated pain**, may be assessed according to AMA5 Section 16.8c 'Strength evaluation'. Other specific shoulder disorders where the loss of shoulder motion does not reflect the severity of the disorder, **associated with pain**, should be assessed by comparison with other impairments that have similar effect(s) on upper limb function.

As noted in AMA5 Section 16.7b 'Arthroplasty', 'In the presence of **decreased motion**, motion impairments are derived separately and **combined** with the arthroplasty impairment'. This includes those arthroplasties in AMA5 Table 16-27 designated as (isolated).

Please note that in AMA5 Table 16-27 (p 506) the figure for resection arthroplasty of the distal clavicle (isolated) has been changed to 5% upper extremity impairment, and the figure for resection arthroplasty of the proximal clavicle (isolated) has been changed to 8% upper extremity impairment.

Please note that in AMA5 Table 16-18 (p 499) the figures for impairment suggested for the sternoclavicular joint have been changed from 5% upper extremity impairment and 3% whole person impairment, to 25% upper extremity impairment and 15% whole person impairment.

2.15 **Ruptured long head of biceps** shall be assessed as an upper extremity impairment (UEI) of 3%UEI or 2%WPI where it exists in isolation from other rotator cuff pathology. Impairment for ruptured long head of biceps cannot be combined with any other rotator cuff impairment or with loss of range of movement.

2.16 Diagnosis of impingement is made on the basis of positive findings on appropriate provocative testing and is only to apply where there is no loss of range of motion. Symptoms must have been present for at least 12 months. An impairment rating of 3% UEI or 2% WPI shall apply.

Fractures involving joints

2.17 Displaced fractures involving joint surfaces are generally to be rated by range of motion. If, however, this loss of range is not sufficient to give an impairment rating, and movement is accompanied by pain and there is 2mm or more displacement, allow 2% UEI (1% WPI).

Epicondylitis of the elbow

2.18 This condition is rated as 2% UEI (1% WPI). In order to assess impairment in cases of epicondylitis, symptoms must have been present for at least 18 months. Localised tenderness at the epicondyle must be present and provocative tests must also be positive. If there is an associated loss of range of movement, these figures are not combined, but the method giving the highest rating is used.

Resurfacing procedures

2.19 No additional impairment is to be awarded for resurfacing procedures used in the treatment of localised cartilage lesions and defects in major joints.

Calculating motion impairment

2.20 When calculating impairment for loss of range of movement, it is most important to always compare measurements of the relevant joint(s) in both extremities. If a contralateral 'normal/uninjured' joint has less than average mobility, the impairment value(s) corresponding to the uninvolved joint serves as a baseline and is subtracted from the calculated impairment for the involved joint. The rationale for this decision should be explained in the assessor's report (see AMA5 Section 16.4c, p 543).

Complex regional pain syndrome (upper extremity)

2.21 Complex regional pain syndrome types 1 and 2 should be assessed using the method in Chapter 17 of the Guidelines.

3. Lower extremity

AMA5 Chapter 17 (p 523) applies to the assessment of permanent impairment of the lower extremities, subject to the modifications set out below. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing
- the appropriate chapter(s) of AMA5 for the body system they are assessing.

The Guidelines take precedence over AMA5.

Introduction

3.1 The lower extremities are discussed in AMA5 Chapter 17 (pp 523–564). This section is complex and provides a number of alternative methods of assessing permanent impairment involving the lower extremity. An organised approach is essential.

The approach to assessment of the lower extremity

3.2 Assessment of the lower extremity involves physical evaluation, which can use a variety of methods. In general, the method should be used that most specifically addresses the impairment present. For example, impairment due to a peripheral nerve injury in the lower extremity should be assessed with reference to that nerve rather than by its effect on gait.

3.3 There are several different forms of evaluation that can be used, as indicated in AMA5 sections 17.2b to 17.2n (pp 528–54). AMA5 Table 17-2 (p 526) indicates which evaluation methods can be **combined** and which cannot. It may be possible to perform several different evaluations, as long as they are reproducible and meet the conditions specified below and in AMA5. The most specific method of impairment assessment should be used. (Please note that in Table 17-2, the boxes in the fourth row (on muscle strength) and seventh column (on amputation) should be closed boxes ☒ rather than open boxes ☐).

3.4 It is possible to use an algorithm to aid in the assessment of lower extremity impairment (LEI). Use of a worksheet is essential. Table 3.5 at the end of this chapter is such a worksheet and may be used in assessment of permanent impairment of the lower extremity.

3.5 In the assessment process, the evaluation giving the highest impairment rating is selected. That may be a combined impairment in some cases, in accordance with the AMA5 Table 17-2 'Guide to the appropriate combination of evaluation methods', using the Combined Values Chart on pp 604–06 of AMA5.

3.6 When the Combined Values Chart is used, the assessor must ensure that all values combined are in the same category of impairment rating (ie percentage of WPI, percentage of lower extremity impairment, foot impairment percentage, and so on). Regional impairments of the same limb (eg several lower extremity impairments) should be combined before converting to a percentage of whole person impairment (WPI).

3.7 AMA5 Table 17-2 (p 526) AMA5) needs to be referred to frequently to determine which impairments can be combined and which cannot. The assessed impairment of a part or region can never exceed the impairment due to amputation of that part or region. For the lower limb, therefore, the maximum evaluation is 40% WPI, the value for proximal above-knee amputation.

Specific interpretation of AMA5 – the lower extremity

Leg length discrepancy

3.8 When true leg length discrepancy is determined clinically (see AMA5 Section 17.2b, p 528), the method used must be indicated (eg tape measure from anterior superior iliac spine to the medial malleolus). Clinical assessment of leg length discrepancy is an acceptable method, but if full-length computerised tomography films are available, they should be used in preference. Such an examination should not be ordered solely for determining leg lengths.

3.9 Note that the figures for lower limb impairment in AMA5 Table 17-4 (p 528) are incorrect. The correct figures are shown below.

AMA5 Table 17-4: Impairment due to limb length discrepancy

Discrepancy (cm)	Whole person (lower extremity) impairment (%)
0–1.9	0
2–2.9	3 (8)
3–3.9	5 (13)
4–4.9	7 (18)
5+	8 (19)

Gait derangement

3.10 Assessment of gait derangement is only to be used as a method of last resort. Methods of impairment assessment most fitting the nature of the disorder should always be used in preference. If gait derangement (AMA5 Section 17.2c, p 529) is used, it cannot be combined with any other evaluation in the lower extremity section of AMA5.

3.11 Any walking aid used by the subject must be a permanent requirement and not temporary.

3.12 In the application of AMA5 Table 17-5 (p 529), delete item 'b', as the Trendelenburg sign is not sufficiently reliable.

Muscle atrophy (unilateral)

3.13 AMA5 Section 17.2d (p 530) is not applicable if the limb other than that being assessed is abnormal (eg if varicose veins cause swelling, or if there is another injury or condition which has contributed to the disparity in size).

3.14 Note that the figures for lower limb impairment given in AMA5 Table 17-6 (p 530) are incorrect. The correct figures are shown below.

AMA5 Table 17-6: Impairment due to unilateral leg muscle atrophy

Difference in circumference (cm)	Impairment degree	Whole person (lower extremity) impairment (%)
a. Thigh: The circumference is measured 10cm above the patella, with the knee fully extended and the muscles relaxed.		
0–0.9	None	0 (0)
1–1.9	Mild	2 (6)
2–2.9	Moderate	4 (11)
3+	Severe	5 (12)

Difference in circumference (cm)	Impairment degree	Whole person (lower extremity) impairment (%)
b. Calf: The maximum circumference on the normal side is compared with the circumference at the same level on the affected side.		
0–0.9	None	0 (0)
1–1.9	Mild	2 (6)
2–2.9	Moderate	4 (11)
3+	Severe	5 (12)

Manual muscle strength testing

3.15 The Medical Research Council gradings for muscle strength are universally accepted. They are not linear in their application, but ordinal. Only the six grades (0–5) should be used, as they are reproducible among experienced assessors. The descriptions in AMA5 Table 17-7 (p 531) are correct. The results of electro-diagnostic methods and tests are not to be considered in evaluating muscle testing, which can be performed manually. AMA5 Table 17-8 (p 532) is to be used for this method of evaluation.

Range of motion

3.16 Although range of motion (ROM) appears to be a suitable method for evaluating impairment (see AMA5 Section 17.2f, pp 533–38), it may be subject to variation because of pain during motion at different times of examination, possible lack of cooperation by the person being assessed and inconsistency. If there is such inconsistency, then ROM cannot be used as a valid parameter of impairment evaluation.

AMA5 Table 17-10 (p 537) is misleading as it has valgus and varus deformity in the same table as restriction of movement, possibly suggesting that these impairments may be combined. This is not the case. Any valgus/varus deformity present which is due to the underlying lateral or medial compartment arthritis, cannot be combined with loss of range of movement. Therefore, when faced with an assessment in which there is a rateable loss of range of movement as well as a rateable deformity, calculate both impairments and use the greater. Valgus and varus knee angulation are to be measured in a weight-bearing position using a goniometer. It is important to bear in mind that valgus and/or varus alignments of the knee may be constitutional. It is also important to always compare with the opposite knee.

3.17 If range of motion is used as an assessment measure, then AMA5 Tables 17-9 to 17 14 (p 537) are selected for the joint or joints being tested. If a joint has more than one plane of motion, the impairment assessments for the different planes should be added. For example, any impairment of the six principal directions of motion of the hip joint are added (see AMA5, p 533).

In AMA5 Table 17-10 (p 537), on knee impairment, the sentence should read: 'Deformity measured by femoral-tibial angle; 3° to 9° valgus is considered normal'.

In AMA5 Table 17-11 (ankle motion) the range for mild flexion contracture should be one to 10°, for moderate flexion contracture it should be 11° to 19°, and for severe flexion contracture it should be 20° plus.

The revised Table 17-11 is below.

AMA5 Table 17-11: Ankle motion impairment estimates

	Whole person (lower extremity) [foot] impairment		
Motion	**Mild** 3% (7%) [10%]	**Moderate** 6% (15%) [21%]	**Severe** 12% (30%) [43%]
Plantar flexion capability	11°–20°	1°–10°	None
Flexion contracture	1°–10°	11°–19°	20°+
Extension	10°–0° (neutral)	-	-

When calculating impairment for loss of range of movement, it is most important to always compare measurements of the relevant joint(s) in both extremities. If a contralateral 'normal/uninjured' joint has less than average mobility, the impairment value(s) corresponding to the uninvolved joint serves as a baseline, and is subtracted from the calculated impairment for the involved joint. The rationale for this decision should be explained in the assessor's report (see AMA5 Section 16.4c, p 454).

Ankylosis

3.18 Ankylosis is to be regarded as the equivalent to arthrodesis in impairment terms only. For the assessment of impairment, when a joint is ankylosed (AMA5 section 17.2g, pp 538-543), the calculation to be applied is to select the impairment if the joint is ankylosed in optimum position (see table 3.1 below), and then if not ankylosed in the optimum position, by adding (not combining) the values of percentage of WPI using tables 17-15 to 17-30 (pp 538-543 AMA5).

Table 3.1: Impairment for ankylosis in the optimum position

Joint	Whole person %	Lower extremity %	Ankle or foot %
Hip	20	50	–
Knee	27	67	–
Pantalar	19	47	67
Ankle	15	37	53
Triple	6	15	21
Subtalar	4	10	14

Note that the figures in Table 3.1 suggested for ankle impairment are greater than those suggested in AMA5.

Ankylosis of the ankle in the neutral/optimal position equates with 15 (37) [53]% impairment as per Table 3.1. Table 3.1(a) is provided below as a guide to evaluate additional impairment owing to variation from the neutral position. The additional amounts at the top of each column are added to the figure for impairment in the neutral position. In keeping with the value given on page 541 of AMA5, the maximum impairment for ankylosis of the ankle remains at 25 (62) [88]% impairment.

Table 3.1(a): Impairment for ankylosis in variation from the optimum position

	Whole person (lower extremity) [foot] impairment			
Position	2 (5) [7]%	4 (10) [14]%	7 (17) [24]%	10 (25) [35]%
Dorsiflexion	5°–9°	10°–19°	20°–29°	30°+
Plantar flexion	–	10°–19°	20°–29°	30°+
Varus	5°–9°	10°–19°	20°–29°	30°+
Valgus	–	10°–19°	20°–29°	30°+
Internal rotation	0°–9°	10°–19°	20°–29°	30°+
External rotation	15°–19°	20°–29°	30°–39°	40°+

Arthritis

3.19 Impairment due to arthritis (AMA5 Section 17.2n, pp 544–45) following a work-related injury is uncommon, but may occur in isolated cases. The presence of arthritis may indicate a pre-existing condition and this should be assessed and an appropriate deduction made (see Chapter 1).

3.20 The presence of osteoarthritis is defined as cartilage loss. Cartilage loss can be measured by properly aligned plain X-ray, or by direct vision (arthroscopy), but impairment can only be assessed according to the radiologically determined cartilage loss intervals shown in AMA5 Table 17-31 (p 544). When assessing impairment of the knee joint, which has three compartments, only the compartment with the major impairment is used in the assessment. That is, measured impairments in the different compartments cannot be added or combined.

3.21 Detecting the subtle changes of cartilage loss on plain radiography requires comparison with the normal side. All joints should be imaged directly through the joint space, with no overlapping of bones. If comparison views are not available, AMA5 Table 17-31 (p 544) is used as a guide to assess joint space narrowing.

3.22 One should be cautious in making a diagnosis of cartilage loss on plain radiography if secondary features of osteoarthritis, such as osteophytes, subarticular cysts or subchondral sclerosis are lacking, unless the other side is available for comparison. The presence of an intra-articular fracture with a step in the articular margin in the weight-bearing area implies cartilage loss.

3.23 The accurate radiographic assessment of joints always requires at least two views. In some cases, further supplementary views will optimise the detection of joint space narrowing or the secondary signs of osteoarthritis.

Sacro-iliac joint: Being a complex joint, modest alterations are not detected on radiographs, and cross sectional imaging may be required. Radiographic manifestations accompany pathological alterations. The joint space measures between 2mm and 5mm. Osteophyte formation is a prominent characteristic of osteoarthritis of the sacro-iliac joint.

Hip: An anteroposterior view of the pelvis and a lateral view of the affected hip are ideal. If the affected hip joint space is narrower than the asymptomatic side, cartilage loss is regarded as being present. If the anteroposterior view of the pelvis has been obtained with the patient supine, it is important to compare the medial joint space of each hip, as well as superior joint space, as this may be the only site of apparent change. If both sides are symmetrical, then other features, such as osteophytes, subarticular cyst formation, and calcar thickening, should be taken into account to make a diagnosis of osteoarthritis.

Knee – Tibio-femoral joint: The best view for assessment of cartilage loss in the knee is usually the erect intercondylar projection, as this profiles and stresses the major weight-bearing area of the joint, which lies posterior to the centre of the long axis. The ideal X-ray is a posteroanterior view, with the patient standing, knees slightly flexed, and the X-ray beam angled parallel to the tibial plateau (Rosenberg view). Both knees can be readily assessed with the one exposure. It should be recognised that joint space narrowing in the knee does not necessarily equate with articular cartilage loss, as deficiency or displacement of the menisci can also have this effect. Secondary features, such as subchondral bone change and past surgical history, must also be taken into account.

Knee – Patello-femoral joint: This should be assessed in the 'skyline' view, again preferably with the other side for comparison. The X-ray should be taken with 30 degrees of knee flexion to ensure that the patella is load-bearing and has engaged the articular surface femoral groove.

Footnote to AMA5 Table 17-31 (p 544) regarding patello-femoral pain and crepitation:

This item is only to be used if there is a history of direct injury to the front of the knee, or in cases of patellar translocation/dislocation without direct anterior trauma. This item cannot be used as an additional impairment when assessing arthritis of the knee joint itself, of which it forms a component. If patello-femoral crepitus occurs in isolation (ie with no other signs of arthritis) following either of the above, then it can be combined with other diagnosis-based estimates (AMA5 Table 17-33, p 546). Signs of crepitus need to be present at least one year post-injury.

Note: Osteoarthritis of the patello-femoral joint cannot be used as an additional impairment when assessing arthritis of the knee joint itself, of which it forms a component.

Ankle: The ankle should be assessed in the mortice view (preferably weight-bearing), with comparison views of the other side, although this is not as necessary as with the hip and knee.

Subtalar: This joint is better assessed by CT (in the coronal plane) than by plain radiography. The complex nature of the joint does not lend itself to accurate and easy plain X-ray assessment of osteoarthritis.

Talonavicular and calcaneocuboid: Anteroposterior and lateral views are necessary. Osteophytes may assist in making the diagnosis.

Intercuneiform and other intertarsal joints: Joint space narrowing may be difficult to assess on plain radiography. CT (in the axial plane) may be required. Associated osteophytes and subarticular cysts are useful adjuncts to making the diagnosis of osteoarthritis in these small joints.

Great toe metatarsophalangeal: Anteroposterior and lateral views are required. Comparison with the other side may be necessary. Secondary signs may be useful.

Interphalangeal: It is difficult to assess small joints without taking secondary signs into account. The plantar-dorsal view may be required to get through the joints, in a foot with flexed toes.

3.24 If arthritis is used as the basis for assessing impairment, then the rating cannot be combined with gait disturbance, muscle atrophy, muscle strength or range of movement assessments. It can be combined with a diagnosis-based estimate (AMA5 Table 17-2, p 526).

Amputation

3.25 Where there has been amputation of part of a lower extremity Table 17-32 (p 545, AMA5) applies. In that table, the references to three inches for below the knee amputation should be converted to 7.5cm.

Diagnosis-based estimates (lower extremity)

3.26 AMA5 Section 17.2j (pp 545–49) lists a number of conditions that fit a category of diagnosis-based estimates. They are listed in AMA5 Tables 17-33, 17-34 and 17-35 (pp 546–49). When using this table it is essential to read the footnotes carefully. The category of mild cruciate and collateral ligament laxity has inadvertently been omitted in Table 17-33. The appropriate rating is 5 (12)% whole person (lower extremity) impairment.

3.27 It is possible to combine impairments from Tables 17-33, 17-34 and 17-35 for diagnosis-related estimates with other components (eg nerve injury) using the Combined Values Chart (AMA5, pp 604–06) after first referring to the Guidelines for the appropriate combination of evaluation methods (see Table 3.5).

3.28 **Pelvic fractures:** Pelvic fractures are to be assessed as per Table 4.3 in the Guidelines, and not as per AMA5 Table 17-33 (p 546).

Hip: The item in relation to femoral neck fracture 'malunion' is not to be used in assessing impairment. Use other available methods.

Femoral osteotomy:

- Good result: 10 (25)
- Poor result: Estimate according to examination and arthritic degeneration

Tibial plateau fractures: Table 3.2 of the Guidelines, replaces the instructions for tibial plateau fractures in AMA5 Table 17-33 (p 546).

Table 3.2: Impairment for tibial plateau fractures

In deciding whether the fracture falls into the mild, moderate or severe categories, the assessor must take into account:

- the extent of involvement of the weight-bearing area of the tibial plateau
- the amount of displacement of the fracture(s)
- the amount of comminution present.

Grade	Whole person (lower extremity) impairment (%)
Undisplaced	2 (5)
Mild	5 (12)
Moderate	10 (25)
Severe	15 (37)

Patello-femoral joint replacement: Assess the knee impairment in the usual way and combine with 9% WPI (22% LEI) for isolated patello-femoral joint replacement.

Total ankle replacement:

Table 3.3: Rating for ankle replacement results

The points system for rating total ankle replacements is to be the same as for total hip and total knee replacements, with the following impairment ratings:

Result		WPI (LEI) %
Good result:	85–100 points:	12 (30)
Fair result:	50–84 points:	16 (40)
Poor result:	<50 points:	20 (50)

	Number of points
a. Pain	
None	50
Slight	
Stairs only	40
Walking and stairs	30
Moderate	
Occasional	20
Continual	10
Severe	0
b. Range of motion	
i. Flexion:	
> 20°	15
11° – 20°	10
5° – 10°	5
< 5°	0
ii. Extension:	
>10°	10
5° – 10°	5
< 5°	0
c. Range of motion	
i. Limp	
None	10
Slight	7
Moderate	4
Severe	0
ii. Supportive device	
None	5
Cane	3
One crutch	1
Two crutches	0
iii. Distance walked	
Unlimited	5
Six blocks	4
Three blocks	3
Indoors	2
Bed or chair	0
iv. Stairs	
Normal	5
Using rail	4
One at a time	2
Unable to climb	0
Sub-total:	

	Number of points
Deductions (minus) d and e	
d. Varus	
< 5°	0
5° – 10°	10
> 10°	15
e. Valgus	
< 5°	0
5° – 10°	10
> 10°	15
Sub-total:	

Tibia-os calcis angle: The table given below for the impairment of loss of the tibia-os calcis angle is to replace AMA5 Table 17-29 (p 542) and the section in AMA5 Table 17-3 (p 546) dealing with loss of tibia-os calcis angle. These two sections are contradictory, and neither gives a full range of loss of angle.

