WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **398/20**
Applicant: **Vikki McGill**
Respondent: **Maitland City Bowls, Sports & Recreation Club Ltd**
Date of Direction: **28 April 2020**
Citation: **[2020] NSWWCC 134**

The Commission determines:

Finding

1. The applicant has 31% whole person impairment as a result of injury deemed to have occurred on 8 December 2004.

Order

2. The respondent pays the applicant compensation pursuant to s 66 of the *Workers Compensation Act 1987* in the sum of $55,000 with credit for the prior s 66 award of $15,500.

JOHN HARRIS
Arbitrator

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

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Ms Vikki McGill (the applicant) was employed by the Maitland City Bowls, Sports & Recreation Club Ltd (the respondent) and sustained a compensable injury to both knees deemed to have occurred on 8 December 2004.

2. The applicant commenced proceedings claiming permanent impairment compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act). The body parts for assessment are both lower extremities and the skin.

3. The matter was listed for telephone conference on 24 April 2020 when Mr Blissett appeared for the applicant and Mr Strachan appeared for the respondent. The parties then agreed that I determine the assessment issue consistent with the decision of the President of the Workers Compensation Commission (Commission) in *Etherton v ISS Properties Services Pty Ltd*[1] (*Etherton*). I was otherwise informed that the applicant had an unrelated serious health condition where time was of critical importance. In these circumstances it is appropriate, given the present climate, that I determine the applicant's entitlement to s 66 compensation.

4. The documentation admitted into evidence without objection was:

   (a) Application to Resolve a Dispute and attachments (Application);
   (b) Reply and attachments (Reply), and
   (c) Application to Admit Late Documents filed by the respondent (late Application).

5. The respondent admits injury. The only issue is the assessment of the degree of whole person impairment (WPI) including the extent of any deduction pursuant to s 323 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act).

6. There was no application by either party to adduce any further evidence. The parties were asked to make oral submissions but the legal representatives declined this invitation.

EVIDENCE

Applicant's evidence

7. The applicant commenced working for the respondent in 1986. She stated that her work was quite physical, involved a lot of standing, walking, bending, kneeling and crawling. In 2004 the applicant noticed that she had pain in both knees due to the nature of her duties with the pain in the right knee being worse than the left. The pain was particularly noticeable when she was kneeling to open poker machines and she experienced pain in the knees and had difficulty standing up. After an eight hour shift the applicant would go home and ice both her knees and take pain killers. The applicant consulted her general practitioner in late 2004 and then made a claim for workers compensation payments.

8. After a dispute concerning liability, proceedings were brought in the Commission when the applicant was awarded 12% WPI and a sum for pain and suffering.

9. In September 2011 Dr Caldwell recommended a total right knee replacement. The surgery was paid by the insurer.

[1] [2019] NSWWCCPD 53.

10. The applicant stated that she had a fall on 17 December 2015 due to the loss of stability in her right knee. She attended Maitland Hospital and underwent further surgery to her right leg requiring the placement of plates and screws into her leg. This surgery was undertaken by Dr Osborne. A claim was made for this treatment and liability was again accepted by the respondent.

11. The applicant stated that she has trouble with both of her legs. She cannot stand, sit, walk long distances, bend or kneel without great difficulty.

12. In a further statement dated 24 July, 2019 the applicant stated that in December 2017 she experienced a worsening in right knee pain and consulted a GP and was again referred to Dr Verheul. The applicant stated that Dr Verheul recommended she consult Dr Chris Dunkley who undertook surgery involving the removal of plates from the right knee. That surgery was paid by the insurer.

Radiology

13. An x-ray of both knees dated 9 December 2004[2] showed slight narrowing of the medial compartments with medial lipping of the margins of the medial compartment in the right knee. Dr Scotton commented that the appearances suggested slight cartilage loss in the medial compartments with minor associated degenerative change in the right side.

14. A right knee MRI scan dated 21 February 2005 was reported by Dr Peter Lau[3] as showing no signs of medial meniscus tear, chrondomalacia involving mainly the medial articular surface of the patella and significant loss of articular cartilage of the medial femoral condyle with associated bone marrow oedema.

15. X-rays of both knees on 3 August 2009 was reported by Dr Scott[4] as showing degenerative narrowing of both medial joint compartments and degenerative spurring of the tibial intercondylar spines and minor degenerative changes of the patella femoral joints.

