WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

Issued in accordance with section 294 of the *Workplace Injury Management and Workers Compensation Act 1998*

Matter Number: **2016/19**
Applicant: **James Kinred**
Respondent: **Secretary, Department of Justice**
Date of Determination: **25 July 2019**
Citation: **[2019] NSWWCC 253**

The Commission determines:

1. The name of the respondent is amended to read "Secretary, Department of Justice".

2. I remit the matter to the Registrar for referral to an Approved Medical Specialist to assess the applicant's permanent impairment as a result of injuries to his left and right lower extremities (knees) on 24 November 2009.

3. All of the material in the Commission's file should be sent to the Approved Medical Specialist, including a copy of this Certificate of Determination.

A statement is attached setting out the Commission's reasons for the determination.

Catherine McDonald
Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OF CATHERINE McDONALD, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Jackson

Ann Jackson
A/Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. James Kinred is employed by the Secretary, Department of Justice (the Department). On 24 November 2009, he was employed as a teacher at Goulburn Gaol. He alleges that he suffered an injury to his left and right knees on that day when he was struck by a laundry trolley pushed by an inmate and pushed against a wall. Mr Kinred claims permanent impairment compensation as a result of those injuries.

2. Even though the Department paid some weekly compensation and medical and hospital expenses, the parties agree that the issue for determination is whether Mr Kinred suffered an injury to which his employment was a substantial contributing factor.

PROCEDURE BEFORE THE COMMISSION

3. The claim was listed for conciliation conference and arbitration hearing in Wollongong on 26 June 2019 when Mr Wilson of counsel appeared for Mr Kinred and Mr Flett of counsel appeared for the Department.

4. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

5. The claim for weekly compensation was discontinued during the conciliation conference.

6. It was agreed that the Application to Resolve a Dispute (ARD) should be amended to name the Department in the way set out in the Reply.

7. The Department's insurer paid the s 60 expenses in respect of the bilateral partial medial meniscectomies undertaken in 2010 and a further arthroscopy in 2015. Mr Flett said that this did not constitute an admission as to injury and that it was open to the Department's insurer to dispute that Mr Kinred had suffered injury once it had the reports of Dr Watson. Mr Wilson agreed that the Department was permitted to place injury in issue.

EVIDENCE

8. The following documents were in evidence before the Commission and taken into account in making this determination:

    (a) ARD, and

    (b) Reply.

9. The Reply is voluminous and unnecessarily repeats most of the annexures to the ARD. The only new documents to which Mr Flett took me were pages 36 to 39 of the annexures to the Reply, being notes from Mr Kinred's general practitioner which were not included in the ARD.

10. There was no oral evidence.

11. Mr Kinred made a statement on 16 November 2016. He said he was born in New Zealand and came to Australia in June 2003. He disclosed that he had undergone surgery to his cervical spine in 1990 and that he had been diagnosed with rheumatoid arthritis in 2006 for which he is treated by Dr Dorai Raj in Canberra. He was also diagnosed with "knee cap tracking" in 2004 or 2005 and underwent a procedure in Sydney which alleviated all of the pain. He was taught how to strap his knee. Until the incident in November 2009, he went to the gym five to six times per week and refereed rugby at the weekend.

12. Mr Kinred commenced work at Goulburn Gaol in about 2004, initially teaching employability skills and later information technology.

13. On 24 November 2009, he was standing in the doorway of the officers' station on a ramp, talking to one of the officers. An inmate wheeled a heavy laundry trolley up the ramp and lost control of it. The trolley collided with Mr Kinred and pinned him against the bars of the door of the officers' station. Mr Kinred took the following day off work then returned to work, losing little time.

14. Mr Kinred underwent surgery in 2010 and 2015. In 2016, he commenced proceedings in the Commission which resolved with an agreement to reimburse Mr Kinred for time off work and the costs of the surgery. There is no other information in the file about those proceedings.

15. As time went on, Mr Kinred suffered more pain in his left knee and he reduced his hours in 2016.

16. Mr Kinred described the medical treatment undertaken. Dr J Herald performed bilateral arthroscopies in 2010. His right knee improved but his left did not. In 2014, Dr W Ihsheish performed an arthroscopy on his left knee. His left knee pain did not resolve and Dr Ihsheish recommended a left total knee replacement.

17. In August 2018, Mr Kinred commenced new employment as a case management officer at Goulburn Correctional Centre. Mr Kinred has continued to work since the injury in 2009 other than when he was undergoing surgical treatment. On 17 February 2016, he was forced to reduce his hours and began to work three days per week with every second day off.

18. Mr Kinred said that before the injury he went to the gym six days a week in the off season and five days a week during the rugby season. He refereed a couple of reserve grade rugby games on the weekend and he admitted that that involved a lot of running around, twisting and turning and strain on his body. He said that he never had problems before the injury in 2009 but was unable to return to those activities after the injury.

19. Mr Kinred completed an incident notification form on 3 December 2009, stating that the inmate "pushed trolly into unit, & pinned me up against wall, twisting knees in process." He nominated Preston Esquilant as a witness.

20. Mr Esquilant prepared a statement dated 23 August 2018 in which he recalled having a conversation with Mr Kinred on the day of the injury in the location described by Mr Kinred. He recalled that Mr Kinred suffered an injury at work but did not recall the circumstances.