Table 3.4 Impairment for loss of the tibia-os calcis angle

Angle (degree)	Whole person (lower extremity) [foot] impairment (%)
110–100	5 (12) [17]
99–90	8 (20) [28]
<90	+1 (2) [3] per degree, up to 15 (37) [54]

Hindfoot intra-articular fractures: In the interpretation of AMA5 Table 17 33 (p 547, AMA5), reference to the hindfoot, intra-articular fractures, the words subtalar bone, talonavicular bone, and calcaneocuboid bone imply that the bone is displaced on one or both sides of the joint mentioned. To avoid the risk of double assessment, if avascular necrosis with collapse is used as the basis of impairment assessment, it cannot be combined with the relevant intra-articular fracture in Table 17-33, column 2. In Table 17-33, column 2, metatarsal fracture with loss of weight transfer means dorsal displacement of the metatarsal head.

Plantar fasciitis: If there are persistent symptoms and clinical findings after 18 months, this is rated as 2% LEI (1% WPI).

Resurfacing procedures: No additional impairment is to be awarded for resurfacing procedures used in the treatment of localised cartilage lesions and defects in major joints.

3.29 AMA5 tables 17-34 and 17-35 (pp 548–49) use a different concept of evaluation. A point score system is applied, and then the total points calculated for the hip (or knee) joint are converted to an impairment rating from Table 17-33. Tables 17-34 and 17-35 refer to hip and knee joint replacements respectively. Note that, while all the points are added in Table 17-34, some points are deducted when Table 17-35 is used. (Note that hemiarthroplasty rates the same as total joint replacement.)

3.30 In respect of 'distance walked' under 'b. Function' in AMA5 Table 17-34 (p 548), the distance of six blocks should be construed as 600 metres, and three blocks as 300 metres.

Note that AMA5 Table 17-35 (p 549) is incorrect. The correct table is shown below.

AMA5 Table 17-35: Rating knee replacement results

	Number of points
a. Pain	
None	50
Mild or occasional	45
Stairs only	40
Walking and stairs	30
Moderate	
Occasional	20
Continual	10
Severe	0
b. Range of motion	
Add 1 point per 5° up to 125°	25 (maximum)
c. Stability	
(maximum movement in any position)	
Anterioposterior	
< 5mm	10
5 – 9mm	5
> 9mm	0
Mediolateral	
5°	15
6 – 9°	10
10 – 14°	5
> 14°	0
Deductions (minus) d, e, f	
d. Flexion contracture	
5 – 9°	2
10 – 15°	5
16 – 20°	10
> 20	20
e. Extension lag	
< 10°	5
10 – 20°	10
> 20°	15
f. Tibio-femoral alignment*	
> 15° valgus	20
11 – 15° valgus	3 points per degree
5 – 10° valgus	0
0 – 4° valgus	3 points per degree
Any varus	20
Deductions sub total:	

*Refer to the unaffected limb to take into account any constitutional variation.

Skin loss (lower extremity)

3.31 Skin loss (AMA5, p 550, AMA5) can only be included in the calculation of impairment if it is in certain sites and meets the criteria listed in AMA5 Table 17-36 (p 550), AMA5).

Peripheral nerve injuries (lower extremity)

3.32 When assessing the impairment due to peripheral nerve injury (AMA5, pp 550–52) assessors should read the text in this section. Note that separate impairments for the motor, sensory and dysaesthetic components of nerve dysfunction in AMA5 Table 17-37 (p 552) are to be combined.

3.33 Note that the (posterior) tibial nerve is not included in Table 17-37, but its contribution can be calculated by subtracting ratings of common peroneal nerves from sciatic nerve ratings.

3.34 Peripheral nerve injury impairments can be combined with other impairments, but not those for gait derangement, muscle atrophy, muscle strength or complex regional pain syndrome, as shown in AMA5 Table 17-2 (p 526). Motor and sensory impairments given in Table 17-37 are for complete loss of function and assessors must still use Table 16-10 and 16-11 in association with Table 17-37.

Complex regional pain syndrome (lower extremity)

3.35 Complex regional pain syndrome types 1 and 2 are to be assessed using the method in Chapter 17 of the Guidelines.

Peripheral vascular disease (lower extremity)

3.36 Lower extremity impairment due to vascular disorders (AMA5, pp 553–54) is evaluated using AMA5 Table 17-38 (p 554). Note that Table 17-38 gives values for lower extremity impairment, not WPI. In that table, there is a range of lower extremity impairments within each of the classes 1 to 5. As there is a clinical description of which conditions place a person's lower extremity in a particular class, the assessor has a choice of impairment rating within a class, the value of which is left to the clinical judgement of the assessor.

Measurement of selected joint motion

3.37 When measuring dorsiflexion at the ankle, the test is carried out initially with the knee in extension and then repeated with the knee flexed to 45 degrees. The average of the maximum angles represents the dorsiflexion range of motion (AMA5 Figure 17-5, p 535).

Table 3.5: Lower extremity worksheet

Item	Impairment	AMA5 table	AMA5 page	Potential impairment	Selected impairment
1	Limb length discrepancy	17–4	528		
2	Gait derangement	17–5	529		
3	Unilateral muscle atrophy	17–6	530		
4	Muscle weakness	17–8	532		
5	Range of motion	17–9 to 17–14	537		
6	Joint ankylosis	17–15 to 17–30	538–543		
7	Arthritis	17–31	544		
8	Amputation	17–32	545		
9	Diagnosis-based estimates	17–33 to 17–35	546–549		
10	Skin loss	17–36	550		
11	Peripheral nerve deficit	17–37	552		
12	Complex regional pain syndrome	Section 16.5e	495–497		
13	Vascular disorders	17–38	554		
Combined impairment rating (refer to AMA5 Table 17 2, p 526, for permissible combinations)					

Potential impairment is the impairment percentage for that method of assessment. Selected impairment is the impairment, or impairments selected, that can be legitimately combined with other lower extremity impairments to give a final lower extremity impairment rating.

4. The spine

AMA5 Chapter 15 (p 373) applies to the assessment of permanent impairment of the spine, subject to the modifications set out below. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing.
- the appropriate chapter(s) of AMA5 for the body system they are assessing.

The Guidelines take precedence over AMA5.

Introduction

4.1 The spine is discussed in Chapter 15 of AMA5 (pp 373–431). That chapter presents two methods of assessment, the diagnosis-related estimates method and the range of motion method. Evaluation of impairment of the spine is only to be done using diagnosis-related estimates (DREs).

4.2 The DRE method relies especially on evidence of neurological deficits and less common, adverse structural changes, such as fractures and dislocations. Using this method, DREs are differentiated according to clinical findings that can be verified by standard medical procedures.

4.3 The assessment of spinal impairment is made when the person's condition has stabilised and has reached maximum medical improvement. This is considered to occur when the worker's condition is well stabilised and unlikely to change substantially in the next year, with or without medical treatment. If surgery has been performed, the outcome of the surgery as well as structural inclusions must be taken into consideration when making the assessment.

Assessment of the spine

4.4 The assessment should include a comprehensive, accurate history, a review of all pertinent records available at the assessment, a comprehensive description of the individual's current symptoms and their relationship to activities of daily living (ADL); a careful and thorough physical examination;, and all findings of relevant laboratory, imaging, diagnostic and ancillary tests available at the assessment. Imaging findings that are used to support the impairment rating should be concordant with symptoms and findings on examination. The assessor should record whether diagnostic tests and radiographs were seen or whether they relied solely on reports.

4.5 The DRE model for assessment of spinal impairment should be used. The range of motion model (AMA5 sections 15.8–15.13 inclusive, pp 398–427) should not be used.

4.6 If a person has spinal cord or cauda equina damage, including bowel, bladder and/or sexual dysfunction, he or she is assessed according to the method described in AMA5 Section 15.7 and AMA5 Table 15.6 (a)–(g) (pp 395–98).

4.7 If an assessor is unable to distinguish between two DRE categories, then the higher of those two categories should apply. The reasons for the inability to differentiate should be noted in the assessor's report.

4.8 Possible influence of future treatment should not form part of the impairment assessment. The assessment should be made on the basis of the person's status at the time of interview and examination, if the assessor is convinced that the condition is stable and permanent. Likewise, the possibility of subsequent deterioration, as a consequence of the underlying condition, should not be factored into the impairment evaluation. Commentary can be made regarding the possible influence, potential or requirements for further treatment, but this does not affect the assessment of the individual at the time of impairment evaluation.

4.9 All spinal impairments are to be expressed as a percentage of WPI.

4.10 AMA5 Section 15.1a (pp 374–77) is a valuable summary of history and physical examination, and should be thoroughly familiar to all assessors.

4.11 The assessor should include in the report a description of how the impairment rating was calculated, with reference to the relevant tables and figures used.

4.12 The optimal method to measure the percentage compression of a vertebral body is a well-centred plain X-ray. Assessors should state the method they have used. The loss of vertebral height should be measured at the most compressed part and must be documented in the impairment evaluation report. The estimated normal height of the compressed vertebra should be determined, where possible, by averaging the heights of the two adjacent (unaffected and normal) vertebrae.

Specific interpretation of AMA5

4.13 The range-of-motion (ROM) method is not used, hence any reference to this is omitted (including AMA5 Table 15-7, p 404).

4.14 Motion segment integrity alteration can be either increased translational or angular motion, or decreased motion resulting from developmental changes, fusion, fracture healing, healed infection or surgical arthrodesis. Motion of the individual spine segments cannot be determined by a physical examination, but is evaluated with flexion and extension radiography.

4.15 The assessment of altered motion segment integrity is to be based upon a report of trauma resulting in an injury, and not on developmental or degenerative changes.

4.16 When routine imaging is normal and severe trauma is absent, motion segment disturbance is rare. Thus, flexion and extension imaging is indicated only when a history of trauma or other imaging leads the physician to suspect alteration of motion segment integrity.

DRE definitions of clinical findings

4.17 The preferred method for recording ROM is as a fraction or percentage of the range or loss of the range. For example, either 'cervical movement was one half (or 50%) of the normal range of motion' or 'there was a loss of one half (or 50%) of the normal range of movement of the cervical spine'.

4.18 DRE II is a clinical diagnosis based upon the features of the history of the injury and clinical features. Clinical features which are consistent with DRE II and which are present at the time of assessment include radicular symptoms in the absence of clinical signs (that is, non-verifiable radicular complaints), muscle guarding or spasm, or asymmetric loss of range of movement. Localised (not generalised) tenderness may be present. In the lumbar spine, additional features include a reversal of the lumbosacral rhythm when straightening from the flexed position and compensatory movement for an immobile spine, such as flexion from the hips. In assigning category DRE II, the assessor must provide detailed reasons why the category was chosen.

4.19 Asymmetric or non-uniform loss of ROM may be present in any of the three planes of spinal movement. Asymmetry during motion caused by muscle guarding or spasm is included in the definition.

Asymmetric loss of ROM may be present for flexion and extension. For example, if cervical flexion is half the normal range (loss of half the normal range) and cervical extension is one-third of the normal range (loss of two thirds of the range), asymmetric loss of ROM may be considered to be present.

4.20 While imaging and other studies may assist medical assessors in making a diagnosis, the presence of a morphological variation from 'normal' in an imaging study does not confirm the diagnosis. To be of diagnostic value, imaging studies must be concordant with clinical symptoms and signs. In other words, an imaging test is useful to confirm a diagnosis, but an imaging study alone is insufficient to qualify for a DRE category (excepting spinal fractures).

4.21 The clinical findings used to place an individual in a DRE category are described in AMA5 Box 15-1 (pp 382–83).

The reference to 'electro-diagnostic verification of radiculopathy' should be disregarded.

(The use of electro-diagnostic procedures such as electromyography is proscribed as an assessment aid for decisions about the category of impairment into which a person should be placed. It is considered that competent assessors can make decisions about which DRE category a person should be placed in from the clinical features alone. The use of electro-diagnostic differentiators is generally unnecessary).

4.22 The cauda equina syndrome is defined in Box 15.1 in Chapter 15 of AMA5 (p 383) as 'manifested by bowel or bladder dysfunction, saddle anaesthesia and variable loss of motor and sensory function in the lower limbs'. For a cauda equina syndrome to be present there must be bilateral neurological signs in the lower limbs and sacral region. Additionally, there must be a radiological study which demonstrates a lesion in the spinal canal, causing a mass effect on the cauda equina with compression of multiple nerve roots. The mass effect would be expected to be large and significant. A lumbar MRI scan is the diagnostic investigation of choice for this condition. A cauda equina syndrome may occasionally complicate lumbar spine surgery when a mass lesion will not be present in the spinal canal on radiological examination.

4.23 The cauda equina syndrome and neurogenic bladder disorder are to be assessed by the method prescribed in the spine chapter of AMA5 Section 15.7 (pp 395–98). For an assessment of neurological impairment of bowel or bladder, there must be objective evidence of spinal cord or cauda equina injury.

Applying the DRE method

4.24 The specific procedures and directions section of AMA5 Section 15.2a (pp 380–81) indicates the steps that should be followed to evaluate impairment of the spine (excluding references to the ROM method). Table 4.1 below is a simplified version of that section, incorporating the amendments listed above.

Table 4.1: Procedures in evaluating impairment of the spine

History

Physical examination

⬇

Diagnosis

⬇

Use clinical findings to place an individual's condition in a DRE category according to AMA5 Box 15.1 (pp 382–83)

⬇

Choose the category that determines the percentage of impairment:

Lumbar region	AMA5 Table 15-3 (p 384)
Thoracic region	AMA5 Table 15-4 (p 389)
Cervical region	AMA5 Table 15-5 (p 392)

4.25 Common developmental findings, spondylosis, spondylolisthesis and disc protrusions without radiculopathy occur in 7%, 3% and up to 30% of cases involving individuals up to the age of 40 respectively (AMA5, p 383). Their presence does not of itself mean that the individual has an impairment due to injury.

4.26 **Loss of sexual function** should only be assessed where there is other objective evidence of spinal cord, cauda equina or bilateral nerve root dysfunction. The ratings are described in AMA5 Table 15-6 (pp 396–97). There is no additional impairment rating system for loss of sexual function in the absence of objective neurological findings. Loss of sexual function is not assessed as an ADL.

4.27 **Radiculopathy** is the impairment caused by malfunction of a spinal nerve root or nerve roots. In general, in order to conclude that radiculopathy is present, two or more of the following criteria should be found, one of which must be major (major criteria in bold):

- **loss or asymmetry of reflexes**
- **muscle weakness that is anatomically localised to an appropriate spinal nerve root distribution**
- **reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution**
- positive nerve root tension (AMA5 Box 15-1, p 382)
- muscle wasting – atrophy (AMA5 Box 15-1, p 382)
- findings on an imaging study consistent with the clinical signs (AMA5, p 382).

4.28 Radicular complaints of pain or sensory features that follow anatomical pathways but cannot be verified by neurological findings (somatic pain, non-verifiable radicular pain) do not alone constitute radiculopathy.

4.29 Global weakness of a limb related to pain or inhibition or other factors does not constitute weakness due to spinal nerve malfunction.

4.30 Vertebral body fractures and/or dislocations at more than one vertebral level are to be assessed as follows:

- Measure the percentage loss of vertebral height at the most compressed part for each vertebra, then
- Add the percentage loss at each level:
  - total loss of more than 50% = DRE IV
  - total loss of 25% to 50% = DRE III
  - total loss of less than 25% = DRE II
- If radiculopathy is present then the person is assigned one DRE category higher

One or more end plate fractures in a single spinal region without measurable compression of the vertebral body are assessed as DRE category II.

Posterior element fractures (excludes fractures of transverse processes and spinous processes) at multiple levels are assessed as DRE III.

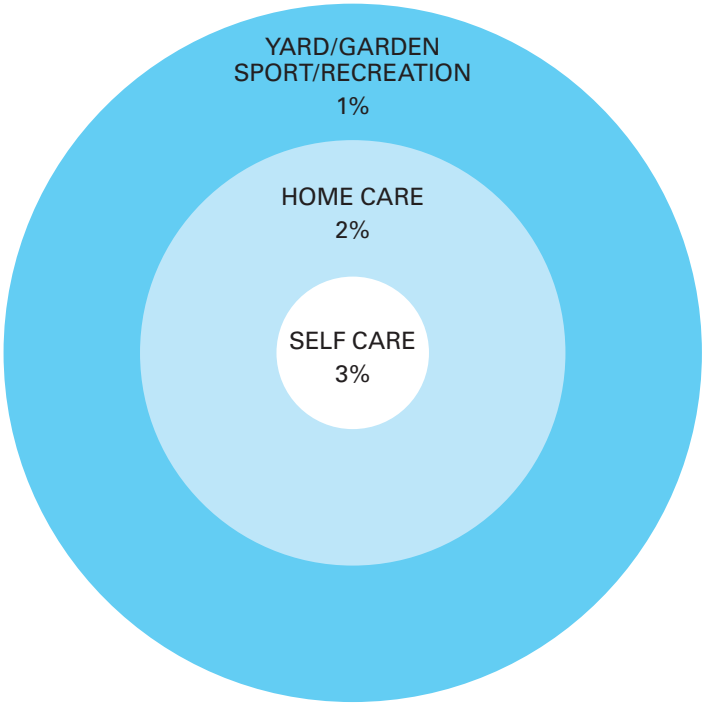
4.31 Displaced fractures of transverse or spinous processes at one or more levels are assessed as DRE category II because the fracture does not disrupt the spinal canal (AMA5, p 385) and do not cause multilevel structural compromise.

4.32 Within a spinal region, separate spinal impairments are not combined. The highest-value impairment within the region is chosen. Impairments in different spinal regions are combined using the combined values chart (AMA5, pp 604-06).

If there are adjacent vertebral fractures at the transition zones (C7/T1, T12/L1), the methodology in paragraph 4.30 in the Guidelines is to be adopted. For fractures of C7 and T1, use the WPI ratings for the cervical spine (AMA5 Chapter 15, Table 15-5, p 392). For fractures of T12 and L1, use the WPI rating for the thoracic spine (AMA5 Chapter 15, Table 15-4, p 389).

4.33 **Impact of ADL.** Tables 15-3, 15-4 and 15-5 of AMA5 give an impairment range for DREs II to V. Within the range, 0%, 1%, 2% or 3% WPI may be assessed using paragraphs 4.34 and 4.35 below. An assessment of the effect of the injury on ADL is not solely dependent on self-reporting, but is an assessment based on all clinical findings and other reports.

4.34 The following diagram should be used **as a guide** to determine whether 0%, 1%, 2% or 3% WPI should be added to the bottom of the appropriate impairment range. This is only to be added if there is a difference in activity level as recorded and compared to the worker's status prior to the injury.



4.35 The diagram is to be interpreted as follows:

Increase base impairment by:

- 3% WPI if the worker's capacity to undertake personal care activities such as dressing, washing, toileting and shaving has been affected
- 2% WPI if the worker can manage personal care, but is restricted with usual household tasks, such as cooking, vacuuming and making beds, or tasks of equal magnitude, such as shopping, climbing stairs or walking reasonable distances
- 1% WPI for those able to cope with the above, but unable to get back to previous sporting or recreational activities, such as gardening, running and active hobbies etc.

4.36 For a single injury, where there has been more than one spinal region injured, the effect of the injury on ADL is assessed once only.

For injuries to one spinal region on different dates, the effect of the injury on ADL is assessed for the first injury. If, following the second injury, there is a worsening in the ability to perform ADL, the appropriate adjustments are made within the range. For example, if WPI for ADL is assessed as 1% following the first injury and 3% after the second injury, then WPI for ADL for the second injury is assessed as 2%.

For injuries to different spinal regions on different dates, where there is a worsening of ability to perform ADL after the second injury, additional impairment may be assessed. For example, if ADL for a cervical spine injury is assessed as 1%, and an assessment of a subsequent lumbar spine injury determined 3% WPI for ADL, then WPI for impact on ADLs for the lumbar injury is assessed as 2% WPI.

4.37 **Effect of surgery:** AMA5 tables 15-3 to 15-5 (pp 384, 389 and 392) do not adequately account for the effect of surgery on the impairment rating for certain disorders of the spine. The assessor should note that:

- Surgical decompression for spinal stenosis is DRE category III (AMA5 Table 15-3, 15-4 or 15-5)
- Operations where the radiculopathy has resolved are considered under the DRE category III (AMA5 Table 15-3, 15-4 or 15-5).
- Operations for spinal fusion (successful or unsuccessful) are considered under DRE category IV (AMA5 Table 15-3, 15-4 or 15-5)
- DRE category V is not to be used following spinal fusion where there is a persisting radiculopathy. Instead, use Table 4.2 in the Guidelines
- Radiculopathy persisting after surgery is not accounted for by AMA5 Table 15-3, and incompletely by tables 15-4 and 15-5, which only refer to radiculopathy that has improved following surgery.