16. An MRI scan of the knees dated 27 May 2010 was reported by Dr Ken Thong[5] as showing chrondomalacia in the patella with mild chondral loss in the medial femoral condyle of the right knee and similar osteoarthritic changes in the left knee.

Other medical reports

17. Dr Joanne Morris provided a short reported dated 8 November 2005[6] stating that she first saw the applicant with complaints of swelling in both knees on 8 November 2004. There was a reported history of no prior injury.

18. Associate Professor Kleinman examined the applicant on behalf of the insurer in December 2004[7]. The doctor recorded that there was no history of knee problems. On examination he noted no obvious malalignment of the knees. The doctor diagnosed bilateral osteoarthritis of the knees which was constitutional but aggravated by the nature and conditions of the work due to the standing for eight hours at a time. He opined that the employment was an aggravating feature of the constitutional changes in the knee joints.

[2] Reply, p 10.
[3] Reply, p 18.
[4] Reply, p 37.
[5] Application, p 38.
[6] Reply, p 26.
[7] Reply, p 11.

19. Dr Peter Berton, orthopaedic surgeon, wrote to the general practitioner in February 2005[8] noting that the applicant presented with problems to her right knee. He recorded that the applicant had been working for the respondent for 18 years with the gradual onset of symptoms over the previous three years associated with stair climbing activity. Duties included repetitive bending and lifting including cartons of beer. The doctor diagnosed medial compartment derangement with an unclear diagnosis. The doctor recommended long term weight loss strategy.

20. A further report by Dr Berton dated 25 February 2005[9] noted that the MRI showed damage to the medial femoral joint lining with sub-condyle oedema and wear of the patella. The doctor reported the ligaments of meniscus appeared intact and the problems appeared to be primarily condyle failure which appear to be in part constitutional and partly due to the nature and conditions of employment over the past 18 years.

21. Dr John Sage, orthopaedic surgeon, reported to the insurer by letter dated 14 March 2005.[10] He noted symptoms related to long periods of standing on concrete floors and the applicant's duties as a bar person. An MRI scan of 21 February 2005 reported articular cartilage loss in the medial femoral condyle and concluded that the right knee showed symptomatic degenerative changes. The doctor opined that medial compartment degenerative changes with articular cartilage loss were progressive.

22. Dr Barry Bracken assessed the applicant on behalf of her lawyers and provided a report dated 7 December 2006.[11] The doctor noted a history that the applicant had worked for the respondent for 20 years, did not play sport and does not have a family history of arthritis. He noted the applicant's work involved continuous standing for her shifts, requiring squatting and crouching to reach trays of glasses at low levels. The doctor opined that the applicant had a genetic predisposition to the development of medial compartment arthritic changes however these changes were aggravated and accelerated by the work over a number of years prior to mid-2004. The doctor noted that the degenerative changes in the knees, particularly the right knee, would be progressive.

23. Dr Bracken provided a further report dated 30 April 2010[12] and stated that his opinion proffered in his earlier report of December 2006 remained valid with respect to diagnosis and causation. He noted the applicant had increasing osteoarthritis affecting the medial compartments of both knees and to a lesser extent the patella femoral compartments. The doctor opined that the applicant had an 8% WPI in each knee which combined to create a 15% WPI. He deducted 20% due to the "underlying genetic tendency for the applicant to develop medial compartment knee arthritis". This resulted in a WPI of 12%.

24. The applicant was examined by Dr Kim Ostinga on behalf of the respondent who provided a report dated 20 January 2011.[13] The doctor opined that there was a constitutional background to the applicant's problem and opined that any aggravation to her condition had ceased.

25. The applicant first consulted Dr Bruce Caldwell, orthopaedic surgeon in July 2011.[14] The doctor recommended a bone scan at that time. The bone scan was reported by Dr Caldwell as showing quite significant medial compartment and patella femoral joint disease. At that stage he did not recommend patella femoral replacement at that time.

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[8] Reply, p 15.
[9] Reply, p 17.
[10] Reply, p 19.
[11] Reply, p 28.
[12] Reply, p 33.
[13] Reply, p 38.
[14] Reply, p 49.

26. In August 2011, Dr Caldwell revisited his advice and recommended a total joint knee replacement of the right knee which was undertaken in September 2011.[15]

27. Subsequent appointments with Dr Caldwell and Dr Richard Verheul in early 2012 recorded histories that the applicant had significant ongoing pain.[16]

28. Dr Verheul consulted the applicant in late 2012[17] when he noted improvement in range of motion but that the applicant suffered from quite significant swelling associated with activity.

