WORKERS COMPENSATION COMMISSION

STATEMENT OF REASONS FOR DECISION OF THE APPEAL PANEL IN RELATION TO A MEDICAL DISPUTE

Matter No:	**M1-1123/19**
Appellant:	**Hallmark Cards Australia Ltd**
Respondent:	**Carolyn Joy Shepherd**
Date of Decision:	**21 August 2019**
Citation:	**[2019] NSWWCCMA 120**

Appeal Panel:	
Arbitrator:	**Mr John Harris**
Approved Medical Specialist:	**Dr Brian Noll**
Approved Medical Specialist:	**Dr Philippa Harvey-Sutton**

BACKGROUND TO THE APPLICATION TO APPEAL

1. Ms Carolyn Shepherd (the respondent) suffered injury on 17 September 2015 in the course of her employment with Hallmark Cards Australia Ltd (the appellant).

2. The respondent brought proceedings claiming permanent impairment compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act). The body part claimed was the lumbar spine.

3. The appellant accepted liability for the injury. This acceptance was confirmed in the letter of offer made by the appellant dated 20 February 2019.[1]

4. The appellant then commenced proceedings in the Commission. As liability was not in issue, the claim was referred to an Approved Medical Specialist (AMS). Dr John Stephenson was appointed as the AMS.

5. The AMS examined the appellant and provided a Medical Assessment Certificate dated 30 May 2019 (MAC). The relevant findings by the AMS pertinent to the various grounds of appeal are set out later in these Reasons. The AMS assessed the lumbar spine at 22% whole person impairment after making a deduction of one-tenth pursuant to s 323 of the 1998 Act.

6. The assessment of whole person impairment is undertaken in accordance with the fourth edition of the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment* (fourth edition guidelines).[2] The fourth edition guidelines adopt the 5th edition of the *American Medical Association's Guides to the Evaluation of Permanent Impairment* (AMA 5). Where there is any difference between AMA 5 and the fourth edition guidelines, the fourth edition guidelines prevail.[3]

[1] Application, pg 883
[2] The 4th edition guidelines are issued pursuant to s 376 of the *Workplace Injury Management and Workers Compensation Act 1998*
[3] Clause 1.1 of the fourth edition guidelines

THE APPEAL

7. On 26 June 2019, the appellant filed an Application to Appeal Against a Medical Assessment (the appeal) to the Registrar of the Workers Compensation Commission (the Commission).

8. The Workers compensation medical dispute assessment guidelines (the Guidelines) set out the practice and procedure in relation to the medical appeal process under s 328 of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act). An Appeal Panel determines its own procedures in accordance with the Guidelines.

9. The appellant claims, in summary, that the medical assessment by the AMS with respect to the assessment of the lumbar spine should be reviewed on the ground that the MAC contains a demonstrable error and/or the assessment was made on the basis of incorrect criteria.

10. The Appeal was filed within 28 days of the date of the MAC. The submissions in support of the grounds of appeal are referred to later in these Reasons.

PRELIMINARY REVIEW

11. The Appeal Panel (AP) conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Guidelines.

12. The appellant submitted no re-examination was required and that the matter could otherwise be determined on the submissions as filed. The respondent agreed with that submission.

EVIDENCE

13. The AP has before it all the documents that were sent to the AMS for the original assessment and has taken them into account in making this determination.

Respondent's statement

14. The respondent provided a statement dated 12 July 2017.[4] The statement includes a reference that the respondent had no prior workers compensation or motor vehicle accidents. The statement is otherwise silent on whether the respondent had prior low back and radicular symptoms.

15. A claim form completed by the respondent and dated 24 September 2015 stated that there was no prior condition.[5]

Clinical note/scans

16. A CT scan of the lumbar spine dated 27 May 2014 reported a clinical history that the respondent was "experiencing severe back pain and pins and needles left lower limb".

17. Dr Chew, Radiologist, concluded that the CT scan showed:[6]

> "Circumferential disc bulging with moderate to high grade central canal stenosis at L4/5 level. Moderate bilateral facet joint degenerative changes. Bilateral foraminal stenosis is seen with partial impingement of the existing L4 nerve roots."

[4] Application, pg 875-877
[5] Application, pg 872
[6] Reply, pg 3

18. Dr Chew recommended a CT guided epidural injection at the L4/5 level.

19. The general practitioner's clinical note of 29 May 2014 refers to the applicant presenting with CT results and is to have a CT guided injection. Recorded history was "12 weeks of pain"[7], which, in the context of the note likely refers to low back pain.

20. A letter dated 13 June 2014 from the general practitioner to Mr Luke Bowen noted back pain "that was resolved following an epidural injection". Review was sought for "neck and back care to help with her headaches and to prevent further flare up of her back pain."[8]

21. Luke Bowen, exercise physiologist, provided a report dated 13 August 2014.[9] He noted that the respondent reported "a constant central ache in her lumbar spine around the left at L4/5" with occasional sharp referral pain in the left glut and dull ache in the front thigh bilaterally at night time. Mr Bowen gave advice concerning core strengthening and actively managing symptoms.

