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

Matter No:	**M1-6736/18**
Appellant:	**Cannavale Constructions Pty Ltd**
Respondent:	**Daniel Joester**
Date of Decision:	**16 July 2019**
Citation:	**[2019] NSWWCCMA 93**

Appeal Panel:	
Arbitrator:	**Gerard Egan**
Approved Medical Specialist:	**Dr David Crocker**
Approved Medical Specialist:	**Dr Tom Mastroianni**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 17 April 2019, Cannavale Constructions Pty Ltd (the appellant employer) made an application to appeal against a medical assessment (the appeal) to the Registrar of the Workers Compensation Commission (the Commission). The medical assessment was made by Dr Tim Anderson an Approved Medical Specialist (the AMS) in a Medical Assessment Certificate dated 20 March 2019 (the MAC).

2. The respondent to the Appeal is Daniel Joester (the Worker).

3. In the Application to Appeal Form, the appellant employer relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

    - the assessment was made on the basis of incorrect criteria,
    - the MAC contains a demonstrable error.

4. However, in submissions, the appellant employer relies only on the presence of a demonstrable error.

5. 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(s) of appeal on which the appeal is made.

6. 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.

7. 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

8. The respondent worker has worked as a concreter since leaving school in year 10.

9. In about 2003 or 2004 he was diagnosed with a Bakers cyst in the left knee, which was surgically drained and gave no further trouble.

10. On 28 July 2011, the worker (then aged 38 years) suffered a left knee injury when his left leg collapsed under him at work. After arranging a MRI scan of the left knee on 1 August 2011, the worker's general practitioner referred him to Dr Bruce Caldwell, knee surgeon. On 9 August 2011, Dr Caldwell described the MRI as showing:

> "1. Mild wear in the patellofemoral joint.
> 2. Intact ACL, PCL, MCL and LCL.
> 3. Mild damage to the medial femoral condyle. The medial meniscus is very degenerate and swollen, but there is no obvious tear. The lateral meniscus is intact."

11. After initially deciding against surgical intervention, on 30 August 2011 Dr Caldwell noted that MRIs are not "perfect" in identifying torn menisci. On 29 September 2011, he said he suspected the worker had a "straight out torn meniscus with a little bit of wear and a simple arthroscopic medial meniscectomy will sort his problem out."

12. The arthroscopic partial meniscectomy and chondroplasty was performed on 18 October 2011, with limited subsequent improvement. At arthroscopy, Dr Caldwell noted

> "The medial compartment was examined and probed. The chondral surfaces were in poor condition with severe damage over the medial femoral condyle with patches to bare bone and a central osteophyte. A chondroplasty removing all loose fragments was performed.
>
> Examination of the meniscus showed an avulsion of the posterior horn of the medial meniscus. A partial posterior medial meniscectomy was performed.
>
> The lateral compartment was examined and probed. The chondral surfaces were in good condition and the meniscus Intact."

13. On 1 November 2011, Dr Caldwell reported two major findings to the general practitioner: severe damage in the medial femoral condyle, possibly old and; a recent avulsion of the posterior horn of the medial meniscus. He said that the injury was devastating in that it compresses the medial compartment and would remain symptomatic.

14. To attempt to correct high loading on the medial side of the worker's left knee, a high tibial osteotomy was performed by Dr Caldwell on 6 December 2011.

15. The worker limped on his right leg. Sometime during 2012 he developed right knee pain. It was determined (and it is accepted) that he suffered a condition in the right knee as a result of the left knee injury.

16. For his right knee, the worker was referred to Dr Chris Dunkley, orthopaedic surgeon. With extensive genu varus of the right knee, and excess loading on the medial side of the right knee joint, a right high tibial osteotomy occurred in September 2013. There were complications with broken hardware in the right knee and genu varus recurred. The broken hardware in the right knee was removed by Dr Dunkley on 25 February 2014. After protracted recovery with much use of crutches, the respondent worker has remained on conservative treatment since.

