WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **1525/20**
Applicant: **Jeanette Strohfeld**
Respondent: **Canley Gardens Pty Ltd**
Date of Direction: **18 May 2020**
Citation: **[2020] NSWWCC 159**

The Commission determines:

Finding

1. The applicant has 24% whole person impairment resulting from injury on 12 November 2011.

Order

2. The respondent pays the applicant compensation pursuant to s 66 of the *Workers Compensation Act 1987* in the sum of $43,312.50 which includes a 5% uplift pursuant to s 66(2A).

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 Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Ms Jeanette Strohfeld (the applicant) was employed by Canley Gardens Pty Ltd (the respondent) and sustained a compensable injury to the lumbar spine on 12 November 2011.

2. The applicant commenced proceedings claiming permanent impairment compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act). The body part for assessment is restricted to the lumbar spine.

3. The matter was listed for telephone conference on 13 May 2020 when Ms Kava appeared for the applicant and Mr Bennett appeared for the respondent. The parties then agreed that the assessment issue be determined consistent with the decision of the President of the Workers Compensation Commission (Commission) in *Etherton v ISS Properties Services Pty Ltd*[1] (*Etherton*).

4. The parties agreed that the applicant suffered whole person impairment (WPI) as a result of injury on 12 November 2011 and that the only difference between the two overall assessments provided by Associate Professor Fernside and Dr Miniter was whether the applicant suffered from radiculopathy and the extent of any deduction pursuant to s 323 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act).

5. The documentation admitted into evidence without objection was:

    (a) Application to Resolve a Dispute and attachments (Application), and
    (b) Reply and attachments (Reply).

6. There was no application by either party to adduce any further evidence.

7. The parties were given the opportunity to make oral submissions. The legal representatives made some brief submissions which are referred to later in the Reasons.

EVIDENCE

Applicant's evidence

8. The applicant provided a statement dated 27 February 2020.[2] The applicant stated that she was asymptomatic prior to injury and set out in detail the nature of her medical treatment and residual difficulties.

9. The applicant commenced employment with the respondent in 2004 and prior to 2011 had not suffered a back injury or back problems[3]. She had been previously diagnosed with rheumatoid arthritis in 2009.

10. The applicant suffered injury on 12 November 2011, when she was working in the section of the facility dealing with high care residents. Whilst lifting what the applicant described as a "morbidly obese patient", she felt a ripping pain in her lower back radiating down the left leg. The applicant reported the injury and sought immediate attention with her general practitioner, Dr John Williams, who referred the applicant for a CT scan.

11. Following conservative treatment, the applicant was referred to Dr McKechnie who recommended surgery. The applicant continued to experience debilitating agony from back pain and pain shooting down in both legs.

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[1] [2019] NSWWCCPD 53.
[2] Application, p 9.
[3] Application, p 9.

12. The matter eventually came before the Commission when the respondent agreed to pay for lumbar spine surgery by way of fusion at multiple levels which was performed on 16 August 2017.

13. The applicant continued to experience leg and back symptoms and further surgery was performed by Dr McKechnie on 13 December 2019 involving an L3/4 discectomy and decompression.

14. The applicant stated that she continues to experience severe and constant lower back pain, burning pain down the right leg through the right calf and right foot and left-sided sciatic pain. She remains under the care at the Sydney Pain Management Centre and is taking extensive medication.

Radiology

15. A CT scan of the lumbar spine dated 30 November 2011, reported by Dr Tom Singh, noted degeneration at various levels including a broad-based left paracentral disc protrusion causing slight displacement of the left S1 nerve root at the L5/S1 level.[4]

16. An MRI scan of the lumbar spine dated 1 December 2014, reported by Dr Luckey, showed broad-based disc protrusion at L3/4 causing impingement on the L4 nerve roots, broad-based disc protrusion at L4/5 extending to the left, impinging on the left L5 nerve root, broad-based disc bulge at L5/S1 causing moderate bilateral foraminal encroachment without definite impingement of the exiting nerve roots.[5]

17. Dr Wijaya reported the regional bone scan with SPECT dated 4 December 2014 as showing mild right discovertebral joint arthritis at L5/S1 of no clinical significance and "no active facet joint arthritis".[6]

18. An MRI scan of the lumbar spine dated 20 June 2018, reported by Dr Ganeshan, showed adequate spinal decompression post L3 to S1 laminectomy and spinal fusion with an L3/4 annular tear and disc protrusion with moderate thecal sac compression and foraminal L5 stenosis and a left nerve root compression.[7]