22. The clinical notes of the general practitioner on 15 July 2014 refer to a "flare up of back pain, good pain relief for 1 month but flare up over last 10 days". The note indicates that the respondent sought "another steroid injection".

23. The doctor's clinical note of 31 July 2014 stated that the respondent presented for review with "good progress but not complete resolution".[10]

Qualified opinions

24. The respondent was examined by Dr Bosanquet who provided a report dated 10 January 2019.[11] The doctor recorded "no past history of back injury".[12] He made a deduction of one-third due to marked degenerative changes at L4/5 with a spondylolisthesis and facet joint arthritis.[13]

25. Dr Neil Berry examined the respondent and provided a report dated 3 September 2018.[14] There is no history of any prior back problems and the doctor made no deduction pursuant to s 323 of the 1998 Act. The doctor concluded that the injury was a disc injury at L4/5 aggravating a pre-existing mild anterolisthesis.[15]

REASONS PROVIDED BY THE AMS

26. The relevant portions of the MAC are set out herein.

27. The AMS recorded the following history relevant to prior and subsequent accidents, injuries or conditions:[16]

[7] Reply, pg 38
[8] Reply, pg 2
[9] Reply, pg 4
[10] Reply, pg 39
[11] Reply, pg 26
[12] Reply, pg 29
[13] Reply, pg 33
[14] Application, pg 1
[15] Application, pg 8
[16] MAC, pg 2

> "On date of injury 17 September 2015, Ms Shepherd was walking from the newsagent where she had been working as a greeting card merchandiser. She had travelled down on the travellator and as it came to the ramp at the end where she had entered the car park she suddenly slipped for no apparent cause. There was no water spilt on the floor that she could see. She fell down backwards falling onto her back and striking the back of her head on the concrete floor. She lay there for a short time and managed to get up. She went to the car and rested and then drove home. She rang her boss and travelled home.
>
> For 15 months she was treated conservatively seeing her GP and having physiotherapy and exercise physiology. There were two or three steroid injections. The first one did not work. These were epidural injections. She was treated by exercise physiologist Mr Luke Bowen at Hills Sports Medicine and still has an exercise routine she attempts at home for her back.
>
> Her GP at MyHealth Medical Centre Baulkham Hills first saw her at the practice four days after the injury on 21 September 2015 and certified her with the diagnosis of back pain, acute flare up of previous L4/5 spondylolisthesis causing foraminal stenosis and nerve impingement and found her fit for part-time light work four hours a day three days a week with no lifting above 2 kg and no pushing of more than 5 kg, with sitting and standing and driving as tolerated."

28. The respondent's injuries and diagnoses were summarised by the AMS as follows:[17]

> "The history is consistent with a diagnosis of an acute aggravation of discal pathology at the L4/5 level. This was confirmed on the MRI scan of 23 March 2016 which confirmed advanced facet joint arthrosis with synovitis and minor marrow oedema. There was a grade I anterolisthesis (2 mm). There was disc dehydration and posterior disc height loss and posterior disc bulging indenting the thecal sac with mild canal stenosis with effacement of the L5 nerve roots from the lateral recesses. There was minimal L4 foraminal narrowing without neural impingement as reported by Dr Harris on that study of 23 March 2016 following the injury six months earlier. That is the radiological diagnosis and also a clinical diagnosis prior to surgery.
>
> Post-surgery with the L4/5 posterior instrumented fusion with pedicle screw technique and connecting rods there is confirmation according to WorkCover Guidelines of radiculopathy persisting post-surgery.
>
> Reference is to AMA5 page 384 Table 15-3 for the Diagnosis Related Lumbar Category IV for a successful attempt at surgical arthrodesis. The DRE Category IV baseline is 20% WPI. To this I have added 2% for ADLs, that is, for assistance with and avoidance of sport, recreation, yards, garden and home care. That gives a 2% WPI add on. Therefore, there is now a 22% WPI. This value is combined using the modifier from Table 4.2 page 29 WorkCover Guidelines namely spinal surgery residual symptoms and radiculopathy with reference to paragraph 4.27. Lumbar spine 3% WPI. The 3% WPI combines with the 22% WPI baseline plus ADLs. The combination of 22% with 3% gains 24% WPI.

[17] MAC, pp 4-5

> I have made a fractional reduction one one-tenth under Section 3.23. That is by virtue of the evidence of degenerative change radiologically including the presence of the grade I anterolisthesis of 2 mm at the L4/5 level. At L4/5 on the MRI of 23 March 2016 Dr Harris noted some disc dehydration with posterior disc height loss and minor disc bulging without central canal lateral recess or foraminal compromise. There is minor facet arthropathy."