21. The notes from Mr Kinred's general practitioners at Goldsmith Street Surgery commence in 2007 and on 23 October 2007, Dr R Edwards requested pathology with respect to polyarthritis and noted that Mr Kinred was to see Dr Dorai Raj. On 25 June 2009, Dr Hancock recorded "RA causing problems with joints – pain."

22. Mr Kinred saw Dr N Wearne on 26 November 2009. Dr Wearne wrote that Mr Kinred complained of ongoing knee pain which had been present for a number of years. He noted that Mr Kinred taped his knee with some benefit and that he saw Dr Raj for psoriatic arthritis. Dr Wearne requested x-rays of Mr Kinred's left and right knees. He queried the need for orthopaedic referral and indicated that he would review with the x-rays.

23. On 2 December 2009, Dr Al-Maliky recorded that Mr Kinred had a two-year history of "twisted injury while he was training in gym…recently he got worse especially when he was his [sic] in left knee while he was working." I presume that "his" should read "hit." Dr Al-Maliky said that he told Mr Kinred it was most likely he had a meniscal injury and that he required an MRI, for which Mr Kinred said he was unable to pay. Dr Al-Maliky said that review would be required the following week if it was getting worse.

24. On 10 December 2009, Dr Wearne wrote:

> "states injury was done at work on Tuesday 24th November – requesting workcover for ongoing symptoms
> on 24th with inmate pushing a large trolley of clothes and ended pinned against the wall – and knees pain since."

25. Dr Wearne provided a medical certificate dated 10 December 2009 which set out the history provided. He certified Mr Kinred fit for suitable duties.

26. The notes do not indicate that x-rays were taken and there are a number of referrals for MRI scans.

27. On 19 January 2010, Mr Kinred saw Dr A Dorai Raj, rheumatologist. After noting that Mr Kinred described regular flare ups for which she adjusted his medication, Dr Dorai Raj wrote:

> "In addition to this, he described the discomfort on the medical aspect of both his knees. This is present almost constantly and regardless of what he does, although certainly climbing stairs would make it worse. I believe he had an x-ray done late last year which did not show any abnormalities. The possibility is there that it is an inflammatory process and it will be useful to see whether the Methotrexate increase will make a difference. The other possibility is that it is mechanical and I have asked his. To do more cycling and reduce the weight-bearing walking exercises that he normally does in the gym.…I do not think that proceeding with further imaging is going to change management at this stage."

28. Dr Dorai Raj had seen Mr Kinred for the first time in April 2008 and obtained a history that he had had joint symptoms for a number of years affecting his large joints including his knees. She noted that he suffered discomfort in a number of joints and that his left knee was tender below the joint line. There was no effusion in either knee. She diagnosed psoriatic arthritis and recommended further investigations.

29. Dr Weane referred Mr Kinred to Dr J Herald, orthopaedic surgeon. In the knee assessment sheet completed for Dr Herald, Mr Kinred said that his knees had been bothering him for three months and that he had suffered injury in October 2009.

30. MRI scans were undertaken on 1 March 2010 of the left knee and 13 March 2010 of both knees at the request of Dr Wearne. That dated 1 March 2010 showed intrasubstance degeneration in the periphery of the medial meniscus and moderate patellofemoral joint degenerative change. MRI scans of both knees on 13 March 2010 showed patellofemoral chondromalacia OA and medial meniscal tear. The scan of the right knee showed intrasubstance degeneration of the medial meniscus, patellofemoral chondromalacia and osteoarthiritis.

31. Dr Herald reported on 15 March 2010. Dr Herald recorded that Mr Kinred suffered a hyperextension injury to both knees about three months before in October 2009 when he was pinned against a wall by a metal trolley. He had ongoing pain over the medial aspect of both knees. On the basis of the history and his examination, including a positive medial McMurray's test bilaterally, Dr Herald diagnosed bilateral meniscal tears and recommended surgery being partial meniscal meniscectomies or meniscal repair, depending on the state of the tear.

32. On 7 April 2010, Dr Herald responded to questions from the Department's insurer. When asked if Mr Kinred's degenerate medial meniscal tear had been aggravated by the injury and if the aggravation had ceased, Dr Herald said that the degenerate tears were caused by the injury on 24 November 2009 and that the aggravation had now ceased. He said that the tears had been caused by the injury when Mr Kinred was pinned by the trolley against the wall. Though his menisci may have suffered some degeneration, it was the injury which caused the tears. Dr Herald believed that the injuries were caused by a violent attack.

33. On 27 April 2010, Dr R Edwards wrote to the Department's insurer, noting that Dr Wearne no longer worked at the practice. She said that Mr Kinred had never had a meniscal injury. He had patellar maltracking which was a congenital condition not an injury. She said that employment was a substantial contributing factor to the injury which occurred as a result of being wedged between a heavy metal trolley and a wall, causing forced external rotation of his knees and bilateral meniscal tears. The letter to which Dr Edwards was replying does not appear in the file.

34. A fax to Dr Herald dated 5 May 2010 said that the Department's insurer accepted liability for the surgery.

35. On 11 October 2010, Dr Dorai Raj noted that Mr Kinred had undergone arthroscopy of both knees for meniscal pathology and was improving.