Table 4.2 indicates the additional ratings which should be combined with the rating determined using the DRE method where an operation for an intervertebral disc prolapse, spinal canal stenosis or spinal fusion has been performed.

Example 15-4 in AMA5 (p 386) should therefore be ignored.

Table 4.2: Modifiers for DRE categories following surgery

Procedures	Cervical	Thoracic	Lumbar
Spinal surgery with residual symptoms and radiculopathy (refer to 4.27 in the Guidelines)	3%	2%	3%
Second and further levels	1% each additional level	1% each additional level	1% each additional level
Second operation	2%	2%	2%
Third and subsequent operations	1% each	1% each	1% each

In summary, to calculate whole person impairment (WPI) for persisting radiculopathy (as per definition) following surgery:

- Select the appropriate DRE category from Table 15-3, 15-4, or 15-5;
- Determine a WPI value within the allowed range in Table 15-3, 15-4 or 15-5 according to the impact on the worker's ADL
- Combine this value with the appropriate additional amount from Table 4.2 to determine the final WPI.

4.38 **Disc replacement surgery:** The impairment resulting from this procedure is to be equated to that from a spinal fusion.

4.39 **Arthritis:** See paragraphs 3.19–3.24 of the Guidelines.

4.40 **Posterior spacing or stabilisation devices:** The insertion of such devices does not warrant any additional WPI.

4.41 **Spinal cord stimulator or similar device:** The insertion of such devices does not warrant any additional WPI.

4.42 Impairment due to pelvic fractures should be evaluated with reference to the following table, which replaces AMA5 Table 15-19.

Table 4.3: Pelvic fractures

Disorder	Whole person impairment (%)
1. Non-displaced, healed fractures	0
2. Fractures of the pelvic bones (including sacrum)	
i. maximum residual displacement <1cm	2
ii. maximum residual displacement 1 to 2cm	5
iii. maximum residual displacement >2cm	8
iv. bilateral pubic rami fractures, as determined by the most displaced fragment:	
a. maximum residual displacement ≤2cm	5
b. maximum residual displacement >2cm	8
3. Traumatic separation of the pubic symphysis	
i. <1cm	5
ii. 1 to 2cm	8
iii. >2cm	12
iv. internal fixation/ankylosis	5
4. Sacro-Iliac joint dislocations or fracture dislocations	
i. maximum residual displacement ≤1cm	8
ii. maximum residual displacement >1cm	12
iii. internal fixation/ankylosis	5
5. If two out of three joints are internally fixed/ankylosed	8
If all three joints are internally fixed/ankylosed	10
6. Fractures of the coccyx	
i. healed, (and truly) displaced fracture	1
ii. excision of the coccyx	5
7. Fractures of the acetabulum: Evaluate based on restricted range of hip motion	

The rating of WPI is evaluated based on radiological appearance at maximum medical improvement, whether or not surgery has been performed. Multiple injuries of the pelvis should be assessed separately and combined, with the maximum WPI for pelvic fractures being 20%.

5. Nervous system

AMA5 Chapter 13 (p 305), applies to the assessment of permanent impairment of the nervous system, subject to the modifications set out below. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing
- the appropriate chapter(s) of AMA5 for the body system they are assessing.

The Guidelines take precedence over AMA5.

Introduction

5.1 AMA5 Chapter 13 'The central and peripheral nervous system' (pp 305–56), provides guidelines on methods of assessing permanent impairment involving the central nervous system. It is logically structured and consistent with the usual sequence of examination of the nervous system. Cerebral functions are discussed first, followed by the cranial nerves, station, gait and movement disorders, the upper extremities related to central impairment, the brain stem, the spinal cord and the peripheral nervous system, including neuromuscular junction and muscular system. A summary concludes the chapter.

5.2 Spinal cord injuries are to be assessed using AMA5 Chapter 15. Table 15-6 (pp 396–97) is to be used for evaluation of spinal cord injuries. These impairments, once selected, are then combined with the corresponding additional spinal impairment from DRE categories II–V for cervical and lumbar impairment and categories II–IV for thoracic impairment to obtain an exact total value.

5.3 Impairments of the peripheral nervous system are assessed by using the relevant parts of the upper extremity, lower extremity and spine sections of AMA5.

The approach to assessment of permanent neurological impairment

5.4 AMA5 Chapter 13 disallows combination of cerebral impairments. However, for the purpose of the Guidelines, cerebral impairments should be evaluated and combined as follows:

- consciousness and awareness
- mental status, cognition and highest integrative function
- aphasia and communication disorders
- emotional and behavioural impairments.

The assessor should take care to be as specific as possible and not to double -rate the same impairment, particularly in the mental status and behavioural categories.

These impairments are to be combined using the Combined Values Chart (AMA5, pp 604–06). These impairments should then be combined with other neurological impairments indicated in AMA5 Table 13-1 (p 308).

5.5 AMA5 sections 13.5–13.6 (pp 336–40) should be used for cerebral, basal ganglia, cerebellar or brain stem impairments. This section, therefore, covers hemiplegia, monoplegia (arm or leg), and upper or lower limb impairment due to incoordination, or movement disorder due to brain injury.

5.6 If a person has a spinal injury with spinal cord or cauda equina, bilateral nerve root or lumbosacral plexus injury causing bowel, bladder and/or sexual dysfunction, he or she is assessed according to the method described in AMA5 Section 15.7 and Table 15-6 (a)–(g) (pp 395–98).

5.7 Complex regional pain syndrome types 1 and 2 are to be assessed using the method in Chapter 17 of the Guidelines.

5.8 AMA5 Chapter 13, on the nervous system, lists many impairments where the range for the associated WPI is 0–9% or 0–14%. Where there is a range of impairment percentages listed, the assessor should nominate an impairment percentage based on the complete clinical circumstances revealed during the consultation, and in relation to all other available information.

Specific interpretation of AMA5

5.9 In assessing disturbances of mental status and integrative functioning; and emotional or behavioural disturbances; disturbances in the level of consciousness and awareness; disturbances of sleep and arousal function; and disorders of communication (AMA5 sections 13.3a, 13.3c, 13.3d, 13.3e and 13.3f; pp 309–311 and 317–327), the assessor should make ratings based on clinical assessment and the results of neuropsychometric testing, where available.

For traumatic brain injury, there should be evidence of a severe impact to the head, or that the injury involved a high-energy impact.

Clinical assessment must include at least one of the following:

- significant medically verified abnormalities in the Glasgow Coma Scale score
- significant medically verified duration of post-traumatic amnesia
- significant intracranial pathology on CT scan or MRI.

Neuropsychological testing should be conducted by a registered clinical neuropsychologist who is a member, or is eligible for membership, of the Australian Psychological Society's College of Clinical Neuropsychology. Neuropsychological test data is to be considered in the context of the overall clinical history, examination and radiological findings, and not in isolation.

5.10 **Assessment of arousal and sleep disorders (AMA5 Section 13.3c, pp 317–319):** refers to assessment of primary sleep disorders following neurological injury. The assessor should make ratings of arousal and sleep disorders based on the clinical assessment that would normally have been done for clinically significant disorders of this type (ie sleep studies or similar tests).

5.11 **Olfaction and taste:** The assessor should use AMA5 Chapter 11, Section 11.4c (p 262) to assess olfaction and taste, for which a maximum of 5% WPI is allowable for total loss of either sense. The effect on activities of daily living should be considered.

5.12 **Visual impairment assessment (AMA4 Chapter 8, pp 209–22):** An ophthalmologist should assess all impairments of visual acuity, visual fields, extra-ocular movements or diplopia.

5.13 **Trigeminal nerve assessment (AMA5, p 331):** Sensory impairments of the trigeminal nerve should be assessed with reference to AMA5 Table 13-11 (p 331). The words 'sensory loss or dysaesthesia' should be added to the table after the words 'neuralgic pain' in each instance. Lesions of the ophthalmic division of the trigeminal nerve with impairment of corneal sensation should be apportioned with extra weighting.

If present, motor loss for the trigeminal nerve should be assessed in terms of its impact on mastication and deglutition (AMA5, p 262).

For bilateral injury to the trigeminal nerves, assess each side separately and combine the assessed WPIs.

5.14 **Spinal accessory nerve:** AMA5 provides insufficient reference to the spinal accessory nerve (cranial nerve XI). This nerve supplies the trapezius and sternomastoid muscles. For loss of use of the nerve to trapezius, the assessor should refer to AMA5 Chapter 16 on upper limb assessment, and a maximum of 10% impairment of the upper limb may be assigned. For additional loss of use of sternomastoid, a maximum of 3% upper limb impairment may be added.

5.15 Impairment of sexual function caused by severe traumatic brain injury is to be assessed using AMA5 Table 13-21 (p 342). For spinal cord, nerve root or more peripheral nerve injury, sexual impairment should only be assessed where there is appropriate objective evidence of spinal cord, cauda equina or bilateral nerve root dysfunction, or lumbosacral plexopathy.

5.16 Impairment due to miscellaneous peripheral nerves should be evaluated with reference to the following table.

Table 5.1 Criteria for rating miscellaneous peripheral nerves

	Whole person impairment rating			
Peripheral nerve	0%	1%	2%–3%	4%–5%
Clinical features	No neuralgia	Sensory loss only in an anatomic distribution	Mild to moderate neurogenic pain and sensory alteration in an anatomic distribution	Severe neurogenic pain and sensory alteration in an anatomic distribution
Greater occipital nerve or Lesser occipital nerve or Greater auricular nerve				
Intercostal nerve				
Genitofemoral				
Ilioinguinal				
Iliohypogastric				
Pudendal				

6. Ear, nose, throat and related structures

AMA5 Chapter 11 (p 245), applies to the assessment of permanent impairment of the ear (with the exception of hearing impairment), nose, throat and related structures, subject to the modifications set out below. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing.
- the appropriate chapter(s) of AMA5 for the body system they are assessing.

The Guidelines take precedence over AMA5.

Introduction

6.1 AMA5 Chapter 11 (pp 245–75) details the assessment of the ear, nose, throat and related structures. With the exception of hearing impairment, which is dealt with in Chapter 9 of the Guidelines, AMA5 Chapter 11 should be followed in assessing permanent impairment, with the variations included below.

6.2 The level of impairment arising from conditions that are not work-related needs to be assessed by the medical assessor and taken into consideration in determining the level of permanent impairment. The level at which pre-existing conditions and lifestyle activities, such as smoking, contribute to the level of permanent impairment requires judgement on the part of the clinician undertaking the impairment assessment. The manner in which any deduction for these is applied needs to be recorded in the assessing specialist's report.

The ear

6.3 Equilibrium is assessed according to AMA5 Section 11.2b (pp 252–55), but add these words to AMA5 Table 11-4, class 2 (p 253): 'without limiting the generality of the above, a positive Hallpikes test is a sign and an objective finding'.

The face (AMA5, pp 255–59)

6.4 AMA5 Table 11-5 (p 256) should be replaced with Table 6.1, below, when assessing permanent impairment due to facial disorders and/or disfigurement.

Table 6.1: Criteria for rating permanent impairment due to facial disorders and/or disfigurement

Class 1 0 5% impairment of the whole person	Class 2 6 10% impairment of the whole person	Class 3 11 15% impairment of the whole person	Class 4 16 50% impairment of the whole person
Facial abnormality limited to disorder of cutaneous structures, such as visible simple scars (not hypertrophic or atrophic) or abnormal pigmentation (refer to AMA5 Chapter 8 for skin disorders) or mild, unilateral, facial paralysis affecting most branches or nasal distortion that affects physical appearance or partial loss or deformity of the outer ear	Facial abnormality involves loss of supporting structure of part of face, with or without cutaneous disorder (eg depressed cheek, nasal, or frontal bones) or near complete loss of definition of the outer ear	Facial abnormality involves absence of normal anatomic part or area of face, such as loss of eye or loss of part of nose, with resulting cosmetic deformity, combine with any functional loss, eg vision (AMA4 Chapter 8) or severe unilateral facial paralysis affecting most branches or mild, bilateral, facial paralysis affecting most branches	Massive or total distortion of normal facial anatomy with disfigurement so severe that it precludes social acceptance or severe, bilateral, facial paralysis affecting most branches or loss of a major portion of or entire nose

Note: Tables used to classify the examples in AMA5 Section 11.3 (pp 256–59) should also be ignored and assessors should refer to the modified table above for classification.

6.5 In AMA5 example 11-11 (p 257), add the words 'visual impairment related to enophthalmos must be assessed by an Ophthalmologist'.

The nose, throat and related structures

Respiration (AMA5 Section 11.4a, pp 259–61)

6.6 In regard to sleep apnoea (third paragraph of AMA5 Section 11.4a, p 259), a sleep study and an examination by an ear, nose and throat specialist is mandatory before assessment by an approved assessor.

6.7 The assessment of sleep apnoea is addressed in AMA5 Section 5.6 (p 105) and assessors should refer to this chapter, as well as paragraphs 8.8–8.10 in the Guidelines.

6.8 AMA5 Table 11-6, 'Criteria for rating impairment due to air passage defects' (p 260), should be replaced with Table 6.2, below, when assessing permanent impairment due to air passage defects.

Table 6.2: Criteria for rating permanent impairment due to air passage defects

Percentage impairment of the whole person					
Class 1a 0–5%	Class 1 0–10%	Class 2 11– 29%	Class 3 30–49%	Class 4 50%–89%	Class 5 90%+
There are symptoms of significant difficulty in breathing through the nose. Examination reveals significant partial obstruction of the right and/ or left nasal cavity or nasopharynx or significant septal perforation.	Dyspnea does not occur at rest and dyspnea is not produced by walking freely on a level surface, climbing stairs freely or performance of other usual activities of daily living and dyspnea is not produced by stress, prolonged exertion, hurrying, hill climbing, or recreational or similar activities requiring intensive effort* and examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea, bronchi or complete (bilateral) obstruction of the nose or nasopharynx	Dyspnea does not occur at rest and dyspnea is not produced by walking freely on a level surface, climbing one flight of stairs or performance of other usual activities of daily living but dyspnea is produced by stress, prolonged exertion, hurrying, hill climbing, or recreational or similar activities (except sedentary forms) and examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea, bronchi or complete (bilateral) obstruction of the nose or nasopharynx	Dyspnea does not occur at rest and dyspnea is produced by walking freely more than one or two level blocks, climbing one flight of stairs, even with periods of rest, or performance of other usual activities of daily living and dyspnea is produced by stress, prolonged exertion, hurrying, hill climbing, or recreational or similar activities and examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea or bronchi	Dyspnea occurs at rest, although individual is not necessarily bedridden and dyspnea is aggravated by the performance of any of the usual activities of daily living (beyond personal cleansing, dressing or grooming) and examination reveals partial obstruction of the oropharynx, laryngopharyx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea, and/or bronchi	Severe dyspnea occurs at rest and spontaneous respiration is inadequate and respiratory ventilation is required and examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea or bronchi

*Prophylactic restriction of activity, such as strenuous competitive sport, does not exclude subject from class 1.

Note: Individuals with successful permanent tracheostomy or stoma should be rated at 25% WPI. AMA5 example 11-16 (p 261), 'Partial obstruction of the larynx affecting only one vocal cord', is better linked to voice (AMA5 Section 11.4e).

6.9 When using AMA5 Table 11-7 'Relationship of dietary restrictions to permanent impairment' (p 262), the first WPI category is to be 0–19%, not 5–19%.

Speech (AMA5, pp 262–64)

6.10 Regarding the first sentence of the 'Examining procedure' subsection of AMA5 (pp 263–64): the examiner should have sufficient hearing for the purpose- disregard 'normal hearing as defined in the earlier section of this chapter on hearing'.

6.11 'Examining procedure' (AMA5, pp 263-64), second paragraph: 'The examiner should base judgements of impairment on two kinds of evidence: (1) attention to and observation of the individual's speech in the office – for example, during conversation, during the interview, and while reading and counting aloud – and (2) reports pertaining to the individual's performance in everyday living situations'. Disregard the next sentence: 'The reports or the evidence should be supplied by reliable observers who know the person well.'

6.12 'Examining procedure' (AMA5, pp 263-64): where the word 'American' appears as a reference, substitute 'Australian', and change measurements to the metric system (eg 8.5 inches = 22 centimetres).

The voice (AMA5 Section 11.4e, pp 264–67)

6.13 Substitute the word 'laryngopharyngeal' for 'gastroesophageal' in all examples where it appears.

6.14 Example 11.25 (AMA5, p 269) 'Impairment rating', second sentence: add the words "including respiratory impairment" into the sentence to read 'Combine with appropriate ratings due to other impairments including respiratory impairment to determine whole person impairment'.

Ear, nose, throat and related structures impairment evaluation summary

6.15 Disregard AMA5 Table 11-10 (pp 272–75), except for impairment of olfaction and/or taste, and hearing impairment as determined in the Guidelines.

7. Urinary and reproductive systems

AMA5 Chapter 7 (p 143) applies to the assessment of permanent impairment of the urinary and reproductive systems, subject to the modifications set out below. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing
- the appropriate chapter(s) of AMA5 for the body system they are assessing.

The Guidelines take precedence over AMA5.

Introduction

7.1 AMA5 Chapter 7 (pp 143–71) provides clear details for assessment of the urinary and reproductive systems. Overall, the chapter should be followed in assessing permanent impairment, with the variations included below.

7.2 For both male and female sexual dysfunction, identifiable pathology should be present for an impairment percentage to be given.

Urinary diversion

7.3 AMA5 Table 7-2 (p 150) should be replaced with Table 7.1, below, when assessing permanent impairment due to urinary diversion disorders. This table includes ratings for neobladder and continent urinary diversion.

7.4 Continent urinary diversion is defined as a continent urinary reservoir constructed of small or large bowel with a narrow catheterisable cutaneous stoma through which it must be emptied several times a day.

Table 7.1: Criteria for rating permanent impairment due to urinary diversion disorders

Diversion type	% Impairment of the whole person
Ureterointestinal	10
Cutaneous ureterostomy	10
Nephrostomy	15
Neobladder/replacement cystoplasty	15
Continent urinary diversion	20

Bladder

7.5 AMA5 Table 7-3 (p 151) should be replaced with Table 7.2, below, when assessing permanent impairment due to bladder disease. This table includes ratings involving urge and total incontinence (defined in 7.8 of the Guidelines).

Table 7.2: Criteria for rating permanent impairment due to bladder disease

Class 1 0 15% impairment of the whole person	Class 2 16 40% impairment of the whole person	Class 3 41 70% impairment of the whole person
Symptoms and signs of bladder disorder and requires intermittent treatment and normal functioning between malfunctioning episodes	Symptoms and signs of bladder disorder eg urinary frequency (urinating more than every two hours), severe nocturia (urinating more than three times a night), urge incontinence more than once a week and requires continuous treatment	Abnormal (ie under or over) reflex activity (eg intermittent urine dribbling, loss of control, urinary urgency and urge incontinence once or more each day) and/or no voluntary control of micturition, reflex or areflexic bladder on urodynamics and/or total incontinence eg fistula

7.6 AMA5 example 7-16 (p 151) should be reclassified as an example of class 2, as the urinary frequency is more than every two hours and continuous treatment would be expected.

Urethra

7.7 AMA5 Table 7-4 (p 153) should be replaced with Table 7.3 below when assessing permanent impairment due to urethral disease. This table includes ratings involving stress incontinence.

Table 7.3: Criteria for rating permanent impairment due to urethral disease

Class 1 0 10% impairment of the whole person	Class 2 11 20% impairment of the whole person	Class 3 21 40% impairment of the whole person
Symptoms and signs of urethral disorder and requires intermittent therapy for control	Symptoms and signs of urethral disorder, stress urinary incontinence more than three times a week and cannot effectively be controlled by treatment	Urethral dysfunction resulting in intermittent urine dribbling, or stress urinary incontinence at least daily

Urinary incontinence

7.8 Urge urinary incontinence is the involuntary loss of urine associated with a strong desire to void. Stress urinary incontinence is the involuntary loss of urine occurring with clinically demonstrable raised intra-abdominal pressure. It is expected that urinary incontinence of a regular or severe nature (necessitating the use of protective pads or appliances) will be assessed as follows:

Stress urinary incontinence (demonstrable clinically):	11–25%, according to severity
Urge urinary incontinence:	16–40%, according to severity
Mixed (urge and stress) incontinence:	16–40%, according to severity
Nocturnal enuresis or wet in bed:	16–40%, according to severity
Total incontinence (continuously wet – eg from fistula):	50–70%

The highest scoring condition is to be used to assess impairment – combinations are not allowed.

Male reproductive organs

Penis

7.9 On page 157 of AMA5, the box labelled 'class 3, 21–35% impairment of the whole person' should read 'class 3, 20% impairment of the whole person', as the descriptor 'no sexual function possible' does not allow a range. (The correct value is shown in AMA5 Table 7-5, p 156). Note, however, that there is a loading for age, so a rate higher than 20% is possible.