29. In providing reasons for assessment the AMS stated:[18]

> "I found evidence of a lumbar spinal fusion at the L4/5 level which carries a baseline according to AMA5 of 20% WPI. I have added 2% for ADLs, that is, for avoidance of and assistance with sport, recreations, yard, garden and home care. Therefore, there is a 22% WPI. I have combined that value with the modifier for the lumbar spine with radiculopathy persisting post-spinal fusion at 3% WPI from Table 4.2. The combination of 22% with 3% gains 24% WPI. With a fraction deduction of one-tenth this gives a deduction of 2.4% with a net rounded 22% WPI which is the total whole person impairment.
>
> In making that assessment I have taken account of the following matters:-
>
> I have referred to the investigation findings and the relevance of previous radiological findings at the L4/5 level.
>
> The history is of a sudden and unexpected fall onto the lower back and buttock region causing the onset of the lumbar pain and left lumbar disc sciatica diagnosis."

30. The AMS also referred to various scan evidence including the CT scan dated 22 September 2015 and the lumbar MRI scan dated 23 March 2016. He did not refer to the CT scan dated 27 May 2014.

GROUND OF APPEAL 1 – SECTION 323 DEDUCTION

Submissions

Appellant's submissions

31. The AMS only applied a one-tenth deduction under s323 of the 1998 "which is insufficient to account for the significant pre-existing injury/condition/abnormality in the respondent worker's lumbar spine." The appellant submitted that there was "extensive medical evidence that was before the AMS" addressing this issue and a failure to "apply a greater than one tenth deduction" amounted to either demonstrable error and/or the assessment was made on the basis of incorrect criteria.[19]

32. The Appellant referred to various evidence which it submitted was not referred to or addressed in the MAC. This evidence was:

    (a) Report from Dr Nicholas Tsang dated 13 June 2014[20];
    (b) CT scan dated 27 May 2014[21];
    (c) Report from Luke Bowen, exercise physiologist dated 13 August 2014[22]; and

[18] MAC, pg 6
[19] Appellant's submissions, paragraph 3
[20] Reply, pg 2
[21] Reply, pp 2-3
[22] Reply, pg 4;

(d) Clinical notes of Dr Tsang on 29 May 2014, 15 July 2014 and 31 July 2014[23].

33. The Appellant also referred to evidence which was addressed by the AMS, namely the CT scan dated 22 September 2015 which revealed pre-existing constitutional degenerative changes at the L4/5 level and the initial WorkCover certificate of capacity dated 12 October 2015 which referred to a "flare up of previous L4/5 spondylolisthesis".[24]

34. The Appellant relied on the opinion expressed by the AMS that the presence of facet arthrosis and spondylosis at L4/5 were determinants of why a lumbar fusion was performed. The pre-existing condition contributed to the impairment in accordance with the reasoning in *Cole v Wenaline Pty Ltd* (*Cole*).[25] There could be "no doubt that the pre-existing conditions contributed to the need for spinal fusions surgery and to the assessment of permanent impairment."[26]

35. The AMS stated that the one-tenth deduction was made as it was not at odds with the available medical evidence and too difficult to determine and noted there were no symptoms of lumbar pain before the fall. The history recorded by the AMS that the respondent was asymptomatic was incorrect given the material referred to previously.[27]

36. In light of the contemporaneous medical evidence available to the AMS, the extent of the deduction was not costly or difficult to determine. A greater deduction of at least one-third ought to have been applied in these circumstances.

Respondent's submissions

37. The Respondent submitted that the AMS referred to the evidence of Dr Tsang and Mr Bowen at page 2 of the MAC under the heading "History Relating to the Injury". Reference was also made to the opinion expressed by Dr Hsu that the respondent had low back pain and lower limb pain related to the L4/5 disc.

38. The CT scan taken five days after the injury showed degenerative changes which were noted by the treating surgeon and the AMS who both opined that the L4/5-disc bulge was productive of back pain and left leg symptoms.

39. Applying *Cole*, it was submitted that the preponderance of the medical opinion was that the L4/5-disc bulge was productive of the pain and the deduction on one-third provide by Dr Bosanquet was "just not appropriate".

40. The AMS provided reasons in its findings that only a 10% deduction for pre-existing changes was appropriate.

41. The Appellant highlights "an episode of back pain in mid-2014 which on the notes of the GP …. clearly resolved and in the context of Ms Shepherd's sporting activities are not significant leading up to the 15 September 2015 incident."[28]

42. The respondent submitted that the complaints in 2014 did not extend to sciatica on the left side. It was submitted:[29]

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[23] Reply, pg 39
[24] Appellant's submissions, paragraphs 6-7
[25] [2010] NSWSC 78
[26] Appellant's submissions, paragraph 12
[27] Appellant's submissions, paragraph 10
[28] Respondent's submissions, paragraph 7
[29] Respondent's submissions, paragraph 7

> "In any event both Dr Bosanquet and the AMS had the same history of no complaints of back pain before the subject incident."

43. The respondent submitted that the complaints of pain in 2014 cannot be a deduction under s 323 as there was "no link between them and the pain suffered after the subject incident". Pursuant to *Cole*, there should be no deduction as the prior complaints are not related to the current complaints.

