WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-5532/19**
Appellant:	**Anglican Community Services (previously called Sydney Anglicare Home Mission Society Council**
Respondent:	**Suzanne Ragip**
Date of Decision:	**19 February 2020**
Citation:	**[2020] NSWWCCMA 25**

Appeal Panel:	
Arbitrator:	**Catherine McDonald**
Approved Medical Specialist:	**Dr Tommasino Mastroianni**
Approved Medical Specialist:	**Dr Brian Noll**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 19 December 2019 Anglican Community Services (Anglicare) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Brian Stephenson, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 6 December 2019.

2. The appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

    - the assessment was made on the basis of incorrect criteria,
    - the MAC contains a demonstrable error.

3. The Registrar is satisfied that, on the face of the application, at least one ground of appeal has been made out, being that in s 327(3)(d). The Appeal Panel has conducted a review of the original medical assessment but limited to the grounds of appeal on which the appeal is made.

4. The Workers compensation medical dispute assessment guidelines set out the practice and procedure in relation to the medical appeal process under s 328 of the 1998 Act. An Appeal Panel determines its own procedures in accordance with the Workers compensation medical dispute assessment guidelines.

5. The assessment of permanent impairment is conducted in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, 4th* ed 1 April 2016 (the Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5).

RELEVANT FACTUAL BACKGROUND

6. Ms Ragip was employed by Anglicare to sort donations at its warehouse in Summer Hill. On 7 September 2011 she injured her right knee when she stumbled after stepping on a pencil on the floor. On 22 May 2013 she was walking at work when her right knee gave way.

7. On 16 December 2014, Ms Ragip underwent a right anterior cruciate ligament (ACL) reconstruction. By June 2017 her knee had deteriorated so that she underwent a right total knee replacement.

8. The AMS determined that Ms Ragip had a fair result from the total knee replacement surgery and assessed 20% whole person impairment (WPI) in respect of the right lower extremity and 2% under the TEMSKI.

9. The only subject of the appeal is the extent of the appropriate deduction under s 323 of the 1998 Act.

PRELIMINARY REVIEW

10. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Workers compensation medical dispute assessment guidelines.

11. As a result of that preliminary review, the Appeal Panel determined that it was not necessary for the worker to undergo a further medical examination because there is sufficient information in the file to determine the appeal.

EVIDENCE

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

13. The parts of the medical certificate given by the AMS that are relevant to the appeal are set out, where relevant, in the body of this decision.

SUBMISSIONS

14. Both parties made written submissions. They are not repeated in full, but have been considered by the Appeal Panel.

15. In summary, Anglicare submitted, through its solicitor, Mr Vrettos, that the AMS erred in not making at least a one-tenth deduction under s 323 of the 1998 Act when advanced osteoarthritis had been observed on x-ray one day after the injury on 8 September 2011, which was a stumble rather than a fall. It submitted that the AMS erred in accepting and adopting the rationale of Dr Mendelsohn because Dr Mendelshon did not see the 8 September x-ray. The AMS appeared to place emphasis on the fact that the osteoarthritis was asymptomatic but Anglicare submitted that this was contrary to authority.

16. In reply, Ms Ragip submitted, through her solicitor, Mr Matthews, that Anglicare did not specifically assert that a deduction should be made in respect of an injury she suffered when she was aged about 15. Her solicitor noted that Dr Rimmer's opinion about the significance of that incident did not correspond with the evidence and that there was no evidence that she suffered an anterior cruciate ligament rupture at age 15. Her solicitor submitted that there was "no evidence whatsoever" that Ms Ragip suffered any disability in her knee before the injury on 7 September 2011. He submitted that there was no evidence that but for the injury on 7 September 2011, Ms Ragip would have suffered an ALC rupture and gone on to total knee replacement. He said that the argument that asymptomatic osteoarthritis resulted in a degree of permanent impairment was contrary to the authorities.

FINDINGS AND REASONS

17. The procedures on appeal are contained in s 328 of the 1998 Act. The appeal is to be by way of review of the original medical assessment but the review is limited to the grounds of appeal on which the appeal is made.