17. On 6 December 2018, Dr Dunkley reported:

> "(the worker) did have an underlying degenerative condition in his right knee prior to the incident in 2011, but as mentioned above already, his physical job and the leg length discrepancy caused by the high tibial osteotomy have accentuated and accelerated the progression of those degenerative changes."

18. Dr Dunkley said that the worker had a constitutional predisposition to develop arthritis in the knee due to varus alignment, but:

> "…. had he not done a physical job for two decades and had an office based job, his arthritis would be nowhere near as significant. It has also been worsened by the leg length discrepancy following the high tibial osteotomy on the left side."

19. Radiological reports of relevance to the appeal issues for the left knee (including those reviewed by the doctors above):

    (a) 1 August 2011, MRI: intermediate grade chondromalacia of the patella and medical femoral condyle, and possible meniscal degeneration.

    (b) X-ray on 27 October 2011 reported "advanced medial OA. There is varus deformity at the knee."

20. Radiological reports of relevance to the appeal issues for the right knee (including those reviewed by the doctors above):

    (a) Long x-ray dated 17 October 2012 reported "advanced medial OA of the knee joint" and varus angulation of 13.2 degrees."

    (b) MRI on 10 March 2013 reported, inter alia: tricompartmental degenerative changes mainly involving the medial joint compartment and the medial aspect of the patellofemoral articulation.

    (c) Bone scan dated 18 March 2013 reported increased uptake only in the medial tibial condylar plateau.

21. The worker eventually returned to work as a concreter but has modified his bending and lifting mechanics to accommodate his ongoing knee problems and pain. It seems to be a common opinion that he will inevitably require knee replacements in both knees.

The proceedings

22. A claim for lump sum compensation on 6 March 2017 was based on medico-legal report of Dr James Bodel dated 23 January 2014 and 9 November 2016.

23. In the 2014 report Dr Bodel concluded that the respondent worker "suffered a tear of the posterior horn of the medial meniscus and an aggravation of medial compartment osteoarthritis in the left knee as a consequence of the injury that occurred at work on 28 July 2011". For the right knee, Dr Bodel said he "suffered an aggravation, acceleration, exacerbation and deterioration of an underlying degenerative condition in the region of the right knee which has been made worse by the leg length inequality and his continued work in concreting".

24. He assessed the worker as suffering 11% WPI (including the left and right oseotomies, and the left meniscectomy) from the left knee, applying AMA 5 Table 17-33, p 546. He separately allowed 3% WPI for surgical scarring. No assessment was made for the right knee.

25. On examination in 2014, Dr Bodel noted various radiological studies, which he described as follows:

    (a) Left knee MRI scan on 1 August 2011:

        > "A tear of the posterior horn of the medical meniscus and also moderate medial compartment osteoarthritis, particularly involving the articular cartilage of the medial femoral condyle. There is some mild articular cartilage damage in the retropatellar region."

    (b) X-ray of both legs on 27 October 2011: "These are long x-rays which are weight bearing films showing the medial compartment narrowing of the knees on both sides".

    (c) X-ray of left knee on 8 December 2011: showed the wedge osteotomy and the fixation plate and screws.

    (d) Bone Scan on 18 March 2013: Dr Ashwell only referred to the left knee showing tracer uptake.

    (e) X-ray of both knees 13 January 2014 showed remaining slight valgus angulation on the left, and failure of the fixating hardware on the right. It was also noted that the left leg was 17 mm longer that the right leg.

26. Dr Bodel also noted the left knee arthroscopy report which he said "confirms the pathology in the medial compartment of the knee prior to the osteotomy.

27. Dr Bodel addressed the requirement to deduct any proportion of the impairment due to pre-existing injury or condition and said that there was pre-existing change in the left knee which was contributing to the overall level of Impairment. He said:

    > "There is no medical evidence to indicate any symptomatic existence of this prior to the injury, in this left knee and therefore it Is too difficult to make a determination as to the significance of that pre-existing Impairment. Because It is too difficult, I have made a one-tenth deduction in accordance with Section 323, which leaves a 9.9% Upper Extremity Impairment…"

28. He therefore allowed 10% WPI from the left lower extremity, before adding 3% WPI for scarring. Although the right high tibial osteotomy occurred in September 2013, Dr Bodel did not note it or assess its consequences.