Reasons

44. The AP is of the view that the AMS was led into error by the incorrect history presented to him by the respondent. The AMS recorded that he was informed by the respondent that "there were no symptoms of lumbar pain before the fall".[30] Dr Bosanquet recorded a similar history.

45. The respondent's statement filed in the proceedings otherwise lacked candour in its preparation and recorded history because it only referred to no prior back injury and otherwise failed to mention her significant back pain with treatment in 2014. Further, the claim form completed by the respondent seven days after the work injury failed to disclose the pre-existing lumbar spine condition.

46. The conclusion reached by the AMS that there was "no symptoms of back pain before the fall" was factually inaccurate as it is inconsistent with the clear evidence recorded by the general practitioner, the radiologist and Mr Bowen that the respondent was suffering from low back pain over an extended period in 2014.

47. Furthermore, the clinical history recorded by Dr Chew of "pins and needles left lower limb" and the history recorded by Mr Bowen of referred pain supports the appellant's submission that the respondent had radicular symptomatology in 2014.

48. The 2014 CT scan establishes that the respondent was suffering from disc pathology at L4/5 impinging on the exiting nerve roots.

49. The history recorded by the AMS and Dr Bosanquet, that there was no prior back condition, was wrong because it is contradicted by clear evidence that the respondent was suffering from low back pain at the L4/5 level in 2014. It is not to the point, as the respondent submitted, that both Dr Bosanquet and the AMS recorded a history of no prior back problems. The history provided to these doctors was incorrect and it does not assist the respondent's position that she provided an incorrect history to both Dr Bosanquet and the AMS. Indeed, the demonstrable error made by the AMS is the acceptance of an incorrect history provided by the respondent.

50. The respondent's submissions that there was no demonstrable error are rejected.

51. The respondent failed to refer in its submissions to the 2014 CT scan which undoubtedly show disc pathology at L4/5. The respondent's submission that she did not have pre-existing disc pathology at that level is contradicted by the 2014 CT scan.

52. The respondent's submission that she did not have prior radicular symptoms is contradicted by the references in the CT scan and Mr Bowen's report to left leg symptomatology.

53. The respondent's submission that the AMS referred to the prior reports of Dr Tsang and Mr Bowen is otherwise wrong. The reference in the MAC to reports from Mr Bowen and Dr Tsang was in the context of post injury treatment and was not directed to the prior condition.

[30] MAC, pg 5

54. The AP is of the view that the manner in which the case was presented by the respondent through her lawyers lacked candour. There is no reference in the respondent's statement to a prior back condition and this was not mentioned in the claim form completed by the respondent. The respondent otherwise provided incorrect histories to doctors, including the AMS, when failing to disclose her prior back condition.

55. Section 327(3)(d) provides that the error must be "demonstrable". In *Vannini v Worldwide Demolitions Pty Ltd* (*Vannini*),[31] Gleeson JA observed that, consistent with the observations of Basten JA in *Mahenthirarasa v State Rail Authority of New South Wales,* a "demonstrable error must be apparent in findings of fact or reasoning contained in the medical assessment certificate, although the error may be established in part by reference to materials that were before the approved medical specialist".[32]

56. The finding by the AMS that there was no prior back condition at the L4/5 level constitutes a demonstrable error.

57. The error is demonstrable because it is obvious, apparent from the material before the AMS and a critical matter in the evaluation of the relevant deduction pursuant to s 323.

58. The AP also accepts that the AMS failed to refer to critical evidence concerning the respondent's pre-existing condition. In *Campbelltown City Council v Vegan*[33] (*Vegan*) the Court of Appeal noted the statutory obligation of the AMS to provide reasons. The Court held that an Appeal Panel was under an implied duty to give reasons. Handley JA described the scope of the duty of both the AMS and the Appeal Panel, was to provide "proper reasons".[34]

59. Basten JA described the adequacy of reasons that must be provided by an Appeal Panel as follows:[35]

> "121. Where it is necessary for the Panel to make findings of primary fact, in order to reach a particular conclusion as to the existence, nature and extent of any physical impairment, it may be expected that the findings of material facts will be set out in its reasons. Where facts are in dispute, it may be necessary to refer to evidence or other material on which findings are based, but the extent to which this is necessary will vary from case to case. More importantly, where more than one conclusion is open, it will be necessary for the Panel to give some explanation of its preference for one conclusion over another. That aspect may have particular significance in circumstances where the medical members of a Panel have made their own assessment of the applicant's condition and have come to a different conclusion from that reached by other medical practitioners, as set out in reports provided to the Panel.
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> 122. On the other hand, to fulfil a minimum legal standard, the reasons need not be extensive or provide detailed explanation of the criteria applied by medical specialists in reaching a professional judgment: see *Soulemezis* at 273-274 (Mahoney JA) and 281-282 (McHugh JA). At least, that will be so where the medical science is not controversial: if it is, a more expansive explanation may be required."

