WORKERS COMPENSATION COMMISSION

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

Matter No:	**M1-832/19**
Appellant:	**State of New South Wales**
Respondent:	**Amanda Louise Worland**
Date of Decision:	**24 July 2019**
Citation:	**[2019] NSWWCCMA 98**

Appeal Panel:	
Arbitrator:	**Mr John Harris**
Approved Medical Specialist:	**Dr Brian Noll**
Approved Medical Specialist:	**Dr Drew Dixon**

BACKGROUND TO THE APPLICATION TO APPEAL

1. Ms Amanda Worland (the respondent) suffered injury on 23 February 2008 in the course of her employment with the State of New South Wales (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 initially accepted liability for the injury.[1] It served a further notice pursuant to s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act) dated 28 August 2018 which confirmed that it accepted injury to the lumbar spine but denied that the respondent was entitled to permanent impairment compensation.

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 Mohammed Assem was appointed as the AMS.

5. The AMS examined the appellant and provided a Medical Assessment Certificate dated 17 April 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 21% whole person impairment.

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, p 297
[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 14 May 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. For the reasons subsequently provided, the AP has rejected the appellant's grounds of appeal and there is no basis for the respondent to be re-examined.

13. The appellant's submissions raised a ground of appeal which appeared inconsistent with the reasoning of Garling J in *Johnson v NSW Workers Compensation Commission*[4] (*Johnson*). Accordingly, the AP issued a direction to the parties on 15 July 2019 in the following terms:

> "The Appeal Panel refers the parties to the decision of *Johnson v NSW Workers Compensation Commission* [2019] NSWSC 347 (*Johnson*), particularly at paragraphs [62]-[71].
>
> The Appeal Panel directs further submissions from the parties on the application of *Johnson* to the third ground of appeal, specifically the submission that the AP should apportion the permanent impairment between the work injury and the subsequent incident in 2011 and/or as the other incidents alleged at paragraph 3.6.
>
> The parties' leave to file further submissions are limited to this issue.
>
> The Appellant is to file and serve further written submissions by close of business, 17 July 2019.
>
> The Respondent is to file and serve further written submissions by close of business, 19 July 2019."

14. The parties filed written submissions in response to this direction. Whilst the direction specifically restricted the extent of the leave, the appellant's submissions went beyond the scope of the direction. In any event, the supplementary submissions are set out and discussed subsequently.

[4] [2019] NSWSC 347(*Johnson*)

EVIDENCE

15. 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

16. The respondent provided a statement dated 12 February 2019.[5]

17. The respondent stated that the only treatment following the incident on 12 October 2006 was for physiotherapy. She was off work for a "short period" before resuming normal duties.

18. The respondent sets out in some detail the treatment she underwent following the February 2008 incident including two epidural injections. Physiotherapy treatment, on and off, continued over the period until late 2010.[6]

19. The respondent referred to the incident at home in June 2011 which caused her to arch backwards. She stated that the "pain didn't increase immediately after this incident" and she was already having left leg pain and taking medication.

20. The respondent informed her general practitioner in late 2011 that her pain had been aggravated when she bumped a metal bar at home. Prior to that incident, the respondent stated that she was in severe pain and had recently undergone a further injection into the low back.

21. In terms of present symptoms, the respondent stated that she experiences pain in her low back radiating into the left buttock, pain in the left hamstring area and cramps in the calves and feet.[7]

Clinical note/scans

22. A barely legible clinical note purportedly from Wollongong Medical Centre dated 28 December 1999 refers to low back pain which radiates to buttocks.[8]

23. A lumbar spine x-ray dated 19 December 2003 was reported by Dr Mark Chapman as showing maintained vertebral height and sagittal alignment in the five lumbar vertebrae with a gentle thoracolumbar curve convex to the left. Disc spaces were maintained and facet joints were normally aligned.[9]

24. A thoracic spine x-ray was requested by the general practitioner on 12 July 2005.[10] No results are disclosed within the documentation.

25. A thoracic spine x-ray dated 18 September 2007 was reported as showing thoracic scoliosis to the left side with degenerative changes at the mid and lower thoracic spine.[11]

---

[5] Application, pp 307-319
[6] Application, pp 312, paragraph 72
[7] Application, p 315, paragraphs 126-128
[8] Reply, p 1
[9] Reply, p 41
[10] Reply, p 40
[11] Reply, p 145

26. A CT scan of the lumbosacral spine dated 18 April 2008 is reported by Dr O'Rourke as showing mild degree of central canal narrowing due to mild diffuse disc bulge and ligamentum flavum and trivial facet joint arthropathy. The clinical history recorded by the radiologist is of a three-week history of back pain now radiating to the left leg.[12] Dr O'Rourke suggested an MRI scan if there are L5 radicular symptoms.

27. Dr Moloney, Neurosurgeon, examined the respondent in August 2008. The history reported to the doctor was of a work incident in March 2008 with back pain radiating into the left lower limb. An MRI scan was requested by the doctor.[13] In a report dated 15 August 2008, Dr Moloney noted "distinct neurological symptoms".[14]

28. An MRI scan dated 3 September 2008 is reported by Dr Blumgart as showing a broad-based posterior bulge at L4/5 causing a prominent impression on the thecal sac. The doctor opined that there appeared to be a focal compression and displacement of the traversing L5 nerve roots.[15] The clinical history recorded by Dr Blumgart was of pain radiating to the left leg with "nerve impingement".

29. Dr Moloney described the changes on the MRI scan as "maximal to the left side at L4/5 with a lateral recess syndrome."[16]

30. A CT scan dated 4 August 2011 noted diffuse bulge at the L4/5 level with eccentric extension of disc material into the right lateral recess.[17]

31. The respondent underwent a cortisone injection into the lumbar spine on 22 September 2008[18] and a second injection in December 2008. In January 2009, the general practitioner stated that the injection only provided temporary relief.[19] Dr Moloney recorded a similar history and in January 2009 recommended a further injection.[20]

32. The respondent underwent a third cortisone injection in February 2009.[21] The following month Dr Moloney recorded ongoing "niggling pain" but somewhat better following the third injection.[22]

33. On 7 December 2009, the general practitioner recorded:[23]

    "H/O ch back pain"

34. The AP accepts that this reference means history of chronic back pain. The doctor then referred the respondent for physiotherapy and prescribed pain relief tablets.[24]

[12] Reply, p 2
[13] Reply, p 3
[14] Application, p 70
[15] Reply, p 5
[16] Application, p 73
[17] Reply, p 7
[18] Application, p 74
[19] Application, p 66
[20] Application, p 77
[21] Application, p 78
[22] Application, p 79
[23] Application, p 100
[24] Application, p 100

35. The applicant stated that she had a number of physiotherapy sessions throughout 2010 and was on pain medication.[25] That history is consistent with the clinical note of 7 December 2009. An email from Corrimal Physiotherapy confirms that the respondent attended on five occasions for physiotherapy in 2010 paid under medicare.[26]

36. The respondent attended her general practitioner on 20 June 2011, complaining of pain in the left leg and low back.[27]

37. A referral from Dr Zafar to Dr Al-Khawaja, Neurosurgeon, dated 8 August 2011, referred to pain and numbness in the left leg. Past history included lumbo-sacral back pain on 7 December 2007.[28] The clinical notes for that period (December 2007) do not correlate with the history of lumbar spine pain in December 2007. Indeed, the clinical note of 3 August 2011 states:[29]

> "Low back pain radiating to Lt leg up to heel
> Had injury 3 yrs ago – since then off n on"

38. The respondent was examined by Dr Al-Khawaja who provided a report dated 29 August 2011. The doctor noted a prior work injury in 2008 when she was found to have a L4/5 disc prolapse. The condition was said to have settled with injections. Recent history included a slip downstairs two months previously with "increasing lower back pain and left leg pain."[30] Dr Al-Khawaja recorded that the respondent "has never been pain free but she could cope until she had the fall". The condition was described as "getting significantly worse."[31]

39. A further MRI scan dated 5 September 2011 is reported by Dr O'Rourke as showing left eccentric diffuse disc at L4/5 with associated changes traversing the left L5 nerve root.[32]

40. On 7 November 2011, the applicant reported that her lumbar pain was aggravated "after bumping in a metal bar".[33]

41. Physiotherapy notes dated 20 July 2012 indicated that the respondent reported lifting a ladder. The notes, inconsistent with the appellant's submissions are as follows:[34]

> "[arrow up] T/S pain last 4/52's. Ongoing LBP and L leg symptoms.
> Getting L/S Sx in Aug with Dr Al-Khawaja."