19. An MRI scan dated 24 July 2019 noted ongoing low back pain extending to the left leg. Dr Rezaee concluded that the scan showed moderate stenosis on the left L3/4 neural exit foramen and mild to moderate bilateral, left worse than right L5/S1 neural exit foraminal narrowing.[8]

Treating reports

20. Medical reports prior to the work injury showed that the applicant was diagnosed with rheumatoid arthritis and was taking various medications in December 2010. Dr Damodaran, rheumatologist, noted that the applicant complained of intermittent small joint pain which had largely settled down. In March 2011, the doctor noted the applicant complained of some pain in the right hip, right knee, right ankle and felt 15 minutes of early morning stiffness. In September 2011, Dr Damodaran noted that there had been some right ankle synovitis.

21. In January 2014, Dr Geraldine Hassett diagnosed left L5 radiculopathy and recommended a repeat L5 perineural injection.[9]

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[4] Application, p 102.
[5] Application, p 370.
[6] Application, p 149.
[7] Application, p 258.
[8] Application, p 420.
[9] Application, p 110.

22. In May 2014, Dr Simon McKechnie reviewed the applicant and noted ongoing back and left leg symptoms consistent with the MRI findings.[10]

23. In December 2014, Dr Teychenne, neurologist, reported that the findings of the MRI scan were consistent with the neuropsychological findings of a bilateral L5/S1 radiculopathy.[11]

24. The applicant was reviewed by Dr McKechnie in May 2016. At that time, the doctor noted persistent pain down in the back through the left leg and into the foot. Dr McKechnie ordered a repeat MRI scan in December 2015, which again demonstrated a left L4/5 disc protrusion impinging mainly upon the L5 nerve root. Surgery was discussed at that time.[12]

25. Dr McKechnie reviewed the applicant in September 2017 approximately one month following a lumbar laminectomy and an L4 to S1 pedicle screw fusion. At the time the doctor noted a good early recovery.[13] In March 2018, Dr McKechnie noted recent deterioration with more back pain radiating into the left leg.[14]

26. In 2018, Dr McKechnie noted persistent back and left leg pain[15] and in August 2018, he opined that the recent MRI scan showed a slightly larger L3/4 disc protrusion.[16]

27. In November 2018, Dr McKechnie recommended surgery to the L3/4 disc protrusion[17] which was undertaken in late 2018.[18] Dr McKechnie noted in various reviews in 2019 that the applicant continued to complain of back and intermittent leg pain.[19]

28. Associate Professor Fearnside saw the applicant on 24 June 2016 and then noted impaired sensation in the L5/S1 dermatomes which was consistent with the radiology and an absent left ankle reflex.[20]

Qualified opinions

29. Associate Professor Fearnside provided a report dated 18 October 2019.[21] The doctor noted that the applicant sustained injury to the back on 12 November 2011 and underwent a partial laminectomy at L3 and an L4 to S1 decompression and pedicle screw fusion on 16 August 2017. He noted a history that six weeks post-operation, the applicant had a fall and her symptoms worsened.

30. On clinical examination Associate Professor Fearnside observed lower back pain with minimal right sciatic pain, severe left sciatic pain with a sharp-shooting pain down the left leg and impaired sensation on the anterior surface of the shin, the dorsum of the foot and the sole of the foot. The doctor noted very little change with regard to the activities of daily living (ADL) since his previous report.

31. After reviewing the radiology, the doctor opined that neurological examination of the lower limbs revealed a weakness of dorsiflexion and eversion of the left ankle including the left great toe, powers otherwise normal but inhibited by pain. There was no measured wasting of the calves or thighs. Knee reflexes were absent even with reinforcement, the right ankle reflex was present with reinforcement and the left ankle reflex was absent.[22]

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[10] Application, p 129.
[11] Application, p 151.
[12] Application, p 178.
[13] Application, p 239.
[14] Application, p 257.
[15] Application, p 354.
[16] Application, p 356.
[17] Application, p 358.
[18] Application, p 364.
[19] Application, pp 365, 366, 367, 368, 369.
[20] Application, p 290
[21] Application, p 13
[22] Application, p 16.