[31] [2018] NSWCA 324 (*Vannini*) at [90]
[32] *Vannini* at [86]
[33] [2006] NSWCA 284
[34] At [26] and [31], McColl JA agreeing at [33]
[35] [121]-[122]

60. Similar observations where made by McColl JA in *Tudor Capital Australia Pty Ltd v Christensen*[36] (*Christensen*) when her Honour stated:[37]

> "387. The principles concerning adequacy of reasons are well known.[311] It is apposite, however, to consider how those principles apply in an appeal confined to a grievance in point of law. In that situation, as Macfarlan JA explained in *Wilkinson*,[312] *Soulemezis v Dudley (Holdings) Pty Ltd*,[313] 'is authority for the proposition that where a right of appeal is given only in respect of a question of law ... reasons for a finding of fact "can be treated less elaborately than [those on] an issue involving a question of law or mixed fact and law". Nevertheless, the principle that justice must not only be done but must be seen to be done remains applicable'.
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> 388. Thus, in *Soulemezis,* McHugh JA held that 'the failure to explain the basis of the crucial finding of fact involves a breach of the principle that justice must not only be done but must be seen to be done' and is an error of law because the decision-maker 'has not properly fulfilled the function which the law calls upon a judicial person to exercise'. There will be a failure to give adequate reasons where a decision-maker ignores evidence critical to an issue in a case and contrary to an assertion of fact made by one party and accepted by the decision-maker."

61. The nature of the duty and scope to provide reasons was also discussed in *El Masri v Woolworths Ltd*, a decision involving judicial review of a decision of a Medical Panel, when Campbell J stated:[38]

> "As I have said, and at the risk of repeating myself unduly, the process is one of expert evaluation. Often when judgment of any type is called for, there will be a gap between expression of reasons and articulation of decision which cannot itself be fully articulated. That gap constitutes what might be called judgment. Although, as Ms Allars reminded me, *Wingfoot* does not necessarily apply to this case because it was a case where there was a statutory obligation to give reasons, and in this case the obligation to give reasons is implied by the general law as explained in *Campbelltown City Council v Vegan* [2006] NSWCA 284; (2006) 67 NSWLR 372, what their Honours said at [55] of *Wingfoot* must be applicable. Basically, the statement of reasons must explain that actual path of reasoning in sufficient detail to enable a court to see whether the opinion does or does not involve any error of law. Applying that standard, it is clear what was decided and why, as is the reasoning process that led to the decision, especially if one has regard to what was said by the Panel at paragraph 18 which I will not further set out."

62. The standard of reasons required by an Appeal Panel under the *Accident Compensation Act, 1985* (Vic) was discussed by the High Court in *Wingfoot Australia Partners Pty Ltd v Kocak*[39] when the plurality stated:[40]

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[36] [2017] NSWCA 260
[37] at [387]-[388]; Mcfarlan JA agreeing at [425]
[38] [2014] NSWSC 1344 at [50]
[39] [2013] HCA 43
[40] at [55] per French CJ, Crennan, Bell, Gageler and Keane JJ

> "The standard required of a written statement of reasons given by a Medical Panel under s 68(2) of the Act can therefore be stated as follows. The statement of reasons must explain the actual path of reasoning by which the Medical Panel in fact arrived at the opinion the Medical Panel in fact formed on the medical question referred to it. The statement of reasons must explain that actual path of reasoning in sufficient detail to enable a court to see whether the opinion does or does not involve any error of law. If a statement of reasons meeting that standard discloses an error of law in the way the Medical Panel formed its opinion, the legal effect of the opinion can be removed by an order in the nature of certiorari for that error of law on the face of the record of the opinion. If a statement of reasons fails to meet that standard, that failure is itself an error of law on the face of the record of the opinion, on the basis of which an order in the nature of certiorari can be made removing the legal effect of the opinion."

63. *Christensen* concerned an appeal from the Workers Compensation Commission to the Court of Appeal where an appeal is limited to an error of law. An appeal to an Appeal Panel from an AMS is limited to the grounds set out in s 327 of the1998 Act. In the present case neither of the grounds in s 327(3)(a) or (b) are relevant and the appeal is limited to an assessment made on the basis of incorrect criteria (s 327(3)(c)) or that the certificate contains a demonstrable error (s 327(3)(d)).

64. Similar observations were also made by the Court of Appeal in *Marina Pitsonis v Registrar of the Workers Compensation Commission*[41] when Mason P stated:[42]

> "I do not exclude the possibility that a Certificate might be capable of challenge by way of judicial review on the ground that there was, for example, a denial of procedural fairness. Sometimes, but only sometimes, the failure of a decision-maker to hear or address relevant factual material or arguments will ground a successful challenge upon this ground."

65. The Panel was unassisted by submissions on the scope of the duty by the AMS to provide reasons. However, the principles are settled and were discussed by the Court of Appeal in *Vegan* which included a reference by Basten JA to the principles articulated in *Soulemezis*. Noting that the nature of the appeal discussed in *Christensen* is different from that arising in the present matter, similar observations were then repeated by the Court of Appeal.

