WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-147/20**
Appellant:	**Keith Williams**
Respondent:	**Trivett Classic BMW**
Date of Decision:	**4 June 2020**
Citation:	**[2020] NSWWCCMA 98**

Appeal Panel:	
Arbitrator:	**Mr William Dalley**
Approved Medical Specialist:	**Dr Drew Dixon**
Approved Medical Specialist:	**Dr David Crocker**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 19 March 2020, Keith Williams (Mr Williams / the appellant) lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Margaret Gibson, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 5 March 2020.

2. The appellant relies on the ground of appeal under s 327(3)(d) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act); 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. The Appeal Panel has conducted a review of the original medical assessment but limited to the ground of appeal on which the appeal is made.

4. The WorkCover Medical 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 WorkCover Medical 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. Mr Williams commenced employment with Trivett Classic BMW (the respondent) in March 1990 as an auto mechanic. On 23 September 2002 he suffered an injury to his right knee when he slipped and fell in the course of his employment (the subject injury).

7. Mr Williams consulted his general practitioner and was off work for a time. The injury was investigated by wave x-ray and MRI scan of the knee. Mr Williams was then referred to an orthopaedic specialist, Dr Jon Harrison who performed an arthroscopy in November 2002.

8. Following the arthroscopy, Mr Williams received physiotherapy treatment and returned to work on normal duties with no restrictions. However in February 2003 Mr Williams again began to experience pain in the right knee but continued in his employment taking care in the way in which he performed his duties so as to avoid problems with the right knee.

9. In 2009, Mr Williams experienced an episode when the right knee gave way. He again consulted his general practitioner and an MRI scan was obtained. Mr Williams was again referred to Dr Harrison who ultimately performed a further arthroscopy with partial meniscectomy and chondroplasty. Dr Harrison's findings on operation included:

> "…chondrocalcinosis with the impregnation of crystals over both articular surfaces and into the synovium as well as meniscal and chondral surfaces throughout the knee joint. There was a mild inflammatory reaction in parts of the synovium. In the medial compartment, he had a degenerate tear involving the posterior horn of the medial meniscus with some attritional changed to the inner third of the mid-third of the medial meniscus are small radial tear was also present."

10. In 2010, Mr Williams made a claim for a lump sum payment in respect of impairment arising from the subject injury and agreement was reached that Mr Williams had suffered 10% WPI.

11. Mr William subsequently experienced recurrence of pain in the right knee. In August 2011, he was again referred to Dr Harrison following an incident when his right knee gave way as he was walking down stairs. Dr Harrison suggested management by a rheumatologist and Mr Williams was referred to Dr Spencer who noted bilateral osteoarthritis of the knees in May 2012. Following further investigations Mr Williams was referred to another orthopaedic surgeon, Dr Viswanathan who performed a partial right knee replacement in April 2015.

12. Mr Williams continued to suffer problems with the right knee and was admitted to Westmead Hospital for aspiration of right knee effusion. Following a right knee arthroscopy performed by Dr Viswanathan in June 2018 Mr Williams was then readmitted in August 2018 for revision right knee replacement.

13. In September 2019, Mr Williams was examined by Dr Alexander Woo who examined Mr Williams for the purpose of assessment of whole person impairment (WPI) resulting from the subject injury.

14. Dr Woo assessed Mr Williams as having a "fair" result of total knee replacement warranting an assessment of 20% WPI. Dr Woo was of the opinion that the impairment was entirely related to the injury on 23 September 2002. A claim for further lump sum compensation in respect of impairment arising from the subject injury was made on Mr Williams' behalf in accordance with that assessment.

15. Mr Williams was examined by Dr James Powell, orthopaedic surgeon, at the request of the respondent. Dr Powell assessed Mr Williams as having a "good" result from the knee replacement warranting an assessment of 15% WPI. Dr Powell was of the opinion that the subject injury had contributed to the requirement for the knee replacement to only a minimal degree, assigning only one fifteenth to the subject injury.

16. Mr Williams' claim was referred to the AMS who assessed Mr Williams as having a "fair" result from the right knee arthroplasty rated at 20% WPI. The AMS deducted three fifths from that assessment as due to non-work-related pathology, attributing 8% WPI as a result of the subject injury. The AMS made no deduction pursuant to section 323 of the 1998 Act in respect of any previous injury, pre-existing condition or abnormality.

PRELIMINARY REVIEW

17. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the WorkCover Medical Assessment Guidelines.

18. 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 sufficient material was available to the Panel to enable the Panel to perform its review. Neither party submitted that re-examination was required.

EVIDENCE

Documentary evidence

19. 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.