42. The discharge notes from Wollongong Hospital recorded an admission on 29 August 2012 with surgery by way of an L4/5 posterolateral interbody fusion with left L5 nerve root decompression.[35]

43. The respondent attended her general practitioner on 10 March 2014 reporting a fall in her shower the previous night with momentary loss of consciousness. There is no reference in the note to the respondent having injured her lower back in the fall.[36]

---

[25] Application, p 312
[26] Application, p 306
[27] Application, p 99
[28] Reply, p 9
[29] Application, p 99
[30] Reply, p 10
[31] Application, p 44
[32] Reply, p 11
[33] Application, p 97
[34] Reply, p 169
[35] Reply, p 13
[36] Reply, p 65

44. The notes of the general practitioner dated 7 October 2014, indicate that the respondent complained of pain in the left hip area and was very tender in the middle of the buttock after she tried to "pick up a bath tub". A reference to an ultrasound questions whether there was a muscle tear.[37] There is no reference to lumbar spine injury in these notes.

45. The respondent attended her general practitioner on 29 September 2015. The doctor recorded:[38]

> "fall 2 weeks ago
> landed on buttocks
> pain over left ischium
> tender ++
> otherwise nad"

46. The respondent was referred for an x-ray of the pelvis. There is no reference to lumbar spine injury in these notes.

47. On 21 December 2016, the respondent attended her general practitioner. Dr Speed recorded:[39]

> "fell on edge of bath tub
> right lower rib pain with all movements"

48. Physiotherapy notes dated 19 July 2017 refer to a past history of a back operation in 2012 and broken right ribs on bath at Christmas 2016. The current history was "back pain A few days of pain – back in old role".[40]

Qualified opinions

49. The respondent was examined by Dr Roger Pillemer who provided a report dated 29 March 2018.[41] Dr Pillemer referred to the work incident with ongoing symptoms which deteriorated in 2010 or 2011. He recorded a history of no prior back symptoms.[42]

50. Examination by the doctor revealed normal reflexes save that he was unable to elicit ankle reflexes. Sensation was described as intact and motor power was good in all groups tested.

51. Dr Pillemer assessed the respondent as DRE Lumbar Category IV and made no deduction pursuant to s 322.

52. The respondent was also examined by Dr Richard Powell, Orthopaedic Surgeon, who provided a report dated 9 July 2018.[43] The doctor noted an earlier history of back injury in October 2006 whilst lifting a tray estimated as weighing 5 kg with no time off work, some light duties and return to full pre-injury duties and resolution of symptoms.

53. Dr Powell referred to the workplace injury with subsequent CT and MRI scans which demonstrated a "broad based posterior disc bulging at L4/5 with some associated central and foraminal stenosis." Treatment provided symptomatic improvement with a graduated return to normal duties.

---

[37] Reply, p 39
[38] Reply, p 37
[39] Reply, p 36
[40] Reply, p 170
[41] Application, p 1
[42] Application, p 3
[43] Reply, p 16

54. An incident in mid-2011 involved the respondent slipping and twisting the lower back without a fall. The lower back and radiating left leg symptoms returned. Dr Powell noted the further CT and MRI scans undertaken in 2011 "confirmed the previously noted degenerative disc pathology at L4/5."[44]

55. Dr Powell noted that the respondent was a most compliant and cooperative patient with no suggestion of overreaction. Neurological examination was reported as normal although the ankle jerks were absent bilaterally. The doctor accepted that the work injuries in 2006 and 2008 aggravated the pre-existing degenerative disease and that the need for the surgical fusion was due to the incident in 2006, 2008 and the non-work-related incident in 2011 as well as some underlying degenerative pathology.[45]

56. The prognosis was described as "guarded" as undergoing a spinal fusion has "irreversibly altered the biomechanics of the lumbar spine". He opined that the "the lower back is likely to continue to represent a source of intermittent symptoms into the future."[46]

57. Dr Powell stated that he was not in a position "to arbitrarily make a deduction for pre-existing pathology."[47] He apportioned the overall impairment, which he assessed at 21% equally to the three incidents, that is, to the work incident in 2006, the incident in 2008 and the non-work incident in 2011. He therefore concluded that the specific workplace incident in February 2008 was responsible for 7% whole person impairment.[48] That apportionment was confirmed in a report dated 31 July 2018.[49]

REASONS PROVIDED BY THE AMS

58. The relevant portions of the MAC in respect of the ground of appeals are set out herein.

59. The AMS recorded the following history relevant to prior and subsequent accidents, injuries or conditions.[50]

> "On 12 October 2006, she was bending forwards to lift a tray of meat from the oven that was estimated to weigh 5kg when she felt pain in her lower back, radiating to her left buttock. She was treated conservatively with physiotherapy and remedial massage. She was on suitable duties for a short period of time before upgrading to her pre-injury duties. She states that she made a complete recovery and there were no longer any symptoms involving her lower back.
>
> In around mid-June 2011, she slipped at home sustaining a jarring injury to her lower back. She did not fall to the ground. She states that there was an aggravation of pre-existing symptoms involving her back and left leg."

60. The physical findings on examination were described by the AMS as:[51]

> "There was flattening of the lumbar lordosis and two healed parallel longitudinal surgical scars measuring 5cm each. There was no significant change in pigmentation or adherence to underlying structures. She was not concerned about the appearance. There was no tenderness on palpation and no muscle guarding or spasm.

[44] Reply, p 18
[45] Reply, p 22
[46] Reply, p 23
[47] Reply, p 24
[48] Reply, p 24
[49] Reply, pp 27-28
[50] MAC, p 4
[51] MAC, p 4

In forward flexion, she was able to reach to the middle of her shin with her knees bent. Extension was markedly restricted to one quarter of normal range. Lateral flexion and rotation were symmetrically reduced to three quarters of normal range.

She did not have any difficulty climbing onto or off the examination couch. Active straight leg raising in the supine position was 60o bilaterally, limited by hamstring tightness. Neural tension signs were negative.

Her knee jerk reflexes were brisk and symmetrical. Her ankle jerk reflexes were absent. There was slight diminution of sensation at the lateral aspect of both feet. There was no measurable difference in the circumference of her calves."

61. The respondent's injuries and diagnoses were summarised by the AMS as follows:[52]

> "Ms Worland is a 53-year-old lady who was employed as a food services assistant. She had previous back complaints in 2006 that subsided. She was able to resume her pre-injury duties without any ongoing symptoms or limitations.
>
> On 23 February 2008, she sustained an injury to her lower back while attempting to lift a trolley over a step. The pain was radiating down her left leg. She received conservative treatment without any benefit.
>
> She sustained a further aggravation after a jarring injury at home in mid-2011. After that time, radiological imaging identified a diffuse disc bulge with potential impingement of the traversing left L5 nerve root. She was given CT guided nerve root blocks and epidural injections without any benefit. She proceeded to have a lumbar fusion at the L4/5 level with a good result."