66. The appellant submitted that the AMS also erred by omitting to refer to the evidence relating to back problems in 2014. That failure included a failure to refer to the 2014 CT scan.

67. The respondent's submissions that the AMS had referred to some of the material is rejected. The reasoning provided by the AMS was directed to the post-injury treatment.

68. It is clear that the AMS did not refer to the prior CT scan. That evidence established that the respondent had prior disc pathology at the L4/5 level with impingement on the exiting nerve roots. The respondent's contrary submissions, that there was no prior disc pathology at the L4/5 level, ignores the clear radiological findings shown in the 2014 CT scan.

69. The AP accepts that the failure to address this evidence also constitutes a demonstrable error because it was critical evidence relevant to the s 323 deduction.

70. Accordingly, the AP is satisfied that the appellant had established that the MAC contains demonstrable errors because the AMS failed to refer to critical evidence and otherwise formed a factual conclusion inconsistent with the evidence.

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[41] [2008] NSWCA 88

[42] at [60], McColl and Bell JJA agreeing

71. In these circumstances it is unnecessary to determine whether there has been an application of incorrect criteria.

GROUND OF APPEAL 2 – ACTIVITIES OF DAILY LIVING

Submissions

Appellant's submissions

72. The appellant submitted that the AMS erred in applying a 2% uplift for the restrictions in the activities of daily living which is either a demonstrable error and/or an assessment made on the basis of incorrect criteria. It was submitted that the AMS should only have awarded "a 1% uplift (at most) … as was appropriately applied by Dr Bosanquet based on the history the worker provided."[43]

73. It was submitted that the only relevant history taken by the AMS related to loss of recreational activities. Based on the "self-report, clinical findings and other reports the AMS erred in applying 2% for ADLs and "an assessment of 1% would have been the most appropriate uplift/modifier to be applied in the circumstances."[44]

Respondent's Submissions

74. The Respondent submitted that the AMS provided reasons based on his clinical examination and questioning set out in the MAC at page 5. The assessment of 2% was based on Table 4.2 of the fourth edition guidelines and should not be interfered with. That Dr Bosanquet reached a different conclusion is not a valid basis of appeal.[45]

Reasons

75. The AMS allowed 2% for the effects on the activities of daily living based on "assistance with and avoidance of sport, recreation, yards, garden and home care." He otherwise noted that social activities were "crosswords and puzzles". Later in his reasons the AMS stated:[46]

> "The clinical findings however are consistent with the need for assistance with activities of daily living which I would assess as a need for four hours of heavy domestic cleaning per fortnight. Hence I have given 2% for ADLs."

76. The appellant did not refer to these findings and otherwise ignored it in the submissions. These reasons are essential to the conclusion reached by the AMS. To ignore the critical findings makes it difficult, if not impossible, for the AP to conclude that the appellant has shown error because the appellant's submissions fail to address the critical finding.

77. The AMS is not obliged to accept the opinion of a specific doctor, such as Dr Bosanquet. An AMS is required to form his or her own medical opinion on the matter.[47] The failure to accept an opinion does not, of itself, amount to demonstrable error or the application of incorrect criteria.

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[43] Appellant's submissions, paragraph 14
[44] Appellant's submissions, paragraph 17
[45] Respondent's submissions, paragraph 9
[46] MAC, pg 7
[47] *State of New South Wales v Kaur* [2016] NSWSC 346 at [26]

78. The AP otherwise notes that Dr Berry made an allowance of 2% on the effects of the activities of daily living.[48] There was a difference of opinion raised by the doctors qualified by the parties. The AMS addressed the issue and formed his opinion as to the appropriate assessment.

79. Paragraphs 4.33 – 4.36 of the *fourth edition guidelines* relate to the assessment of an appropriate percentage for the activities of daily living. Paragraph 4.33 provides that an "assessment of the effect of the injury on ADL is not solely dependent on self-reporting but it is an assessment based on all clinical findings and other reports".

80. Paragraph 4.34 provides that the diagram "should be used as a guide" in determining the appropriate percentage. There can be no doubt about the significance of the word "guide" as the *4th edition Guidelines* has used bold print to emphasise the word.

81. Paragraph 4.35 provides that the base impairment is increased 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 if the worker can manage personal care and household tasks but is unable to get back to previous sporting or recreational activities.

82. The AMS was clearly entitled to form the view that, consistent with the clear clinical signs which were not disputed in this appeal, the respondent was assessed at 2% for the effects on the activities of daily living. No error, let alone demonstrable error, has been established.

83. The appellant failed to articulate how the assessment was made on the basis of incorrect criteria. On the facts as found by the AMS, particularly with respect to the effects on recreational and sporting activities and difficulties with aspects of household tasks, the AMS was clearly entitled to assess the effects on the activities of daily living at 2%.