18. In *Campbelltown City Council v Vegan* [2006] NSWCA 284 the Court of Appeal held that the Appeal Panel is obliged to give reasons. Where there are disputes of fact 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. Where more than one conclusion is open, it will be necessary to explain why one conclusion is preferred. On the other hand, the reasons need not be extensive or provide a detailed explanation of the criteria applied by the medical professionals in reaching a professional judgement.

The MAC

19. The AMS set out the history he obtained with respect to the injuries and treatment. He recorded that at arthroscopy there was Grade IV osteoarthritic change in the medial femoral condyle and medial tibial plateau. The ACL was chronically disrupted.

20. With respect to previous accidents or injuries the AMS recorded:

> "At age 15, she injured the right knee when at the gymnasium with a friend and her mother. She was doing exercise at that time. She said there was no fracture involved. She said there was a twisting injury and pain. There has been no surgery involved and she was able to get back on the bicycle to exercise and worked subsequently satisfactorily after leaving school."

21. The AMS set out his findings on examination. He considered the x-ray dated 8 September 2011 and noted:

> "History of injury at work. There is quite advanced longstanding osteoarthritis in the medial compartment. The joint space is narrow and there are marginal spurs. The lateral and patellofemoral compartments are normal depth. No loose bodies. d There was no fracture. Alignment was satisfactory, Dr Harding-Smith."

22. With respect to an MRI scan dated 7 May 2013, the AMS recorded:

> "Comment: Chronic rupture of the ACL. There is moderately severe osteoarthritis involving the right knee most marked in the medial tibiofemoral compartment, Dr O'Connell."

23. The AMS summarised the injury and diagnoses:

> "There has been an injury on 7 September 2011 to right knee, which interfered with her activities of daily living and physical activities and eventually inability to work. Prior to the injury she was able to wear high heeled shoes and undertake salsa dancing with high heeled shoes required, as well as bushwalking and walking on uneven ground. These activities no longer became possible after the injury incidence: There has been an anterior cruciate ligament reconstruction for right medial compartment osteoarthritis and a chronic ACL tear as well as a right partial medial meniscectomy. Date 7 January 2015 for the first operation.
>
> The second operation was the right total knee arthroplasty successfully undertaken at Sutherland Hospital 28 November 2017 with no complications."

24. When setting out his reasons for the assessment, the AMS said:

> "Matters of history that have determined the assessment: Prior to the fall she was active in bushwalking and salsa dancing with latter requiring high heeled shoes. She can no longer wear high heeled shoes. Those activities are no longer possible following injury and knee replacement. Initially an anterior cruciate ligament reconstruction was undertaken by Dr Michael Dixon.

> Subsequently with further deterioration of the knee related to medial compartment osteoarthritis Ms Suzanne Ragip was admitted to Sutherland Hospital when a right total knee replacement was undertaken 28 November 2017 and an x-ray on 28 November 2017 revealed a right total knee replacement with patellar resurfacing, which was a part of the investigation findings. I have noted she was well and conducted activities of daily living, including salsa dancing prior to the injury and subsequent surgical management. These activities are no longer possible."