62. In providing reasons for assessment the AMS stated (footnotes omitted):[53]

> "Ms Worland has undergone a lumbar fusion and is therefore entitled to a DRE lumbar category IV or 20% whole person impairment. In addition, she has 1% whole person impairment for a mild limitation in activities of daily living.
>
> There is a symmetrical reduction in ankle jerk reflex and slight sensory loss at the lateral aspect of both feet. As there is concordant evidence of pathology at the same level, she was considered to have radiculopathy after surgery and awarded 3% whole person impairment.
>
> Of this amount, a deduction was appropriate as there was previous injury, pre-existing degenerative pathology and a subsequent injury in 2011. Radiological imaging on 1 September 2008 showed a broad-based disc bulge or protruding disc that was compressing the disc space and traversing the left L5 nerve root. Since the aggravation in mid-June 2011, there was similar pathology with impingement, irritation and swelling of the left L5 nerve root. It was difficult to determine whether the aggravation was significant as she was symptomatic prior to the aggravation and requiring analgesia. The medical records of Dr Zafar did not clarify whether there was any significant aggravation at that time. He noted the pain and numbness in the left leg in August 2011. She was treated with Temazepam and Mersyndol

[52] MAC, pp 4-5
[53] MAC, p 6

> Forte. Her symptoms subsequently deteriorated and she elected to undergo surgery. I have therefore reached the conclusion that a one tenth deduction was applicable."

63. In a footnote to his reasons, the AMS referenced paragraph 1.28 of the fourth edition guidelines when he assessed a one-tenth deduction pursuant to s 323.[54]

64. The AMS also referred to various scan evidence including the 2003 lumbar spine x-ray which was described as normal and the CT scans of April 2008 and August 2011.

65. Observations were made by the AMS on inconsistencies between his findings and those of other specialists. The AMS stated:[55]

> "Dr Powell, Orthopaedic Surgeon examined her on 9 July 2018. He noted absence of the ankle jerk reflexes bilaterally. He did not document any sensory changes. He therefore did not consider that she had radiculopathy after surgery.
>
> He correctly awarded a DRE lumbar category IV or 21% whole person impairment. This involved 1% for a mild limitation in activities of daily living. He considered the pre-existing degenerative pathology and aggravation that occurred afterwards. He did not apply any deductions and awarded 21% whole person impairment despite noting that the forces involved in the incident in 2008 and 2011 by themselves would not normally lead to the development of such significant structural pathology in the lumbar spine that would require a fusion procedure.
>
> Dr Roger Pillemer, Orthopaedic Surgeon examined her on 29 March 2018. He was also unable to elicit her ankle jerk reflexes. Sensation at that time was intact. He also awarded 21% whole person impairment.
>
> My assessment differs from Dr Pillemer and Dr Powell as there was an absence of her ankle jerk reflexes bilaterally, sensory loss at the lateral aspect of both her feet which I considered to be in the L5 dermatome distribution and concordant evidence of pathology at the same level.
>
> Dr Al-Khawaja, Neurosurgeon reviewed her on 29 August 2011 and noted that there was decreased sensation in the left L5 dermatome distribution."

GROUND FOR APPEAL 1 – FINDING OF RADICULOPATHY

Submissions

Appellant's submissions

66. The appellant submitted:

> "The AMC contains a demonstrable error in relation to the assessment of radiculopathy and/or the assessment was made on the basis of incorrect criteria in that the AMS incorrectly assessed the Respondent Worker as meeting the criteria for an assessment of radiculopathy."

[54] MAC, p 6, footnote 5
[55] MAC, pp 6-7

67. It was submitted that the meaning of "incorrect criteria" was discussed in *Campbelltown City Council v Vegan*[56] where it was held that if the AMS fails to correctly apply the fourth edition guidelines and AMA 5 then "the MAC is made on the basis of incorrect criteria".[57]

68. After referring to paragraph 4.27 of the fourth edition guidelines which defines "radiculopathy" and the findings of the AMS, the appellant submitted that the "diagnosis of radiculopathy is at odds with the available evidence".[58]

69. The appellant referred to the assessments provided by both Dr Powell and Dr Pillemer that the ankle jerks were absent but that sensation was intact. In these circumstances, it was submitted that "there was insufficient evidence to make a finding of radiculopathy in accordance with the [fourth edition guidelines] and that this finding is at odds with the available evidence".[59]

70. The appellant submitted in the alternative that if radiculopathy was present, then the condition arose following the subsequent non-work-related injury in June 2011 and that there was "no evidence of objective verifiable radiculopathy following the work injury on 23 February 2008".[60]

71. It was submitted that if there is radiculopathy then "this is not related to the work injury and should not be included as part of the assessment of impairment related to same."[61]

72. It was also submitted that the MAC contains "a demonstrable error in relation to the assessment of radiculopathy".[62]

Appellant's supplementary submissions

73. The appellant's supplementary submissions are set out under the third ground of appeal.

Respondent's submissions

74. The respondent referred to the reasons and submitted that they established that there were asymmetry of reflexes and reproducible impairment of sensation.[63] These findings were stated to be consistent with a finding of radiculopathy.

75. The respondent observed that she was properly assessed as DRE Lumbar Category IV in accordance with paragraph 4.37 of the fourth edition guidelines. The AMS had correctly applied Table 4.2, as part of paragraph 4.37 of the fourth edition guidelines, as an applicable modifier that could be added to the assessment of 21% for the spinal fusion surgery.

76. The respondent submitted that the AMS had explained why his finding differed from that expressed by both Dr Pillemer and Dr Powell.

77. In response to the appellant's submission that the radiculopathy occurred after the 2011 incident, the respondent otherwise submitted that the other events were considered by the AMS when assessing the s 323 deduction.

---

[56] [2004] NSWSC 1129 at [59]
[57] Appellant's submissions, paragraph 1.2
[58] Appellant's submissions, paragraph 1.7
[59] Appellant's submissions, paragraph 1.9
[60] Appellant's submissions, paragraph 1.10
[61] Appellant's submissions, paragraph 1.10
[62] Appellant's submissions, paragraph 1.11
[63] Respondent's submissions, paragraph 1.3

Respondent's supplementary submissions

78. The respondent's supplementary submissions are set out in the third ground of appeal.

Reasons

79. The principle ground raised by the appellant is a dispute against the finding by the AMS that there was sensory loss. It was submitted that these findings are "at odds with the available evidence" and that there was "insufficient evidence". These submissions were based on the findings by Dr Pillemer and Dr Powell that there was normal sensation.

80. The AMS was clearly aware that both Dr Pillemer and Dr Powell found normal sensation because he referred to their findings on this issue when discussing their opinions.[64]

81. The AMS correctly noted that Dr Al-Khawaja noted decreased sensation in the left L5 dermatome when he reviewed the respondent on 29 August 2011[65]. The appellant's submissions did not address that observation.

82. The finding by the AMS of "slight diminution of sensation"[66] is a clear clinical finding by the AMS made on the day of assessment.[67] It was made in the context where the AMS opined that the respondent's presentation was "consistent".

83. The appellant did not argue a matter which the AP raise in their medical expertise. The clinical findings including loss of sensation are those of bilateral abnormality of the S1 nerve roots. Whilst the AP accepts that S1 nerve root impingement invariably occurs due to pathology at the L5/S1 level, it is probable that the S1 nerve roots would be compromised by scarring resulting from surgery at the L4/5 level as the S1 nerve roots cross the L4/5-disc space in order to get to the exit foramina at the L5/S1 level.

84. The absence of sufficient pathology on the scans at the L5/S1 level means that the probable explanation in this situation is that the S1 nerve roots were compromised by surgical scarring at the L4/5 level.