84. This ground of appeal is rejected.

GROUND OF APPEAL 3 – FINDING OF RADICULOPATHY

Submissions

Appellant's submissions

85. The appellant submitted that the AMS erred in applying a 3% uplift for radiculopathy persisting post-spinal fusion and that this amounts to a demonstrable error and/or that the assessment was made on the basis of incorrect criteria.

86. The appellant referred to the opinion of Dr Bosanquet that any ongoing pain is due to the pre-existing condition, the report of Mr Bowen in August 2014 that the respondent had lower limb pain and the CT scan dated 27 May 2014 which included a history of "pins and needles left lower limb".

[48] Application, pg 1

87. It was submitted that, given the pre-existing condition "the AMS has erred in applying an uplift/modifier in respect of radiculopathy".[49]

Respondent's submissions

88. The respondent submitted that the AMS has explained his reasons at page 3 of the MAC under the heading "Physical Symptoms". These symptoms were "radiculopathy remaining after the operation".[50]

Reasons

89. The appellant appears to be submitting that the radiculopathy did not result from the injury as the respondent had left lower extremity symptoms prior to injury.

90. The appellant's submissions address the incorrect test. The relevant test under s 66 of the 1987 Act is whether the injury "results in a degree of permanent impairment".

91. These principles were recently discussed by two members of this Appeal Panel in *State of New South Wales v Worland*[51] and are repeated as part of these reasons. The AMS is required to address whether the impairment, including the radiculopathy, is causatively related to the injury. It is an incorrect characterisation, as the appellant submitted, to inquire whether the radiculopathy is also causatively related to a previous incident or condition. There can be multiple causes of the impairment despite the fact that the applicant had a pre-existing condition.

92. The AP refers to its findings and reassessment in respect of the first ground of appeal. It is satisfied for the reasons given, that the appropriate deduction pursuant to s 323 is one-fifth. The injury aggravated the discal pathology at L4/5 which has contributed to the ongoing radiculopathy.

93. The AMS has set out in some detail the ongoing radiculopathy in paragraph 5 of the MAC including asymmetry of reflexes, reproducible impairment of sensation localised to the nerve root distribution at L4/5, positive nerve root tension, muscle wasting and atrophy, and restricted straight leg raising. These findings are consistent with radiological investigations.

94. The relevant findings made by the AMS of radicular signs and symptoms are produced below. The AMS held that these were:[52]

- Radiculopathy was evident in the left lower extremity.
- There was asymmetry of reflexes which were hyperactive at both knees but present at both ankles.
- There was no muscle weakness.
- There was a reproducible impairment of sensation anatomically localised to the appropriate spinal nerve root distribution at L4/5.
- There was reduced sensation on the lateral aspect of the left leg below the knee extending to the lateral aspect and dorsum on the lateral side left foot.
- Positive nerve root tension.
- Straight leg raise when supine: right leg 70°.
- Straight leg raise when supine: left leg resisted at 50° which is reinforced by dorsal flexion of the foot with pain felt in the lumbar and left gluteal region.

[49] Appellant's submissions, paragraph 23
[50] Respondent's submissions, paragraph 10
[51] [2019] NSWWCCMA 98
[52] MAC, pg 4

- Muscle wasting and atrophy.
- Right mid-calf circumference 35 cm; left mid-calf circumference 34 cm, measured at 12 cm distal to the tibial tuberosity.
- Findings on imaging studies are consistent with the clinical signs.

95. The appellant referred to the prior radicular symptoms as recorded by Luke Bowen. However, the nature of the radicular symptoms recorded by the AMS far exceed that previously recorded by Mr Bowen in 2014.

96. Further, it is insufficient in asserting demonstrable error that a doctor, such as Dr Bosanquet, formed a different conclusion. The relevant issue is whether there is error in the conclusion made by the AMS. Simply referring to a contrary opinion does not establish error.

97. The appellant did not dispute the radicular signs found by the AMS. These findings clearly satisfy the concept of radiculopathy as defined in paragraph 4.27 of the fourth edition guidelines.

98. The AP has concluded that the relevant s 323 deduction should be one-fifth. The work injury remains a material cause of the impairment. The fact, as the appellant submitted, that the AMS referenced Dr Bosanquet's opinion that ongoing pain is due to pre-existing changes, does not mean that that the AMS accepted that view. It is otherwise inconsistent with the AMS's conclusion that the injury caused impairment.

99. A material cause of the radiculopathy was the work injury. This ground of appeal is rejected.

REASSESSMENT

100. Having found error, the AP is required to reassess according to law: *Drosd v Nominal Insurer.*[53]

101. The parties did not seek a re-examination in the event that error was shown. The AP is satisfied that we can properly perform the statutory function to reassess in the absence of a re-examination.

102. The AP agrees with the AMS finding that:[54]

> "The presence of facet arthrosis and a spondylosis at L4/5 are factors which influence the choice of fusion rather than merely a decompression."