29. The applicant underwent revision of the right knee replacement by Dr Verheul in May 2013.[18] Small to moderate infusion was then noted and the patella periphery was cleared and found to be solid. Eight weeks post-surgery, Dr Verheul recorded that the applicant still required Panadol Osteo and the occasional Panadeine Forte.[19]

30. Dr Raymond Wallace was qualified by the respondent and assessed the applicant in August 2014.[20] He opined that the applicant's bilateral knee condition was due to the nature and conditions of employment with a proportion being due to the pre-existing degenerative osteoarthritis of the bilateral knees.

31. In November 2014, Dr Verheul reported that the applicant was 12 months post knee replacement and further gains in the knee were unlikely.[21]

32. In August 2015 Dr Verheul reported that the applicant's symptoms were ongoing and in fact had deteriorated since he last saw her. He noted infusion in the right knee.[22]

33. The applicant consulted Dr Verheul in March 2016 and reported that on 16 December 2015, she turned around on her right knee, it gave way and she sustained a fairly significant peri-prosthetic fracture of the right knee.[23] He noted the applicant was treated at Maitland District Hospital and a LISS plate was applied to the femur.

34. Subsequent reports from Dr Verheul in 2016 showed that the fracture union was solid and progressing.[24] In late 2016 Dr Verheul reported that the applicant's right knee remained "quite dreadful" and was on strong analgesics.[25] He opined that the applicant was not fit for either manual or sedentary work. In April 2018 Dr Verheul recommended removal of the plate and suggested that this be undertaken by Dr Dunkley.[26]

35. Dr Chris Dunkley provided a number of reports in relation to the removal of the plate and screws around the right femur. Post operatively Dr Dunkley noted the applicant was doing well.

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[15] Reply, p 50.
[16] Reply, p 57.
[17] Reply, p 61.
[18] Reply, p 63.
[19] Reply, p 64.
[20] Reply, p 79.
[21] Reply, p 65.
[22] Reply, p 67.
[23] Reply, p 68.
[24] Reply, p 70.
[25] Reply, p 71.
[26] Reply, p 73.

Previous MAC

36. The applicant was referred to Dr David O'Keefe, Orthopaedic Surgeon, an Approved Medical Specialist (AMS) appointed by the Commission. The AMS provided a Medical Assessment Certificate dated 28 February 2011 (MAC) when he assessed the applicant's impairment of both lower extremities from the nature and conditions of employment from April 1990 to 8 December 2004, with a deemed date of injury on 8 December 2004.[27]

37. The AMS opined the applicant had patella femoral arthritis of both knees with significant medial compartment osteoarthritis. There was no other evidence of intra articular pathology. The AMS observed that the applicant presented quite well with no evidence of embellishment.

38. Dr O'Keefe opined that the applicant's patella femoral arthritis was due to the nature and conditions of employment over the period and that she had a constitutional tendency to develop medial compartmental arthritis due to her varus alignment.[28]

39. The AMS expressed disagreement with Dr Sage's opinion that there was no component of work-related injury for the above reasons and opined that the nature and conditions of employment had contributed 100% to the current patella femoral arthritis but not to the medial compartment arthritis which he opined was constitutional in aetiology.[29]

40. The AMS assessed 8% WPI for the right lower limb associated with a 0 mm measured gap and 4% WPI of the left lower limb associated with a 2 mm measured gap. The doctor made no deduction pursuant to s 323 and assessed the applicant's WPI at 12%.

41. Given that the AMS made no s 323 deduction, it appears that the assessment of the loss of cartilage related only to the patello-femoral joint.

Assessments of Whole Person Impairment

42. Dr John Bentivoglio, Orthopaedic Surgeon, was qualified by the respondent and provided a report dated 15 March 2017.[30] The doctor observed a valgus alignment in the right knee with restricted movement and opined that the applicant had developed degenerative osteoarthritis predominantly involving the right knee where the symptoms had reached the point where she required a knee joint replacement.[31]

43. Dr Bentivoglio noted ongoing symptoms in the right knee following the operation and patella femoral replacement. He noted the applicant also had some degree of degenerative changes involving the left knee. The doctor opined that given the length of time the applicant had worked for the respondent "a significant proportion of the degenerative changes present in the knee has developed as a result of her work activities".[32]

44. Dr Bentivoglio assessed the applicant as having a fair result from the total knee replacement and this equated to 20% WPI. He noted that the applicant "has only spent 10% of her life" with the respondent and therefore a 50% deduction pursuant to s 323.[33]

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[27] Reply, p 43.
[28] Reply, p 46.
[29] Reply, p 46.
[30] Reply, p 103.
[31] Reply, p 107.
[32] Reply, p 107.
[33] Reply, p 108.