85. Table 15-2 and Figure 15-1 of AMA 5 clearly support the medical opinion set out above on the loss of sensation from the various dermatomes.

86. The AP, through its medical expertise, states that there are clear medical explanations for the differences in the findings by the AMS on sensation and those expressed by Drs Pillemer and Powell sometime prior to the examination. First, sensory loss is not always present and can vary on a daily basis.

87. Secondly, and more likely, as Dr Powell acknowledged, the respondent's prognosis was guarded because the biomechanics of the lumbar spine had been irreversibly altered having undergone a spinal fusion. Dr Powell noted that the respondent was at risk of adjacent segment disease and the lower back was likely to represent a source of intermittent symptoms into the future. The respondent's condition could easily have deteriorated over this time period due to the spinal fusion affecting the biomechanics of the lumbar spine and the effects from the scarring associated with such a procedure.

[64] MAC, pp 6-7
[65] Reply, p 10
[66] MAC, p 4
[67] Forth edition guidelines, paragraph 1.6

88. Dr Powell examined the respondent in June 2018 and Dr Pillemer some three months prior to that. In her statement dated 12 February 2019, the respondent said that she had cramps in her calves and feet. Whilst this evidence does not, of itself, satisfy the concept of radiculopathy, these symptoms are otherwise consistent with those found by the AMS.

89. It is entirely medically plausible that the respondent's condition deteriorated from when she was examined by Dr Powell in late June 2018 and when she was examined by the AMS over nine months later.

90. The appellant's submissions that there was "insufficient evidence" or "at odds with the available evidence" seeks to put one side the clinical findings made by the AMS as not constituting sufficient evidence.

91. The AMS was satisfied that radiculopathy was present because there was an absence of ankle jerks bilaterally and sensory loss at the lateral aspect of both feet.[68] These separate findings constitute a major criteria as defined in paragraph 4.27 of the fourth edition guidelines.

92. Accordingly, the AP is satisfied that the findings made by the AMS were clearly open to him and we discern no error. The AP rejects the appellant's submissions that the finding of radiculopathy by the AMS is at odds with the available evidence and/or there was insufficient evidence to make such a finding. To the extent that the appellant has suggested that the MAC contains a demonstrable error, this ground is rejected.

93. The factual findings made by the AMS constitute radiculopathy as defined in paragraph 4.27 of the fourth edition guidelines and otherwise do not involve an application of incorrect criteria. Accordingly, the ground of appeal as raised is rejected.

94. The appellant made an alternative submission that the finding of radiculopathy did not relate to the work injury as there was only "evidence of sensation loss in an L5 dermatome" following the non-work-related incident in June 2011. This submission was also raised under the third ground of appeal.[69]

95. The AP, for the reasons it provides under the third ground of appeal, also rejects this ground of appeal.

GROUND FOR APPEAL 2 – SECTION 323 DEDUCTION

Submissions

Appellant's submissions

96. The appellant submitted that there was a demonstrable error in relation to the one-tenth deduction made by the AMS pursuant to s 323 of the 1998 Act.

97. The appellant referred to paragraphs 1.27 and 1.28 of the fourth edition guidelines and the finding by the AMS that there was a proportion of the whole person impairment due to previous injury, pre-existing condition or abnormality.

[68] MAC, p 7
[69] Appellant's submissions, paragraph 3.5

98. It was submitted that the one-tenth deduction made pursuant to s 323 was "inadequate"[70] and noted the following matters:

    (a) The evidence of pre-existing degenerative pathology;

    (b) The evidence that the respondent complained of low back pain with radicular symptoms on 28 September 1999;

    (c) The lumbar spine x-ray dated 17 December 2003 and the subsequent referral for physiotherapy;

    (d) The x-ray of the thoracic spine dated 12 July 2005;

    (e) The x-ray of the thoracic spine dated 18 September 2007 showing changes in the thoracic spine;

    (f) The history taken by Dr Zafar on 8 August 2011 that the respondent complained of lumbosacral pain on 7 December 2007;

    (g) The CT scan performed on 17 April 2008;

    (h) The CT scan performed on 4 August 2011;

    (i) The MRI scan dated 3 September 2008.

99. The appellant submitted that having regard to these matters, the one-tenth deduction was "inadequate" and this amounted to a demonstrable error.[71]

Respondent's Submissions

100. The respondent referred to the lumbar fusion surgery undertaken on 29 August 2012 after progression of her symptoms. It was submitted "that there is nothing remarkable in the history listed by the Appellant to prove that Dr Assem did not make an appropriate deduction."[72]

Reasons

101. The respondent complained of low back pain into the buttocks on one occasion in December 1999. The clinical notes did not show ongoing complaints of low back pain. The reference in 1999 is a long time prior to injury and represents a one-off complaint.

102. The appellant referred to prior thoracic spine x-rays and presumably to symptoms in that area of the spine. Those symptoms have nothing to do with the respondent's disc pathology at L4/5 and the need for spinal fusion at that level. That part of the appellant's submission is rejected as being irrelevant to this issue.

103. The appellant otherwise referred to the lumbar spine x-ray undertaken in 2003. As the AMS correctly noted,[73] this x-ray was reported by Dr Chapman as normal. This x-ray does not show a pre-existing condition of the lumbar spine.

[70] Appellant's submissions, paragraph 2.5
[71] Appellant's submissions, paragraphs 2.8-2.9
[72] Respondent's submissions, paragraph 2.2
[73] MAC, p 4

104. The respondent underwent an x-ray of the thoracic spine on 12 July 2005 and a further thoracic spine x-ray on 18 September 2007. These x-rays do not indicate any pre-existing disorder of the lumbar spine.

105. The CT scan taken on 14 April 2008 shows L4/5 evidence of central canal narrowing and diffuse disc bulge and 'trivial facet joint arthropathy'. This scan was taken two months after the work-related injury and shows no significant evidence of a pre-existing disorder.

106. An MRI scan of the lumbar spine taken on 3 September 2008 revealed evidence of a broad-based posterior bulge or protruding disc at the L4/5 level with spinal canal stenosis. This was undertaken six months after the work-related injury and could have related to the injury only.

107. The AP accepts that the 2008 scans taken after the incident show only minor changes prior to the 2008 work injury.

108. The respondent sustained a work injury in 2006 although did not plead that incident as part of this claim. The AMS referred to the 2006 incident and obtained a history of a general recovery from that incident with minimal time off work.[74] No scans were performed at that time. That history is consistent with the respondent's evidence that the effects of the 2006 injury were of relative short duration.[75] Dr Powell recorded a similar history.

109. Furthermore, the clinical notes of the general practitioner prior to the 2008 work injury have only minor if any references to low back pain. In that respect, the appellant relied on a report dated 8 August 2011 suggesting low back pain in December 2007. This report, authored some years later, is inconsistent with the contemporaneous notes for that period which do not record low back pain. Furthermore, the clinical note of 3 August 2011, written five days prior to the relevant report, refers to the work injury three years previously and back pain on and off since that time.[76] The report of 8 August 2011 where it refers to back pain in December 2007 is probably incorrect given the clinical notes of the doctor immediately preceding the report which indicate back pain "on and off" since the 2008 work injury.

110. The radiological evidence shows only minor changes that pre-existed the injury. In these circumstances, the AP accepts that the AMS was entitled to form the view that the proviso in s 323(2) of the 1998 Act applied and that it is appropriate to make a one-tenth deduction. For these reasons, the view expressed by Dr Powell of a much greater deduction lacks a proper foundation and was rightly rejected.[77]

111. The conclusion reached by Dr Pillemer of no s 323 deduction was made in the absence of a full history and analysis of the 2008 scan evidence.