Testicles, epididymides and spermatic cords

7.10 AMA5 Table 7-7 (p 159) should be replaced with Table 7.4, below, when assessing permanent impairment due to testicular, epididymal and spermatic cord disease. This table includes rating for infertility and equates impairment with female infertility (see Table 7.5 in the Guidelines). Infertility in either sex must be considered to be of equal impact, age for age.

7.11 Male infertility is defined as azoospermia or other cause of inability to cause impregnation, even with assisted contraception techniques.

7.12 Loss of sexual function related to spinal injury should only be assessed as an impairment where there is other objective evidence of spinal cord, cauda equina or bilateral nerve root dysfunction. The ratings described in AMA5 Table 13-21 (p 342) are used in this instance. There is no additional impairment rating system for loss of sexual function in the absence of objective clinical findings.

Table 7.4: Criteria for rating permanent impairment due to testicular, epididymal and spermatic cord disease

Class 1 0 10% impairment of the whole person	Class 2 11 15% impairment of the whole person	Class 3 16 35% impairment of the whole person
Testicular, epididymal or spermatic cord disease symptoms and signs and anatomic alteration and no continuous treatment required and no seminal or hormonal function or abnormalities or solitary testicle	Testicular, epididymal or spermatic cord disease symptoms and signs and anatomic alteration and cannot effectively be controlled by treatment and detectable seminal or hormonal abnormalities	Trauma or disease produces bilateral anatomic loss of the primary sex organs or no detectable seminal or hormonal function or infertility

Female reproductive organs

Fallopian tubes and ovaries

7.13 AMA5 Table 7-11 (p 167) should be replaced with Table 7.5, below, when assessing permanent impairment due to fallopian tube and ovarian disease. This table includes rating for infertility and equates impairment with male infertility (see Table 7.4, above). Infertility in either sex must be considered to be of equal impact, age for age.

7.14 **Female infertility:** A woman in the childbearing age is infertile when she is unable to conceive naturally. This may be due to anovulation, tubal blockage, cervical or vaginal blocking or an impairment of the uterus.

Table 7.5: Criteria for rating permanent impairment due to fallopian tube and ovarian disease

Class 1 **0 15% impairment of the whole person**	**Class 2** **16 25% impairment of the whole person**	**Class 3** **26 35% impairment of the whole person**
Fallopian tube or ovarian disease or deformity symptoms and signs do not require continuous treatment or only one functioning fallopian tube or ovary in the premenopausal period or bilateral fallopian tube or ovarian functional loss in the postmenopausal period	Fallopian tube or ovarian disease or deformity symptoms and signs require continuous treatment, but tubal patency persists and ovulation is possible	Fallopian tube or ovarian disease or deformity symptoms and signs and total tubal patency loss or failure to produce ova in the premenopausal period or bilateral fallopian tube or bilateral ovarian loss in the premenopausal period; infertility

8. Respiratory system

AMA5 Chapter 5 (p 87) applies to the assessment of permanent impairment of the respiratory system, subject to the modifications set out below. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing
- the appropriate chapter(s) of AMA5 for the body system they are assessing.

The Guidelines take precedence over AMA5.

Introduction

8.1 AMA5 Chapter 5 provides a useful summary of the methods for assessing permanent impairment arising from respiratory disorders.

8.2 The level of impairment arising from conditions that are not work-related needs to be assessed by the medical assessor and taken into consideration in determining the level of permanent impairment. The level at which pre-existing conditions and lifestyle activities, such as smoking, contribute to the level of permanent impairment requires judgement on the part of the clinician undertaking the impairment assessment. The manner in which any deduction for these is applied needs to be recorded in the assessing specialist's report.

Examinations, clinical studies and other tests for evaluating respiratory disease (AMA5 Section 5.4)

8.3 AMA5 tables 5-2b, 5-3b, 5-4b, 5-5b, 5-6b and 5-7b (pp 95–100) give the lower limits of normal values for pulmonary function tests. These are used in AMA5 Table 5-12 (p 107) to determine the impairment classification for respiratory disorders.

8.4 Classes 2, 3 and 4 in Table 5-12 list ranges of whole person impairment (WPI). The assessor should nominate the nearest whole percentage based on the complete clinical circumstances when selecting within the range.

Asthma (AMA5 Section 5.5)

8.5 In assessing permanent impairment arising from occupational asthma, the assessor will require evidence from the treating physician that:

- at least three lung function tests have been performed over a six-month period and that the results were consistent and repeatable over that period
- the worker has received maximal treatment and is compliant with his or her medication regimen.

8.6 Bronchial challenge testing should not be performed as part of the impairment assessment. Therefore, in AMA5 Table 5-9 (p 104), ignore column 4 (PC20 mg/mol or equivalent, etc.).

8.7 Permanent impairment due to asthma is rated by the score for the best post-bronchodilator forced expiratory volume in one second (FEV1) (score in column 2, AMA5 Table 5-9) plus per cent of FEV1 (score in column 3) plus minimum medication required (score in column 5). The total score derived is then used to assess the per cent impairment in AMA5 Table 5-10 (p 104).

Obstructive sleep apnoea (AMA5 Section 5.6)

8.8 This section needs to be read in conjunction with AMA5 sections 11.4 (p 259) and 13.3c (p 317).

8.9 Before permanent impairment can be assessed, the person must have appropriate assessment and treatment by an ear, nose and throat surgeon and a respiratory physician who specialises in sleep disorders.

8.10 The degree of permanent impairment due to sleep apnoea should be calculated with reference to AMA5 Table 13-4 (p 317).

Hypersensitivity pneumonitis (AMA5 Section 5.7)

8.11 Permanent impairment arising from disorders included in this section are assessed according to the impairment classification in AMA5 Table 5-12 (p 107).

Pneumoconiosis (AMA5 Section 5.8)

8.12 This section is excluded from the Guidelines, as these are the subject of the Dust Diseases Legislation.

Lung cancer (AMA5 Section 5.9)

8.13 Permanent impairment due to lung cancer should be assessed at least six months after surgery. AMA5 Table 5-12 (p 107), not Table 5-11, should be used for assessment of permanent impairment.

8.14 Persons with residual lung cancer after treatment are classified in respiratory impairment class 4 (AMA5 Table 5-12).

Permanent impairment due to respiratory disorders (AMA5 Section 5.10)

8.15 AMA5 Table 5-12 should be used to assess permanent impairment for respiratory disorders. The pulmonary function tests listed in Table 5-12 must be performed under standard conditions. Exercise testing is not required on a routine basis.

8.16 An isolated abnormal diffusing capacity for carbon monoxide (DCO) in the presence of otherwise normal results of lung function testing should be interpreted with caution and its aetiology should be clarified.

9. Hearing

AMA5 Chapter 11 (p 245) applies to the assessment of permanent impairment of hearing, subject to the modifications set out below. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- the Introduction in the Guidelines
- the appropriate chapter(s) of the Guidelines for the body system they are assessing.
- the National Acoustic Laboratories Report No. 118 January 1988 'Improved procedure for determining percentage loss of hearing'.

The Guidelines take precedence over AMA5.

Assessment of hearing impairment (hearing loss)

9.1 A worker may present for assessment of hearing loss for compensation purposes before having undergone all or any of the health investigations that generally occur before assessment of permanent impairment. For this reason, and to ensure that conditions other than 'occupational hearing impairment' are precluded, the medical assessment should be undertaken by an ear, nose and throat specialist or other appropriately qualified medical specialist. The medical assessment needs to be undertaken in accordance with the hearing impairment section of AMA5 Table 11-10 (pp 272–275). The medical specialist performing the assessment must examine the worker. The medical specialist's assessment must be based on medical history and ear, nose and throat examination, evaluation of relevant audiological tests, and evaluation of other relevant investigations available to the medical assessor. Only medical specialists can sign medical reports.

9.2 Disregard AMA5 sections 11.1b and 11.2 (pp 246–55), but retain Section 11.1a, 'Interpretation of symptoms and signs' (p 246).

9.3 Some of the relevant tests are discussed in the AMA5 hearing impairment evaluation summary in AMA5 Table 11-10 (pp 272–75). The relevant row for the Guidelines is the one headed 'hearing impairment', with the exception of the last column, headed 'degree of impairment'. The degree of impairment is determined according to the Guidelines.

9.4 The level of hearing impairment caused by non-work-related conditions is assessed by the medical specialist and considered when determining the level of work-related hearing impairment. While this requires medical judgement on the part of the examining medical specialist, any non-work-related deductions should be recorded in the report.

9.5 Disregard AMA5 tables 11-1, 11-2 and 11-3 (pp 247–50). For the purposes of the Guidelines, National Acoustic Laboratory (NAL) tables from the NAL Report No. 118, 'Improved procedure for determining percentage loss of hearing' (January 1988) are adopted as follows:

- Tables RB 500-4000 (pp 11–16)
- Tables RM 500-4000 (pp 18–23)
- Appendices 1 and 2 (pp 8–9)
- Appendices 5 and 6 (pp 24–26)
- Tables EB 4000–8000 (pp 28–30) (The extension tables)
- Table EM 4000–8000 (pp 32–34) (The extension tables)

Where an assessor uses the extension tables, they must provide an explanation of the worker's 'special requirement to be able to hear at frequencies above 4000 Hz' (NAL Report No.118, p 6).

In the presence of significant conduction hearing loss, the extension tables do not apply.

AMA5 Table 11-3 is to be replaced by Table 9.1 at the end of this chapter.

Hearing impairment

9.6 Impairment of a worker's hearing is determined according to evaluation of the individual's binaural hearing impairment (BHI).

9.7 Permanent hearing impairment should be evaluated when the condition is stable. Prosthetic devices (that is, hearing aids) must not be worn during the evaluation of hearing sensitivity.

9.8 Hearing threshold level for pure tones is defined as the number of decibels above standard audiometric zero for a given frequency at which the listener's threshold of hearing lies when tested in a suitable sound attenuated environment. It is the reading on the hearing level dial of an audiometer that is calibrated according to Australian Standard AS 2586 1983.

9.9 Evaluation of binaural hearing impairment is determined by using the tables in the 1988 NAL publication with allowance for presbyacusis according to the presbyacusis correction table, if applicable, in the same publication.

The binaural tables RB 500-4000 (NAL publication, pp 11–16) are to be used. The extension tables EB 4000-8000 (NAL publication, pp 28–30) may be used when the worker has a 'special requirement to be able to hear at frequencies above 4000 Hz' (NAL publication, p 6). Where an assessor uses the extension tables, they must provide an explanation of the worker's special requirement to be able to hear at frequencies above 4000 Hz. For the purposes of calculating binaural hearing impairment, the better and worse ear may vary as between frequencies.

Where it is necessary to use the monaural tables, the binaural hearing impairment (BHI) is determined by the formula:

$$\text{BHI} = \frac{[4 \times (\text{better ear hearing loss})] + \text{worse ear hearing loss}}{5}$$

9.10 Presbyacusis correction (NAL publication, p 24) only applies to occupational hearing loss contracted by a gradual process (eg occupational noise-induced hearing loss and/or occupational solvent-induced hearing loss). Please note that when calculating by formula for presbyacusis correction (eg when the worker is older than 81), use the formula shown in Appendix 6, line 160 of the NAL publication (p 26), which uses the correct number of 1.79059. Note: there is a typographical error in Table P on p 25 of the NAL publication, where the number 1.79509 is incorrectly used.

9.11 Binaural hearing impairment and severe tinnitus: Up to 5 per cent may be added to the work-related binaural hearing impairment for severe tinnitus caused by a work-related injury:

- after presbyacusis correction, if applicable
- before determining whole person impairment (WPI).

Assessment of severe tinnitus is based on a medical specialist's assessment.

9.12 **Only hearing ear:** A worker has an 'only hearing ear' if he or she has suffered a non-work related severe or profound sensorineural hearing loss in the other ear. If a worker suffers a work-related injury causing a hearing loss in the only hearing ear of x dB HL at a relevant frequency, the worker's work-related binaural hearing impairment at that frequency is calculated from the binaural tables using x dB as the hearing threshold level in both ears. Deduction for presbyacusis, if applicable, and addition for severe tinnitus, is undertaken according to the Guidelines.

9.13 When necessary, binaural hearing impairment figures should be rounded to the nearest 0.1%. Rounding up should occur if equal to or greater than 0.05%, and rounding down should occur if equal to or less than 0.04%.

9.14 Table 9.1 in the Guidelines is used to convert binaural hearing impairment, after deduction for presbyacusis if applicable and after addition for severe tinnitus, to WPI.

9.15 The method of subtracting a previous impairment for noise-induced hearing loss, where the previous impairment was not assessed in accordance with the Guidelines, is as shown in the following example:

- The current level of binaural hearing impairment is established by the relevant specialist.
- Convert this to WPI using Table 9.1 in the Guidelines.
- Calculate the proportion of the current binaural hearing impairment that was accounted for by the earlier assessment and express it as a percentage of the current hearing impairment.
- The percentage of current hearing impairment that remains is the amount to be compensated.
- This needs to be expressed in terms of WPI for calculation of compensation entitlement.

Example:

- The current binaural hearing impairment is 8%.
- The WPI is 4%.
- The binaural hearing impairment for which compensation was paid previously is 6%, which is 75% of the current binaural hearing impairment of 8%.
- The remaining percentage, 25% is the percentage of WPI to be compensated.
- Twenty-five per cent of the WPI of 4% is 1% WPI.

Table 9.1: Relationship of binaural hearing impairment to whole person impairment

% Binaural hearing impairment	% Whole person impairment	% Binaural hearing impairment	% Whole person impairment
0.0–5.9	0	51.1–53.0	26
		53.1–55.0	27
6.0–6.7	3	55.1–57.0	28
6.8–8.7	4	57.1–59.0	29
8.8–10.6	5	59.1–61.0	30
10.7–12.5	6	61.1–63.0	31
12.6–14.4	7	63.1–65.0	32
14.5–16.3	8	65.1–67.0	33
16.4–18.3	9	67.1–69.0	34
18.4–20.4	10	69.1–71.0	35
20.5–22.7	11	71.1–73.0	36
22.8–25.0	12	73.1–75.0	37
25.1–27.0	13	75.1–77.0	38
27.1–29.0	14	77.1–79.0	39
29.1–31.0	15	79.1–81.0	40
31.1–33.0	16	81.1–83.0	41
33.1–35.0	17	83.1–85.0	42
35.1–37.0	18	85.1–87.0	43
37.1–39.0	19	87.1–89.0	44
39.1–41.0	20	89.1–91.0	45
41.1–43.0	21	91.1–93.0	46
43.1–45.0	22	93.1–95.0	47
45.1–47.0	23	95.1–97.0	48
47.1–49.0	24	97.1–99.0	49
49.1–51.0	25	99.1–100	50

9.16 AMA5 examples 11.1, 11.2 and 11.3 (pp 250–51) are replaced by examples 9.1–9.7, below, which were developed by the working party.

Table 9.2: Medical assessment elements in examples

Element	Example no.
General use of binaural table – NAL 1988	1, 2
'Better ear' – 'worse ear' crossover	1, 2
Assessable audiometric frequencies	7 – also 1, 2, 4, 5, 6
Tinnitus	1, 2, 3, 4
Presbycusis	All examples
Binaural hearing impairment	All examples
Conversion to WPI	All examples
Gradual process injury	3
Noise-induced hearing loss	1, 2, 3, 5, 6, 7
Solvent-induced hearing loss	3
Acute occupational hearing loss	4, 5
Acute acoustic trauma	5
Pre-existing non-occupational hearing loss	6
Only hearing ear	6
NAL 1988 extension table use	7
Multiple causes of hearing loss	3, 5, 6
Head injury	4

Example 9.1: Occupational noise-induced hearing loss and severe tinnitus

A 55-year-old man, who worked as a boilermaker for 30 years, gave a history of progressive hearing loss and tinnitus. The assessing medical specialist has assessed the tinnitus as severe. The external auditory canals and tympanic membranes were normal. Rinne test was positive bilaterally and the Weber test result was central. Clinical assessment of hearing was consistent with results of pure tone audiometry, which showed a bilateral sensorineural hearing loss. The medical specialist diagnosed noise induced hearing loss.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)
500	15	10	0
1000	20	20	0.8
1500	25	25	1.4
2000	35	35	3.4
3000	60	60	6.3
4000	75	75	8.2
6000	30	30	-
8000	20	20	-
Total %BHI			20.1
No presbycusis correction			20.1
Add 4.0% for severe tinnitus			24.1
Adjusted total %BHI			24.1
Resultant total BHI of 24.1% = 12% WPI (Table 9.1)			

Example 9.2: Occupational noise-induced hearing loss and mild tinnitus

A 55-year-old man who worked as a steelworker for 30 years gave a history of increasing difficulties with hearing and tinnitus. The assessing medical specialist diagnosed occupational noise-induced hearing loss with mild tinnitus.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)
500	15	15	0.0
1000	15	15	0.0
1500	20	25	1.0
2000	30	35	2.5
3000	50	45	4.2
4000	55	55	5.2
6000	30	30	-
8000	20	20	-
Total %BHI			12.9
No presbycusis correction			12.9
Adjusted total %BHI			12.9
Resultant total BHI of 12.9% = 7% WPI (Table 9.1)			

Comment

The assessing medical specialist's opinion is that the tinnitus suffered by the worker is not severe and thus no addition to the binaural hearing impairment was made for tinnitus.

Example 9.3: Multiple gradual process occupational hearing loss

A 63-year-old male boat builder and printer gave a history of hearing difficulty and tinnitus. There had been marked chronic exposure to noise and solvents in both occupations for a total of 35 years. The assessing medical specialist diagnosed bilateral noise-induced hearing loss and bilateral solvent-induced hearing loss with severe tinnitus.

The assessing medical specialist's opinion is that the solvent exposure contributed to the hearing impairment as a gradual process injury. The total noise-induced and solvent-induced BHI was 17.5%.

The appropriate presbyacusis deduction was applied. Then, the assessing medical specialist added 2% to the after-presbyacusis binaural hearing impairment for severe tinnitus.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)
500	15	15	0.0
1000	15	15	0.0
1500	25	25	1.4
2000	35	40	3.8
3000	60	60	6.3
4000	60	60	6.0
6000	45	50	-
8000	40	40	-
Total noise-induced and solvent-induced BHI (%)			17.5
Presbycusis correction of 1.7%			15.8
2% addition for medically assessed severe tinnitus			17.8
Adjusted total BHI			17.8
Resultant total BHI of 17.8% = 9% WPI (Table 9.1)			

Example 9.4: Occupational hearing loss from head injury

A 62-year-old male worker sustained a head injury after falling from a ladder. He suffered left hearing loss and tinnitus unaccompanied by vertigo. The assessing medical specialist assesses his tinnitus as severe. External auditory canals and tympanic membranes are normal. Rinne test is positive bilaterally and Weber test lateralises to the right. CT scan of the temporal bones shows a fracture on the left. Clinical assessment of hearing is consistent with pure tone audiometry, which shows a flat left sensorineural hearing loss and mild right sensorineural hearing loss.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)
500	50	15	2.3
1000	55	15	3.1
1500	60	20	3.4
2000	65	20	2.6
3000	65	25	2.2
4000	65	30	2.1
6000	65	20	-
8000	65	20	-
Total % BHI			15.7
No correction for presbycusis applies			-
Add 5.0% for severe tinnitus			20.7
Adjusted total BHI			20.7
Resultant total BHI of 20.7% = 11% WPI (Table 9.1)			

Example 9.5: Occupational noise-induced hearing loss with acute occupational hearing loss

A 65-year-old who has been a production worker for 10 years was injured in an explosion at work. He reported immediate postinjury otalgia and acute hearing loss in the left ear. The assessing medical specialist diagnosed occupational noise-induced hearing loss and left acute acoustic trauma. The assessing medical specialist had no medical evidence that, immediately before the explosion, the hearing in the left ear was significantly different from that in the right ear.