36. Dr Imran, general practitioner, referred Mr Kinred to Dr Ihsheish on 10 November 2014 with respect to left knee pain, noting "he had a workplace injury in year 2009 when a laundry trolley hit his knee joints causing meniscal tears in both knee joints." On 27 November 2014, Dr Ihsheish said that Mr Kinred presented with "pain and intermittent locking of his left knee on a background of a previous arthroscopy and meniscal repair from work-related injury." Dr Ihsheish said that an MRI confirmed that the previous meniscal tear had failed and that it was fair to say it was related to the previous work injury. He recommended a further arthroscopy.

37. On 1 April 2015, Dr Ihsheish reported that he undertook a partial medial meniscectomy and chondroplasty. He also undertook an open lateral release of "very tight lateral patellofemoral retinacular ligaments".

38. Dr Imran referred Mr Kinred to Dr Ihsheish again on 11 February 2016 with a history of worsening left knee pain and noting the history of the injury in 2009.

39. Mr Kinred completed a recurrence report of injury form on 18 February 2016. The date of the original injury was noted s 24 November 2009. He said that the pain inflammation and reduced movement had always been present but it was not improving and he was unable to stand the pain any more.

40. On 31 March 2016 Dr Ihsheish again noted the history of a work-related injury which required medial meniscal repair in 2010 and 2015. He reported that Mr Kinred's pain and swelling had increased over the previous 10 months. Given the amount of wear in Mr Kinred's knee, Dr Ihsheish did not recommend further arthroscopy. He noted that Mr Kinred had undergone two steroid injections and recommended a third. He considered that total knee replacement surgery was warranted.

41. A left total knee replacement was undertaken on 27 March 2017 at Goulburn Base Hospital.

Medico-legal reports

42. Dr J M Harrison, orthopaedic surgeon, saw Mr Kinred at the request of his solicitors and reported on 14 November 2017. He recorded that Mr Kinred was injured when he was standing in a corridor talking to a warder and, partly facing a ramp up which an inmate was pushing a heavy trolley. Mr Kinred was hit "effectively head on", struck around both knees and pushed back against the wall behind him.
43. Dr Harrison described the treatment undergone by Mr Kinred. He set out his past medical history, including an underlying inflammation joint disorder initially diagnosed as rheumatoid arthritis but now diagnosed as psoriatic arthritis. Dr Harrison set out his examination findings in detail. He considered that Mr Kinred had suffered impact forces to the front of both knees when he was caught unprepared whilst standing. He considered that the subsequent surgery was a consequence of the injury. He said:

> "When I examined him, I found a man who had mechanical disquiet affecting his knees at and following the accident at work on 24 June 2009 and which had led to sequential surgical ventures done in a well-meaning manner to his knees that have culminated in a left total knee arthroplasty being undertaken in March this year for him with a reasonable outcome to date."

44. Dr Harrison said that despite a number of medical co-morbidities, including what were probably adolescent patella-femoral knee pain issues. That condition was treated, allowing Mr Kinred to play rugby as a front rower. There was no other clear-cut injury, despite vulnerabilities including psoriatic arthritis. Dr Harrison assessed 22% whole person impairment.

45. Dr Harrison prepared a further report dated 12 November 2018 after reviewing documents including those from Goulburn Base Hospital and Dr Dorai Raj. He noted that Dr Dorai Raj had diagnosed psoriatic arthritis affecting Mr Kinred's major joints including his knees for which treatment had been tailored in an effective way. Based on those documents, he considered that it was appropriate to reduce his assessment by one tenth because of a "predisposing condition to arthritic joint wear."

46. The Department's insurer arranged for Mr Kinred to be examined by Dr J Watson, orthopaedic surgeon, who reported for the first time on 27 April 2016. The history of the incident recorded by Dr Watson was that Mr Kinred was pinned against the wall by a large laundry trolley and that he had pain in both knees as a result of being pinned. After describing his examination, Dr Watson noted a history of developing pain, with symptoms related to a degenerative left knee. He noted that Dr Ihsheish had suggested a unicompartment right total knee replacement and that there were few clinical signs apart from slight varus deformity of the left knee. He considered that standing x-rays were required before making a decision about surgery.

47. Dr Watson's reference to a right total knee replacement appears to be an error. His diagnosis was "OA left knee" which was consistent with his presentation. He conceded that employment may well be a substantial contributing factor to the condition.

48. Dr Watson was asked if the main need for total knee replacement was the injury on 24 November 2009 or whether it would have been required without the injury. Dr Watson said that he had not seen any x-rays but suggested that some of the "changes" were probably related to constitutional pathology and some a direct result of injury.

49. Dr Watson was asked to prepare a supplementary report after reviewing an MRI scan and/or report dated 24 June 2016. He said that investigation conformed severe osteoarthritis of the medial tibiofemoral joint and moderately severe osteoarthritis of the patellofemoral joint. Dr Watson considered that the persistent symptoms were directly related to degenerative changes and that most were directly related to constitutional pathology though some could be related to the partial meniscectomy in 2009. He did not consider that employment was a substantial contributing factor to the current presentation.

50. Dr Watson reported to the Department's solicitors on 31 January 2018 after the total knee replacement surgery. He was asked to review the medical reports which post-dated the injury. On this occasion, he recorded that Mr Kinred was effectively hit head on and pinned against the wall. Dr Watson noted that Mr Kinred had been treated by Dr Dorai Raj for psoriatic arthritis.