45. The doctor stated that he could not find any x-rays taken of the left knee but assessed the applicant as having a 3 mm cartilage interval loss in the medial compartments giving rise to 3% WPI. He said once again he would make a 50% deduction, rounding this up to 2% WPI.[34]

46. Dr Bentivoglio provided a further report dated 16 September 2019.[35] The doctor recorded current symptoms of constant pain in the right knee, not confined to any specific site and involving the whole knee. The knee tended to swell and give way with decreased movement and decreased strength. Knee symptoms were noted to fluctuate in severity and were made worse with activity. The applicant noted difficulty with stairs and tries to avoid them, avoids kneeling and squatting and is unable to get up from these positions. The applicant was reported as saying if anything the knee symptoms are worsening.[36] The pain in the left knee was predominantly over the anterior medial aspect of the knee with some crepitation.

47. Medication intake included four to six tablets of Panadeine Forte per day. Dr Bentivoglio noted the applicant had a well healed scar measuring 16 cm in length over the anterior aspect of the knee, not attached to the underlying tissues and a well healed scar measuring 25 cm involving five or six smaller scars. Portions of the latter scar were somewhat dehisced and not attached to the underlying tissues.[37]

48. The doctor noted there were eight degrees of valgus alignment in the right knee and six degrees in the left knee.

49. Dr Bentivoglio noted an MRI scan of the right knee in February of 2005 showed loss of articular cartilage involving the medial femoral condyle region of the right knee. The doctor opined in the absence of any specific injury of the right knee that the applicant had both constitutional as well as a work reason for the development of the degenerative arthritis in the right knee.

50. Dr Bentivoglio assessed the applicant's permanent impairment of the right knee applying Table 17-33 of the 5th edition of the *American Medical Association's Guides to the Evaluation of Permanent Impairment* (AMA 5) and after deducting nine points for the increased valgus alignment present in the knee, to rate at 45 points. The doctor opined that this was a poor result from a total joint knee replacement and amounted to 30% WPI.

51. The doctor assessed a further 2% WPI for the scars.

52. In respect of the left knee, the doctor said there was 3% WPI as a result of medial compartment joint space (3 mm joint separation).

53. Dr Bentivoglio referred to Dr Ghabrial's 2017 report and observed that the doctor had assessed a fair result at that time. Dr Bentivoglio now opined that the result from the total knee replacement was poor.

54. Dr Bentivoglio also compared the assessments of the left knee. He observed there was no rating of 12% WPI in respect of a measured 2 mm joint space separation under Table 17-31 of AMA 5 and that the assessment should be 8%. However, Dr Bentivoglio said that on his measurement that day he felt the joint space separation was 3 mm and not 2 mm. He noted that it was two years since the applicant had seen Dr Ghabrial and thought that the assessment of 2 mm separation was not appropriate.

55. Dr Bentivoglio's explanation for his s 323 deduction of 50% and why he disagreed with Dr Ghabrial's opinion is set out later in these reasons.

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[34] Reply, p 108.
[35] Reply, p 1.
[36] Reply, p 4
[37] Reply, p 5.

56. Dr Ghabrial provided a report dated 13 December 2017.[38] The doctor noted that the applicant had post traumatic osteoarthritis in the right knee requiring two operative procedures for replacement surgery and one operative procedure for the fracture above the prosthesis when the right knee gave way. He assessed the applicant at that time as having a fair result following the right knee total knee replacement, 1% for scarring and a further 12% WPI in respect of the left knee in accordance with Table 17-31.[39]

57. Dr Ghabrial reassessed the applicant on 7 August 2019.[40] The doctor recorded that the applicant's symptoms continued to deteriorate and her walking ability was "markedly reduced".[41] The applicant was only able to walk a few hundred metres on a flat surface before she stopped, found it difficult to go up and down stairs and walk on slopes or uneven grounds. The applicant was unable to squat.

58. Dr Ghabrial noted two major scars, moderate swelling, effusion and quadriceps wasting with moderate tenderness over the right knee. The range of motion was 0-105 degrees with discomfort with no crepitations and slight instability of the ligaments of the right knee. There was discomfort over the patella femoral joint.

