WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**1069/20**
Applicant:	**Mary Ann McKelligott**
Respondent:	**Gwydir Shire Council**
Date of Determination:	**28 May 2020**
Date of Amendment:	**28 May 2020**
Citation:	**[2020] NSWWCC 177**

The Commission determines:

Finding

1. The applicant has 16% whole person impairment resulting from injury on 21 May 2017.

Order

2. The respondent pays the applicant compensation pursuant to s 66 of the *Workers Compensation Act 1987* in the sum of $37,670.

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 Mary Ann McKelligott (the applicant) is employed by the Gwydir Shire Council (the respondent) and sustained a compensable injury to the left knee on 21 May 2017.

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 the left lower extremity and the skin.

3. The essential facts are not in dispute.

4. The applicant sustained injury to her left knee on 21 May 2017 when she stepped down from a raised garden bed. An x-ray on 22 May 2017 revealed multiple fractures to the left tibial plateau.

5. The applicant was transferred to Tamworth Hospital where external fixateurs of the left knee was inserted on 23 May 2017. The operation report noted the joint depression on the lateral tibial plateau was unable to be addressed.

6. Due to the complexity of the fracture, the applicant was then transferred to John Hunter Hospital in Newcastle where she underwent a further surgical procedure involving open reduction internal fixation of the left tibial plateau fracture using a plate and screw fixation. Post-operative x-rays showed that several fragments had not been adequately reduced and Dr Balogh undertook further revision on 29 May 2017.

7. The applicant underwent extensive rehabilitation over the following year including a washout and debridement in July 2018 and the removal of the plates and screws in August 2018. Dr Mackenzie performed a total left knee replacement on 14 November 2018.

8. The applicant was examined by Dr Hopcroft and Dr Rimmer who both assessed a 15% whole person impairment (WPI) as a result of injury on 21 May 2017 based on a total left knee replacement.

9. The only issues are the extent of any deduction pursuant to s 323 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) and whether the skin, by reason of the surgical scar, should be assessed at 0 or 1% WPI.

Proceedings before the Commission

10. The matter was listed for telephone conference on 22 May 2020 when Ms Robinson appeared for the applicant and Ms Ralph 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*).

11. The documentation admitted into evidence at the telephone conference without objection was:

    (a) Application to Resolve a Dispute and attachments (Application), and

    (b) Reply and attachments (Reply).

[1] [2019] NSWWCCPD 53.

12. Within the material are photographs of the surgical scar taken when the applicant consulted Dr Hopcroft in August 2019.[2] One scar is clearly visible and approximately 20 centimetres in length.

13. In November 2019 Dr Rimmer described the scar as a "good colour match of surrounding skin" and stated that the applicant was not conscious of it.

14. Given the difference in the description between the photographs taken in August 2019 and Dr Rimmer's description of the scar in November 2019, the applicant was granted leave to file an updated photograph. The applicant stated at the telephone conference that she then forwarded the photograph to her solicitor and that the photograph was a true depiction of the scar.

15. Two photographs were forwarded to the Commission in accordance with the direction. The photographs depict a scar less visible than that shown in the photographs attached to Dr Hopcroft's report.

16. The parties were given the opportunity to make oral submissions. The applicant asserted that there was no evidence that there was a pre-existing condition which contributed to impairment and otherwise relied upon the opinion expressed by Dr Hopcroft.

17. The respondent relied on the opinion expressed by Dr Rimmer.

EVIDENCE

18. It is unnecessary to set out the details of the various surgical procedures and the extensive rehabilitation undertaken by the applicant. The summary of the evidence is directed to the two issues for determination.

Radiology

19. Dr Hopcroft described the initial treatment and x-rays taken shortly after the injury as follows. After noting the applicant was transferred by ambulance to Inverell Hospital on 22 May 2017, Dr Hopcroft accurately described the scans taken at that time as follows:[3]

> "***X-RAY LEFT KNEE***
> ***The non-standard view demonstrates an extensive comminuted tibial plateau fracture. The patient has proceeded to CT assessment.***
>
> ***CT LEFT KNEE***
> ***There is an extensive comminuted intra-articular fracture of the proximal tibia with splaying of the articular surface on the coronal images involving the lateral tibial plateau of 3cm with complete involvement of the articular surface on the sagittal reconstructions and posteroinferior displacement measuring approximately 9mm. The lateral femoral condyle occupies the majority of this particular surface defect. There is involvement of the medial tibial plateau articular surface which is nondisplaced. There is a large lipohaemarthrosis present*** (free fat and blood within the joint effusion).
>
> Following that diagnosis and with her left leg immobilised, she was taken back to the Warialda Hospital for just one day before being transferred by ambulance to the Tamworth Base Hospital. There she underwent a progress x-ray of her left knee on 23 May 2017 which described in conclusion:

[2] Application, pp 14-15
[3] Application, pp 6-7

Markedly comminuted depressed intra-articular proximal tibial fracture involving predominantly the lateral tibial plateau….
In the John Hunter Hospital on 26 May 2017 Dr Mackenzie undertook open reduction internal fixation of the patient's left tibial fracture using plate and screw fixation, with intra-operative x-ray control.

A CT scan of the left knee performed pre operatively describes:

There is a severely comminuted fracture involving the left tibial plateau extending into the proximal tibial metadiaphyseal region. There is marked fracture fragment separation and displacement in the region of the tibial spine. Extensive posterior fracture fragment depression and displacement is also noted.
No femoral fracture. There is a large joint effusion.
Images provided for preoperative planning."