51. After setting out his findings on examination, Dr Watson said that Mr Kinred attributed his history of pain to the injury on 24 November 2009. He repeated much of the history he had set out earlier in his report. He considered that Mr Kinred had ongoing subjective symptoms in the left knee including swelling and intermittent pain. He had minor wasting of the left quads. Dr Watson did not consider that he required any ongoing treatment.

52. Dr Watson considered that the ongoing pain probably had three causes – a history of playing rugby "which probably led to some knee symptoms", a history of knee cap maltracking requiring treatment in New Zealand "probably in 2005" and "the injury in the jail requiring two arthroscopies, the second one in 2014 and he has a history of psoriatic arthritis." Dr Watson conceded that ongoing treatment for psoriatic arthritis was required. He did not consider that Mr Kinred "requires any treatment in relation to the incident going back to 2009 requiring arthroscopy at that time. He said that he believed that the "reason for the total knee replacement, is that psoriatic arthritis must have been one of the major reasons for the insertion of a total knee replacement."

53. Dr Watson assessed 10% whole person impairment in respect of Mr Kinred's left knee stating:

> "I believe his left knee is directly related to psoriatic arthritis which amounts to probably 50% of his impairment and his total impairment for his left total knee replacement would be 10%."

54. Dr Watson prepared a further report dated 5 March 2018, having reviewed the notes of Mr Kinred's general practitioner at Goldsmith Street Surgery, Dr Ihsheish and Dr Herald. Based on that material, Dr Watson considered that the notes of the general practitioners were not consistent with Mr Kinred's history. He noted that Dr Wearne did not record any mention of the work injury on 26 November 2009, that on 2 December 2009 Dr Al-Maliky had a history of a twisting injury in the gym two years before and noted "the comments that the pan got worse especially when his left knee was hurt when he was working." Dr Watson said that the records of the general practitioners were not consistent with the history provided by Dr Kinred. He considered that most of the symptoms were directly related to his psoriatic arthritis and that rugby could well have been a factor in his presentation of knee pain. He said that Dr Herald's notes showed that the meniscal tear was a degenerative tear. He did not believe "this is consistent" with being pinned against the wall by a trolley. When asked if the material caused him to change his view, Dr Watson repeated that the tear was degenerative which could be a result of rugby playing and that the reason for the total knee replacement was directly related to psoriatic arthritis.

55. A letter in the Reply dated 17 October 2018 from the Department's solicitors asked Dr Watson to review the notes of Dr Raj and to prepare a supplementary report. A response dated 18 October 2018 says that Dr Watson retired as an independent medical examiner on 7 May 2018 and was no longer preparing supplementary reports.

Dispute notices

56. The first dispute notice was issued under the former s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) on 10 June 2016. It disputed that he had suffered an injury within the meaning of s 4 of the 1987 Act. The insurer noted that the recurrence form had been submitted in February 2016 and that Mr Kinred's general practitioner, Dr Imran certified him fit for pre-injury duties with restrictions including being unable to work more than two consecutive days. The insurer denied liability for the recurrence on the basis that Dr Watson had insufficient medical information and no recent imaging to provide a final answer as to liability for the recurrence. It indicated that the claim would be reviewed when updated imaging was received.

57. The second dispute notice was issued on 20 March 2018 after Mr Kinred had undergone the knee replacement surgery. It denied that Mr Kinred had suffered any injuries to his knees on 24 November 2009 and that employment was a substantial contributing factor to his knee injuries. The insurer said that the evidence in Dr Wearne's medical certificate dated 10 December 2009 was inconsistent with the notes of his clinic which showed that Mr Kinred was treated for polyarthritis at the commencement of the notes in 2007 and for joint pain in February 2009. It noted the histories to Dr Wearne on 26 November 2009 and Dr Al-Maliky on 2 December 2009. It said that the records showed he had "injuries to your knees prior to 24 November 2009. You did not disclose same in your report of injury or to Dr Watson." The insurer said that Dr Watson had reviewed the notes and concluded that the injury was inconsistent with being pinned against the wall by a trolley and were related to pre-existing degenerative changes. It considered that Dr Harrison did not have a complete history and preferred the opinion of Dr Watson.

58. A third s 74 notice was issued on 4 October 2018, noting that a claim had recently been made for s 60 expenses and that a previously unnotified claim for weekly compensation had been included in proceedings filed on 6 June 2018. In addition to the matters in the previous notice, the insurer denied that Mr Kinred suffered incapacity as a result of his injuries and that treatment was not related to any injury. The denial was based on the opinion of Dr Watson that the symptoms were related to pre-existing psoriatic arthritis.

SUBMISSIONS

59. Mr Wilson said that the dynamics of the injury were relevant, noting the significant weight of the trolley and the gradient of the ramp. He took me to the history provided to Dr Harrison that Mr Kinred had been pushed back against the wall. He said that the injury was clearly reported to Dr Wearne on 10 December 2009 ad that there was a consistent history of treatment until Mr Kinred underwent a left total knee replacement in 2017. Until the reports of Dr Watson, the injury had been accepted by the Department's insurer.