59. The doctor noted the left knee showed evidence of osteoarthritic changes with 2 mm cartilage interval in the medial compartment and the patella femoral compartment.[42]

60. Dr Ghabrial opined that clinical assessment and investigations suggested the development of post-traumatic osteoarthritis of both knees. The doctor again assessed a fair result for the total replacement of the right knee, assessed the scarring at 2% and again reported that the left knee was 12% WPI in accordance with Table 17-31. He made no s 323 deduction.[43]

REASONS

61. The assessment of WPI is undertaken in accordance with the fourth edition of the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment* (fourth edition guidelines).[44] The fourth edition guidelines adopt the 5th edition of the AMA 5. Where there is any difference between AMA 5 and the fourth edition guidelines, the fourth edition guidelines prevail.[45]

62. The common opinion of both Dr Ghabrial and Dr Bentivoglio is that the applicant has assessable impairment of both lower extremities and the skin as a result of the accepted work injury.

63. In *Secretary, Department of Education v Johnson*[46] (*Johnson*) Emmett JA stated:[47]

> "The phrase 'the degree of permanent impairment of the person as a result of an injury' appears in both ss 319(c) and s 326(1)(a) of the Management Act. That composite phrase requires an enquiry as to the causal connection between the degree, or percentage, of assessed permanent impairment of a worker, on the one hand, and the compensable injury, on the other. That is to say, it was necessary for the AMS and the Appeal Panel to assess the degree, or percentage, of whole person impairment of the

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[38] Application, p 81.
[39] Application, p 84.
[40] Application, p 87.
[41] Application, p 88.
[42] Application, p 88.
[43] Application, p 90.
[44] The 4th edition guidelines are issued pursuant to s 376 of the 1998 Act.
[45] Clause 1.1 of the fourth edition guidelines.
[46] [2019] NSWCA 321.
[47] At [55], Macfarlane JA agreeing.

Worker that was caused by or is attributable to the First Injury. In doing so, common law principles of causation in tort are to be applied."

64. There was a common view expressed by Dr Bentivoglio and Dr Ghabrial that the applicant's total right knee replacement is a result of the accepted work injury. The issues for determination were restricted to the extent of the degree of permanent impairment and the amount of any s 323 deduction.

65. I acknowledge that my determination is at the date of this decision.[48] In circumstances where the consistent medical opinion is that the applicant's condition has not improved and indeed deteriorated over time, it is reasonable to determine the present impairment in the context of the assessments undertaken by Dr Ghabrial and Dr Bentivoglio in August/September 2019.

66. There are no liability issues raised by the respondent including the need for surgery and the subsequent fracture.[49]

67. Both Dr Ghabrial and Dr Bentivoglio assessed the scars at 2% WPI. The scars are clearly described in the detailed reports of Dr Bentivoglio.[50] Accordingly, I adopt the agreed assessment for skin impairment.

Left lower extremity

68. In respect of the assessment of the left lower extremity, Dr Ghabrial assessed 12% under Table 17-31. The doctor referred to osteoarthritic changes with 2 mm cartilage interval in the medial compartment and the patello-femoral compartment.[51]

69. Dr Bentivoglio stated that he did not understand how Dr Ghabrial arrived at 12% WPI for the left knee. However, Dr Ghabrial appears to have added the cartilage interval of 2 mm for the medial compartment of the left knee (8% WPI) with the cartilage interval of 2 mm for the patellofemoral joint (4% WPI). The simple addition of 8% and 4% would equate to 12% WPI under Table 17-31.

70. Dr Bentivoglio has not considered the separate assessments for the knee and the patellofemoral joint. His assessment of 3% WPI was only based on the medial joint compartment.[52]

71. In 2011 the AMS assessed the WPI of the left lower extremity by reference to loss of cartilage in the patello-femoral joint at 2 mm cartilage interval with no s 323 deduction[53]. He then awarded 4% WPI. The AMS did not assess WPI for the medial joint.[54]

72. It would be inconsistent with the prior determination based on the MAC to assess the patellofemoral joint at anything other than 4% WPI unless that condition had changed. The assessment of Dr Bentivoglio of the left knee was restricted to the assessment of the medial joint space of 3 mm separation which was assessed under Table 17-31 at 3% WPI. Dr Bentivoglio did not assess the loss of cartilage in the patellofemoral joint of the left knee.

73. Dr Ghabrial appears to have assessed the medial joint space at 2 mm (8% WPI) and the patellofemoral joint at 2 mm (4% WPI).