Medical Assessment Certificate

20. The AMS examined Mr Williams on 18 February 2020. The AMS noted the history of injury, subsequent treatment and the findings on investigation and at surgery. The AMS noted investigations as follows:

> "**CT arthrogram right knee** performed on 8 November 2012 showed previous partial meniscectomy, mild medial compartmental OA, synovitis and chondromalacia of the lateral femoral condyle.
>
> **MRI right knee** performed on 30 June 2014 showed previous partial meniscectomy and horizontal cleavage tear of the anterior horn of the lateral meniscus with sparing of the body and posterior horn. Subtle OA changes seen to the medial and patellofemoral compartments.
>
> **Plain x-ray right knee** performed 17 April 2015 showed medial compartment replacement components an appropriate position and orientation.
>
> **Ultrasound right knee** performed 16 June 2015 showed synovitis and mild insertional patellar tendinosis.
>
> **Plain x-ray right knee** performed 21 April 2016 showed unicompartmental arthroplasty in good alignment with no complications evident. There was a small amount of fluid is [sic] seen in the suprapatellar recess. No fractures of [?or] loose intra-articular osseous fragments.
>
> **MRI right knee** performed 26 October 2016 complex tear/degenerative wear involving the anterior horn of the lateral meniscus with the cruciate ligaments appearing grossly intact. There was a large knee joint effusion in keeping with synovitis with no significant chondropathy involving the patellofemoral compartment all the lateral compartment. There was evidence of scarring of the patellar tendon.
>
> **MRI right knee** performed on 8 August 2017 showed complex tear of the anterior horn extending to the body of the lateral meniscus. Under surface fraying and possible oblique tear of the posterior horn of the lateral meniscus. Suggestion of interosseous ganglion at the lateral tibial plateau and lateral femoral condyle. Marked popliteus tendinosis. ACL intact. Mild to moderate joint effusion with synovitis. Marked patellar tendinosis distally.

Plain x-ray right knee performed 29 September 2017 showed medial compartment arthroplasty noted.

Plain x-ray right knee performed 26 August 2018 showed medial compartment replacement components in appropriate position.

Plain x-ray right knee performed 19 December 2018 showed a right total knee replacement in anatomic alignment."

21. The AMS noted that when Dr Harrison performed the right knee arthroscopy on 11 December 2009 he recorded the presence of "synovitis and chondrocalcinosis with crystals over both articular surfaces and degenerative tear of the posterior horn of the medial meniscus with attritional changes in the medial meniscus and a small radial tear". The AMS noted that a partial medial meniscectomy and chondroplasty was performed.

22. The AMS also reported a partial right knee replacement performed by Dr Viswanathan on 17 April 2015, the revision right knee replacement on 17 August 2018 and the washout and liner exchange on 19 August 2018. The AMS noted that Mr Williams had suffered a fall in the kitchen at home fracturing his right medial condyle in October 2018 with no ongoing impact on the work injury.

23. The AMS assessed Mr Williams in accordance with Table 17 – 33 of AMA5 rating the outcome of the surgery as a "fair" result attracting 20% WPI. The AMS said:

> "However, there are grounds to make a deduction as there is non-work related pathology including crystalline arthropathy and osteoarthritis. And the osteoarthritis worsens over time and be impacted by work and personal factors (sic). Therefore 3/5 deduction is in my opinion appropriate to take into account these factors."

24. Noting the history since the subject injury, the AMS said:

> "Therefore, there is an initial injury in 2002, sometime later there is a further insult to the same meniscus (whether by work factors or attritional changes noted by Dr Harrison) and this is complicated by an underlying crystal arthropathy. The subject accident would have contributed proportionately to the later onset of arthritic change, but so with the subsequent partial meniscectomy and ongoing physical work over many years."

25. In answer to the question "Is any proportion of loss of efficient use or impairment or whole person impairment, due to a previous injury, pre-existing condition or abnormality?" The AMS answered "NO".

SUBMISSIONS

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

27. In summary, the appellant submits that the AMS has failed to give sufficient reasons for making a deduction of 3/5 from the assessment.

28. In reply, the respondent submits that the AMS had carried out her assessment in accordance with the Guidelines and AMA5. The AMS had provided a detailed and considered examination of the evidence which adequately explained her reasons for making the 3/5 deduction.

29. The respondent also addressed submissions relevant to section 323 of the 1998 Act but the AMS in fact made no deduction pursuant to that section, having appropriately found there was no evidence of any previous injury or pre-existing condition or abnormality.

FINDINGS AND REASONS

30. 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.

31. 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.

32. The appellant submits that the AMS fell into error in not providing sufficient reasons for her conclusion that the assessment of 20% WPI should be reduced by 3/5 as attributable to a non-work-related condition.

33. Section 325 (2) (c) of the 1998 Act requires an AMS to provide reasons for assessment. For the reasons set out below the Panel accepts that the reasons set out in the MAC are not sufficient to explain the conclusion reached by the AMS. Failure to provide adequate reasons constitutes demonstrable error.

34. The approach to the assessment of whole person impairment where that impairment is attributable to more than one cause was discussed by the Court of Appeal in *Secretary, Department of Education v Johnson*[1] (*Johnson*). Emmett AJA (Macfarlan JA and Simpson AJA agreeing) noted (at [12]) that while, section 323 of the 1998 Act required a deduction for any proportion of the impairment that is due to any previous injury there was no requirement for apportionment “where there is an injury subsequent to the injury that is the subject of a claim”. His Honour concluded (at [14]): “That is to say, it must be possible to demonstrate that there is a causal connection between the compensable injury and the impairment.”