60. Mr Wilson said that Dr Dorai Raj had treated Mr Kinred for some time and had a history of the events in 2009.

61. Dr Harrison obtained a detailed history and, in his second report, took the notes of Dr Dorai Raj into account. Dr Watson, on the other hand, did not say that he had seen Dr Dorai Raj's notes and he did not differentiate between the rheumatological problems and the injury. Mr Wilson submitted that when all of those matters were taken into account, I would find that employment was a substantial contributing factor to the injury.

62. Mr Wilson said that in his first report, Dr Watson "sat on the fence". He appeared to accept that the 2009 injury led to the need for the meniscectomies but did not disclose the totality of his reasoning to support his final conclusion that employment was not a substantial contributing factor to the injury. Though Mr Kinred had undergone a number of MRI scans, His reports did not fulfil the requirements for expert evidence set out in *Makita (Australia) Pty Ltd v Sprowles*[1] (*Makita*).

63. Mr Wilson noted that Mr Kinred had undergone a number of MRI scans dating back to March 2010 but Dr Watson had relied only on that dated 2016. The opinions expressed by Dr Watson were, in the end, not medical opinions and outside the scope of his expertise.

64. Mr Wilson said that I would accept the opinion of Dr Harrison which was consistent with the contemporaneous medical evidence over that of Dr Watson.

65. Mr Flett said that *Makita* was relevant to Dr Harrison's opinion and not that of Dr Watson. When he prepared his first report in 2016, Dr Watson had little information but by 2018 he had a substantial body of reports. Though Dr Raj's reports are not mentioned, it is clear that he had them because he knew the medication which Mr Kinred was taking. Mr Flett said that Dr Watson's opinion evolved and firmed as he obtained more material.

66. Mr Flett said that an analysis of the medical reports before 2009 and 2010 was instructive. In 2008, Dr Dorai Raj noted that Mr Kinred's left knee was tender below the joint line. In August 2008, the medication to which Dr Watson referred had been introduced. MRI scans undertaken in 2010 showed meniscal tears but also degeneration.

67. Mr Flett also summarised the notes of the general practitioners just after the injury, noting that Mr Kinred had seen Dr Wearne two days after the injury but had not done so. On 2 December, Dr Al-Maliky had recorded a history of an injury at the gym. In January 2010, Mr Kinred had the opportunity to tell Dr Dorai Raj, a doctor he had seen for a number of years about the injury but did not. Mr Flett said that Dr Watson was referring to the failure to report the injury when he said that the notes were not consistent with Mr Kinred's history. While Dr Harrison had a history of the ore-existing psoriatic arthritis, he did not have a history of treatment for patellar maltracking in 2005 or twisting at the gym. On that basis, s 9A of the *Workers Compensation Act 1987* (the 1987 Act) was not satisfied and Mr Kinred had not proved that employment was a substantial contributing factor to the injury, referring briefly to the decision of the Court of Appeal in *Badawi v Nexon Asia Pacific Pty Ltd*[2].

68. In response to my question as to how I should deal with Dr Herald's opinion, Mr Flett said that Dr Herald had a history of a hyperextension injury not a twisting injury. Despite the history provided to Dr Herald, Mr Kinred's knees had been bothering him for more than three months. Mr Flett submitted that I should discount Dr Herald's opinion because he did not have the full picture.

69. In reply, Mr Wilson submitted that Dr Herald was in a good position to make the causal link between the injury described to him and what he found. His opinion was that the tears had been caused by the injury the aggravation had ceased because the tears were repaired.

70. While Dr Watson could express an opinion about the medication Mr Kinred took and the condition for which it was prescribed, it was not clear that he had Dr Dorai Raj's notes. Her report dated 19 January 2010 can be explained by the fact that her treatment did not only relate to Mr Kinred's knee and he was not seeing her for treatment for the injury. He said that Dr Watson's opinion that there was a pre-existing tear was speculative. Dr Watson did not mention the MRI scans undertaken in 2010. If he was of the view that the tears were not a result of the incident, he would have expressed that view clearly. He did not.

[1] [2001] NSWCA 205.
[2] [2009] NSWCA 324.

71. Mr Wilson noted that the clinical notes of a general practitioner cannot always be relied on to establish whether or not an injury was suffered. Mr Kinred provided a history of the injury on 24 November 2009, the same day that he made a report.

FINDINGS AND REASONS

Treating doctors' notes and reports

72. The notes made by the general practitioners are brief but they do not persuade me that Mr Kinred provided an inconsistent history with respect to the onset of pain in his knees.

73. Dr Wearne did not record a history of the injury on 26 November 2009. He ordered x-rays and queried the need for orthopaedic review. Dr Al-Maliky did not record a specific history on 2 December 2009. While he or she noted a two-year history of a twisted injury, they also noted that Mr Kinred had recently got worse when he was hit in the left knee while working. That statement is consistent with the mechanism of the injury. After an examination, a meniscal injury was suspected. On 16 December 2009, Dr Wearne obtained a more accurate history.

74. In *Nominal Defendant v Clancy*[3] Santow JA said:

> "While clinical notes…, may in common experience be the raw data on which diagnosis and opinions are based, it does not follow that they will be comprehensive … clinical notes are written in the course of a busy practice where the clinician is primarily there to observe and administer treatment. They should not be construed with the minute attention one might give a formal legal document. It is fair to say a report to another doctor [or a medico-legal report] is likely to have been written with more deliberate consideration than rough notes."