32. The doctor noted sensory testing of the right leg revealed impaired sensation in the right S1 dermatome along the lateral border of the right foot and of the dorsum of the foot. Sensory testing in the left leg revealed sensory loss in the left L4 through to S1 dermatomes below the knee with impaired sensation of the medial service of the left shin (L4), the anterior surface of the shin and the dorsum of the foot (L5) and the lateral border of the left foot (S1), although there was preservation of sensation at the sole of the foot.[23]

33. Associate Professor Fearnside assessed permanent impairment of the lumbar spine based on the fusion as being DRE Lumbar Category IV together with a further 2% for the effects of the injury on the activities of daily living. With regards to the effects of surgery, the doctor noted additional permanent impairment ratings of 3% for radiculopathy based on tension signs, segmental motor weakness, reflex asymmetry and dermatomal sensory loss. The doctor made an allowance for surgery at two additional levels and an allowance for a second operation. Accordingly, the total WPI for the effects of the surgery were an additional 7%.

34. With respect to the s 323 deduction, the doctor noted the applicant was asymptomatic at the time of the accident but on the balance of probabilities there was significant lumbar spondylosis present which was aggravated by the injury. He noted that of itself this would not contribute to the assessed WPI but it was quite probable on balance that the effects of injury would have been less had the applicant had a normal spine. The doctor opined that the amount of contribution from the constitutional condition of lumbar spondylosis was difficult to determine and therefore deducted one-tenth from the assessed impairment. Accordingly, he concluded, after the s 323 deduction, that the applicant had 24% WPI.

35. Dr Azhar Khan, Occupational Physician, provided a report to the respondent dated 30 September 2019.[24] On neurological examination, the doctor measured a calf circumference of 40 cm bilaterally, normal tone and power that was suboptimal due to pain. There was normal ankle dorsiflexion but weakness with respect to left ankle dorsiflexion and plantar flexion. The doctor could not elicit left knee reflexes. The doctor opined that the applicant was unfit for her preinjury role and required ongoing multidisciplinary care for chronic pain.

36. Dr Miniter has provided a series of reports where he opined that the applicant's condition was unrelated to injury and was due to the progression of osteoarthritic disease.[25] He also opined in June 2017 that it was quite possible that the applicant's condition was related to rheumatoid arthritis.[26]

37. In his latest report dated 27 December 2019[27] Dr Miniter noted the applicant had undergone a fusion from L4 to S1 with neurological decompression and that subsequent to surgery, the applicant fell over with increased left leg pain. Subsequent further surgery involved an L3/4 discectomy on the left-hand side undertaken by Dr McKechnie in December 2018. Dr Miniter noted that the MRI of the lumbar spine in June 2018 showed an adequate spinal decompression from L3 to S1 with a spinal fusion from L4 to S1 which appeared to be uncomplicated. He also noted a possibility of a left-sided L4 lateral recess compression syndrome at L3-4 level and the possibility of an L5 stenosis on the left-hand side with nerve root compression.

[23] Application, pp 16-17.
[24] Reply, p 10.
[25] Reply, p 20.
[26] Reply, p 20.
[27] Reply, p 3.

38. Dr Miniter opined that the applicant had issues with rheumatoid arthritis which may have been contributory and opined that the leg pain did not have a rational explanation.[28] The doctor opined that the applicant voluntarily exaggerated her symptoms that there was a definite pre-existing condition which was relevant to the "alleged injury"[29] and there was a lack of consistency in the history.

39. Dr Miniter opined that there was no "convincing evidence of ongoing radiculopathy"[30] and did not make an additional allowance for this. Otherwise the doctor agreed with the assessments provided by Associate Professor Fearnside.

40. In respect of any s 323 deduction, Dr Miniter stated:[31]

> "For the reasons that I had given in the past, and I have been consistent in this ever since I first saw this lady, there is significant pre-existing pathology. I would therefore make an allowance of 25% which I believe is a reasonable representation. This allows for the possible effects of rheumatoid arthritis, for the clear pre-existing pathology identified in the MRI scan and for the poor outcome from the surgery".

41. Dr Miniter again opined that he found it difficult to ascribe the applicant's condition entirely due to the nature and conditions of her employment but noted the matter had been with the Commission and therefore he felt it was "not unreasonable to subtract a one-quarter moiety" and allowed final assessment of 18%" WPI.[32]

REASONS

42. 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).[33] 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.[34]

43. Given the parties' agreement and the admission of injury, the issues on assessment are restricted to whether the applicant has ongoing radiculopathy and the extent of the s 323 deduction. There is no dispute that the overall impairment results from injury and that the impairment is permanent.