35. Referring to the decision in *State Government Insurance Commission v Oakley*[2] (*Oakley*) Emmett AJA noted:

> “There are three possible categories where an earlier injury is followed by a later injury, as follows:
>
> Where the later injury results from the subsequent accident that would not have occurred had the victim not been in the physical condition caused by the earlier accident, the second injury should be treated as having a causal connection with the earlier accident.
>
> Where an earlier injury is exacerbated by subsequent injury, there will be a causal connection between the original injury and the subsequent damage unless it can be shown that some part of the subsequent damage would have been occasioned even if the original injury had not occurred.
>
> Where a victim, who had previously suffered an injury, suffers a subsequent injury and the subsequent injury would have occurred whether or not the victim had suffered the original injury and the damage sustained by reason of the subsequent injury includes no element of aggravation of the earlier injury, there will be no causal connection between the original injury and the damage subsequently sustained.”[3]

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[1] [2019] NSWCA 321

[2] (1990) 10 MVR 570; [1990] Aust Torts Reports 81-003.

[3] Per Emmett AJA at [70]

36. The reasoning provided by the AMS in the MAC clearly establishes that the AMS made an appropriate assessment of the extent of impairment at the date of her examination. The AMS however did not explain how the deduction of three fifths should be applied consistently with the reasoning in *Johnson*.

37. The evidence establishes that the parties had agreed that Mr Williams in 2010 was suffering 10% WPI as result of the subject injury.

38. The AMS appears to have accepted that, for at least the extent of two fifths, the subject injury contributed to the overall level of impairment. That finding placed Mr Williams within the first or second category identified in *Oakley*. The chain of causation is established from the subject injury which gave rise to a continuing impairment agreed to be 10% WPI in 2010 of a permanent nature and which materially contributed to the necessity for the surgery that followed leading up to the most recent revision arthroplasty.

39. The decision in *Johnson* is authority for the proposition that a deduction from the assessed level of impairment is only authorised when the impairment assessed is not causally related to the subject injury or there is a deduction to be assessed pursuant to section 323 of the 1998 Act.

40. The reasoning of the AMS is insufficient in that she has failed to consider the reasoning in *Johnson* and demonstrable error is established.

41. No submissions have been addressed to the level of impairment assessed by the AMS on examination and there is nothing to suggest that the extent of impairment assessed by the AMS was not appropriate.

42. The Panel is satisfied that the subject injury materially contributed to the pathology that led to the right knee arthroplasty. It is the result of that surgery that attracts the rating assessed by the AMS of 20% WPI in accordance with Table 17-33 in AMA 5 and the amended Table set out in the Guidelines at page 21, Table 17-35. The Panel accepts that the assessment of 20% WPI accords with the evidence.

43. The AMS concluded that there was no pre-existing condition or abnormality and no relevant previous injuries requiring to be taken into account pursuant to section 323 of the 1998 Act. In reviewing the evidence. The Panel has come to a different conclusion with regard to the existence of a pre-existing condition based on the findings recorded by Dr Harrison at arthroscopy in December 2009.

44. The operative note recorded by Dr Harrison in respect of the right knee arthroscopy carried out on 11 December 2009 records the presence of “synovitis ++” and “chondrocalcinosis ++” with crystals over both articular surfaces. Dr Harrison’s report to the general practitioner is noted above.

45. The nature and extent of the chondrocalcinosis noted by Dr Harrison establishes on the balance of probabilities that this condition was longstanding and one which would have been present prior to the subject injury in 2002 and which would have contributed to the ultimate impairment in the right lower extremity assessed.

46. The extent of that contribution is difficult to quantify. Contribution from the pre-existing condition would be relatively minor compared to the course of events set in train by the subject injury and a deduction of one tenth pursuant to section 323 is not, in the opinion of the Panel, at odds with the available evidence and is appropriate in the circumstances.

47. For these reasons, the Appeal Panel has determined that the MAC issued on 5 March 2020 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

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **147/20**
Applicant: **Keith Williams**
Respondent: **Trivett Classic BMW**

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 Margaret Gibson 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 WorkCover Guides	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 (knee)	23/09/02	Ch 3, p 13 – 23, amended Table 17-35 p. 21	Ch 17, Table 17-33 p.546, 547	20%	1/10	18%
Total % WPI (the Combined Table values of all sub-totals)					**18%**	

The above assessment is made in accordance with the Guidelines for the Evaluation of Permanent Impairment for injuries received after 1 January 2002.

Mr William Dalley
Arbitrator

Dr David Crocker
Approved Medical Specialist

Dr Drew Dixon
Approved Medical Specialist

4 June 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

Lucy Golic
Dispute Services Officer
As delegate of the Registrar