75. It is clear from the tenor of the notes and the requests for investigations that Mr Kinred's general practitioners were concerned with treatment. Mr Kinred had continued to work, as he had done at all times other than when he was recovering from surgery. The medical records show a number of intercurrent conditions which did not prevent Mr Kinred from working or being involved with rugby. That suggests a degree of stoicism. Dr Al-Maliky did obtain a history that Mr Kinred was recently hit in the knee while working. That is consistent with the history of the injury. While Dr Wearne did not record a history of the injury on 26 November 2009, his notes suggest that his focus was on Mr Kinred's function and on treatment.

76. There is no dispute that Mr Kinred suffers psoriatic arthritis and that he had complained of joint pain. The condition appears to have been diagnosed by Dr Edwards in 2007 and he was under active treatment from Dr Dorai Raj from 2008. There are only two complaints of pain as a result of that condition in the general practitioners' notes in the two years before the injury and they are not specific as to the location of the pain.

77. Dr Dorai Raj treated Mr Kinred's psoriatic arthritis and her report dated 19 January 2010 is written in the course of that treatment. Her comment that x-rays did not show abnormalities is incorrect – Mr Kinred had MRI scans rather than x-rays and they did show abnormalities. She considered knee pain suffered by Mr Kinred was possibly inflammatory or possibly mechanical and proposed treatment. Her later reports deal with the treatment for psoriatic arthritis.

[3] [2007] NSWCA 349, [54]-[55].

78. The medical records do not suggest ongoing knee pain in the period before the injury. His statement confirms that he was active. Dr Edwards resumed treating Mr Kinred in 2010 and her short report dated 27 April 2010 deals with the causation of the meniscal tears. She stressed that the only pre-existing knee condition was an unrelated problem of patellar maltracking.

79. The notes of Mr Kinred's treating doctors, particularly his general practitioners are consistent with him suffering injury on 24 November 2009.

Expert evidence

80. The submissions of counsel focussed on the medico-legal reports of Drs Harrison and Watson and their compliance with the requirements for expert evidence, though they referred to *Makita* rather than the specific requirements in the Commission. The relevant principles follow. They must be taken into account in analysing the expert evidence.

81. Rule 15.2 of the Workers Compensation Commission Rules 2011 provides:

> **"15.2 Principles of procedure**
> When informing itself on any matter, the Commission is to bear in mind the following principles:
> (1) evidence should be logical and probative,
> (2) evidence should be relevant to the facts in issue and the issues in dispute,
> (3) evidence based on speculation or unsubstantiated assumptions is unacceptable,
> (4) unqualified opinions are unacceptable."

82. In *South Western Sydney Area Health Service v Edmonds*[4] McColl JA said:

> In *Hevi Lift (PNG) Ltd v Etherington* at [84] I said (Mason P and Beazley JA agreeing) that "[a] court should not act upon an expert opinion the basis for which is not explained by the witness expressing it*".* In so saying, I referred with approval (inter alia) to Heydon JA's analysis of the admissibility of expert evidence in *Makita (Australia) Pty Limited v Sprowles* (at [59] – [82]). In that case (at [59]) Heydon JA cited with apparent approval Lord President Cooper's statement in *Davie v The Lord Provost, Magistrates and Councillors of the City of Edinburgh* (1953) SC 34 at 39-40 that:
>
> > '… the bare *ipse dixit* of a scientist, however eminent, upon the issue in controversy, will normally carry little weight, for it cannot be tested by cross-examination nor independently appraised, and the parties have invoked the decision of a judicial tribunal and not an oracular pronouncement by an expert.'
>
> …
> In my view [the] statement that "in general all the problems are work-related" which the Arbitrator accepted in concluding that the respondent's duties were sufficient to cause her injury (apparently within the meaning of s 16) amounted to a bare *ipse dixit*."

[4] [2007] NSWCA 16 at [130] and [132].

83. In *Hancock v East Coast Timber Products Pty Ltd*[5], Beazley JA said:

> "Although not bound by the rules of evidence, there can be no doubt that the Commission is required to be satisfied that expert evidence provides a satisfactory basis upon which the Commission can make its findings. For that reason, an expert's report will need to conform, in a sufficiently satisfactory way, with the usual requirements for expert evidence. As the authorities make plain, even in evidence-based jurisdictions, that does not require strict compliance with each and every feature referred to by Heydon JA in *Makita* to be set out in each and every report. In many cases, certain aspects to which his Honour referred will not be in dispute. A report ought not be rejected for that reason alone."

Substantial contributing factor

84. There is no dispute that an event occurred on 24 November when Mr Kinred was pushed against a wall by a trolley.

85. Section 9A of the 1987 Act relevantly provides:

> **"No compensation payable unless employment substantial contributing factor to injury**
>
> (1) No compensation is payable under this Act in respect of an injury (other than a disease injury) unless the employment concerned was a substantial contributing factor to the injury.
>
> **…**
>
> (2) The following are examples of matters to be taken into account for the purposes of determining whether a worker's employment was a substantial contributing factor to an injury (but this subsection does not limit the kinds of matters that can be taken into account for the purposes of such a determination):
>
> (a) the time and place of the injury,
>
> (b) the nature of the work performed and the particular tasks of that work,
>
> (c) the duration of the employment,
>
> (d) the probability that the injury or a similar injury would have happened anyway, at about the same time or at the same stage of the worker's life, if he or she had not been at work or had not worked in that employment,
>
> (e) the worker's state of health before the injury and the existence of any hereditary risks,
>
> (f) the worker's lifestyle and his or her activities outside the workplace.
>
> (3) A worker's employment is not to be regarded as a substantial contributing factor to a worker's injury merely because of either or both of the following:
>
> (a) the injury arose out of or in the course of, or arose both out of and in the course of, the worker's employment,
>
> (b) the worker's incapacity for work, loss as referred to in Division 4 of Part 3, need for medical or related treatment, hospital treatment, ambulance service or workplace rehabilitation service as referred to in Division 3 of Part 3, or the worker's death, resulted from the injury."