29. Dr Bodel re-examined the worker on 9 November 2016 and noted the consequential condition in the right knee which he said was the result "the continued favouring of the right side to protect the injured left side and the leg length inequality has put an undue load on the right knee and the right knee has become symptomatic over time".

30. Dr Bodel noted the Bakers cyst in about 2003 and recorded that the appellant worker had "no further treatment for the knee until after the aggravation caused by the ongoing problems with the left knee". He also noted the x-rays of both knees dated 13 January 2014; a CT scan of the right upper tibia on 28 May 2014; and the report of the MRI scan of the left knee in August 2011, which he said, "medial compartment osteoarthritis and retropatellar articular cartilage damage and the tear of the posterior horn of the medial meniscus".

31. He diagnosed the original left knee injury as a "tear of the posterior horn of the medial meniscus and an aggravation of medial compartment osteoarthritis in the left knee".

32. From the osteotomies, he assessed 10% WPI on the left, and 15% WPI on the right. he made no allowance for the left meniscectomy and allowed 1% WPI for scarring this time.

33. Combined, this made 25% WPI.

34. As for the application of s 323 of the 1998 Act, he said:

> "There is no deduction for pre-existing impairment as this gentleman was asymptomatic in both knees prior to the original injury that occurred at work on the left hand side."

and

> "There is evidence of pre-existing pathology with medial compartment osteoarthritis in both knees. This was asymptomatic and not causing any impairment to the knees until the original injury that occurred at work on 28 July 2011. There is therefore no basis for a deduction for pre-existing impairment."

35. A claim was made for compensation based on Dr Bodel's assessment of 25% WPI on 6 March 2017. The appellant employer did not accept the claim and arranged examination of the worker by Dr Chris Harrington, orthopaedic surgeon on 9 May 2017.

36. After recording the history, Dr Harrington noted that the worker provided many scans for his perusal. Specific comments in his report are restricted to the left knee MRI on 1 August 2011, he said this showed "a ruptured Baker's cyst and a posterior horn tear of the medial meniscus", without comment on degenerative changes. He also specifically cited the left knee x-ray on 8 December 2011 and right knee x-ray on 17 October 2012, without comment on what they showed. He concluded the review with the comment "There are certainly advanced degenerative changes in both knees".

37. Dr Harrington's opinion was expressed as follows:

> "(the worker) suffered a twisting injury to his left knee at work in July 2011, which warranted an arthroscopic meniscectomy and chondroplasty by Dr Caldwell. He then had a high tibial osteotomy which left him with a leg length discrepancy. Following this his right knee became symptomatic. The symptoms can be attributed to accelerated changes and perhaps the leg length discrepancy which may have added further stress and strain to the right knee joint.
>
> Treatment for the right knee has included an arthroscope and a high tibial osteotomy, both of which were self-funded.
>
> He now presents with varus deformities of both knees and advanced changes.
>
> The Baker's cyst that occurred in the right knee some 10 years ago was drained then recurred. The background of a Baker's cyst is a precursor to arthritis. His varus deformity and strain on the right leg during the long recovery of his left high tibial osteotomy would be considered a contributing factor to the pathology."

38. When expressing impairment assessment, Dr Harrington juxtaposed the left and right knees, but it is clear enough that he believed the left knee osteotomy was a contributing factor to the right knee condition. His assessment for the right knee proximal tibial osteotomy was 25% LEI, and a further 2% LEI for the partial meniscectomy, equating to 27% LEI. This converts to 11% WPI. He deducted two-thirds of that for "constitutional changes", leaving 4% WPI.