103. The medical opinion is accurate. The respondent's pre-existing condition meant that a fusion was a more appropriate medical procedure than a discectomy. This meant that the respondent's assessment was DRE lumbar category IV following a fusion rather than lumbar category III following a discectomy.

104. The respondent was suffering from a pre-existing mild grade 1 spondylolisthesis at the L4/5 level. As our earlier reasons explain, the respondent also had pre-existing disc pathology at the L4/5 level and complained of radicular symptoms in 2014 with back pain at that level. These symptoms were treated by probably one and possibly a second injection.

105. We previously noted that the respondent's reported history did not assist the AMS in determining the nature and extent of the pre-existing complaints. The AP has resorted to cotemporaneous documents, such as the reports of Dr Tsang, Dr Chew (the CT scan) and Mr Bowen in 2014 in determining the likely position.

[53] [2016] NSWSC 1053
[54] MAC, pg 5

106. Based on an absence of complaints recorded by the general practitioner in her clinical notes following the 2014 treatment, it appears that the respondent had a degree of recovery of the back and leg symptoms until the work aggravation caused by the 2015 injury. The AP accepts only that portion of the respondent's submission that there was some recovery following treatment provided by health practitioners. Unfortunately, that inference is not based on direct evidence from the respondent, who denied or neglected to mention any prior symptomatology, but from an absence of complaint in the notes of the general practitioner.

107. A deduction pursuant to s 323 of the 1998 Act is required if a proportion of the permanent impairment is due to previous injury or due to pre-existing condition or abnormality: *Vitaz v Westform (NSW) Pty Ltd (Vitaz)*[55]; Ryder *v Sundance Bakehouse* (*Ryder*)[56]*; Cole v Wenaline Pty Ltd* (*Cole*)[57].

108. The AP accepts that a proportion of the permanent impairment is due to the pre-existing condition. That conclusion is based on the facet arthrosis and a spondylosis at L4/5 and the pre-existing discal pathology at L4/5. As we have noted and express concurrence with the opinion expressed by the AMS, the pre-existing spondylosis at L4/5 and facet arthrosis were determinative factors in the respondent undergoing a fusion. Absent that pathology and ignoring the pre-existing discal pathology, it is unlikely that the respondent would have required a fusion.

109. The AP also opines that, contrary to the respondent's submission, there was pre-existing discal pathology at L4/5.

110. Based on the above conclusions, the AP is satisfied that one-fifth of the respondent's impairment is due to the respondent's pre-existing condition.

111. The AP does not accept that the proviso contained in s 323(2) of the 1998 Act applies to these facts. The extent of any deduction is not difficult or costly to determine within the meaning of s 323(2) of the 1998 Act. The AP is also of the view that a 10% deduction is inconsistent with the available evidence referred to herein, particularly the pre-existing spondylosis that was a significant factor in the appellant undergoing a lumbar fusion.

112. The AP otherwise confirms the findings of the AMS concerning the impairment assessment which includes the effects on the activities of daily living and the finding of radiculopathy that results from the injury.

113. Given the duration of symptoms, the AP is satisfied that the impairment is permanent.

DECISION

114. For these reasons, the Medical Assessment Certificate given in this matter is revoked and a new Medical Assessment Certificate is issued. The new Medical Assessment Certificate is attached to this statement of reasons.

[55] [2011] NSWCA 254
[56] [2015] NSWSC 526 (*Ryder*) at [54]
[57] [2010] NSWSC 78 at [29] - [30]

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE REASONS FOR DECISION OF THE MEDICAL APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

A Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL

MEDICAL ASSESSMENT CERTIFICATE

Matter No: **1123/19**
Applicant: **Carolyn Joy Shepherd**
Respondent: **Hallmark Cards Australia Ltd**

This Certificate is issued pursuant to section 328(5) of the *Workplace Injury Management and Workers Compensation Act 1998.*

The Appeal Panel revokes the Medical Assessment Certificate of Dr Brian Stephenson and issues this new Medical Assessment Certificate as to the matters set out in the Table below:

Table - Whole Person Impairment (WPI)

Body Part or system	Date of Injury	Chapter, page and paragraph number in NSW Workers Compensation guidelines	Chapter, page, paragraph, figure and table numbers in AMA5 Guides	% WPI	% WPI deductions pursuant to S323 for pre-existing injury, condition or abnormality	Sub-total/s % WPI (after any deductions in column 6)
Lumbar Spine	17/09/2015	Chapter 4, Pages 17-29, Paragraphs 4.27, 4.34 – 4.35	Chapter 5 Page 384 Table 15-3	24%	1/5th	19%
Total % WPI (the Combined Table values of all sub-totals)					**19%**	

John Harris
Arbitrator

Dr Brian Noll
Approved Medical Specialist

Dr Philippa Harvey-Sutton
Approved Medical Specialist

21 August 2019

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE MEDICAL ASSESSMENT CERTIFICATE OF THE MEDICAL APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

A Shaw

Andrew Shaw
Dispute Services Officer
As delegate of the Registrar