[5] [2011] NSWCA 11 at [82].

86. The focus of s 9A is on the causation of the injury. Employment must be “a” not “the” substantial contributing factor to the injury.

87. The Department argued that the mechanism of the injury was unlikely to cause meniscal tears. Dr Herald recorded a history consistent with that relied on by Mr Kinred. In his report to Dr Wearne dated 15 March 2010, he said that Mr Kinred sustained a hyperextension injury to both knees when a trolley was pushed against his legs. He developed anterior medial sided knee pain, after which he noted clicking in his knees. The examination was consistent with meniscal tears though Dr Herald also noted degeneration on the MRI scans.

88. Dr Herald responded to questions asked of him by the Department’s insurer on 7 April 2010. Those questions focussed on Dr Herald’s reference to degenerate meniscal tears. The first question contained the assumption that the tears were pre-existing. Dr Herald said that the tears were caused by the injury. Though there was some degeneration, the injury was what caused them to tear. Though Dr Herald misunderstood the circumstances of the injury as a violent attack, his reports show that he understood that Mr Kinred was struck by the trolley on his knees with some force and pushed against a wall. His opinion does not carry less weight because of that misunderstanding.

89. Dr Harrison’s history is detailed and it is consistent with that in Mr Kinred’s statement. Dr Harrison considered the way that Mr Kinred was struck – that he was struck head on, around both his knees and pushed back against the wall. This is consistent with the hyperextension injury described by Dr Herald.

90. Dr Harrison considered the MRI scans undertaken in 2010 and the photographs taken by Dr Ihsheish at the arthroscopy in 2015. He noted the continuum of treatment from the time of the injury in 2009. He undertook an examination and considered the medical co-morbidities suffered by Mr Kindred. He considered the treatment undertaken for patellofemoral pain and the fact that Mr Kinred was able to continue playing sport. He said there was no other clear-cut injury effecting Mr Kinred’s knees. He noted that Mr Kinred had psoriatic arthritis.

91. Dr Harrison considered extensive medical records to prepare his report dated 12 November 2018. He particularly noted the documents from Dr Dorai Raj and the “diagnosis of psoriatic arthritis in his knees.” Dr Harrison considered that condition warranted a one-tenth deduction because that was a predisposing condition to arthritic joint wear. The explanation provided for that deduction is brief but clear.

92. Mr Flett said that Dr Watson’s opinion evolved as he obtained further information and that appears to be correct. In his first report, Dr Watson recorded that Mr Kinred was pinned against the wall by a trolley as a result of which he had pain in his left and right knees. In his report dated 31 January 2018, he a history that Mr Kinred was struck head on.

93. By the time of his first report dated 27 April 2016, Mr Kinred had undergone two arthroscopies on his left knee and one on his right. Dr Watson accepted that Mr Kinred probably had osteoarthritis. He did not see any investigations.

94. Dr Watson was asked if employment was a substantial contributing factor to the *condition* by reference to the examples of matters to be considered set out in s 9A(2). He said that employment may well be a substantial contributing factor to the condition, but said that standing x-rays were required before considering if total knee replacement was warranted. Dr Watson was not asked at the time of preparing that report or his later reports whether employment was a substantial contributing factor to the *injury*.

95. Rather than arranging for Mr Kinred to undergo those x-rays, the insurer declined the claim in a s 74 notice dated 10 June 2016 on the basis that Mr Kinred had not suffered an injury because Dr Watson was not able to determine if the insurer was liable for the recurrence. Dr Watson's opinion did not in fact go to that question – he was ÷÷÷considering whether total knee replacement was warranted.

96. Despite declining the claim, the insurer provided Dr Watson with a copy of the MRI scan dated 24 June 2016 and sought a further report. On the basis of that scan, Dr Watson diagnosed severe degenerative changes in the left knee. He was asked the same question about whether employment was a substantial contributing factor to Mr Kinred's condition. He said that most of the present symptoms were directly related to degenerative changes but a percentage could be related to the partial meniscectomy in 2009. He did not consider employment was a substantial contributing factor to the "current presentation." He failed to consider the cause of the partial meniscectomies in 2009. He considered that the need for the surgery was directly related to constitutional pathology. He said that the arthroscopy would not have led to significant degenerative changes.

97. Dr Watson was also asked the wrong question with respect to the need for total knee replacement. He was asked if it was a "direct result of the workplace injury" not whether it was reasonably necessary medical treatment as a result of the injury in accordance with s 60. He was not directed to consider if the injury had materially contributed to the need for surgery.