Table 9.7: Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)	Binaural hearing impairment due to noise induced hearing loss (%BHI)
500	30	15	1.0	0.0
1000	45	15	2.5	0.0
1500	55	15	2.5	0.0
2000	70	15	2.2	0.0
3000	80	25	2.4	0.7
4000	80	30	2.3	0.8
6000	>80	30	-	-
8000	>80	25	-	-
Total BHI (%)			12.9	
Occupational noise-induced BHI (%) before presbycusis correction				1.5
Occupational noise-induced BHI (%) after presbycusis correction of 2.4%				0
Acute acoustic trauma BHI (%)			11.4	
Presbycusis does not apply to acute acoustic trauma			-	
Resultant total BHI due to acute acoustic trauma of 11.4% = 6% WPI (Table 9.1)				

Example 9.6: Occupational noise-induced hearing loss in an only hearing ear

A 66-year-old woman has been a textile worker for 30 years. Childhood mumps had left her with profound hearing loss in the left ear. She gave a history of progressive hearing loss in her only hearing ear unaccompanied by tinnitus or vertigo. External auditory canals and tympanic membranes appeared normal. Rinne test was positive on the right and was false negative on the left. Weber test lateralised to the right. Clinical assessment of hearing is consistent with pure tone audiometry, showing a profound left sensorineural hearing loss and a partial right sensorineural hearing loss. The medical assessor diagnosed noise induced hearing loss in the right ear.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)	Occupational %BHI
500	>95	10	3.4	0
1000	>95	15	4.3	0
1500	>95	20	4.2	0.6
2000	>95	25	3.8	1.1
3000	>95	50	5.4	4.8
4000	>95	70	8.0	7.5
6000	>95	50	-	-
8000	>95	40	-	-
Total %BHI			29.1	
Total occupational %BHI				14.0
Presbycusis correction does not apply to a 66 year old woman				-
No addition for tinnitus				-
Adjusted total occupational %BHI				14.0
Total occupational BHI of 14% = 7% WPI (Table 9.1)				

Example 9.7: Occupational noise-induced hearing loss where there is a special requirement for the ability to hear at frequencies above 4000 Hz

A 56-year-old female electronics technician who worked in a noisy factory for 20 years had increasing hearing difficulty. The diagnosis made was bilateral occupational noise-induced hearing loss extending to 6000 Hz or 8000 Hz. The assessing medical specialist was of the opinion that there was a special requirement for hearing above 4000 Hz. There was no conductive hearing loss.

Pure tone audiometry

			Binaural hearing impairment (%BHI)	
Frequency (Hz)	**Left (dB HL)**	**Right (dB HL)**	**Using extension table 4000, 6000 and 8000 Hz**	**Not using extension table**
			0.0	0.0
1000	15	15	0.0	0.0
1500	20	25	1.0	1.0
2000	30	35	2.5	2.5
3000	45	45	4.1	4.1
4000	45	50	2.2	3.6
6000	60	55	1.6	-
8000	50	20	0.2	-
Total BHI (%) using extension table			11.6	
Total BHI (%) not using extension table				11.2
Presbycusis correction			0	
The assessing medical specialist is of the opinion that the binaural hearing impairment in this matter is 11.6% rather than 11.2%				
Adjusted total %BHI			11.6	
Resultant total BHI of 11.6% = 6% WPI (Table 9.1)				

10. The visual system

AMA4 Chapter 8 (p 209) applies to the assessment of permanent impairment of the visual system, subject to the modifications set out below. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing
- the appropriate chapter(s) of AMA4 for the body system they are assessing.

The Guidelines take precedence over AMA4 and AMA5.

Introduction and approach to assessment

10.1 The visual system must be assessed by an ophthalmologist.

10.2 AMA4 Chapter 8 (pp 209–22) is adopted for the Guidelines, without significant change.

10.3 AMA4 is used rather than AMA5 for the assessment of permanent impairment of the visual system because:

- the equipment recommended for use in AMA5 is expensive and not owned by most privately practising ophthalmologists (eg the Goldman apparatus for measuring visual fields)
- the assessments recommended in AMA5 are considered too complex, raising a risk that resulting assessments may be of a lower standard than if the AMA4 method is used
- there is little emphasis on diplopia in AMA5, yet this is a relatively frequent problem
- many ophthalmologists are familiar with the Royal Australian College of Ophthalmologists' impairment guide, which is similar to AMA4.

10.4 Impairment of vision should be measured with the injured worker wearing their prescribed corrective spectacles and/or contact lenses, if that was normal for the injured worker before the workplace injury. If, as a result of the workplace injury, the injured worker has been prescribed corrective spectacles and/or contact lenses for the first time, or different spectacles and/or contact lenses than those prescribed before injury, the difference should be accounted for in the assessment of permanent impairment.

10.5 The ophthalmologist should perform, or review, all tests necessary for the assessment of permanent impairment rather than relying on tests, or interpretations of tests, done by the orthoptist or optometrist.

10.6 An ophthalmologist should assess visual field impairment in all cases.

10.7 In AMA4 Section 8.5 'Other conditions' (p 222), the reference to 'additional 10% impairment' means 10% WPI, not 10% impairment of the visual system.

11. Psychiatric and psychological disorders

AMA5 Chapter 14 is excluded and replaced by this chapter. Before undertaking an impairment assessment, users of the Guidelines must be familiar with (in this order):

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing.

The Guidelines replace the psychiatric and psychological chapter in AMA5.

Introduction

11.1 This chapter lays out the method for assessing psychiatric impairment. The evaluation of impairment requires a medical examination.

11.2 Evaluation of psychiatric impairment is conducted by a psychiatrist who has undergone appropriate training in this assessment method.

11.3 Permanent impairment assessments for psychiatric and psychological disorders are only required where the primary injury is a psychological one. The psychiatrist needs to confirm that the psychiatric diagnosis is the injured worker's primary diagnosis.

Diagnosis

11.4 The impairment rating must be based upon a psychiatric diagnosis (according to a recognised diagnostic system) and the report must specify the diagnostic criteria upon which the diagnosis is based. Impairment arising from any of the somatoform disorders (DSM IV TR, pp 485–511) are excluded from this chapter.

11.5 If pain is present as the result of an organic impairment, it should be assessed as part of the organic condition under the relevant table. This does not constitute part of the assessment of impairment relating to the psychiatric condition. The impairment ratings in the body organ system chapters in AMA5 make allowance for any accompanying pain.

11.6 It is expected that the psychiatrist will provide a rationale for the rating based on the injured worker's psychiatric symptoms. The diagnosis is among the factors to be considered in assessing the severity and possible duration of the impairment, but is not the sole criterion to be used. Clinical assessment of the person may include information from the injured worker's own description of his or her functioning and limitations, and from family members and others who may have knowledge of the person. Medical reports, feedback from treating professionals and the results of standardised tests – including appropriate psychometric testing performed by a qualified clinical psychologist and work evaluations – may provide useful information to assist with the assessment. Evaluation of impairment will need to take into account variations in the level of functioning over time. Percentage impairment refers to whole person impairment (WPI).

Permanent impairment

11.7 A psychiatric disorder is permanent if, in your clinical opinion, it is likely to continue indefinitely. Regard should be given to:

- the duration of impairment
- the likelihood of improvement in the injured worker's condition
- whether the injured worker has undertaken reasonable rehabilitative treatment
- any other relevant matters.

Effects of treatment

11.8 Consider the effects of medication, treatment and rehabilitation to date. Is the condition stable? Is treatment likely to change? Are symptoms likely to improve? If the injured worker declines treatment, this should not affect the estimate of permanent impairment. The psychiatrist may make a comment in the report about the likely effect of treatment or the reasons for refusal of treatment.

Co-morbidity

11.9 Consider comorbid features (eg bi-polar disorder, personality disorder, substance abuse) and determine whether they are directly linked to the work-related injury, or whether they were pre-existing or unrelated conditions.

Pre-existing impairment

11.10 To measure the impairment caused by a work-related injury or incident, the psychiatrist must measure the proportion of WPI due to a pre-existing condition. Pre-existing impairment is calculated using the same method for calculating current impairment level. The assessing psychiatrist uses all available information to rate the injured worker's pre-injury level of functioning in each of the areas of function. The percentage impairment is calculated using the aggregate score and median class score using the conversion table below. The injured worker's current level of WPI% is then assessed, and the pre-existing WPI% is subtracted from their current level, to obtain the percentage of permanent impairment directly attributable to the work-related injury. If the percentage of pre-existing impairment cannot be assessed, the deduction is 1/10th of the assessed WPI.

Psychiatric impairment rating scale (PIRS)

11.11 Behavioural consequences of psychiatric disorder are assessed on six scales, each of which evaluates an area of functional impairment:

1. Self care and personal hygiene (Table 11.1)
2. Social and recreational activities (Table 11.2)
3. Travel (Table 11.3)

} Activities of daily living

4. Social functioning (relationships) (Table 11.4)
5. Concentration, persistence and pace (Table 11.5)
6. Employability (Table 11.6).

11.12 Impairment in each area is rated using class descriptors. Classes range from 1 to 5, in accordance with severity. The standard form must be used when scoring the PIRS. The examples of activities are examples only. The assessing psychiatrist should take account of the person's cultural background. Consider activities that are usual for the person's age, sex and cultural norms.

Table 11.1: Psychiatric impairment rating scale – self care and personal hygiene

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population
Class 2	Mild impairment: able to live independently; looks after self adequately, although may look unkempt occasionally; sometimes misses a meal or relies on take-away food.
Class 3	Moderate impairment: Can't live independently without regular support. Needs prompting to shower daily and wear clean clothes. Does not prepare own meals, frequently misses meals. Family member or community nurse visits (or should visit) 2–3 times per week to ensure minimum level of hygiene and nutrition.
Class 4	Severe impairment: Needs supervised residential care. If unsupervised, may accidentally or purposefully hurt self.
Class 5	Totally impaired: Needs assistance with basic functions, such as feeding and toileting.

Table 11.2: Psychiatric impairment rating scale – social and recreational activities

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: regularly participates in social activities that are age, sex and culturally appropriate. May belong to clubs or associations and is actively involved with these.
Class 2	Mild impairment: occasionally goes out to such events eg without needing a support person, but does not become actively involved (eg dancing, cheering favourite team).
Class 3	Moderate impairment: rarely goes out to such events, and mostly when prompted by family or close friend. Will not go out without a support person. Not actively involved, remains quiet and withdrawn.
Class 4	Severe impairment: never leaves place of residence. Tolerates the company of family member or close friend, but will go to a different room or garden when others come to visit family or flat mate.
Class 5	Totally impaired: Cannot tolerate living with anybody, extremely uncomfortable when visited by close family member.

Table 11.3: Psychiatric impairment rating scale – travel

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: Can travel to new environments without supervision.
Class 2	Mild impairment: can travel without support person, but only in a familiar area such as local shops, visiting a neighbour.
Class 3	Moderate impairment: cannot travel away from own residence without support person. Problems may be due to excessive anxiety or cognitive impairment.
Class 4	Severe impairment: finds it extremely uncomfortable to leave own residence even with trusted person.
Class 5	Totally impaired: may require two or more persons to supervise when travelling.

Table 11.4: Psychiatric impairment rating scale – social functioning

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: No difficulty in forming and sustaining relationships (eg a partner, close friendships lasting years).
Class 2	Mild impairment: existing relationships strained. Tension and arguments with partner or close family member, loss of some friendships.
Class 3	Moderate impairment: previously established relationships severely strained, evidenced by periods of separation or domestic violence. Spouse, relatives or community services looking after children.
Class 4	Severe impairment: unable to form or sustain long term relationships. Pre-existing relationships ended (eg lost partner, close friends). Unable to care for dependants (eg own children, elderly parent).
Class 5	Totally impaired: unable to function within society. Living away from populated areas, actively avoiding social contact.

Table 11.5: Psychiatric impairment rating scale – concentration, persistence and pace

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population. Able to pass a TAFE or university course within normal time frame.
Class 2	Mild impairment: can undertake a basic retraining course, or a standard course at a slower pace. Can focus on intellectually demanding tasks for periods of up to 30 minutes, then feels fatigued or develops headache.
Class 3	Moderate impairment: unable to read more than newspaper articles. Finds it difficult to follow complex instructions (eg operating manuals, building plans), make significant repairs to motor vehicle, type long documents, follow a pattern for making clothes, tapestry or knitting.
Class 4	Severe impairment: can only read a few lines before losing concentration. Difficulties following simple instructions. Concentration deficits obvious even during brief conversation. Unable to live alone, or needs regular assistance from relatives or community services.
Class 5	Totally impaired: needs constant supervision and assistance within institutional setting.

Table 11.6: Psychiatric impairment rating scale – employability

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population. Able to work full time. Duties and performance are consistent with the injured worker's education and training. The person is able to cope with the normal demands of the job.
Class 2	Mild impairment. Able to work full time but in a different environment from that of the pre-injury job. The duties require comparable skill and intellect as those of the pre-injury job. Can work in the same position, but no more than 20 hours per week (eg no longer happy to work with specific persons, or work in a specific location due to travel required).
Class 3	Moderate impairment: cannot work at all in same position. Can perform less than 20 hours per week in a different position, which requires less skill or is qualitatively different (eg less stressful).
Class 4	Severe impairment: cannot work more than one or two days at a time, less than 20 hours per fortnight. Pace is reduced, attendance is erratic.
Class 5	Totally impaired: Cannot work at all.

Using the PIRS to measure impairment

11.13 Rating psychiatric impairment using the PIRS is a two-step procedure:

1. Determine the median class score.
2. Calculate the aggregate score.

Determining the median class score

11.14 Each area of function described in the PIRS is given an impairment rating which ranges from Class 1 to 5. The six scores are arranged in ascending order, using the standard form. The median is then calculated by averaging the two middle scores eg:

Example A: 1, 2, **3**, **3**, 4, 5 Median Class = 3

Example B: 1, 2, **2**, **3**, 3, 4 Median Class = 2.5 = 3*

Example C: 1, 2, **3**, **5**, 5, 5 Median Class = 4

*If a score falls between two classes, it is rounded up to the next class. A median class score of 2.5 thus becomes 3.

11.15 The median class score method was chosen as it is not influenced by extremes. Each area of function is assessed separately. While impairment in one area is neither equivalent nor interchangeable with impairment in other areas, the median seems the fairest way to translate different impairments onto a linear scale.

Median class score and percentage impairment

11.16 Each median class score represents a range of impairment, as shown below:

Class 1 = 0–3%

Class 2 = 4–10%

Class 3 = 11–30%

Class 4 = 31–60%

Class 5 = 61–100%

Calculation of the aggregate score

11.17 The aggregate score is used to determine an exact percentage of impairment within a particular median class range. The six class scores are added to give the aggregate score.

Use of the conversion table to arrive at percentage impairment

11.18 The aggregate score is converted to a percentage score using the conversion Table 11.7, below.

11.19 The conversion table was developed to calculate the percentage impairment based on the aggregate and median scores.

11.20 The scores within the conversion table are spread in such a way to ensure that the final percentage rating is consistent with the measurement of permanent impairment percentages for other body systems.

Table 11.7: Conversion table

% Impairment	Aggregate score																								
	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Class 1	0	0	1	1	2	2	2	3	3																
Class 2				4	5	5	6	7	7	8	9	9	10												
Class 3								11	13	15	17	19	22	24	26	28	30								
Class 4												31	34	37	41	44	47	50	54	57	60				
Class 5																66	65	70	74	78	83	87	91	96	100

Conversion table — explanatory notes

a. Distribution of aggregate scores

- The lowest aggregate score that can be obtained is: 1+1+1+1+1+1=6.
- The highest aggregate score is 5+5+5+5+5+5= 30.
- The table therefore has aggregate scores ranging from six to 30.
- Each median class score has an impairment range, and a range of possible aggregate scores (eg class 3 = 11-30 per cent).
- The lowest aggregate score for class 3 is 13 (1 + 1 + 2 + 3 + 3 + 3 = 13).
- The highest aggregate score for class 3 is 22 (3 + 3 + 3 + 3 + 5 + 5 = 22).
- The conversion table distributes the impairment percentages across aggregate scores.

b. Same aggregate score in different classes

- The conversion table shows that the same aggregate score leads to different percentages of impairment in different median classes.
- For example, an aggregate score of 18 is equivalent to an impairment rating of
  - 10% in Class 2,
  - 22% in Class 3,
  - 34% in Class 4.
- This is due to the fact that an injured worker whose impairment is in median class 2 is likely to have a lower score across most areas of function. They may be significantly impaired in one aspect of their life, such as travel, yet have low impairment in social function, self-care or concentration.
- Someone whose impairment reaches median class 4 will experience significant impairment across most aspects of his or her life.

Examples: (Using the previous cases)

Example A

PIRS scores						Median class
1	2	3	3	4	5	= 3

Aggregate score						Total	% Impairment
1 +	2 +	3 +	3 +	4 +	5 =	18	22%

Example B

PIRS scores						Median class
1	2	2	3	3	4	= 3

Aggregate score						Total	% Impairment
1 +	2 +	2 +	3 +	3 +	4 =	15	15%

Example C

PIRS scores						Median class
1	2	3	5	5	5	= 4

Aggregate score						Total	% Impairment
1 +	2 +	3 +	5 +	5 +	5 =	21	44%

Table 11.8: PIRS rating form

Name		**Claim reference number**	
Date of birth		**Age at time of injury**	
Date of injury		**Occupation before injury**	
Date of assessment		**Marital status before injury**	

Psychiatric diagnoses	1.	2.
	3.	4.
Psychiatric treatment		
Is impairment permanent?	☐ Yes ☐ No (Tick one)	

PIRS category	Class	Reason for decision
Self care and personal hygiene		
Social and recreational activities		
Travel		
Social functioning		
Concentration, persistence and pace		
Employability		

Score class

Median

=

Aggregate score

+	+	+	+	+	+	=	

Total %

Impairment (%WPI) from Table 11.7

Less pre-existing impairment (if any)

Final impairment (%WPI)

12. Haematopoietic system

AMA5 Chapter 9 (p 191) applies to the assessment of permanent impairment of the haematopoietic system, subject to the modifications set out below. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing
- the appropriate chapter(s) of AMA5 for the body system they are assessing.

The Guidelines take precedence over AMA5.

Introduction

12.1 AMA5 Chapter 9 (pp 191–210) provides guidelines on the method of assessing permanent impairment of the haematopoietic system. Overall, that chapter should be followed when conducting the assessment, with variations indicated below.

12.2 Impairment of end organ function due to haematopoietic disorder should be assessed separately, using the relevant chapter of the Guidelines. The percentage whole person impairment (WPI) due to end organ impairment should be combined with any percentage WPI due to haematopoietic disorder, using the combined values table in AMA5 (pp 604–06).

Anaemia

12.3 Table 12.1 (below) replaces AMA5 Table 9-2 (p 193).

Table 12.1: Classes of anaemia and percentage whole person impairment

Class 1: 0 10% WPI	Class 2: 11 30% WPI	Class 3: 31 70% WPI	Class 4: 71 100% WPI
No symptoms and haemoglobin 100-120g/L and no transfusion required	Minimal symptoms and haemoglobin 80-100g/L and no transfusion required	Moderate to marked symptoms and haemoglobin 50-80g/L before transfusion and transfusion of 2 to 3 units required, every 4 to 6 weeks	Moderate to marked symptoms and haemoglobin 50-80g/L before transfusion and transfusion of 2 to 3 units required, every 2 weeks

12.4 The assessor should exercise clinical judgement in determining WPI, using the criteria in Table 12.1. For example, if comorbidities exist which preclude transfusion, the assessor may assign class 3 or class 4, on the understanding that transfusion would under other circumstances be indicated. Similarly, there may be some claimants with class 2 impairment who, because of comorbidity, may undergo transfusion.

12.5 Pre-transfusion haemoglobin levels in Table 12.1 are to be used as indications only. It is acknowledged that for some claimants, it would not be medically advisable to permit the claimant's haemoglobin levels to be as low as indicated in the criteria of Table 12.1.

12.6 The assessor should indicate a percentage WPI, as well as the class.

Polycythaemia and myelofibrosis

12.7 The level of symptoms (as in Table 12.1) should be used as a guide for the assessor in cases where non-anaemic tissue iron deficiency results from venesection.

White blood cell diseases

12.8 In cases of functional asplenia, the assessor should assign 3% WPI. This should be combined with any other impairment rating, using the Combined Values Table in AMA5 (pp 604–06).

Haemorrhagic and platelet disorders

12.9 AMA5 Table 9-4 (p 203) is to be used as the basis for assessing haemorrhagic and platelet disorders.

12.10 For the purposes of the Guidelines, the criteria for inclusion in class 3 of AMA5 Table 9-4 (p 203) are:

- symptoms and signs of haemorrhagic and platelet abnormality
- requires continuous treatment
- interference with daily activities; requires occasional assistance.

12.11 For the purposes of the Guidelines, the criteria for inclusion in class 4 of AMA5 Table 9-4 (p 203) is:

- symptoms and signs of haemorrhagic and platelet abnormality
- requires continuous treatment
- difficulty performing daily activities; requires continuous care.

Thrombotic disorders

12.12 AMA5 Table 9-4 (p 203) is used as the basis for determining impairment due to thrombotic disorder.

13. The endocrine system

AMA5 Chapter 10 (p 211) applies to the assessment of permanent impairment of the endocrine system, subject to the modifications set out below. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing
- the appropriate chapter(s) of AMA5 for the body system they are assessing.

The Guidelines take precedence over AMA5.

Introduction

13.1 AMA5 Chapter 10 provides a useful summary of the methods for assessing permanent impairment arising from disorders of the endocrine system.