Qualified opinions

20. Dr Hopcroft diagnosed a comminuted fracture of the left tibial plateau resulting in several surgical procedures ultimately coming to a total left knee arthroplasty. He described the surgical scar as "a well-healed anterior longitudinal scar approximately 20 cm in length with a classical lateral numbness".[4]

21. Attached to the report are three photographs showing a clearly visible scar in accordance with Dr Hopcroft's opinion.

22. Dr Hopcroft assessed the applicant at 15% WPI for the left lower extremity and 1% WPI for the skin to produce a combined assessment of 16% WPI.

23. Dr Rimmer examined the applicant in November 2019. He noted that x-rays taken in October 2018 showed "secondary post-traumatic degenerative osteoarthritis".[5] The doctor diagnosed a comminuted displaced fracture of the tibial plateau resulting in extensive surgical procedures and leading to a total knee replacement.[6]

24. Dr Rimmer also assessed a 15% WPI for the left lower extremity due to the total knee replacement. His reasons for making a s 323 deduction were limited to the following observation:[7]

> "Deducting one-tenth for pre-existing degenerative changes gives 13.5% which rounds up to 14%."

25. In respect of the surgical scar, Dr Rimmer opined:[8]

> "SIRA Guidelines, page 74, table 17.1 is 0% whole person impairment, i.e. claimant is not conscious of scar, good colour match of surrounding skin, any suture marks are barely visible, no contour defect, no effect on ADL's, which is 0%."

26. Accordingly, Dr Rimmer assessed the applicant at 14% WPI.

[4] Application, p 10
[5] Application, p 23
[6] Application, p 24
[7] Application, p 26
[8] Application, p 26

REASONS

27. 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).[9] 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.[10]

Section 323 deduction

28. 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."

29. 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)*[11]; *Ryder v Sundance Bakehouse* (*Ryder*)[12]*; Cole v Wenaline Pty Ltd* (*Cole*).[13]

30. In *Vannini v Worldwide Demolitions Pty Ltd*[14] 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".[15]

31. 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.[16] 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.

32. In *Matthew Hall Pty Ltd v Smart*[17] (*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).[18]

33. Dr Rimmer does not refer to the basis for which he opined that there was a pre-existing condition. There is a reference within the report to the development of "secondary post-traumatic degenerative osteoarthritis" which cannot be a basis for concluding that there was a pre-existing condition.

34. Dr Rimmer has otherwise not explained how the unknown pre-existing condition contributed to the applicant's impairment.

---

[9] The 4th edition guidelines are issued pursuant to s 376 of the 1998 Act.
[10] Clause 1.1 of the fourth edition guidelines.
[11] [2011] NSWCA 254.
[12] [2015] NSWSC 526 (*Ryder*) at [54].
[13] [2010] NSWSC 78 at [29]-[30].
[14] [2018] NSWCA 324 (*Vannini*) at [90].
[15] At [90].
[16] At [52]-[54].
[17] [2000] NSWCA 284 at [32], Mason P and Powell JA agreeing.
[18] At [37].

35. It is not evident from any of the x-rays or scans that the applicant had pre-existing degenerative changes.

36. The applicant's impairment arises from the total knee replacement which was due to the severe fractures suffered in the work injury[19]. There is no analysis by Dr Rimmer that the need for the knee replacement was, in part, due to the unknown pre-existing condition. The bare expression of opinion was made in circumstances where the applicant sustained a serious comminuted fracture, underwent several operations and an extensive rehabilitation process.

37. In these circumstances the bare opinion expressed by Dr Rimmer lacks any probative value and is rejected.

38. The respondent has failed to discharge the onus of establishing that there should be any deduction pursuant to s 323 of the 1998 Act.

Skin

39. The applicant's statement unfortunately does not address the relevant matters for consideration under Table 14.1 of the fourth edition guidelines. It is evident from the photographs that the applicant has two surgical scars although this is unclear from the medical reports. The fact that there are two surgical scars is unsurprising given the number of surgical procedures undertaken following the injury.

40. The smaller thinner scar is barely visible and would attract a 0% WPI.

41. I accept that parts of the larger scar fall within 0% WPI including that there is no adherence, no treatment is required and the scar has no effect on any activities of daily living. There is also no suggestion of any contour defect.

42. However, the larger scar is clearly visible in the photographs taken in August 2019 and the photograph taken recently. The scar is 20 cm in length and has a colour contrast with the surrounding skin with visible staple marks. I accept, given the obvious appearance, that the applicant would be conscious of the scar and that she could easily locate it. The wearing of normal clothes in the warmer months would also show a visible scar. These matters fall within 1 or 2% WPI.

43. I do not accept that part of Dr Rimmer's opinion concerning the description and appearance of the scar as it is inconsistent with that shown on the photographs attached to Dr Hopcroft's report and those recently forwarded to the Commission.

44. Table 14.1 of the fourth edition guidelines provides that the determination is based on a "best fit". Given the length, visible appearance and position of the scar, I accept that the surgical scar is assessed at 1% WPI.

Assessment

45. The applicant has a 15% WPI of the left lower extremity with no s 323 deduction and a 1% WPI for the skin. The combined assessment is 16% WPI.

CONCLUSION

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

[19] The description of the fractures is set out at paragraph 19 herein.