Radiculopathy

44. The onus of proof lies on the applicant to establish the extent of any permanent impairment.

45. Despite my preliminary view that the applicant would have difficulties establishing that she had ongoing radiculopathy as defined by paragraph 4.27 of the fourth edition guidelines, I am satisfied that she has discharged this onus based on the preponderance of medical opinion.

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[28] Reply, p 6.
[29] Reply, p 7.
[30] Reply, p 7.
[31] Reply, p 8.
[32] Reply, p 8.
[33] The 4th edition guidelines are issued pursuant to s 376 of the 1998 Act.
[34] Clause 1.1 of the fourth edition guidelines.

46. Associate Professor Fearnside was satisfied that the applicant has an absent left ankle jerk. AMA 5 makes it clear what the doctor otherwise stated, that the ankle reflex is in the S1 dermatome emerging from the spine at the L5/S1 level.[35] The doctor was also satisfied that the applicant had sensory loss in this distribution[36] which otherwise accords with Table 15-2 of AMA 5.

47. The most recent MRI scan in July 2019 was reported as showing left worse than right neural exit foraminal narrowing at L5/S1.[37]

48. Dr McKechnie, treating neurosurgeon, referred to ongoing left leg pain throughout 2019.[38]

49. Dr Khan's neurological findings in September 2019 included "weakness with respect to left ankle dorsiflexion and plantar-flexion".[39]

50. Dr Miniter's findings on examination were generally critical of the applicant who showed symptoms of chronic pain. The relevant neurological findings in the doctor's latest report were:[40]

> "She is unable to lie on her back and said to me that when she tries to lie on her back she has severe pain down her left leg. This is certainly an unusual complaint and I was unable to relate it to any frank neurological compression.
>
> In the prone position, noting that she finds it difficult to lie on her stomach, an attempted femoral nerve stretch test causes pain in the right buttock and also in the left buttock. There is no pain in the thigh. This test, of course, is not consistent as if there is nerve root compression, performing a femoral nerve stretch test should cause pain in the anterior thigh if there is ongoing L4 nerve root compression and should not result in buttock pain. The test is therefore inconsistent and does not make sense in view of her investigative findings."

51. The findings on physical examination do not record a reference to reflex testing nor sensory testing in the S1 distribution. The doctor has rejected radiculopathy in the L4 distribution because of inconsistency but has not addressed the other levels other than in general terms.

52. The applicant has undergone surgery from L3 through to S1 where both Dr Khan and Associate Professor Fearnside have identified an absent left ankle reflex. Associate Professor Fearnside has also identified sensory loss in that distribution. There is also undoubtedly a minor criteria under paragraph 4.27 due to the presence of imaging which is confirmed by the fact that surgery was carried out at this level.

53. Given the precise opinion expressed by Associate Professor Fearnside, which is in part supported by Dr Khan's findings on asymmetry of ankle reflex loss, I am satisfied that the applicant has established two major criteria in the S1 distribution, that is sensory loss localised to the S1 distribution and asymmetry of reflexes at that level. These findings are consistent with a minor criteria being the recent 2019 imaging showing pathology at L5/S1.

54. For these reasons the applicant is entitled to a further 3% under Table 4.2 of the fourth edition guidelines for residual symptoms and radiculopathy following surgery.

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[35] AMA 5 at p 376. See also Dr Teychenne at Application p 151 and Associate Professor Fearnside at Application at p 290.
[36] Application, p 16.
[37] Application, p 420
[38] Application, pp 366 – 369.
[39] Reply, p 13.
[40] Reply, pp 5-6.

Section 323

55. Section 323 relevantly provides:

> "(1) In assessing the degree of permanent impairment resulting from an injury, there is to be a deduction for any proportion of the impairment that is due to any previous injury (whether or not it is an injury for which compensation has been paid or is payable under Division 4 of Part 3 of the 1987 Act) or that is due to any pre-existing condition or abnormality."

56. I again repeat the relevant legal principles because Dr Miniter's reasoning for the extent of the s 323 deduction generally does not accord with established legal principles.

57. 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)*[41]; *Ryder v Sundance Bakehouse* (*Ryder*)[42]*; Cole v Wenaline Pty Ltd* (*Cole*).[43]

58. In *Vannini v Worldwide Demolitions Pty Ltd*[44] 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".[45]

59. 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.[46] 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.