13.2 Refer to other chapters in AMA5 for related structural changes – the skin (eg pigmentation, in Chapter 8), the central and peripheral nervous system (eg memory, in Chapter 13), the urinary and reproductive system (eg infertility renal impairment, in Chapter 7), the digestive system (eg dyspepsia, in Chapter 6) and the cardiovascular system (in chapters 3 and 4) and visual system (Chapter 8 AMA4).

13.3 The clinical findings to support the impairment assessment are to be reported in the units recommended by the Royal College of Pathologists of Australia. (See Appendix 13.1).

13.4 Westergren erythrocyte sedimentation rate (WSR) is equivalent to ESR.

Adrenal cortex

13.5 AMA5 (p 222) first paragraph: disregard the last sentence, 'They also affect inflammatory response, cell membrane permeability, and immunologic responses, and they play a role in the development and maintenance of secondary sexual characteristics'. Replace with: 'Immunological and inflammatory responses are reduced by these hormones and they play a role in the development and maintenance of secondary sexual characteristics.'

13.6 AMA5 example 10-18 (pp 224–25): See reference to ESR (paragraph 13.4, above).

13.7 AMA5 example 10-20, regarding history (p 225): Instead of 'hypnotic bladder', read 'hypotonic bladder'.

Diabetes mellitus

13.8 AMA5 (p 231): refer to the Australian Diabetes Association Guidelines with regard to levels of fasting glucose. (The position statement from the Australian Diabetes Society is reprinted in Appendix 13.2).

13.9 AMA5 (p 231): At the end of the second paragraph insert, 'The goal of treatment is to maintain haemoglobin A1c within 1% of the normal range (4.0–6.3%)'.

Mammary glands

13.10 AMA5 example 10-45, regarding current symptoms (p 239): Disregard the last sentence, 'Both bromocriptine and cabergoline cause nausea, precluding use of either drug'. Replace with: 'Routine use of bromocriptine and cabergoline is normal in Australia. It is rare that nausea precludes their use'.

Criteria for rating permanent impairment due to metabolic bone disease

13.11 AMA5 (p 240): Impairment due to a metabolic bone disease itself is unlikely to be associated with a work injury and would usually represent a pre-existing condition.

13.12 Impairment from fracture, spinal collapse or other complications may arise as a result of a work injury associated with these underlying conditions (as noted in AMA5 Section 10.10c) and would be assessed using the other chapters indicated, with the exception of Chapter 18, on pain, which is excluded from the Guidelines.

Appendix 13.1: Interpretation of pathology tests

From the *Manual of use and interpretation of pathology tests,* 3rd edition. Reprinted with kind permission of the Royal College of Pathologists of Australasia.

Reference ranges, plasma or serum, unless otherwise indicated		
Alanine aminotransferase (ALT)	(adult)	<35 U/L
Albumin	(adult)	32–45 g/L
Alkaline phosphatase (ALP)	(adult, non-pregnant)	25–100 U/L
Alpha fetoprotein	(adult, non-pregnant)	<10 g/L
Alpha-1-antitrypsin		1.7–3.4 g/L
Anion gap		8–16 mmol/L
Aspartate aminotransferase (AST)		<40 U/L
Bicarbonate (total CO_2)		22–32 mmol/L
Bilirubin (total)	(adult)	< 20 µmol/L
Calcium	(total)	2.10–2.60 mmol/L
	(ionised)	1.17–1.30 mmol/L
Chloride		95–110 mmol/L
Cholesterol (HDL)	(male)	0.9–2.0 mmol/L
	(female)	1.0–2.2 mmol/L
Cholesterol (total) (National Heart Foundation (Australia) recommendation)		<5.5 mmol/L
Copper		13–22 µmol/L
Creatine kinase (CK)	(male)	60–220 U/L
	(female)	30–180 U/L
Creatinine	(adult male)	0.06–0.12 mmol/L
	(adult female)	0.05–0.11 mmol/L
Gamma glutamyl transferase (GGT)	(male)	<50 U/L
	(female)	<30 U/L
Globulin	adult	25–35 g/L
Glucose	(venous plasma) – (fasting)	3.0–5.4 mmol/L
	(venous plasma) – (random)	3.0–7.7 mmol/L
Lactate dehydrogenase (LD)	(adult)	110–230 U/L
Magnesium	(adult)	0.8–1.0 mmol/L
Osmolality	(adult)	280–300 m.osmoll/kg water
pCO2	(arterial blood)	4.6–6.0 kPa (35–45 mmHg)
pH	(arterial blood)	7.36–7.44 (36–44 nmol/L)
Phosphate		0.8–1.5 mmol/L
pO2	(arterial blood)	11.0–13.5 kPa (80–100 mmHg)
Potassium	(plasma)	3.4–4.5 mmol/L
	(serum)	3.8–4.9 mmol/L
Prolactin	(male)	150–500 mU/L
	(female)	0–750 mU/L
Protein, total	(adult)	62–80 g/L
Sodium		135–145 mmol/L
Testosterone and related androgens	See Table A (on following page)	

Therapeutic intervals		
Amitriptyline	150–900 nmol/L	60–250 µg/L
Carbamazepine	20–40 µmol/L	6–12 mg/L
Digoxin	0.6–2.3 nmol/L	0.5–1.8 µg/L
Lithium	0.6–1.2 mmol/L	
Nortriptyline	200–650 nmol/L	50–170 µg/L
Phenobarbitone	65–170 µmol/L	15–40 mg/L
Phenytoin	40–80 µmol/L	10–20 mg/L
Primidone	22–50 µmol/L	4.8–11.0 mg/L
Procainamide	17–42 µmol/L	4–10 mg/L
Quinidine	7–15 µmol/L	2.3–4.8 mg/L
Salicylate	1.0–2.5 mmol/L	140–350 mg/L
Theophylline	55–110 µmol/L	10–20 mg/L
Valproate	350–700 µmol/L	50–100 mg/L
Thyroid stimulating hormone (TSH)		0.4–5.0 mIU/L
Thyroxine (free)		10–25 pmol/L
Triglycerides (fasting)		<2.0 mmol/L
Triiodothyronine (free)		4.0–8.0 pmol/L
Urate	(male)	0.20–0.45 mmol/L
	(female)	0.15–0.40 mmol/L
Urea	(adult)	3.0–8.0 mmol/L
Zinc		12–20 µmol/L

Table A: Reference intervals for testosterone and related androgens (serum)

	Male		Female	
	Pre pubertal	Adult (age related)	Pre pubertal	Adult (age related)
Free testosterone (pmol/L)		170–510		<4.0
Total testosterone (nmol/L)	<0.5	8–35	<0.5	<4.0
SHBG (nmol/L)	55–100	10–50	55–100	30–90 (250–500 in the third trimester)
Dihydrotestosterone (nmol/L)		1–2.5		

Reference ranges, urine		
Calcium		2.5–7.5 mmol/24 hours
Chloride (depends on intake, plasma levels)		100–250 mmol/24 hours
Cortisol (free)		100–300 nmol/24 hours
Creatinine	(child) (male) (female)	0.07–0.19 mmol/ 24 hours/kg 9–18 mmol/24 hours 5–16 mmol/24 hours
HMMA	(infant) (adult)	<10 mmol/mol creatinine <35 µmol/24 hours
Magnesium		2.5–8.0 mmol/24 hours
Osmolality (depends on hydration)		50–1200 m.osmol/kg water
Phosphate (depends on intake, plasma levels)		10–40 mmol/24 hours
Potassium (depends on intake, plasma levels)		40–100 mmol/24 hours
Protein, total	 (pregnancy)	<150 mg/24 hours <250 mg/24 hours
Sodium (depends on intake, plasma levels)		75–300 mmol/24 hours
Urate	(male) (female)	2.2–6.6 mmol/24 hours 1.6–5.6 mmol/24 hours
Urea (depends on protein intake)		420–720 mmol/24 hours

Reference ranges, whole blood		
Haemoglobin (Hb)	(adult male) (adult female)	130–180 g/L 115–165 g/L
Red cell count (RCC)	(adult male) (adult female)	4.5–6.5 x 10^{12}/L 3.8–5.8 x 10^{12}/L
Packed cell volume (PCV)	(adult male) (adult female)	0.40–0.54 0.37–0.47
Mean cell volume (MCV)		80–100 fL
Mean cell haemoglobin (MCH)		27–32 pg
Mean cell haemoglobin concentration (MCHC)		300–350 g/L
Leucocyte (White Cell) Count (WCC)		4.0–11.0 x 10^9/L
Leucocyte differential count • Neutrophils • Eosinophils • Basophils • Monocytes • Lymphocytes Platelet count		 2.0–7.5 x 10^9/L 0.04–0.4 x 10^9/L < 0.1 x 10^9/L 0.2–0.8 x 10^9/L 1.5–4.0 x 10^9/L 150–400 x 10^9/L
Erythrocyte sedimentation rate (ESR)	male 17–50 yrs male >50 yrs female 17–50 yrs female >50 yrs	1–10 mm/hour 2–14 mm/hour 3–12 mm/hour 5–20 mm/hour
Reticulocyte count		10–100 x 10^9/L (0.2–2.0%)

Reference ranges, plasma or serum, unless otherwise indicated		
Iron	(adult)	10–30 µmol/L
Iron (total) binding capacity (TIBC)		45–80 µmol/L
Transferrin		1.7–3.0 g/L
Transferrin saturation		0.15–0.45 (15–45%)
Ferritin	(male) (female)	30–300 µg/L 15–200 µg/L
Vitamin B12		120–680 pmol/L
Folate	(red cell) (serum)	360–1400 nmol/L 7–45 nmol/L

Reference ranges, citrated plasma	
Activated partial thromboplastin time (APTT	25–35 seconds
• Therapeutic range for continuous infusion heparin	1.5–2.5 x baseline
Prothrombin time (PT)	11–15 seconds
International normalised ratio (INR)	
• Therapeutic range for oral anticoagulant therapy	2.0–4.5
Fibrinogen	1.5–4.0 g/L

Reference ranges, serum	
Rheumatoid factor (nephelometry)	<30 IU/L
C3	0.9–1.8 g/L
C4	0.16–0.50 g/L
C-reactive protein	<5.0 mg/L
Immunoglobulins:	
• IgG	6.5–16.0g/L
• IgA	0.6–4.0g/L
• IgM	0.5–3.0g/L

Reference intervals for lymphocyte subsets	
	Adult
Total lymphocytes	1.5–4.0
CD3	0.6–2.4
CD4 (T4)	0.5–1.4
CD8 (T8)	0.2–0.7
CD19	0.04–0.5
CD16	0.2–0.4
CD4/CD8 ratio	1.0–3.2

Appendix 13.2: New classification and criteria for diagnosis of diabetes mellitus

Position Statement from the Australian Diabetes Society*, New Zealand Society for the Study of Diabetes†, Royal College of Pathologists of Australasia‡ and Australasian Association of Clinical Biochemists§.

Peter G Colman*, David W Thomas‡, Paul Z Zimmet*, Timothy A Welborn*, Peter Garcia-Webb§ and M Peter Moore†.

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Introduction

Recently, there has been major growth in knowledge about the aetiology and pathogenesis of different types of diabetes and about the predictive value of different blood glucose levels for development of complications. In response, both the American Diabetes Association (ADA) and the World Health Organization (WHO) have re-examined, redefined and updated the classification of and criteria for diabetes, which have been unchanged since 1985. While the two working parties had cross-representation, they met separately, and differences have emerged between their recommendations.

The ADA published its final recommendations in 1997[1], while the WHO group published its provisional conclusions for consultation and comment in June 1998[2].

The WHO process called for comments on the proposal by the end of September 1998, with the intention of finalising definitive classification and criteria by the end of December 1998 and of publishing these soon thereafter. However, WHO publications need to go through an internal approval process and it may be up to 12 months before the final WHO document appears.

A combined working party of the Australian Diabetes Society, New Zealand Society for the Study of Diabetes, Royal College of Pathologists of Australasia and Australasian Association of Clinical Biochemists was formed to formulate an Australasian position on the two sets of recommendations and, in particular, on the differences between them. This is an interim statement pending the final WHO report, which will include recommendations on diabetes classification as well as criteria for diagnosis. We see it as very important to inform Australasian health professionals treating patients with diabetes about these changes.

Key messages

Diagnosis of diabetes is not in doubt when there are classical symptoms of thirst and polyuria and a random venous plasma glucose level ≥ 11.1 mmol/L.

The Australasian Working Party on Diagnostic Criteria for Diabetes Mellitus recommends:

- immediate adoption of the new criterion for diagnosis of diabetes as proposed by the ADA and the WHO – fasting venous plasma glucose level ≥ 7.0 mmol/L
- immediate adoption of the new classification for diabetes mellitus proposed by the ADA and WHO, which comprises four aetiological types – type 1, type 2, other specific types, and gestational diabetes – with impaired glucose tolerance and impaired fasting glycaemia as stages in the natural history of disordered carbohydrate metabolism
- awareness that some cases of diabetes will be missed unless an oral glucose tolerance test (OGTT) is performed. If there is any suspicion or other risk factor suggesting glucose intolerance, the OGTT should continue to be used pending the final WHO recommendation.

What are the new diagnostic criteria?

The new WHO criteria for diagnosis of diabetes mellitus and hyperglycaemia are shown in Box 1. The major change from the previous WHO recommendation[3] is the lowering of the diagnostic level of fasting plasma glucose to ≥7.0 mmol/L, from the former level of ≥7.8 mmol/L. For whole blood, the proposed new level is ≥6.1 mmol/L, from the former ≥6.7 mmol/L.

This change is based primarily on cross-sectional studies demonstrating the presence of microvascular[4] and macrovascular complications at these lower glucose concentrations. In addition, the 1985 WHO diagnostic criterion for diabetes based on fasting plasma glucose level (≥7.8 mmol/L) represents a greater degree of hyperglycaemia than the criterion based on plasma glucose level two hours after a 75g glucose load (≥11.1 mmol/L)[6]. A fasting plasma glucose level of ≥7 mmol/L accords more closely with this 2 h post-glucose level.

Recommendation: The ADA and the WHO committee are unanimous in adopting the changed diagnostic level, and the Australasian Working Party on Diagnostic Criteria recommends that healthcare providers in Australia and New Zealand should adopt it immediately.

Clinicians should note that the diagnostic criteria differ between clinical and epidemiological settings. In clinical practice, when symptoms are typical of diabetes, a single fasting plasma glucose level of ≥7.0 mmol/L or 2 h post-glucose or casual postprandial plasma glucose level of ≥11.1 mmol/L suffices for diagnosis. If there are no symptoms, or symptoms are equivocal, at least one additional glucose measurement (preferably fasting) on a different day with a value in the diabetic range is necessary to confirm the diagnosis. Furthermore, severe hyperglycaemia detected under conditions of acute infective, traumatic, circulatory or other stress may be transitory and should not be regarded as diagnostic of diabetes. The situation should be reviewed when the primary condition has stabilised.

In epidemiological settings, for study of high-prevalence populations or selective screening of high-risk individuals, a single measure – the glucose-level 2 h post glucose load – will suffice to describe prevalence of impaired glucose tolerance (IGT).

1: Values for diagnosis of diabetes mellitus and other categories of hyperglycaemia[2]

	Glucose concentration (mmol/L (mg/dL))			
	Whole blood		Plasma	
	Venous	Capillary	Venous	Capillary
Diabetes mellitus fasting	≥6.1 (≥110)	≥6.1 (≥110)	≥7.0 (≥126)	≥7.0 (≥126)
or 2 h post-glucose load	≥10.0 (≥180)	≥11.1 (≥200)	≥11.1 (≥200)	≥12.2 (≥220)
or both				
Impaired glucose tolerance (IGT)	<6.1 (<110)	<6.1 (<110)	<7.0 (<126)	<7.0 (<126)
Fasting (if measured) and 2 h post-glucose load	≥6.7 (≥120) and <10.0 (<180)	≥7.8 (≥140) and <11.1 (<200)	≥7.8 (≥140) and <11.1 (<200)	≥8.9 (≥160) and <12.2 (<220)
Impaired fasting glycaemia (IFG)	≥5.6 (≥100) and	≥5.6 (≥100) and	≥6.1 (≥110) and	≥6.1 (≥110) and
Fasting	<6.1 (<110)	<6.1 (<110)	<7.0 (<126)	<7.0 (<126)
2 h post-glucose load (if measured)	<6.7 (<120)	<7.8 (<140)	<7.8 (<140)	<8.9 (<160)

For epidemiological or population screening purposes, the fasting or 2 h value after 75g oral glucose may be used alone. For clinical purposes, the diagnosis of diabetes should always be confirmed by repeating the test on another day, unless there is unequivocal hyperglycaemia with acute metabolic decompensation or obvious symptoms. Glucose concentrations should not be determined on serum unless red cells are immediately removed, otherwise glycolysis will result in an unpredictable underestimation of the true concentrations. It should be stressed that glucose preservatives do not totally prevent glycolysis. If whole blood is used, the sample should be kept at 0–4°C or centrifuged immediately, or assayed immediately. Table reproduced with permission from Alberti KGMM, Zimmet PZ. Definition, diagnosis and classification of diabetes mellitus and its complications. Part 1: diagnosis and classification of diabetes mellitus. Provisional Report of a WHO Consultation. *Diabet Med* 1998; 15: 539-553. Copyright John Wiley & Sons Limited.

What about the oral glucose tolerance test?

Previously, the oral glucose tolerance test (OGTT) was recommended in people with a fasting plasma glucose level of 5.5–7.7 mmol/L or random plasma glucose level of 7.8–11.0 mmol/L. After a 75g glucose load, those with a 2 h plasma glucose level of <7.8 mmol/L were classified as normoglycaemic, of 7.8–11.0 mmol/L as having IGT and of ≥11.1 mmol/L as having diabetes.

The new diagnostic criteria proposed by the ADA and WHO differ in their recommendations on use of the OGTT. The ADA makes a strong recommendation that fasting plasma glucose level can be used on its own and that, in general, the OGTT need not be used[1]. The WHO group[2] argues strongly for the retention of the OGTT and suggests using fasting plasma glucose level alone only when circumstances prevent the performance of the OGTT.

There are concerns that many people with a fasting plasma glucose level <7.0mmol/L will have manifestly abnormal results on the OGTT and are at risk of microvascular and macrovascular complications. This has major ramifications for the approach to diabetes screening, particularly when the Australian National Diabetes Strategy proposal[7], launched in June 1998 by Dr Michael Wooldridge, then Federal Minister for Health and Aged Care, has early detection of type 2 diabetes as a key priority.

Recommendation: The Australasian Working Party on Diagnostic Criteria has major concerns about discontinuing use of the OGTT and recommends that a formal recommendation on its use in diabetes screening be withheld until the final WHO recommendation is made. However, in the interim, the OGTT should continue to be used.

2: Aetiological classification of disorders of glycaemia*

Type 1 (β-cell destruction, usually leading to absolute insulin deficiency)

- Autoimmune
- Idiopathic

Type 2 (may range from predominantly insulin resistance with relative insulin deficiency to a predominantly secretory defect with or without insulin resistance)

Other specific types

- Genetic defects of β-cell function
- Genetic defects in insulin action
- Diseases of the exocrine pancreas
- Endocrinopathies
- Drug or chemical induced
- Infections
- Uncommon forms of immune-mediated diabetes
- Other genetic syndromes sometimes associated with diabetes

Gestational diabetes

Diabetes in pregnancy

The ADA has retained its old criteria for diagnosis of gestational diabetes[1].These differ from those recommended by both WHO[2] and the Australian Working Party on Diabetes in Pregnancy[8] and are generally not recognised outside the United States. The new WHO statement retains the 1985 WHO recommendation that both IGT and diabetes should be classified as gestational diabetes. This is consistent with the recommendations of the Australasian Diabetes in Pregnancy Society, which recommended a diagnostic 2 h venous plasma glucose level on the OGTT of ≥8.0 mmol/L. In New Zealand, a cut-off level of ≥9.0 mmol/L has been applied[8].

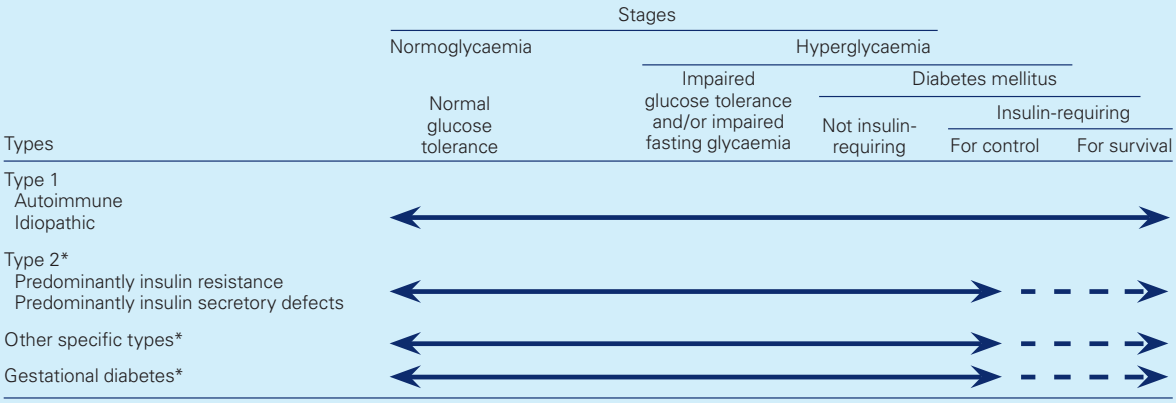
How has the classification of diabetes changed?