112. The appellant submitted that this ground of appeal was based on both demonstrable error and the application of incorrect criteria. Part of the underlying facts relied upon by the appellant as suggesting a higher deduction were irrelevant to the issue as they related to the thoracic spine.

113. The AP does not accept that the assessment was made on the basis of incorrect criteria. The appellant referred to paragraphs 1.27 and 1.28 of the fourth edition guidelines which do no more than restate s 323 of the 1998 Act. Further, in his reasons, the AMS footnoted paragraph 1.28 of the fourth edition guidelines. This is inconsistent with the appellant's submission that he incorrectly applied that paragraph of the fourth edition guidelines.

---

[74] MAC, p 3
[75] Application, p 307
[76] Application, p 99
[77] Dr Powell suggested that the 2006 work injury, not pleaded by the Applicant, was responsible for one-third of the overall impairment

114. Accordingly, the basis for the finding by the AMS of a one-tenth deduction pursuant to s 323 was an application of correct rather than incorrect criteria within the meaning of s 327(3)(c) of the 1998 Act: see *Marina Pitsonis v Registrar of the Workers Compensation Commission of New South Wales*[78] applying Basten JA in *Campbelltown City Council v Vegan*.[79]

115. Section 327(3)(d) provides that the error must be "demonstrable". In *Vannini v Worldwide Demolitions Pty Ltd* (*Vannini*),[80] 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".[81] The AP has referred to the various evidence referred to by the appellant and rejects its submissions that there has been error, let alone "demonstrable" error.

116. The AP otherwise notes the observations of Gleeson JA in *Vannini* that the relevant proportion under s 323 "permits some latitude of opinion such as to admit of a range of legally permissible outcomes."[82] In this respect, given the summary of the evidence set out herein, the AMS was clearly entitled to form the view that there should only be a one-tenth deduction.

117. This ground of appeal is rejected.

GROUND FOR APPEAL 3 – SUBSEQUENT INJURIES
Submissions

Appellant's submissions

118. The ground of appeal was phrased in the following form:

> "The Appellant Employer submits that the MAC contains a demonstrable error and/or the assessment was based on incorrect criteria as the AMS erred in failing to address the effect of the Respondent's subsequent injuries and exclude any impairment flowing from those injuries from his assessment of whole person impairment."

119. The appellant referred to the statement of the AMS that there was a subsequent injury in June 2011 which caused additional impairment. It was submitted that the subsequent injury was "significant" and that the AMS "does not exclude the impairment related to this subsequent injury from the overall impairment, nor does he provide reasons for why he has/has not deducted same."[83]

120. This ground of appeal is based on both demonstrable error and/or the application of incorrect criteria.[84]

121. The appellant referred to its previous submission under Ground 1 that there was "no evidence of a diagnosis of objective verifiable radiculopathy prior to the June 2011 injury" and submitted that "it follows, that any impairment for radiculopathy (if the AMS's diagnosis of same is accepted) is attributable to the subsequent injury".[85]

---

[78] [2008] NSWCA 88 (*Marina Pitsonis*) at [40]-[42], McColl and Bell JJA (as their Honours then were) agreeing
[79] [2006] NSWCA 284 at [94], McColl JA agreeing
[80] [2018] NSWCA 324 (*Vannini*) at [90]
[81] *Vannini* at [86]
[82] *Vannini* at [92], Macfarlan JA and Barrett AJA agreeing
[83] Appellant's submissions, paragraph 3.3
[84] Appellant's submissions, paragraph 3.10
[85] Appellant's submissions, paragraph 3.5

122. The appellant referred to other injuries or aggravations "which may also give rise to a portion of the Respondent Worker's impairments"[86]. These incidents were:

    (a) The respondent aggravated her condition on 7 November 2011, when she bumped on a metal bar;

    (b) On 20 July 2012, the respondent reported that she lifted a ladder and has had ongoing lower back pain and left leg symptoms;

    (c) On 10 March 2014, the respondent reported that she fell in the shower the night before and lost consciousness;

    (d) Prior to 7 October 2014, the respondent tried to pick up a bathtub and was "very tender in middle of the back";

    (e) On 29 September 2015, the respondent reported that two weeks prior she fell on her buttocks, and

    (f) On 21 December 2016, the respondent reported that she fell on the edge of the bath tub. In July 2017, the respondent reported the she broke right ribs in Christmas 2016 on the bath.

123. The appellant submitted that the AMS failed to properly consider the material before him and failed to take the subsequent matters into account when assessing the respondent's "impairment as a result of the work injury".[87] It was submitted that a "proportion of the … impairment must be considered as flowing from the subsequent events."[88]

124. The appellant also submitted that it relied upon *Broadspectrum (Australia) Pty Ltd v Leach* [2019] NSWWCCMA 23 (*Leach*).

Appellant's supplementary submissions

125. The appellant submitted that the respondent's condition "progressed or advanced following the 2011 event" and referred to various evidence. The AP has summarised this evidence earlier in these Reasons.

126. The appellant submitted that the respondent returned to pre-injury duties in late 2008 and the "claim was subsequently closed, given that she required no further medical treatment and was performing her pre-injury duties and hours."[89]

127. The appellant distinguished the decision of *Johnson* on the following bases:

    (a) The injury was psychological in nature;

    (b) There was no clear evidence of any alteration in diagnosis;

    (c) There was no clear evidence of any progression or advancement in pathology;

    (d) There was no clear evidence that the assessment of whole person impairment altered as a result of the subsequent employment/injury, or

[86] Appellant's submissions, paragraph 3.6
[87] Appellant's submissions, paragraph 3.7
[88] Appellant's submissions, paragraph 3.8
[89] Appellants supplementary submissions, paragraph 2 (f)

(e) There was no evidence in respect of severance of the causal chain.

128. Consistent with the histories recorded by Dr Al-Khawaja in August 2011 and Dr Powell in 2018, the respondent's condition had "resolved (at least to a degree) following treatment … until it was again rendered symptomatic following the subsequent event in 2011."[90] If there is a finding of radiculopathy then this was caused by the subsequent incident in June 2011 as it was not present prior to the incident. This is also evidence of an alteration in diagnosis.

129. It was submitted that the 2011 incident severed the chain of causation because:[91]

(a) there was no evidence in the treating material that there was any suggestion that the respondent required surgery following the 2008 work injury;

(b) that there was no indication that the respondent required a fusion until after the 2011 incident;

(c) the 2011 event "resulted in the need for further treatment, including but not limited to surgery, which in turn resulted in an increase in the WPI assessment", and

(d) had the respondent been assessed prior to the intervening event in 2011 then there would have been an assessment "far less" then the assessment following the 2011 incident.

130. Accordingly, there has been an advancement of symptoms, pathology, an altered diagnosis, need for treatment including a spinal fusion and an altered whole person impairment following the 2011 incident which severed the causal chain. The case of *Johnson* is distinguishable and "any impairment resulting from the subsequent event (including any finding of radiculopathy) should be excluded from the overall assessment of permanent impairment."[92]

131. The appellant maintained that there should be an apportionment between the 2008 work injury and the subsequent 2011 incident and the other matters raised in its submissions.

132. The appellant referred to the decision of *Nicol v Macquarie University*[93] (*Nicol*) and suggested that if the subsequent injury is deemed to have resulted from the work injury then there should be a "deduction" greater than one-tenth in addition to any s 323 deduction.