25. The AMS offered brief comments about other medical reports in the file and said:

> "X-ray confirmed the right total knee replacement in situ with patellar resurfacing also. Dr Graeme Mendelsohn, general surgeon reported 24 June 2019 who notes the history in terms of the diagnosis, the incident at work on 7 September 2011 suffered a rupture of the anterior cruciate ligament and a medial meniscal injury.
>
> I would agree with that historical opinion. The initial injury 7 September 2011 caused a rupture of the anterior cruciate ligament and the medial meniscal injury. The anterior cruciate ligament reconstruction was required as well as partial medial meniscectomy, which led eventually to further deterioration of the knee and eventually the need for a total knee replacement.
>
> Dr Mendelsohn notes at page 5, she also had degenerative arthritis on the right knee. I do not know whether this preceded her injury but it was present. It was asymptomatic not causing any problems. The injury to her knee has led to the requirement for surgical intervention with initially an anterior cruciate ligament reconstruction, later total knee replacement. Both of these procedures would not have been necessary had she not suffered an initial incident on 7 September 2011 as described .
>
> Comment: I fully agree with that methodology of the injury as set out by Dr Mendelsohn. Dr Stephen Rimmer, orthopaedic surgeon dated 4 September 2013. He did note a past history at age 16 of twisting heavily on the right knee whilst performing aerobics. He said the exact nature of the problem she cannot recall.
>
> He considered the current diagnosis was due to the injury to the right knee at age 16. I disagree with that as she was able to recover following that injury and was able to work, doing fairly active work with Anglicare and sales and warehouse work until the date of injury when she twisted the knee on the pencil on the warehouse floor. That in my opinion tipped the balance into a process where she required the initial anterior cruciate ligament reconstruction but with residual ligamentous instability at the knee she eventually required a total knee replacement due to the advancement of osteoarthritis of right knee particularly in the medial compartment.
> …
> I have agreed with the methodology, rationale as set out by Dr Mendelsohn as to the absence of a fractional deduction under section 323."

Other medical evidence

26. Dr G Mendelsohn, general surgeon and musculo-skeletal consultant, reported to Ms Ragip's solicitors on 24 June 2019. He obtained a history of the injury at about age 15 which:

> "was apparently a mild injury and she did not have any specific treatment at the time. Her symptoms there completely resolved after a few weeks and she had no further problems. She was able to carry out all activities following this including all working activities and was able to dance regularly without problems."

27. Dr Mendelsohn did not describe the 2011 x-ray. His diagnosis was:

> "Ms Ragip suffered an injury to her right knee in an incident at work on 7 September 2011. She would appear to have suffered a rupture of her anterior cruciate ligament and a medial meniscus injury in that incident. There was a further, relatively minor jarring incident to that same knee on 22 May 2013. She also had degenerative arthritis in her right knee. I do not know whether this preceded her injury but if it was present, it was asymptomatic, not causing any problems. The injury to her knee has led to the requirement for surgical intervention with initially an anterior cruciate ligament reconstruction and later a total knee replacement. Both of these procedures would not have been necessary had she not suffered the initial incident on 7 September 2011 as described."

28. When asked about a s 323 deduction, Dr Mendelsohn said:

> "Although Ms Ragip may have suffered osteoarthritic changes in her knee predating the injury under discussion, she was asymptomatic and is unlikely to have required a total knee replacement and certainly not an ACL reconstruction but for the injury having occurred. If a total knee replacement had been necessary in the future as a result of the osteoarthritic process, it would have been many years down the track. It certainly would not have been required at the date on which it was In fact undertaken. Therefore, I believe it is appropriate to make no deduction for pre-existing condition or abnormality and the 22% whole person impairment calculated above, I believe is the final whole person impairment."

29. Dr Rimmer considered that the diagnosis was a chronic rupture of the anterior cruciate ligament and subsequent secondary development of medial compartment osteoarthritis which is degenerative in origin. He considered that the main contributing factor to Ms Ragip's diagnosis was the injury she suffered at about age 16 because:

> "The incident at age 16 of injuring her knee would be the only explanation of the MRI findings of advanced medial compartment osteoarthritis in a setting of a chronic anterior cruciate ligament rupture. "

Consideration

30. Both parties referred to *Cole v Wenaline Pty Ltd* [1] (*Cole*) and *Vitaz v Westform (NSW) Pty Ltd*[2] *(Vitaz)*.

31. In *Cole*, Schmidt J said:

> "Section 323 does not permit that assessment to be made on the basis of an assumption or hypothesis, that once a particular injury has occurred, it will always, 'irrespective of outcome', contribute to the impairment flowing from any subsequent injury. The assessment must have regard to the evidence as to the actual consequences of the earlier injury, pre-existing condition or abnormality. The extent that the later impairment was due to the earlier injury, pre-existing condition or abnormality must be determined. The only exception is that provided for in s 323(2), where the required deduction 'will be difficult or costly to determine (because, for example, of the absence of medical evidence)'. In that case, an assumption is provided for, namely that the deduction 'is 10% of the impairment'. Even then, that assumption is displaced, if it is at odds with the available evidence."