The proposed new classification encompasses both clinical stages and aetiological types of hyperglycaemia and is supported by numerous epidemiological studies. The classification by aetiological type (box 2) results from new knowledge of the causes of hyperglycaemia, including diabetes. The terms insulin-dependent and non-insulin dependent diabetes (IDDM and NIDDM) are eliminated and the terms type 1 and type 2 diabetes retained. Other aetiological types, such as diabetes arising from genetic defects of β-cell function or insulin action, are grouped as 'other specific types', with gestational diabetes as a fourth category.

The proposed staging (box 3) reflects the fact that any aetiological type of diabetes can pass or progress through several clinical phases (both asymptomatic and symptomatic) during its natural history. Moreover, individuals may move in either direction between stages.

Impaired glucose tolerance and impaired fasting glycaemia

Impaired glucose tolerance (IGT), a discrete class in the previous classification, is now categorised as a stage in the natural history of disordered carbohydrate metabolism. Individuals with IGT are at increased risk of cardiovascular disease, and not all will be identified by fasting glucose level.



*In rare instances, patients in these categories (eg vacor toxicity, type 1 diabetes presenting in pregnancy) may require insulin for survival. Table reproduced with permission from Altberti KGMM. Zimmet PZ. Definition, diagnosis and classification of diabetes mellitus and its complications. Part 1: diagnosis and classification of diabetes mellitus. Provisional Report of a WHO Consullation. Diabet Med 1998; 15: 539-553. Copyright John Wiley & Sons Limited.

In reducing the use of the OGTT, the ADA recommended a new category – impaired fasting glycaemia (IFG) – when fasting plasma glucose level is lower than that required to diagnose diabetes but higher than the reference range (<7.0 mmol/L but ≥6.1 mmol/L). Limited data on this category show that it increases both risk of progressing to diabetes[9] and cardiovascular risk[5]. However, data are as yet insufficient to determine whether IFG has the same status as IGT as a risk factor for developing diabetes and cardiovascular disease and as strong an association with the metabolic syndrome (insulin resistance syndrome).

IFG can be diagnosed by fasting glucose level alone, but if 2 h glucose level is also measured, some individuals with IFG will have IGT and some may have diabetes. In addition, the number of people with OGTT results indicating diabetes but fasting plasma glucose level <7.0 mmol/L is unknown, but early data suggest there may be major variation across different populations[10]. A number of studies, including the DECODE initiative of the European Diabetes Epidemiology Group, have reported that individuals classified with IFG are not the same as the IGT group[11-15]. The European Group believes that, on available European evidence, the ADA decision to rely solely on fasting glucose level would be unwise.

Recommendation: The Australasian Working Party on Diagnostic Criteria recommends immediate adoption of the new classification. However, clinicians should be aware that some cases of diabetes will be missed unless an OGTT is performed. Thus, if there is any suspicion or other risk factor suggesting glucose intolerance, the working party continues to recommend use of an OGTT pending the final WHO recommendation.

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14. The skin

AMA5 Chapter 8 (p 173) applies to the assessment of permanent impairment of the skin, subject to the modifications set out below. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing
- the appropriate chapter(s) of AMA5 for the body system they are assessing.

The Guidelines take precedence over AMA5.

Introduction

14.1 AMA5 Chapter 8 (pp 173–90) refers to skin diseases generally rather than work related skin diseases alone. This chapter has been adopted for measuring impairment of the skin system, with the following variations.

14.2 Disfigurement, scars and skin grafts may be assessed as causing significant permanent impairment when the skin condition causes limitation in the performance of activities of daily living (ADL).

14.3 For cases of facial disfigurement, refer to Table 6.1 in the Guidelines.

14.4 AMA5 Table 8-2 (p 178) provides the method of classification of impairment due to skin disorders. Three components – signs and symptoms of skin disorders, limitations in ADL and requirements for treatment – define five classes of permanent impairment. The assessing specialist should derive a specific percentage impairment within the range for the class that best describes the clinical status of the claimant.

14.5 The skin is regarded as a single organ and all non-facial scarring is measured together as one overall impairment, rather than assessing individual scars separately and combining the results.

14.6 A scar may be present and rated as 0% WPI.

Note that uncomplicated scars for standard surgical procedures do not, of themselves, rate an impairment.

14.7 The table for the evaluation of minor skin impairment (TEMSKI) (see Table 14.1) is an extension of Table 8-2 in AMA5. The TEMSKI divides class 1 of permanent impairment (0–9%) due to skin disorders into five categories of impairment. The TEMSKI may be used by trained assessors (who are not trained in the skin body system), for determining impairment from 0–4% in the class 1 category, that has been caused by minor scarring following surgery. Impairment greater than 4% must be assessed by a specialist who has undertaken the requisite training in the assessment of the skin body system.

14.8 The TEMSKI is to be used in accordance with the principle of 'best fit'. The assessor must be satisfied that the criteria within the chosen category of impairment best reflect the skin disorder being assessed. If the skin disorder does not meet all of the criteria within the impairment category, the assessor must provide detailed reasons as to why this category has been chosen over other categories.

14.9 Where there is a range of values in the TEMSKI categories, the assessor should use clinical judgement to determine the exact impairment value.

14.10 The case examples provided in AMA5 Chapter 8 do not, in most cases, relate to permanent impairment that results from a work-related injury. The following NSW examples are provided for information.

14.11 Work-related case study examples 14.1–14.6 are included below, in addition to AMA5 examples 8.1–8.22 (pp 178–87).

Table 14.1 Table for the evaluation of minor skin impairment (TEMSKI)

Criteria	0% WPI	1% WPI	2% WPI	3 4% WPI	5 9% WPI*
Description of the scar(s) and/or skin condition(s) (shape, texture, colour)	Claimant is not conscious or is barely conscious of the scar(s) or skin condition.	Claimant is conscious of the scar(s) or skin condition.	Claimant is conscious of the scar(s) or skin condition.	Claimant is conscious of the scar(s) or skin condition.	Claimant is conscious of the scar(s) or skin condition.
	Good colour match with surrounding skin, and the scar(s) or skin condition is barely distinguishable. Claimant is unable to easily locate the scar(s) or skin condition.	Some parts of the scar(s) or skin condition colour contrast with the surrounding skin as a result of pigmentary or other changes.	Noticeable colour contrast of scar(s) or skin condition with surrounding skin as a result of pigmentary or other changes.	Easily identifiable colour contrast of scar(s) or skin condition with surrounding skin as a result of pigmentary or other changes.	Distinct colour contrast of scar(s) of skin condition with surrounding skin as a result of pigmentary or other changes.
	No trophic changes.	Claimant is able to locate the scar(s) or skin condition.	Claimant is able to easily locate the scar(s) or skin condition.	Claimant is able to easily locate the scar(s) or skin condition.	Claimant is able to easily locate the scar(s) or skin condition.
	Any staple or suture marks are barely visible.	Minimal trophic changes.	Trophic changes evident to touch.	Trophic changes evident to touch.	Trophic changes are visible.
		Any staple or suture marks are visible.	Any staple or suture marks are clearly visible.	Any staple or suture marks are clearly visible.	Any staple or suture marks are clearly visible.
Location	Anatomic location of the scar(s) or skin condition not clearly visible with usual clothing/hairstyle.	Anatomic location of the scar(s) or skin condition is not usually visible with usual clothing/ hairstyle	Anatomic location of the scar(s) or skin condition is usually visible with usual clothing/hairstyle.	Anatomic location of the scar(s) or skin condition is visible with usual clothing/hairstyle.	Anatomic location of the scar(s) or skin condition is usually and clearly visible with usual clothing/hairstyle.
Contour	No contour defect.	Minor contour defect	Contour defect visible.	Contour defect easily visible.	Contour defect easily visible.
ADL/treatment	No effect on any ADL.	Negligible effect on any ADL .	Minor limitation in the performance of few ADL.	Minor limitation in the performance of few ADL **and** exposure to chemical or physical agents (eg sunlight, heat, cold etc)may temporarily increase limitation.	Limitation in the performance of few ADL (**including** restriction in grooming or dressing) **and** exposure to chemical or physical agents (eg sunlight, heat, cold etc) may temporarily increase limitation or restriction.
	No treatment, or intermittent treatment only, required.	No treatment, or intermittent treatment only, required.	No treatment, or intermittent treatment only, required.	No treatment, or intermittent treatment only, required.	No treatment, or intermittent treatment only, required.
Adherence to underlying structures	No adherence.	No adherence.	No adherence.	Some adherence.	Some adherence.

This table uses the principle of 'best fit'. You should assess the impairment to the whole skin system against each criteria and then determine which impairment category best fits (or describes) the impairment. Refer to 14.8 regarding application of this table.

Example 14.1:	Cumulative irritant dermatitis
Subject:	42-year-old man.
History:	Spray painter working on ships in dry dock. Not required to prepare surface but required to mix paints (including epoxy and polyurethane) with 'thinners' (solvents) and spray metal ships' surface. At end of each session, required to clean equipment with solvent. Not supplied with gloves or other personal protective equipment until after onset of symptoms. Gradual increase in severity in spite of commencing to wear gloves. Off work two months leading to clearance, but frequent recurrence, especially if the subject attempted prolonged work wearing latex or PVC gloves or wet work without gloves.
Current:	Returned to dry duties only at work. Mostly clear of dermatitis, but flares.
Physical examination:	Varies between no abnormality detected to mild dermatitis of the dorsum of hands.
Investigations:	Patch test standard + epoxy + isocyanates (polyurethanes) – no reactions
Impairment:	0%
Comment:	No interference with ADL.

Example 14.2:	Allergic contact dermatitis to hair dye
Subject:	30-year-old woman.
History:	Hairdresser 15 years, with six-month history of hand dermatitis, increasing despite beginning to wear latex gloves after onset. Dermatitis settled to very mild after four weeks off work, but not clear. As the condition flared whenever the subject returned to hairdressing, she ceased and is now a computer operator.
Current:	Mild continuing dermatitis of the hands, which flares when doing wet work (without gloves) or when wearing latex or PVC gloves. Has three young children and impossible to avoid wet work.
Investigation:	Patch test standard + hairdressing series – possible reaction to paraphenylene diamine
Impairment:	5%
Comment:	Able to carry out ADL with difficulty, therefore limited performance of some ADL.

Example 14.3:	Cement dermatitis due to chromate in cement
Subject:	43-year-old man.
History:	Concreter since age 16. Eighteen-month history of increasing hand dermatitis, eventually on dorsal and palmar surface of hands and fingers. Off work, and treatment led to limited improvement only.
Physical examination:	Fissured skin, hyperkeratotic chronic dermatitis.
Investigation:	Patch test – positive reaction to dichromate.
Current:	Intractable, chronic, fissured dermatitis.
Impairment:	12%
Comment:	Unable to obtain any employment because has chronic dermatitis, and is on disability support pension. Difficulty gripping items, including steering wheel, hammer and other tools. Unable to do any wet work (eg painting). Former home handyman, now calls in tradesman to do any repairs and maintenance. Limited performance in some ADL.

Example 14.4:	Latex contact urticaria/angioedema with cross reactions
Subject:	40-year-old female nurse.
History:	Six-month history of itchy hands minutes after applying latex gloves at work. Later swelling and redness associated with itchy hands and wrists, and subsequently widespread urticaria. One week off led to immediate clearance. On return to work wearing PVC gloves, developed anaphylaxis on first day back.
Physical examination:	No abnormality detected or generalised urticaria/angioedema.
Investigation:	Latex radioallergosorbent test, strong positive response.
Current:	The subject experiences urticaria and mild anaphylaxis if she enters a hospital, some supermarkets or other stores (especially if latex items are stocked), at children's parties, or in other situations where balloons are present, or on inadvertent contact with latex items, including sporting goods handles, some clothing and many shoes (latex-based glues). Also has restricted diet (must avoid bananas, avocados and kiwi fruit).
Impairment:	17%
Comment:	Severe limitation in some ADL in spite of intermittent activity.

Example 14.5:	Non-melanoma skin cancer
Subject:	53-year-old married man.
History:	Road worker since 17 years of age. Has had a basal cell carcinoma on the left forehead, squamous cell carcinoma on the right forehead (graft), basal cell carcinoma on the left ear (wedge resection) and squamous cell carcinoma on the lower lip (wedge resection) excised since 45 years of age. No history of loco-regional recurrences. Multiple actinic keratoses treated with cryotherapy or Efudix over 20 years (forearms, dorsum of hands, head and neck).
Current:	New lesion right preauricular area. Concerned over appearance – 'I look a mess'.
Physical examination:	Multiple actinic keratoses forearms, dorsum of hands, head and neck. Five millimetre diameter nodular basal cell carcinoma right preauricular area; hypertrophic red scar, 3cm length, left forehead; 2cm-diameter graft site (hypopigmented with 2mm contour deformity) right temple; non-hypertrophic scar left lower lip (vermilion) with slight step deformity; and non-hypertrophic pale wedge resection scar left pinna, leading to 30% reduction in size of the pinna. Graft sites taken from right post-auricular area. No regional lymphadenopathy.
Impairment rating:	6%
Comment:	Refer to Table 6.1 (facial disfigurement)

Example 14.6:	Non-melanoma skin cancer
Subject:	35-year-old single female professional surf life-saver.
History:	Occupational outdoor exposure since 19 years of age. Basal cell carcinoma on tip of nose excised three years ago with full thickness graft following failed intralesional interferon treatment.
Current:	Poor self-esteem because of cosmetic result of surgery.
Physical examination:	One–centimetre diameter graft site on the tip of nose (hypopigmented with 2mm depth contour deformity, cartilage not involved). Graft site taken from right post-auricular area.
Impairment rating:	10%
Comment:	Refer to Table 6.1 (facial disfigurement).

15. Cardiovascular system

AMA5 chapters 3 and 4 (pp 23 and 65) apply to the assessment of permanent impairment of the cardiovascular system, subject to the modifications set out below. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing
- the appropriate chapter(s) of AMA5 for the body system they are assessing.

The Guidelines take precedence over AMA5.

Introduction

15.1 The cardiovascular system is discussed in AMA5 chapters 3 (Heart and Aorta) and 4 (Systemic and Pulmonary Arteries) (pp 25–85). These chapters can be used to assess permanent impairment of the cardiovascular system with the following minor modifications.

15.2 It is noted that in these chapters there are wide ranges for the impairment values in each category. When conducting an assessment, assessors should use their clinical judgement to express a specific percentage within the range suggested.

Exercise stress testing

15.3 As with other investigations, it is not the role of an assessor to order exercise stress tests purely for the purpose of evaluating the extent of permanent impairment.

15.4 If exercise stress testing is available, then it is a useful piece of information in arriving at the overall percentage impairment.

15.5 If previous investigations are inadequate for a proper assessment to be made, the assessor should consider the value of proceeding with the evaluation of permanent impairment without adequate investigations and data (see Chapter 1 of the Guideline – ordering of additional investigations).

Permanent impairment – maximum medical improvement

15.6 As for all assessments, maximal medical improvement is considered to have occurred when the worker's condition is well stabilised and unlikely to change substantially in the next year, with or without medical treatment.

Vascular diseases affecting the extremities

15.7 Note that in this section, AMA5 tables 4-4 and 4-5 (p 76) refer to percentage impairment of the upper or lower extremity. Therefore, an assessment of impairment concerning vascular impairment of the arm or leg requires that the percentages identified in these tables be converted to whole person impairment (WPI). The table for conversion of the upper extremity is AMA5 Table 16-3 (p 439), and the table for conversion of the lower extremity is AMA5 Table 17-3 (p 527).

Thoracic outlet syndrome

15.8 Impairment due to thoracic outlet syndrome is assessed according to AMA5 Chapter 16, relating to the upper extremities, and Chapter 2 of the Guidelines.

16. Digestive system

AMA5 Chapter 6 (p 117) applies to the management of permanent impairment of the digestive system. Before undertaking an impairment assessment, users of the Guidelines must be familiar with:

- the Introduction in the Guidelines
- chapters 1 and 2 of AMA5
- the appropriate chapter(s) of the Guidelines for the body system they are assessing.
- the appropriate chapter(s) of AMA5 for the body system they are assessing.

The Guidelines take precedence over AMA5.

Introduction

16.1 The digestive system is discussed in AMA5 Chapter 6 (pp 117–42). This chapter can be used to assess permanent impairment of the digestive system.

16.2 AMA5 Section 6.6, 'Hernias' (p 136): Occasionally in regard to inguinal hernias, there is damage to the ilio-inguinal nerve following surgical repair. Where there is loss of sensation in the distribution of the ilio-inguinal nerve involving the upper anterior medial aspect of the thigh, a 1% WPI should be assessed as per Table 5.1 in the Guidelines. This assessment should not be made unless the symptoms have persisted for 12 months.

16.3 Where, following repair, there is severe dysaesthesia in the distribution of the ilio inguinal nerve, a maximum of 5% whole person impairment (WPI) may be assessed as per Table 5.1 in the Guidelines. This assessment should not be made unless the symptoms have persisted for 12 months.

16.4 Where, following repair of a hernia of the abdominal wall, there is residual persistent excessive induration at the site, which is associated with significant discomfort, this should be assessed as a class 1 herniation (AMA5 Table 6-9, p 136). This assessment should not be made unless symptoms have persisted for 12 months.

16.5 Impairments due to nerve injury and induration cannot be combined. The higher impairment should be chosen.

16.6 A person who has suffered more than one work-related hernia recurrence at the same site and who now has limitation of activities of daily living should be assessed as herniation class 1 (AMA5 Table 6-9, p 136).

16.7 A diagnosis of a hernia should not be made on the findings of an ultrasound examination alone. For the diagnosis of a hernia to be made there must be a palpable defect in the supporting structures of the abdominal wall and either a palpable lump or a history of a lump when straining.

16.8 A divarication of the rectus abdominus muscles in the upper abdomen is not a hernia, although the supporting structures have been weakened, they are still intact.

16.9 **Effects of analgesics on the digestive tract:**

- AMA5 Table 6-3 (p 121) Class 1 is to be amended to read 'there are symptoms and signs of digestive tract disease'.
- Nonsteroidal anti-inflammatory agents, including Aspirin, taken for prolonged periods can cause symptoms in the upper digestive tract. In the absence of clinical signs or other objective evidence of upper digestive tract disease, anatomic loss or alteration a 0% WPI is to be assessed.
- Effects of analgesics on the lower digestive tract:
  - Constipation is a symptom, not a sign and is generally reversible. A WPI assessment of 0% applies to constipation.
  - Irritable bowel syndrome without objective evidence of colon or rectal disease is to be assessed at 0% WPI.

- Assessment of colorectal disease and anal disorders requires the report of a treating doctor or family doctor, which includes a proper physical examination with rectal examination if appropriate, and/or a full endoscopy report.
- Failure to provide such reports may result in a 0% WPI.

16.10 **Splenectomy:** Post-traumatic splenectomy or functional asplenia following abdominal trauma should be assessed as 3% WPI.

16.11 **Abdominal adhesions:** Intra-abdominal adhesions following trauma requiring further laparotomy should be assessed according to AMA5 Table 6-3 (p 121).

17. Evaluation of permanent impairment arising from chronic pain

(exclude AMA5 Chapter 18)

17.1 The International Association for the Study of Pain (IASP) has defined pain as:

'An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage'.

17.2 For chronic pain assessment using AMA5 and the Guidelines, exclude AMA5 Chapter 18, on pain (p 565–91).

17.3 The reasons for excluding chronic pain, as a separate condition from the Guidelines are:

- It is a subjective experience and is, therefore, open to exaggeration or fabrication in the compensation setting. Assessment depends on the credibility of the subject being assessed. In order to provide reliability, applicants undergoing pain assessments require more than one examiner at different times, concordance with the established conditions, consistency over time, anatomical and physiological consistency, agreement between the examiners and exclusion of inappropriate illness behaviour.
- Pain cannot be measured and no objective assessment can be made.
- Tools to measure pain are based on self-reports and may be inherently unreliable.
- Some impairment ratings take symptoms into account and some of the ranges of impairment – eg whole person impairment (WPI) of the spine, may reflect the effect of the injury and pain on activities of daily living (ADL). This is not so for impairment assessment of the upper and lower limb, which is based on range of movement and diagnosis-based estimates, other than for peripheral nerve injury.