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[48] See 1.6a of the fourth edition guidelines.
[49] See *State of New South Wales v Bishop* [2014] NSWCA 437.
[50] Reply, p 5.
[51] Application, p 88.
[52] Reply, p 8.8.
[53] Reply, p 45 and p 48.
[54] Reply, pp 46-48.

74. An issue is whether the applicant has a medial joint space of 3 mm as Dr Bentivoglio opined or 2 mm as Dr Ghabrial opined.

75. As the applicant bears the onus of proof in establishing the extent of the degree of permanent impairment, I accept the analysis which provides a lesser impairment involving a greater cartilage interval. Accordingly, I adopt Dr Bentivoglio's assessment of 3 mm cartilage interval for the medial joint space because there is no clear basis for accepting one opinion over the other. Accordingly, the applicant has not discharged the onus of proof in establishing that there is 2 mm of cartilage of the medial joint equating to 8% WPI.

76. A finding of 3 mm of cartilage interval for the medial joint space equates to 3% WPI under Table 17-31 of AMA 5.

77. Paragraph 3.20 of the fourth edition guidelines modifies Table 17-31 of AMA 5. The fourth edition guidelines provide that only the compartment with the "major impairment" is used and the different compartments cannot be added or combined.

78. The AMS previously assessed the patellofemoral joint at 2 mm and Dr Ghabrial agreed with that assessment. That conclusion amounts to 4% WPI. Dr Bentivoglio did not assess that compartment of the knee.

79. The assessment of the medial joint is 3% WPI pursuant to Dr Bentivoglio's assessment.

80. Accordingly, pursuant to paragraph 3.20 of the fourth edition guidelines, the applicant is only entitled to the greatest assessment of the particular knee compartment. The assessment of the left lower extremity is therefore 4% based on loss of cartilage in the patellofemoral joint.

81. In this respect I adopt the previous reasons and findings provided by the AMS for the left lower extremity including that there is no s 323 deduction. There is nothing inconsistent with that finding and Dr Bentivoglio's opinion as the doctor did not assess that compartment. Dr Ghabrial's current assessment is the same as that reached by the AMS for the patellofemoral compartment.

82. Accordingly, I adopt the assessment previously provided by the AMS and reiterated by Dr Ghabrial for the patellofemoral compartment. The applicant has a 4% WPI with no s 323 deduction for the left lower extremity.

Right lower extremity

83. The issue for the assessment of the right lower extremity is whether the applicant obtained a fair or a poor result under Table 17-33 following the total right knee replacement.

84. Both Dr Bentivoglio and Dr Ghabrial assessed the applicant in 2017 as having attained a fair result for the total right knee replacement.

85. In his 2019 assessment Dr Bentivoglio provided the points regime for assessing a poor result in accordance with Table 31-33.[55] His calculations are otherwise consistent with the applicant's description of the difficulties she was having with her right knee and consistent with observations by both doctors in 2019 that the right knee had deteriorated during this period.

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[55] Reply, p 7.

86. Dr Ghabrial has provided no calculations as to how and why he recently concluded, pursuant to Table 17-33 of AMA 5, that the outcome from the total right knee replacement was "fair". Accordingly, there is no basis to critically analyse Dr Ghabrial's opinion as to how he formed the opinion that the applicant has attained a fair result from her total right knee replacement. One such example is that Dr Bentivoglio allowed a deduction of nine points for valgus alignment[56]. Such a deduction for the purposes of calculating the appropriate points is not referenced by Dr Ghabrial.

87. In these circumstances I reject Dr Ghabrial's assessment because he has not adequately explained how he arrived at the conclusion that the applicant has attained a fair outcome as a result of the total knee replacement.[57] On this issue I accept Dr Bentivoglio's detailed opinion.

88. For these reasons, I accept Dr Bentivoglio's opinion that the applicant has a poor result from the total right knee replacement. The right lower extremity is assessed at 30% WPI.