98. In *Murphy v Allity Management Pty Limited*, Roche DP considered whether a claim for s 60 expenses as a result of a work injury was defeated by a subsequent non-work-related fall and said:

> "Moreover, even if the fall at Coles contributed to the need for surgery, that would not necessarily defeat Ms Murphy's claim. That is because a condition can have multiple causes (*Migge v Wormald Bros Industries Ltd* (1973) 47 ALJR 236; *Pyrmont Publishing Co Pty Ltd v Peters* (1972) 46 WCR 27; *Cluff v Dorahy Bros (Wholesale) Pty Ltd* (1979) 53 WCR 167; *ACQ Pty Ltdv Cook* [2009] HCA 28 at [25] and [27]; [2009] HCA 28; 237 CLR 656). The work injury does not have to be the only, or even a substantial, cause of the need for the relevant treatment before the cost of that treatment is recoverable under s 60 of the 1987 Act.
>
> Ms Murphy only has to establish, applying the common sense test of causation (*Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796), that the treatment is reasonably necessary "as a result of" the injury (see *Taxis Combined Services (Victoria) Pty Ltd v Schokman* [2014] NSWWCCPD 18 at [40]–[55]). That is, she has to establish that the injury materially contributed to the need for the surgery (see the discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716)."

99. In January 2018, Dr Watson reported to the Department's solicitors. He had a more detailed history of the injury, recording that Mr Kinred was hit head on and pinned against the wall. On this occasion, he reviewed material sent to him, all of which post-dated the injury. Apparently for the first time he was provided with the MRI scans undertaken in 2010. He noted that Mr Kinred had undergone a total knee replacement. He also noted the medication prescribed by Dr Dorai Raj. On this occasion, Dr Watson obtained a history of patella maltracking.

100. Dr Watson considered that there were three causes for Mr Kinred's ongoing pain though nominated four. They were the fact that playing rugby union probably led to knee symptoms, the treatment for patella maltracking, and the injury requiring two arthroscopies and the diagnoses of psoriatic arthritis. He said, without providing any explanation:

> "I believe the reason for the total knee replacement, is that psoriatic arthritis must have been one of the major reasons for the insertion of a total knee replacement."

101. The report contains significant repetition and no explanation of Dr Watson's opinions with respect to the impact of playing rugby and the connection between psoriatic arthritis and knee replacement.

102. Dr Watson's final report was prepared after reviewing the notes of Goldsmith Street Surgery, Dr Ihsheish and Dr Herald. He was asked if the records were consistent with the history provided by Mr Kinred and said they were not. He said that Dr Herald's report (rather than the MRI scan) showed that the meniscal tear was degenerative. He did not believe that "this" was consistent with the history of being pinned against the wall by a trolley. He did not say why. He appears to limit his opinion to Mr Kinred's left knee because he referred to the tear rather than tears.

103. Dr Watson also did not explain why the meniscal tear was pre-existing and not related to the injury. He repeated the opinions that the tear was related to playing rugby and that the reason for deterioration as the psoriatic arthritis.

104. Dr Watson was asked the wrong questions and his reports are of no assistance in determining if employment was a substantial contributing factor to the injury. He did not see the 2010 MRI scans and the first scan he saw was that taken in 2016. His opinions with respect to the role of rugby and the role of psoriatic arthritis in the need for the knee replacement are unexplained. They are "bare ipse dixits." His reading of Dr Herald's report is inaccurate.

105. Despite Mr Flett's submission that Dr Watson saw Dr Dorai Raj's notes, it does not appear that he saw all of them. They were not sent to him until after he had retired.

106. The s 74 notice dated 20 March 2018 is based on the notes from Goldsmith Street Surgery as well as the report of Dr Watson but is littered with errors. Despite quoting the notes from Dr Al-Maliky and the reference to being hit in the knee, the insurer said there was no reference to the injury. It ignored the notes of Dr Wearne on 10 December. The insurer said that Mr Kinred had "injuries to your knees prior to 24 November 2009" which he did not disclose. However, the only examples are the reference to polyarthritis in 2007 and joint pain in 2009. The insurer said that Dr Harrison did not have a complete history of previous injuries.

107. The last statement is incorrect as Dr Harrison did have a history of the pre-existing conditions, which he referred to in both reports.

108. While the parties said that the issue was whether employment was a substantial contributing factor to the injury, the fact than an incident occurred on 24 November 2009 has never been denied. After that injury, Dr Herald diagnosed and treated meniscal tears. There are other conditions which may impact on his condition and Mr Kinred concedes that they may sound in a deduction under s 323 of the 1998 Act. However, the evidence shows that the connection between the injury suffered and his employment is real and of substance. There is no probative evidence to the contrary.

109. I therefore remit the matter to the Registrar for referral to an Approved Medical Specialist (AMS) to assess the applicant's permanent impairment as a result of injuries to his left and right lower extremities (knees) on 24 November 2009.

110. Most of the material in the Reply appears in the ARD, with the exception of some notes of Goldsmith Street Surgery found at pages 36 to 39 of the annexures to the Reply. In an effort to avoid sending multiple copies of reports to the AMS, I asked Mr Flett to obtain instructions as to the pages of the Reply relied on. The response received by the Commission was that the Department's solicitors indicated that they relied on the whole of the Reply. It is therefore necessary to send a copy of the entire file to the AMS. A copy of this Certificate of Determination should also be sent to the AMS.