17.4 Where there is a peripheral nerve injury and there is sensory loss, some of the sensory nerve impairment categories permit pain to be included (AMA5 Table 16-10, categories 1-5, p 482).

17.5 AMA5 Section 17.2m, 'Causalgia and complex regional pain syndrome (reflex sympathetic dystrophy)' (p 553), should not be used. AMA5 Table 16-16 (p 496) has been replaced by Table 17.1 in the Guidelines. Table 17.1 is used to determine if complex regional pain syndrome (CRPS) is a rateable diagnosis. It is important to exclude diagnoses that may mimic CRPS, such as disuse atrophy, unrecognised general medical problems, somatoform disorders and factitious disorder. Once the diagnosis is established, assess impairment as in AMA5.

Complex Regional Pain Syndrome Type 1

For Complex Regional Pain Syndrome Type 1 (CRPS1) to be present for the purposes of assessment:

- the diagnosis is to be confirmed by criteria in Table 17.1
- the diagnosis has been present for at least one year (to ensure accuracy of the diagnosis and to permit adequate time to achieve maximum medical improvement)
- the diagnosis has been verified by more than one examining physician
- other possible diagnoses have been excluded.
- CRPS1 is to be assessed as follows:
  - Apply the diagnostic criteria for complex regional pain syndrome type 1 (Table 17.1).

Table 17.1 Diagnostic Criteria for Complex Regional Pain Syndrome types 1 and 2

1. Continuing pain, which is disproportionate to any causal event.
2. Must report at least one symptom in each of the four following categories: • **Sensory:** Reports of hyperaesthesiae and/or allodynia. • **Vasomotor:** Reports of temperature asymmetry and/or skin colour changes and/or skin colour asymmetry. • **Sudomotor/oedema:** Reports of oedema and/or sweating increase or decrease and/or sweating asymmetry. • **Motor/trophic:** Reports of decreased range of joint motion and/or motor dysfunction (tremor, dystonia) and/or trophic changes (hair, nail, skin).
3. Must display at least one sign* at time of evaluation in all of the following four categories: • **Sensory:** Evidence of hyperalgesia (to pin prick) and/or allodynia (to light touch and/or deep somatic pressure and/or joint movement). • **Vasomotor:** Evidence of temperature asymmetry and/or asymmetric skin colour changes. • **Sudomotor/oedema:** Evidence of oedema and/or sweating asymmetry. • **Motor/trophic:** Evidence of decreased active joint range of motion and/or motor dysfunction (tremor, dystonia) and/or trophic changes (hair, nail, skin).
4. There is no other diagnosis that better explains the signs and symptoms.
*A sign is included only if it is observed and documented at time of the impairment evaluation.

Then consider the following in assessing CRPS1:

- If the criteria in each of the sections 1, 2, 3 and 4 in Table 17.1, above, are satisfied, the diagnosis of CRPS1 may be made.
- Rate the extremity impairment resulting from loss of motion of each individual joint involved.
- Rate the extremity impairment resulting from sensory deficits and pain, according to the grade that best fits the degree or amount of interference with ADL, as described in AMA5 Table 16.10a (p 482). Use clinical judgement to select the appropriate severity grade and the appropriate percentage from within the range shown in each grade. The maximum value is not automatically applied. The value selected represents the extremity impairment. A nerve value multiplier is not used.
- Combine the extremity impairment for loss of joint motion with the impairment for pain or sensory deficit using the Combined Values Chart (AMA5, p 604) to obtain the final extremity impairment.
- Convert the final extremity impairment to WPI using AMA5 Table 16.3, (p 439) for the upper extremity and AMA5 Table 17.3 (p 527) for the lower extremity.

Complex Regional Pain Syndrome Type 2, causalgia

For Complex Regional Pain Syndrome Type 2 (CRPS2), the mechanism is an injury to a specific nerve. The methodology in AMA5 (pp 496–97) is to be followed:

- If the criteria in each of sections 1, 2, 3 and 4 in Table 17.1, above, are satisfied and there is objective evidence of an injury to a specific nerve, the diagnosis of CRPS2 may be made.
- Rate the extremity impairment due to loss of motion of each individual joint involved.
- Rate the extremity impairment resulting from sensory deficits and pain of the injured nerves according to the determination methods described in AMA5 Chapter 16, Section 16.5b and Table 16-10a. Use clinical judgement to select the appropriate severity grade and the appropriate percentage from within each range shown in the grade.
- Rate the extremity impairment resulting from motor deficits and the loss of power of the injured nerve according to the determination method in AMA5 Chapter 16, Section 16.5b and Table 16-11a.

- Combine the extremity impairment percentages for loss of range of motion of the joints involved, pain or sensory deficits, and motor deficits, if present, to determine the final extremity impairment, using the Combined Values Chart in AMA5 (p 604).
- Convert the final extremity impairment to WPI using AMA5 Table 16.3 (p 439) for the upper extremity and AMA5 Table 17.3 (p 527) for the lower extremity.

Appendix 1: Key definitions

AMA5

The 5th edition of the American Medical Association's (AMA) *Guides to the evaluation of permanent impairment* and any published errata.

AMA4

The 4th edition of the American Medical Association's (AMA) *Guides to the evaluation of permanent impairment*.

Approved Medical Specialist (AMS)

A senior practising specialist with a sound knowledge of the NSW workers compensation system and workplace-based injury management. They are appointed by the Workers Compensation Commission to assess disputes about medical issues for workers compensation claims lodged on or after 1 January 2002.

Assessor

An assessor will be a registered medical practitioner recognised as a medical specialist.

- 'Medical practitioner' means a person registered in the medical profession under the *Health Practitioner Regulation National Law (NSW)* No. 86a, or equivalent Health Practitioner Regulation National Law in their jurisdiction with the Australian Health Practitioner Regulation Agency.
- 'Medical specialist' means a medical practitioner recognised as a specialist in accordance with the *Health Insurance Regulations 1975,* Schedule 4, Part 1, who is remunerated at specialist rates under Medicare.

The assessor will have qualifications, training and experience relevant to the body system being assessed. The assessor will have successfully completed requisite training in using the Guidelines for each body system they intend on assessing. They will be listed as a trained assessor of permanent impairment for each relevant body system(s) on the State Insurance Regulatory Authority website at sira.nsw.gov.au.

Degree of impairment

The degree of permanent impairment as assessed according to section 65 of the *Workers Compensation Act 1987*.

Injury

A personal injury arising out of or in the course of employment and includes a disease injury.

Maximum medical improvement (MMI)

This is considered to occur when the worker's condition is well stabilised and is unlikely to change substantially in the next year, with or without medical treatment.

NSW Guidelines

The *NSW workers compensation guidelines for the evaluation of permanent impairment*.

Secondary injury

Means an injury to the extent that it arises as a consequence of, or secondary to, another injury.

The Act

The *Workers Compensation Act 1987*

The *Workplace Injury Management and Workers Compensation Act 1998*

The *Workers Compensation Regulation 2010*

Appendix 2: Working groups on permanent impairment

Permanent Impairment Co-ordinating Group 2001

Name	Position
Dr Jim Stewart	Chair
Ms Kate McKenzie	WorkCover
Mr John Robertson	Labor Council of NSW
Ms Mary Yaager	Labor Council of NSW
Dr Ian Gardner	Medical Representative to Workers Compensation and Workplace Occupational Health and Safety Council of NSW
Dr Stephen Buckley	Rehabilitation Physician
Prof Michael Fearnside	Professor of Neurosurgery
Dr John Harrison	Orthopaedic Surgeon
Dr Jonathan Phillips	Psychiatrist
Professor Bill Marsden	Professor of Orthopaedic Surgery
Dr Dwight Dowda	Occupational Physician
Associate Professor Ian Cameron	Associate Professor of Rehabilitation Medicine
Dr Robin Chase	Australian Medical Association
2005 Revisions	
Dr Roger Pillemer	Orthopaedic Surgeon
Dr John Dixon Hughes	General Surgeon
Dr Yvonne Skinner	Psychiatrist

Permanent Impairment Co-ordinating Committee 2008

Name	Position
Mr Rob Thomson	Chair
Ms Mary Yaager	Unions NSW
Dr Ian Gardner	Workers Compensation and Workplace Occupational Health and Safety Council of NSW
Associate Professor Michael Fearnside	Associate Professor of Neurosurgery, Neurosurgical Society of Australasia
Dr John Harrison	Orthopaedic Surgeon, Australian Orthopaedic Association, Australian Society of Orthopaedic Surgeons
Dr Yvonne Skinner	Psychiatrist, Royal Australian and New Zealand College of Psychiatrists
Professor Ian Cameron	Professor of Rehabilitation Medicine, Australasian Faculty of Rehabilitation Medicine
Dr Roger Pillemer	Approved Medical Specialist
Dr Michael Gliksman	Australian Medical Association
Dr Neil Berry	Royal Australasian College of Surgeons

Permanent Impairment Co-ordinating Committee 2013

Name	Position
Mr Gary Jeffery	Chair
Mr Kim Garling	WorkCover Independent Review Officer
Ms Alisha Wilde/Mr Shay Degaura	Unions NSW
Dr Mark Burns	Australian Faculty of Occupational and Environmental Medicine
Associate Professor Michael Fearnside	Associate Professor of Neurosurgery, Neurosurgical Society of Australasia
Dr John Harrison	Orthopaedic Surgeon, Australian Orthopaedic Association, Australian Society of Orthopaedic Surgeons
Dr Yvonne Skinner	Psychiatrist, Royal Australian and New Zealand College of Psychiatrists
Professor Ian Cameron	Professor of Rehabilitation Medicine, Australasian Faculty of Rehabilitation Medicine
Dr Roger Pillemer	Workers Compensation Commission, Senior Approved Medical Specialist
Dr Michael Gliksman	Australian Medical Association
Dr Neil Berry	Royal Australasian College of Surgeons
Mr Kevin Gillingham	WorkCover WA
Mr David Caulfield/ Mr Phil Waddas	WorkCover SA
Ms Meg Brighton	WorkSafe ACT

Working Groups		
Psychiatric and psychological	**Spine**	**Upper limb**
Dr Julian Parmegiani Dr Derek Lovell Dr Rod Milton Dr Yvonne Skinner Dr Jonathan Phillips Dr Chris Blackwell Dr Bruce Westmore Dr Susan Ballinger Ms Lyn Shumack Dr Jack White Ms Sandra Dunn Dr Tim Hannon	Professor Michael Fearnside Dr John Cummine Professor Michael Ryan Dr Dwight Dowda Associate Professor Ian Cameron Dr Hugh Dickson Dr Conrad Winer Dr Mario Benanzio Dr Jim Ellis Dr Jim Bodel Dr William Wolfenden Dr Kevin Bleasel Dr John Harrison Professor Sydney Nade **2005 Revisions** Dr Roger Pillemer **2008 Revisions** Dr Phillipa Harvey-Sutton Associate Professor Michael Fearnside Dr Jim Bodel Associate Professor Michael Ryan Dr Roger Pillemer Professor Ian Cameron **2012 Revisions** Associate Professor Michael Fearnside Dr Phillipa Harvey-Sutton Dr Jim Bodel Associate Professor Michael Ryan Dr Roger Pillemer Professor Ian Cameron	Dr Dwight Dowda Associate Professor Ian Cameron Professor Bill Marsden Associate Professor Bruce Connelly Dr David Crocker Dr Richard Honner Dr Jim Ellis Dr Conrad Winer Dr David Duckworth **2005 Revisions** Dr Roger Pillemer Dr Graham McDougall Dr Brian Noll Dr Bruce Connelly **2012 Revisions** Dr Roger Pillemer Dr John Harrison Dr Brian Noll Dr James Bodel Dr John Cross Dr Mark Burns Dr Michael Gliksman Dr Robert Breit Professor Ian Cameron

Hearing	Urinary and reproductive	Respiratory, ear, nose and throat
Dr Brian Williams Dr Joseph Scoppa Dr Stanley Stylis Dr Paul Niall Associate Professor Ian Cameron	Professor Richard Millard Dr Kim Boo Kuah Associate Professor Ian Cameron	Dr Julian Lee Professor David Bryant Dr Joseph Scoppa Dr Michael Burns Dr Frank Maccioni Dr Peter Corte Dr Brian Williams Associate Professor Ian Cameron
Skin	**Vision**	**Lower Limb**
Dr Victor Zielinski Dr Scott Menzies Dr Edmund Lobel Associate Professor Ian Cameron	Dr Michael Delaney Dr Peter Duke Dr Peter Anderson Dr John Kennedy Dr Neville Banks Associate Professor Ian Cameron	Dr Dwight Dowda Associate Professor Ian Cameron Professor Bill Marsden Dr Peter Holman Dr Jay Govind Dr Jim Bodel Dr Mario Benanzio Dr Jim Ellis Dr Conrad Winer Dr Cecil Cass Dr John Harrison Dr John Korber **2008 Revisions** Dr Roger Pillemer Dr John Harrison Professor Ian Cameron Dr Michael Gliksman Dr Jim Bodel Dr Robert Breit Dr Ian Meakin **2012 Revisions** Dr Roger Pillemer Dr John Harrison Dr Brian Noll Dr James Bodel Dr John Cross Dr Mark Burns Dr Michael Gliksman Dr Robert Breit Professor Ian Cameron
Cardiovascular	**Digestive**	**Haematopoietic**
Dr Thomas Nash Dr John Gunning Dr George Michell Dr Stephen Buckley Dr Melissa Doohan Dr Charles Fisher	Professor Philip Barnes Dr David De Carle Dr Dwight Dowda **2012 Revisions** Dr Neil Berry Dr John Garvey Dr John Duggan Dr Nick Talley Dr David Johnson Dr John Dixon-Hughes	Professor John Gibson Dr Stephen Flecknoe Dr Peter Slezak Professor John Dwyer Associate Professor Ian Cameron

Endocrine	Nervous system	Evaluation of permanent impairment arising from chronic pain
Dr Alfred Steinbeck Professor Peter Hall Dr Stephen Buckley	Dr Stephen Buckley Associate Professor Ian Cameron Dr Dwight Dowda Dr Ivan Lorentz Dr Keith Lethlean Dr Peter Blum Professor Michael Fearnside Dr Tim Hannon **2012 Revisions** Associate Professor Michael Fearnside Dr Mark Burns Dr Ross Mellick Professor Ian Cameron	Associate Professor Michael Fearnside

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COUNCIL NOTICES

BATHURST REGIONAL COUNCIL

ROADS ACT 1993
Section 10

Dedication of Land as a Public Road

Notice is hereby given that in accordance with section 10 of the *Roads Act 1993*, the land described in the Schedule below is dedicated as a Public Road.

DAVID SHERLEY, General Manager, Bathurst Regional Council, Private Mail Bag 17, Bathurst NSW 2795

Schedule

Lots 102 and Lot 103 in DP 1196767 being land situated on Lagoon Road, The Lagoon. [8248]

BATHURST REGIONAL COUNCIL

ROADS ACT 1993
Section 10

Dedication of Land as a Public Road

Notice is hereby given that in accordance with section 10 of the *Roads Act 1993*, the land described in the Schedule below is dedicated as a Public Road.

DAVID SHERLEY, General Manager, Bathurst Regional Council, Private Mail Bag 17, Bathurst NSW 2795

Schedule

Lot 1 in DP 1192034 being land situated on Hill End Road, Crudine. [8249]

BATHURST REGIONAL COUNCIL

ROADS ACT 1993
Section 10

Dedication of Land as a Public Road

Notice is hereby given that in accordance with section 10 of the *Roads Act 1993*, the land described in the Schedule below is dedicated as a Public Road.

DAVID SHERLEY, General Manager, Bathurst Regional Council, Private Mail Bag 17, Bathurst NSW 2795

Schedule

Lot 1 in DP 1194111 being land situated on Sofala Road, Wiagdon. [8250]

LAKE MACQUARIE CITY COUNCIL

ROADS ACT 1993

ROADS REGULATION 2008

Naming of Roads

Lake Macquarie City Council advises that in accordance with *Roads Act 1993* section 162 and the *Roads Regulation 2008* has named the following road.

Location/Description	Road Name
Known locally as Coorumbung Road at Dora Creek, commencing at the intersection of Newport Road being the western corner of Lot 20 DP 236664 and heading in a south easterly direction and terminating at the intersection of Watt Street being the north eastern corner of Lot 17 Sec 1 DP 2799	Coorumbung Road

BRIAN BELL, General Manager, Lake Macquarie City Council, Box 1906, Hunter Region Mail Centre NSW 2310 [8251]

ORANGE CITY COUNCIL

ROADS ACT 1993

LAND ACQUISITION (JUST TERMS COMPENSATION) ACT 1991

Notice of Compulsory Acquisition of Land

Orange City Council declares with the approval of His Excellency the Governor that the land described in the Schedule below, excluding any mines or deposits of minerals in the land, is acquired by compulsory process in accordance with the provisions of the *Land Acquisition (Just Terms Compensation) Act 1991* for public road.

Dated at Orange this 4th day of November 2015

GARRY STYLES, General Manager

Schedule

Lot 600 DP 1202981 [8252]

CITY OF SYDNEY COUNCIL

ROADS ACT 1993

Naming of Roads

Notice is hereby given that the City of Sydney, in accordance with section 162 (1) of the *Roads Act 1993*, has named the road dedicated as public road by the registration of DP 1208903 on 20/8/2015, as 'GALARA STREET'.

Authorised by Resolution of Council dated 14 May 2012.

MONICA BARONE, Chief Executive Officer, Council of the City of Sydney, 456 Kent Street, Sydney NSW 2000 [8253]

THE HILLS SHIRE COUNCIL

ROADS ACT 1993
Section 10

Notice is hereby given that The Hills Shire Council dedicates the land described in the schedule below as public road under section 10 of the *Roads Act 1993*.

General Manager, The Hills Shire Council, 3 Columbia Court, Baulkham Hills NSW 2153

Schedule

All that piece or parcel of land known as Lot 21 in DP 1208838 in The Hills Shire Council, Parish of Castle Hill, County of Cumberland, and as described in Folio Identifier 21/1208838

[8254]

THE HILLS SHIRE COUNCIL

ROADS ACT 1993
Section 10

Notice is hereby given that The Hills Shire Council dedicates the land described in the schedule below as public road under section 10 of the *Roads Act 1993*.

General Manager, The Hills Shire Council, 3 Columbia Court, Baulkham Hills NSW 2153

Schedule

All that piece or parcel of land known as Lot 23 in DP 1208839 in The Hills Shire Council, Parish of Castle Hill, County of Cumberland, and as described in Folio Identifier 23/1208839

[8255]

COWRA SHIRE COUNCIL

LOCAL GOVERNMENT ACT 1993
Section 713

Sale of Land for Overdue Rates

Notice is hereby given to the owners of the properties listed hereunder that Cowra Shire Council has resolved, in pursuance of section 713 of the *Local Government Act 1993*, to sell the land described hereunder and on which the amount of rates stated in each case as at 30 June 2015 is due:

Owners or persons having an interest in the land **(a)**	**Description of the Land** **(b)**	**Amount of rates (including extra charges) overdue for more than five (5) years** **(c)** **$**	**Amount of all other rates (including extra charges) due and in arrears** **(d)** **$**	**Total** **(e)** **$**
WEALTH PROPERTY MANAGEMENT PTY LIMITED	Grenfell Road Cowra Lot 35 DP 1123388	$ 4,147.86	$ 14,539.48	$ 18,687.34
C. A MARTIN	Clements Road Woodstock Lot 6 DP 1092288	$ 1,452.87	$ 3,978.83	5,431.70
Estate of LF RYAN	10 Illunie Street Wattamondara Lot 19 Section 5 DP 759060	$588.76	$2,341.04	$2,929.80
C DOLBEL	Rivers Road Canowindra Lot 2 DP 114678	$533.31	$901.91	$1,435.22
P McLAUGHLIN & MARIA'S HOLDINGS PTY LTD & RED RIDGE COMPANY PTY LIMITED Mortgage to SUNCORP-METWAY Caveat by ACE OHLSSON PTY LIMITED as regards to PAUL MCLAUGHLIN GROUP PTY LIMITED	Rivers Road Canowindra Lot 1 DP 114679	$342.59	$1,459.81	$1,802.40
MI BOND	Belmore Street Woodstock Lot 254 DP 864432	$457.50	$2,109.85	$2,567.35

In default of payment to the Council of the amount stated above and any other rates (including extra charges) becoming due and payable after 30 June 2015, before the time fixed for the sale, the said land will be offered for sale by public auction on Wednesday 24 February 2016 at 10am in the Council Chambers, located at 116 Kendal Street, Cowra.

PAUL DEVERY, General Manager, Cowra Shire Council, 116 Kendal Street, Cowra NSW 2794 [8256]

PRIVATE ADVERTISEMENTS

DISSOLUTION OF WICKS ROAD PARTNERSHIP

This notice is to advise that the Wicks Road Property Management partnership has now been dissolved.

Should you require any further information please contact Mark Mastroianni 03 9541 9948. [8257]

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