Respondent's submissions

133. The respondent referred to the history taken by the AMS of the jarring incident at home in June 2011. It was submitted that this incident was taken into account when determining "the deductible amount".[94]

134. The respondent noted that the fusion surgery occurred on 29 August 2012 and was entitled to be assessed as DRE Category IV by reason of that surgery. Accordingly, the incidents that occurred post-surgery "could only affect the assessment of radiculopathy".[95]

---

[90] Appellant's supplementary submissions, paragraph 2(k)
[91] Appellant's supplementary submissions, paragraphs 3-6
[92] Appellant's supplementary submissions, paragraph 8
[93] [2018] NSWSC 530
[94] Respondent's submissions, paragraph 3.3
[95] Respondent's submissions, paragraph 3.5

135. The respondent submitted that Dr Powell only made a deduction for the incident in June 2011 and the work event in 2006 and did not make any deduction for the other incidents described by the appellant in its submissions.

136. The AMS referred to the earlier work incident. It was submitted that the AMS "considered all relevant pre-incident and post-incident factors in determining the correct deductible amount."[96]

137. In commenting on the appellant's reference to the Medical Appeal Panel decision in *Leach*, the respondent submitted that she could not discern "any relevance to the assessment of this matter."[97]

138. The respondent otherwise referred to the observations of Campbell J in *Ryder v Sundance Bakehouse*[98] and submitted that the only matters that could have made a difference to the assessment of the whole person impairment "were taken into account" by the AMS.[99]

139. It was submitted that there was no demonstrable error or application of incorrect criteria.

Respondent's supplementary submissions

140. The respondent referred to the findings made by the AMS and submitted that he formed the view that the subsequent incident did not sever the chain of causation. Accordingly, the respondent is entitled to be assessed as DRE Lumbar Category IV because of the connection between the injury and fusion surgery.

141. The remaining issue is whether the radiculopathy was connected to the injury and subsequent surgery.

Reasons

142. Some of the matters raised by the appellant under this ground of appeal lack a proper factual basis in asserting that the respondent suffered further injury to the lumbar spine.

143. The incident on 20 July 2012, according to the contemporaneous notes, involved an injury to the thoracic spine because the arrow appears immediately prior to the letters "T/S". The reference in the notes to ongoing lumbar pain is a reference to that existing problem for which the respondent was then currently awaiting surgery. The clinical note, read in proper context, does not indicate that the respondent suffered an aggravation of her lumbar condition in this incident.

144. The clinical notes for the incident on 10 March 2014, when the respondent lost consciousness, do not suggest that there was injury to the lumbar spine.

145. The incident on 7 October 2014 involved injury to the left hip area and tenderness in the middle of the buttock. The clinical notes do not suggest injury to the lumbar spine.

146. The clinical notes for the injury on 29 September 2017 suggest that the injury was to the pelvis and not to the lumbar spine.

147. The incident on 21 December 2016 clearly involved a fall when the respondent broke her ribs. There is no suggestion in these notes and the subsequent notes from the physiotherapist that the fall involved an injury to the lumbar spine.

---

[96] Respondent's submissions, paragraph 3.6
[97] Respondent's submissions, paragraph 3.9
[98] [2015] NSWSC 526 at [45]
[99] Respondent's submissions, paragraph 3.10

148. Of the other six incidents referred to by the appellant in its submissions in addition to the event in June 2011, only one, the incident on 7 November 2011, suggested an exacerbation of the lumbar spine condition.

149. The AP observes that the appellant's submissions on these matters were factually inaccurate and otherwise irrelevant to the determination of this ground of appeal as five of these incidents did not involve injury to or aggravation of the lumbar spine condition.

150. Another issue raised in the appellant's supplementary submissions is the state of the respondent's condition both before and after the June 2011 incident.

151. The AP refers to the MRI scans given their much higher quality resolution compared to the CT scans.

152. The September 2008 scan was described by Dr Blumgart as showing a "broad based posterior bulging or protruding disc at the L 4/5 level" and moderately severe central spinal canal stenosis that "appears to be focal compression and displacement of the traversing L5 nerve roots"[100].

153. The September 2011 MRI scan refers to a "left eccentric diffuse disc" at L4/5 with a mild degree of central canal stenosis traversing the left L5 nerve root.[101]

154. The AP opines, in its expert medical view, that the MRI scan in September 2011 is substantially the same as that shown by the September 2008 MRI scan. To the extent that the appellant submits otherwise in relation to the interpretation of the scans, the AP, based on a plain reading of the material prefers its own medical expertise to the summary provided by the appellant. Indeed, whilst the appellant summarised the scans it proffered no medical opinion that the 2011 MRI scan was substantially different to the 2008 MRI scan.

155. What the appellant referred to[102] was Dr Powell's opinion that the "degenerative lumbar spine **condition**" (emphasis added) was different. Furthermore, Dr Powell otherwise opined that the repeat CT and MRI scans obviously a reference to those undertaken in 2011, "confirmed the previously noted degenerative disc pathology at L4/5."[103]

156. The AMS expressed a similar view. After referring to the 2008 scans, the AMS stated that following the aggravation in mid-June 2011 "there was similar pathology with impingement, irritation and swelling of the left L5 nerve root." [104] The AP accepts this view. No error is shown in the view reached by the AMS on this finding.

157. The AP is of the view that the respondent had serious pathology at L4/5 as shown by the September 2008 MRI scan. We accept, given the clinical history, as did the AMS, Dr Pillemer and Dr Powell, that the 2008 work injury was a material cause of this pathology.

158. The AMS is required to determine the "degree of permanent … as a result of an injury". The relevant causal test involves an assessment "as a result of an injury", words which have appeared in various aspects of the workers compensation legislation and continue to appear in other sections of the 1987 Act.

---

[100] Application, p 9
[101] Application, p 12
[102] Appellant's supplementary submissions, paragraph 2(a), (b), (h) and (i)
[103] Reply, p 18
[104] MAC, p 6

159. Similar words appear in s 33 of the 1987 Act where the test is whether incapacity "results from an injury" and s 60 of the 1987 Act where the worker must show that the treatment is "as a result of an injury".
160. The relevance of a subsequent as opposed to previous injury or condition was recently discussed by Garling J in *Johnson*. In that case the worker suffered a compensable injury and a subsequent non-compensable injury. The Appeal Panel held that both injuries contributed to the overall impairment and then made an apportionment between the two incidents. The Court quashed the decision of the Appeal Panel. In the course of his reasons, Garling J stated:

> "66. It is significant that the Panel did not conclude that the later injury was of a kind or nature that severed the causal chain between the NSW Education injury and the plaintiff's impairment. If it had come to such a conclusion, then it was obliged to find that there was no impairment as a result of the NSW Education injury. However, to the contrary, it concluded that the plaintiff's impairment resulted from the NSW Education injury and the later Hostels injury.
>
> 67. The task required by ss 9 and 9A of the 1987 Act is for a determination to be made about whether the relevant employment was a substantial contributing factor to the injury. If it was, then the AMS or the Panel is to assess the permanent impairment, by a clinical assessment of the claimant, as they present on the day of the assessment having regard to the matters set out in Clause 1.6 of the Guidelines. That task does not involve any process of apportionment between injuries.
>
> 68. Section 323 of the 1998 Act provides an exception to that general approach, but only in the limited circumstances which that provision contemplates. Here those provisions did not apply."

161. Roche DP discussed the relevant causal connection required for the receipt of medical expenses under s 60 of the 1987 Act in *Murphy v Allity Management Services Pty Ltd*.[105] Roche DP stated:[106]

> "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 Ltd v 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)."