60. In *Matthew Hall Pty Ltd v Smart*[47] (*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).[48]

61. 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: *Secretary, Department of Education v Johnson*.[49]

62. Dr Miniter's explanation for a one-quarter deduction is set out at paragraph 40 herein. There are a number of errors with respect to Dr Miniter's assessment.

63. On any rational interpretation of s 323, a poor outcome from surgery due to injury is not a relevant factor in determining the extent of the s 323 deduction. The doctor has stated that he has taken this into account. It is an irrelevant consideration.

64. Dr Miniter also stated that he included the applicant's diagnosis of rheumatoid arthritis as a consideration in making the one-quarter deduction.

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[41] [2011] NSWCA 254.
[42] [2015] NSWSC 526 (*Ryder*) at [54].
[43] [2010] NSWSC 78 at [29]-[30].
[44] [2018] NSWCA 324 (*Vannini*) at [90].
[45] At [90].
[46] At [52]-[54].
[47] [2000] NSWCA 284 at [32], Mason P and Powell JA agreeing.
[48] At [37].
[49] [2019] NSWCA 321 at [119] per Simpson AJA, Emmett JA agreeing.

65. I reject that the applicant's rheumatoid arthritis is a relevant consideration for a number of reasons. First, in the report dated 19 June 2017, Dr Miniter only described that pre-existing rheumatoid condition as a "possible" factor to the applicant's condition[50]. That opinion of itself does not satisfy the onus of proof. Secondly, the prior treating reports from Dr Hassett indicate that the arthritis was associated with the "small joints" such as the ankle and did not affect the lumbar spine. Thirdly, the regional bone scan with SPECT dated 4 December 2014 showed no active facet joint arthritis and only mild discovertebral joint arthritis of no clinical significance in the lumbar spine. Fourthly, there is no explanation by Dr Miniter as to how rheumatoid arthritis contributed to the impairment.

66. Accordingly, I am not satisfied on the balance of probabilities that the applicant's pre-existing rheumatoid arthritis contributed to impairment and is a relevant factor in the issue of the extent of the deduction pursuant to s 323.

67. I observe that Dr Miniter has further stated that "it is not unreasonable to subtract a one-quarter moiety". If the doctor is referring to the previous three reasons he provided, then two of these, the poor outcome from surgery and rheumatoid arthritis, are rejected. If the doctor is making a general statement, then the analysis is incorrect and inconsistent with the recent observations of the Court of Appeal in *Johnson*[51] and otherwise inconsistent with the discussion by Beech-Jones J in *Cullen v Woodbrae Holdings Pty Ltd* (*Cullen*)[52] when his Honour stated:[53]

> "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."

68. I reject Dr Miniter's opinion that the s 323 deduction is one-quarter.

69. 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."

70. Section 323(3) of the 1998 Act provides meaning to the reference in s 323(2) of "available evidence". I do not accept Dr Miniter's opinion that the s 323 deduction should be one-quarter. Accordingly, I do not accept that a one-tenth deduction "is at odds with the available evidence" as I do not accept Dr Miniter's opinion.

71. I apply the statutory one-tenth deduction in accordance with s 323(2) and the opinion expressed by Associate Professor Fearnside.

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[50] Reply, p 20.
[51] See paragraph 35 herein.
[52] [2015] NSWSC 1416.
[53] At [57].

Assessment

72. In *Robbie v Strasburger Enterprises Pty Ltd*[54] (*Strasburger*) the Court confirmed the procedure adopted by the Approved Medical Specialist that the WPI and ADL figures should be added together and then combined (using the combined values chart) with the assessment for modifiers under Table 4.2. The assessment for modifiers in Table 4.2 are internally added together.[55]

73. The applicant has a 20% rated under DRE lumbar category IV and a further 2% for the effects on the ADL which total 22% WPI.

74. The modifiers under Table 4.2 total 7% due to the first surgery at two additional levels, a second surgery and the ongoing radiculopathy. The 22% is combined with the 7% under Table 4.2 to produce a combined assessment of 27% WPI.[56]

75. A one-tenth deduction pursuant to s 323(2) means that the applicant has a 24% WPI after this figure is rounded down.[57]

CONCLUSION

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

[54] [2017] NSWSC 363.
[55] The method adopted by the AMS in *Strasburger* is set out at [34] of her Honours reasons.
[56] See AMA 5 at p 605.
[57] See paragraph 1.26 of the fourth edition guidelines.