Section 323

89. The remaining issue is the extent of the s 323 deduction.

90. A deduction pursuant to s 323 of the 1998 Act is required if a proportion of the permanent impairment is due to previous injury or due to pre-existing condition or abnormality: *Vitaz v Westform (NSW) Pty Ltd (Vitaz)*[58]; *Ryder v Sundance Bakehouse* (*Ryder*)[59]*; Cole v Wenaline Pty Ltd* (*Cole*).[60]

91. In *Vannini v Worldwide Demolitions Pty Ltd*[61] Gleeson JA stated that an Appeal Panel, when considering the reasoning of an Approved Medical Specialist on the question of causation under s 323, was required to determine "whether any proportion of the impairment was due to any previous injury, or pre-existing condition or abnormality" and if so, "what was that proportion".[62]

92. There must be a pre-existing condition or abnormality and not a genetic predisposition to such condition: *Matthew Hall Pty Ltd v Smart*[63] (*Smart*). The Court of Appeal recently made similar observations concerning the distinction between a genetic disposition to a disease and the existence of "disease" for the purposes of s 4(b) of the 1987 Act: *Booth v Fourmeninapub Pty Ltd.*[64]

93. The applicant's genetic predisposition to arthritis is not a pre-existing condition within the meaning of s 323.

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[56] See paragraph 50 herein.

[57] See the discussion in *Hancock v East Coast Timber Products Pty Ltd* [2011] NSWCA 11 at [82]-[83] per Beazley JA; Giles & Tobas JJA agreeing.

[58] [2011] NSWCA 254.

[59] [2015] NSWSC 526 (*Ryder*) at [54].

[60] [2010] NSWSC 78 at [29] - [30].

[61] [2018] NSWCA 324 (*Vannini*) at [90].

[62] At [90].

[63] [2000] NSWCA 284 at [32] and [37], Mason P and Powell JA agreeing.

[64] [2020] NSWCA 57 (*Booth*) at [58] per Leeming JA, Bell P and White JA agreeing.

94. The onus of proof in establishing the s 323 defence lies on the respondent. In *Asbestos Remover & Demolition Contractors Pty Ltd v Kruse* [2017] NSWWCCMA 51, a Medical Panel concluded that the onus of proof was on the employer to establish a non-compensable cause in industrial deafness cases.[65] Reference was made by that Panel to the observations of Barwick CJ in *Sadler v Commissioner for Railways* (1969) 123 CLR 216 and Garling J in *Pereira v Siemens Ltd* [2015] NSWSC 1133.

95. In *Smart*, Giles JA accepted the employer's concession that it bore the onus in establishing a deduction under s 68A (the statutory predecessor to s 323).[66]

96. Section 323 applies only to an apportionment for an earlier injury or pre-existing condition of abnormality. It has no operation with respect to a subsequent injury or condition: *Johnson.*[67]

97. The opinion expressed by Dr Bentivoglio of a 50% deduction pursuant to s 323 is inconsistent with the above legal principles in a number of critical respects. In assessing a 50% deduction, Dr Bentivoglio relevantly stated:[68]

> "He [Dr Ghabrial] also accepted that 100% of her current disability (without any specific injury to her knee) had come about by her employment. This would mean that this lady would have to stop doing any activity after leaving work and before going back to work for this to be the case. That is totally incorrect. Without a specific injury I would feel that at least a 50% deduction should be made for constitutional changes."

98. Similar observations were echoed by Dr Bentivoglio in his earlier report dated 15 March 2017.[69]

99. Dr Bentivoglio does not specifically address what was the nature of the pre-existing condition and how that pre-existing condition contributed to the final impairment. His overall assessment is otherwise inconsistent with the opinion expressed by the AMS in 2011 that the entire condition in the patello-femoral compartment was caused by the work with the respondent.

100. Dr Bentivoglio addresses the applicant's overall condition and has made no attempt to delineate the "pre-existing" condition. His opinion of the apportionment is expressed as between work and non-work causes and considers subsequent aggravation through an ongoing degenerative process.

101. That analysis undertaken by the doctor is inconsistent with the recent observations of the Court of Appeal in *Johnson*[70] and otherwise inconsistent with the discussion by Beech-Jones J in *Cullen v Woodbrae Holdings Pty Ltd* (*Cullen*)[71] when his Honour stated:[72]

> "Overall, the approach of the MAP was to treat a pre-existing condition as a condition that existed outside the course of employment whereas in this case it had to be a condition that existed prior to Mr Cullen's employment."

102. Dr Bentivoglio has made the same error in this matter.

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[65] at [52]-[54].
[66] At [37].
[67] At [119] per Simpson AJA, Emmett JA agreeing.
[68] Reply, p 9.
[69] Reply, p 108.
[70] See paragraph 96 herein.
[71] [2015] NSWSC 1416.
[72] At [57].