32. In *Vitaz*, Basten JA considered earlier decisions and said:

[1] [2010] NSWSC 78.
[2] [2011] NSWCA 254.

> "The resulting principle is that if a pre-existing condition is a contributing factor causing permanent impairment, a deduction is required even though the pre-existing condition had been asymptomatic prior to the injury."

33. In *Ryder v Sundance Bakery*[3] Campbell J said:

> "What s 323 requires is an inquiry into whether there are other causes, (previous injury, or pre-existing abnormality), of an impairment caused by a work injury. A proportion of the impairment would be due to the pre-existing abnormality (even if that proportion cannot be precisely identified without difficulty or expense) only if it can be said that the pre-existing abnormality made a difference to the outcome in terms of the degree of impairment resulting from the work injury. If there is no difference in outcome, that is to say, if the degree of impairment is not greater than it would otherwise have been as a result of the injury, it is impossible to say that a proportion of it is due to the pre-existing abnormality. To put it another way, the Panel must be satisfied that but for the pre-existing abnormality, the degree of impairment resulting from the work injury would not have been as great."

34. The x-ray report dated 8 September 2011, one day after the injury, clearly showed evidence of well established, pre-existing osteoarthritis of Ms Ragip's right knee. That degenerative change pre-dated the injury. At surgery on 16 December 2014, Dr Dixon noted Grade IV osteoarthritis, indicating bone on bone contact.

35. The severity of that pathology indicates that it was a contributing factor to Ms Ragip's condition and that it contributed to the need for a total knee replacement, regardless of the fact that Ms Ragip said that it was asymptomatic. Without that degenerative change, the degree of impairment would not have been as great. A deduction under s 323 was appropriate and the AMS was in error not to make one. The extent of the degenerative change suggests that a deduction of more than one-tenth might be appropriate.

36. The MRI scan dated 7 May 2013 – about one year and eight months after the initial injury - was reported to show evidence of a chronic rupture of the ACL. The MRI does not help to distinguish when the rupture occurred and it may have occurred at the time of the injury in 2011. It is not possible to categorically attribute that rupture to the injury when Ms Ragip was about 15.

37. The Panel considers that the appropriate deduction under s 323 is one-tenth. This allows for the possibility that Ms Ragip could have sustained an ACL rupture at the time of the injury in September 2011. The ACL rupture was a contributing factor leading to deterioration which ultimately required knee replacement arthroplasty. So too was the severe pre-existing osteoarthritis.

38. For these reasons, the Appeal Panel has determined that the MAC issued on 6 December 2019 should be revoked, and a new MAC should be issued. The new certificate is attached to this statement of reasons.

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

L Golic

Lucy Golic
Dispute Services Officer
As delegate of the Registrar

[3] [2015] NSWSC 526.

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **5532/19**
Applicant: **Suzanne Ragip**
Respondent: **Anglican Community Services (previously called Sydney Anglicare Home Mission Society Council)**

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

The Appeal Panel revokes the Medical Assessment Certificate of Dr [insert name of Doctor] 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 the Guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA 5 Guides**	**% WPI**	**Proportion of permanent impairment due to pre-existing injury, abnormality or condition**	**Sub-total/s % WPI (after any deductions in column 6)**
1. Right lower extremity	7.9.2011 and 22.5.2013	Chapter 3, Table 17-35, Page 21	Table 17-35; Table 17-33, Page 546	20%	1/10	18%
2. Scarring (TEMSKI)	7.9.2011 and 22.5.2013	Chapter 14, Table 14.1, Page 74	Chapter 8	2%	0%	2%
Total % WPI (the Combined Table values of all sub-totals)						**20%**

Catherine McDonald
Arbitrator

Dr Tommasino Mastroianni
Approved Medical Specialist

Dr Brian Noll
Approved Medical Specialist

19 February 2020

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

L Golic

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Dispute Services Officer
As delegate of the Registrar