[105] [2015] NSWWCCPD 49
[106] at [57]-[58]

162. In *McCarthy v Department of Corrective Services* (*McCarthy*)[107] Roche DP made similar observations concerning the appropriate test on causation for establishing an entitlement to weekly compensation. Roche DP stated:[108]

> "It is trite law that a loss can result from more than one cause (*ACQ Pty Ltd v Cook* [2009] HCA 28 at [25] and [27]; [2009] HCA 28; (2009) 83 ALJR 986). The authority of *Calman* is also instructive on this issue. The Court held (at [38], excluding footnotes):
>
> > 'Once the appellant established that his underlying anxiety disorder was an injury within the meaning of the Workers Compensation Act, he was entitled 'to compensation ... under [that] Act' upon proof that his total or partial incapacity for work resulted from that injury. The question then for the Tribunal was whether the appellant's incapacity was causally connected to the underlying anxiety disorder. It has long been settled that incapacity may result from an injury for the purposes of workers' compensation legislation even though the incapacity is also the product of other - even later - causes. Indeed, death or incapacity may result from a work injury even though the death or incapacity also results from a later, non-employment cause. Thus, in *Conkey & Sons Ltd v Miller*, Barwick CJ, with whose judgment Gibbs, Stephen, Jacobs and Murphy JJ agreed, held that it was open to the Workers' Compensation Commission to find from the medical evidence in that case 'that the death by reason of myocardial infarction when it did ultimately occur, 'resulted' from the work-caused injury of the first infarction, even if it could not be said that the final infarction was itself caused by work-caused injury.'"

163. In *Murphy*, Roche DP cited *Sutherland Shire Council v Baltica General Insurance Co Ltd* as authority for the proposition that the injury must "materially contribute to the need for surgery". Those observations probably relate to the decision of Clarke JA, who after a thorough analysis of the law including the observations of Kirby P (as his Honour then was) in *Kooragang Cement Pty Ltd v Bates* stated[109]:

> "I agree with those observations but would add that in the light of the judgment in *Heath*, I do not think there is any impediment to my acceptance of the view that the common law test applies and that the relevant inquiry directs attention to whether the injury caused or materially contributed to the incapacity."

164. Further, in the unanimous decision of the High Court decision in *Calman v Commissioner of Police* (*Calman*) referred to and quoted by Roche DP in *McCarthy*, the High Court went further and stated:[110]

> "39. Whether incapacity results from injury is a question of fact. Upon the findings in this case, however, the answer to that question could admit of only one answer. As a matter of law, the Tribunal was bound to find that the incapacity of the appellant resulted from injury within the meaning of s 33 of the Workers Compensation Act. Although the incapacity would not have arisen but for the appellant being told that he was to be transferred, there would have been no incapacity but for the existence of his underlying anxiety disorder. The incident,

[107] [2010] NSWWCCPD 27
[108] at [148]-[149]
[109] (1994) 35 NSWLR 452 at 463-464
[110] [1999[HCA 60 at [39]-[40]

> which was the immediate cause of his incapacity, merely exacerbated the underlying anxiety disorder which continued to exist, notwithstanding that immediately before the incident it manifested no symptoms. In those circumstances, the injury was a contributing cause to the incapacity. As Jordan CJ pointed out in *Salisbury v Australian Iron and Steel Ltd* [20]:
>
> > 'It is not necessary that the employment injury should be the sole cause of disability. It is sufficient if it is a contributing cause[21]. It may be the catalyst which precipitates disability in a medium of disease. But when the stage is reached at which the employment injury ceases to produce effects and could therefore no longer be a contributing cause to any incapacity which may then exist, the right to compensation ceases.'
>
> 40. In the present case, the underlying anxiety disorder continued and was capable of producing serious effects if exacerbated or aggravated, as the Tribunal's findings showed. That being so, the Tribunal was bound to find as a matter of law [22] that the appellant's incapacity resulted from injury within the meaning of s 33 of the Workers Compensation Act."

165. It is settled law through various superior Court decisions, referred to in the above passages, that a subsequent non-work injury does not prevent a worker's entitlement to either weekly compensation or medical expenses provided the work injury was causative of the entitlement.

166. The appellant's initial submissions accepted that the work injury was responsible for a significant proportion of the lumbar spine impairment but sought a contribution by the subsequent incidents. That submission is inconsistent with the reasoning in *Johnson*. It is otherwise inconsistent with the relevant statutory test that must be applied, that is, the assessment of the degree of permanent impairment is "as a result of an injury".

167. The appellant referred to the decision of *Leach* in support of its submission that there be an apportionment of the permanent impairment between the work injury and a concurrent non-work incident. In *Leach* the Appeal Panel noted that the provisions of s 323 did not apply with respect to a concurrent non-work injury and correctly observed that the relevant test was whether the permanent impairment "results from an injury". However, the final decision of the Panel in *Leach* supports[111] the appellant's submission because it then held that there should be a contribution between a work injury and a concurrent non-work event and assessed the non-work incident as causing 15% of the total impairment. The overall assessment of permanent impairment was reduced by 15%.

168. The AP is bound by and applies the reasoning in *Johnson.* The decision in *Johnson* is otherwise consistent with the various superior Court decisions referred to in these Reasons. To the extent that *Leach* is inconsistent with *Johnson*, the AP declines to follow the reasoning in *Leach*.

169. In its supplementary submissions, the appellant referred to *Nicol* as support for its submission on apportionment.

[111] *Leach* at [58]

170. The facts in *Nicol* were that the worker suffered a compensable injury with Macquarie University and brought proceedings against that party for permanent impairment compensation. The worker also sustained a subsequent psychological injury with Cambridge for which proceedings were not brought. Her Honour quashed the decision, in part, because the findings by the Appeal Panel on causation of loss were inconsistent with principles including those laid by Mason P in *Government Insurance Office of NSW v Aboushadi.*[112] Her Honour noted that there was no suggestion that the effects of the compensable injury had fully resolved and that the discussion by the Appeal Panel was that the subsequent injury with Cambridge was described in terms of an aggravation of an earlier injury.

171. Her Honour's reasons were referred to by Garling J in *Johnson*. The reasons emphasise that an aggravation of the work injury by a subsequent incident falls with principles of causation due to the first injury. Her Honour stated:[113]

> "144. The language used by the Appeal Panel also indicated that the new injury caused Mr Nicol's symptoms to recur, yet made no reference to any novus actus that broke the chain of causation from Mr Nicol's earlier injury sustained at Macquarie University.
>
> 145. The characterisation of the new injury as causing symptoms to recur suggests that the new injury and prior injury are linked. Based upon the decision of *Aboushadi* (which I have set out above), the present circumstances appear to fall into the second category. In other words, the further injury which resulted at Cambridge would have occurred even if Mr Nicol had been in normal health, but the damage sustained was greater because it was an aggravation of the earlier injury from Macquarie University. It is this additional damage resulting from the aggravated injury that remains causally linked to the first injury at Macquarie University. "

172. The AP otherwise notes the observations in *Nicol* on s 9A of the 1987 Act. Section 9A is a matter of liability and within the sole province of the Commission and not an AMS. In *Bindah v Carter Holt Harvey Wood Products Australia Pty Ltd*[114]*(Bindah)* Emmett JA observed that the Commission must determine whether a worker has suffered injury within the meaning of s 4 and "must also determine whether there are any disentitling provisions, such that compensation is not payable in respect of that injury".[115] Section 9A is a disentitling provision to the award of compensation.

173. *Bindah* was referred to and applied by the Court of Appeal in *Jaffarie v Quality Castings Pty Ltd (Jaffarie No 2)*[116] where White JA observed that the jurisdiction extended to a finding on "the nature of the injury sustained"[117]. White JA noted that similar observations were made by Meagher JA in *Bindah*.[118]

174. The decision in *Johnson* refers to the necessity of a determination about ss 9 and 9A of the 1987 Act prior to the assessment undertaken by the AMS or a Panel.[119] That reasoning does not suggest that the task is undertaken by the AMS and is consistent with the Court of Appeal decision in *Bindah*.