103. The AMS addressed the issue of a s 323 deduction in 2011. Relevantly the AMS then stated:[73]

> "I disagree with Dr Sage in that he states there is no component of work-related injury for the reasons above and I agree that the nature and conditions of her employment over the period has contributed to 100% of her current patello-femoral arthritis but not her medial compartment arthritis which is constitutional in aetiology."

104. There is evidence that the applicant had a pre-existing condition in 2004. However, the medical evidence does not adequately address the situation prior to the period of the nature and conditions of employment.

105. The 2004 x-ray refers to slight narrowing of the medial compartment. Dr Kleinman opined in 2004 that there was pre-existing degeneration although he did not directly address the question prior to the period of employment aggravating the disease. The same observations could be made to the opinions expressed by other doctors such as Dr Bracken and Dr Wallace.

106. The AMS concluded that the applicant suffered from constitutional condition in the medial joint compartment. Consistent with the opinions expressed by other doctors it is probable that this osteoarthritic condition pre-existed the time when work commenced to aggravate the degenerative condition.

107. The applicant's evidence, which I accept, is that the knees were asymptomatic until the employment duties caused an onset of pain in the period leading up to the claim of injury in 2004.

108. With some hesitation, I am satisfied that the respondent has established that the applicant had some degeneration in the right medial compartment prior to the period of injury.

109. I accept the opinion of the treating specialist, Dr Caldwell, that the need for the total right knee replacement was due to disease in both the medial compartment and the patellofemoral joint.[74] In that respect the pre-existing medial joint disease contributed to the impairment because it contributed to the need for the total right knee replacement. Such a conclusion is not inconsistent with the finding reached by the AMS in 2011 that there was no s 323 deduction for the right knee because at that time, the AMS only assessed impairment for the patellofemoral compartment. The current impairment is based on a larger part of the knee of which there was a pre-existing condition, that is degeneration in the medial compartment.

110. The absence of proper medical opinion of the degree of the pre-existing condition in accordance with law means that the determination of the s 323 deduction for the right lower extremity is difficult to determine. It is extremely difficult on the state of the medical opinion to determine the exact nature of pre-existing degeneration prior to employment and/or prior to the deemed date of injury.

111. The 2004 x-ray only described the applicant's degeneration in the medial compartment as "slight". Medical opinion, which I accept, such as the opinion expressed by Dr Bracken establishes that the applicant's degeneration has deteriorated since injury. That subsequent deterioration is not a pre-existing condition within the meaning of s 323 and not a factor which can be considered in assessing the extent of any deduction.

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[73] Reply, p 46.
[74] Reply, p 50.

112. A statutory deduction of one-tenth is prescribed by s 323(2) which relevantly provides:

> "(2) If the extent of a deduction under this section (or a part of it) will be difficult or costly to determine (because, for example, of the absence of medical evidence), it is to be assumed (for the purpose of avoiding disputation) that the deduction (or the relevant part of it) is 10% of the impairment, unless this assumption is at odds with the available evidence.
>
> (3) The reference in subsection (2) to medical evidence is a reference to medical evidence accepted or preferred by the approved medical specialist in connection with the medical assessment of the matter."

113. Section 323(3) of the 1998 Act provides meaning to the reference in s 323(2) of "available evidence". I have earlier provided reasons why I do not accept Dr Bentivoglio's opinion that the s 323 deduction should be 50%. Accordingly, I do not accept that a one-tenth deduction "is at odds with the available evidence" as I do not accept Dr Bentivoglio's opinion that there should be a deduction of 50% pursuant to s 323.

114. In these circumstances, I find that the assessment is difficult to determine because of the absence of medical evidence properly addressing the requirements of the section. In these circumstances I apply the statutory deduction pursuant to s 323(2) of one-tenth to the right lower extremity.

115. The skin impairment is associated with the total right knee replacement and a further scar associated with a fall from the right knee problem. Accordingly, the s 323 deduction of one-tenth also applies to the skin assessment.

116. Given the unanimous medical opinion and the duration of symptoms, I accept that the applicant's impairment is permanent.

117. The applicant has a 30% WPI of the right lower extremity with a one-tenth deduction totalling 27% WPI, a 4% WPI of the left lower extremity with no deduction and a 2% WPI for the skin less a one-tenth deduction. The assessment of the skin is rounded up to 2% WPI.[75]

118. The overall WPI assessment using the combined tables is 31% WPI.

CONCLUSION

119. The findings and orders are set out in the Certificate of Determination.

[75] Paragraph 1.26 of the fourth edition guidelines.