---

[112] [1999] NSWCA 396 at [22] (Meagher JA and Barr J agreeing)
[113] At [144]-[145]
[114] [2014] NSWCA 264 at [111]
[115] *Bindah* at [111], Ward JA agreeing
[116] [2018] NSWCA 88
[117] At [80]-[82], Macfarlan and Leeming JJA agreeing on this point
[118] *Jaffarie No 2* at [72] applying *Bindah* at [26] (Ward JA also agreeing with Meagher JA)
[119] At [67]

175. The AP observes that the appellant purported to distinguish *Johnson* on the basis that it involved a psychological injury. However, the appellant also relied on two decisions (*Leach* and *Nicol*) which both involved psychological injury as supporting its position.

176. The factual distinction that *Johnson* involved a psychological injury is not relevant to the legal principle determined by Garling J. Furthermore, the decision in *Nicol* concerning the subsequent incident not severing the causal chain is entirely consistent with *Johnson*. The decision of *Nicol* which was relied upon by the appellant, does not support its submissions.

Application of legal principles

177. The AP accepts the appellant's submission that the respondent suffered an aggravation of her pain in June 2011 because the contemporaneous complaints establish a deterioration of the symptoms at that time. However, the preponderance of the evidence is that the respondent slipped without falling. She likely twisted her back at that time and stirred up the serious pathology in the low back. This was not a significant incident and the consequences were dramatic due to the underlying serious pathology caused by the 2008 work injury.

178. We otherwise observe that the incident in November 2011 was of such a minor nature that an aggravation of symptoms only occurred because the respondent already had a serious condition.

179. Whilst the respondent undoubtedly complained of more symptoms following the incident in June 2011, the underlying cause of the problem had arisen following the February 2008 work injury. We have previously discussed the significance of the various scans in this ground of appeal.

180. The appellant's submissions that the need for fusion was not causally related to the 2008 incident is contrary to the opinion expressed by Dr Powell.[120] That part of his opinion is specifically endorsed by the AP, that is the need for surgery was materially caused by the 2008 work injury because the underlying pathology was a significant and material cause of the need for the surgery.

181. The AMS referred to the incident in June 2011 and stated:[121]

> "It was difficult to determine whether the aggravation was significant as she was symptomatic prior to the aggravation and requiring analgesia."

182. This finding was consistent with the respondent's evidence. It was not rebutted by the appellant's submission that the insurer had closed its file. The AP has otherwise referred to the ongoing physiotherapy undertaken by the respondent throughout 2010 and which is confirmed by notes from that physiotherapist.

183. Further, as the AP has held in rejecting the second ground of appeal, the prior incidents and/or pre-existing condition prior to the compensable 2008 injury are responsible for one-tenth of the impairment.

184. As previously identified by the AP in this ground of appeal, the pathology shown in the 2011 scans after the 2011 incident was essentially the same as that shown after the 2008 work injury. For these reasons the appellant's submissions that there was an "alteration in diagnosis"[122] and "progression or advancement in pathology"[123] following the 2011 incident is rejected.

---

[120] Reply, p 22 (last paragraph)
[121] MAC, p 6
[122] Appellant's supplementary submissions, paragraph 1 (b)
[123] Appellant's supplementary submissions, paragraph 1 (c)

185. The appellant otherwise submitted that there was an increase in impairment due to the subsequent injury and therefore this established that there should also be an apportionment and/or that the causal chain was severed.

186. There are at least three major errors with respect to this submission. The first is that the AMS is obliged to assess permanent impairment as the worker presents on the day of the assessment.[124]

187. Secondly, it is the view of the AP that the respondent's subsequent need for spinal fusion as assessed by the AMS was caused and materially contributed by the 2008 work injury.

188. Thirdly, the appellant is repeating the incorrect legal test. The relevant test for consideration by the AMS (and the Panel) under s 326 of the 1998 Act is to identify the impairment "as a result of any injury". Whilst expressing an opinion on that matter necessarily involves examining subsequent events, the determination is based on the causative effect of the work injury. That conclusion is not negated because there is a subsequent non-work event which is also a contributing factor to the impairment. This analysis is consistent with the discussion by the High Court in *Calman*.

189. The appellant otherwise submitted in its supplementary submissions that the June 2011 incident was a novus actus. The submission was made without medical opinion to support the proposition. Dr Powell, accepted that the compensable 2008 injury was causative of the overall impairment. Indeed, Dr Powell stated:-[125]

> "Based on the available information I believe it is reasonable to conclude that Ms Worland's ongoing symptoms remain directly related to injuries sustained in the course of her employment."

190. Whilst this opinion also encompasses the 2006 work injury, the opinion nevertheless attributes the ongoing problems as being casually related to the 2008 work injury. The appellant's submission that the 2011 incident was a novus actus is made without any medical evidence to support the proposition and contrary to the medical opinion of Dr Powell tendered in its case.

191. The submission that there is a novus actus is rejected because the underlying pathology was in existence prior to the 2011 incident and this invariably led to the need for the spinal fusion. Given the nature of the pathology caused by and following the 2008 work injury, it is entirely likely, as what occurred with the respondent, that subsequent innocuous incidents would exacerbate the respondent's lumbar condition.

192. In these circumstances, we reject the submission that the causal chain between the respondent's work injury and the need for surgery and/or the respondent's condition as she presented to the AMS was severed.

193. The appellant's submissions that the subsequent events severed the causal chain is otherwise grossly inconsistent with its submission that the subsequent incidents contributed "at least one-third of the impairment."[126]

194. The appellant otherwise submitted that the (denied) radiculopathy resulted from the work injury and submitted that it related to the 2011 incident and following incidents.

195.

---

[124] Paragraph 1.6 of the fourth edition guidelines
[125] Reply, p 21
[126] Appellant's supplementary submissions, paragraph 12(c)

196. In rejecting this submission whilst acknowledging the leg symptoms came on again after the June 2011 incident, the AP repeats the matters discussed above.[127] The AP also observes that left sided neurological symptoms were observed by Dr Moloney in 2008[128] and left sided complaints were referenced in the 2008 scans.

197. The AP accepts the AMS' finding that the radiculopathy is as a result of the work injury. As the AP previously noted in its expert medical view, both deterioration of the condition following fusion surgery which undoubtedly affects the biomechanics of the spine, and surgical scarring, are the obvious medical explanations of the cause for the radiculopathy found by the AMS.

198. Based on those reasons, the present radiculopathy diagnosed by the AMS is "as a result of" the 2008 injury as it arises from the fusion surgery.

Conclusions

199. The ground of appeal as framed is that the AMS erred in "excluding any impairment" by reason of the subsequent incidents.

200. As the Court of Appeal in *Vannini*[129] observed, a finding of demonstrable error may be apparent in findings of fact or reasoning contained in the medical assessment certificate or by reference to the materials.

201. Given the scope of the appellant's submissions, the AP in rejecting this ground of appeal, has had regard to the documents before the AMS. We are satisfied that there was no error by the AMS in concluding that the degree of permanent impairment of 21% is "as a result of the injury" on 23 February 2008. We also accept that the radiculopathy, as found by the AMS, is as a result of the injury.

202. The AP otherwise rejects the appellant's submissions that the June 2011 incident and the November 2011 incident severed the causal chain between the work injury and the respondent's current condition and resultant whole person impairment.

203. The AP refuses to reduce or apportion the whole person impairment by a percentage to reflect a contribution by the June 2011 and November 2011 incidents as such submissions, in the circumstances of this matter, are wrong in law.

204. For these reasons, we reject this ground of appeal that the MAC contains demonstrable error or the assessment was made on the basis of incorrect criteria.

DECISION

205. For these reasons, the Medical Assessment Certificate given in this matter is confirmed.

[127] Paragraphs [83]-[85] herein
[128] Application, p 70
[129] *Vannini* at [86]

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 MacLeod

Ann MacLeod
Dispute Services Officer
As delegate of the Registrar