39. For the left knee, his gross assessment was the same (11% WPI), with no deductions for pre-existing injury or conditions.

40. The appellant employer denied liability for the right knee, and an Application to Resolve a Dispute (ARD) was lodged in the Commission.

41. The ARD claimed, as an injury description: ”Left Lower Extremity, Right Lower Extremity and TEMSKI”. When asked to “Describe how the injury happened”, the ARD contained the following:

> “On 28 July 2011, during the course of his duties, the Applicant stepped onto a pod whilst carrying mesh when his leg gave way, causing injury to his left knee. Subsequent to this incident, the Applicant a consequential condition in the form of an aggravation of a pre-existing condition [sic].”

42. This does not identify the nature of the consequential condition.

43. A statement by the worker dated 1 June 2016 was attached to the ARD. In that statement, he described the injury only by reference to the incident on 28 June 2011, without reference to the nature of concreting work. He says he was cleared for pre-injury duties around January 2013 (after the left high tibial osteotomy). When he first saw Dr Dunkley on 1 March 2013, he was still working as a concreter. As for the consequential condition, he says:

> “At this point, my left leg was now longer than my right leg. I believe this aggravated my right knee I began to experience a consequential injury to my right knee In approximately October 2012.”

44. This would seem to identify the consequential condition in the right knee only.

45. After the dispute regarding liability regarding the right knee was resolved the matter was referred to the AMS, leading to the MAC under appeal. In a Direction dated 6 February 2019, Arbitrator Wynyard directed:

> “1. I remit this matter to the Registrar for referral to an AMS for a whole person impairment assessment on the following bases:
>
> (a) Date of injury: 28 July 2011.
>
> (b) Matters for assessment: Left lower extremity (knee) and consequential right lower extremity (knee).
>
> (c) Evidence:
>
> (i) Application to Resolve a Dispute and attached documents;
> (ii) Reply and attached documents.”

46. In the referral to the AMS dated 11 February 2019, the Registrar’s Delegate, Ms Dotti provided the following details, consistent with the Arbitrator’s Direction:

> “Date of Injury: 28 July 2011
>
> Body part/s referred: Left lower extremity (knee)
> Consequential injury to right lower extremity (knee)
> Scarring - TEMSKI
>
> Method of assessment: Whole Person Impairment”

The MAC

47. The AMS noted the precise terms of the referral as set out above. Relevant to the nature of the injuries referred to him, he recorded:

> "**Details of any previous or subsequent accidents, injuries or condition:**
> There was apparently pathology of his right knee some 10 years previously. This is thought to be associated with a Baker's cyst. I was unable to obtain any further specific information about this**.**
> **……**
>
> **Work history:**
> (1) For just about all of his working life, Mr Joester has been a concreter. His formal schooling finished at year 10….."

48. The AMS assessed 11% WPI for the Left Lower Extremity; 15% WPI for the Right Lower Extremity; and 0% WPI for scarring. These gross assessments are not appealed.

49. When considering any deduction for impairment due to any previous injury or pre-existing condition or abnormality, the AMS made no deduction for the left knee or the right knee.

50. Relevant to these conclusions, the AMS said:

    (a) The right leg was 17mm shorter than the left and there was genu varus (bowing) of the right knee.

    (b) The AMS said the MRI scan of the left knee on 1 August 2011 showed "Probable medial meniscus tear and associated degenerative changes on the medial side".

    (c) He did not have, or note, the weight bearing x-ray films of both legs on 27 October 2011 reportedly showing "medial compartment narrowing of the knees on both sides".

    (d) When asked directly whether any proportion of loss of efficient use or impairment or whole person impairment, due to a pre-existing injury, abnormality or condition:

        > "Although there is evidence of extensive pre-existing degenerative change in each knee, bearing in mind that this event occurred when he was in his late 30s, it has been assessed that the extensive degenerative changes of his knees is almost certainly a reflection of the heavy concreting occupation which he was pursuing."

    (e) Although the AMS agreed with Dr Bodel's assessments (other than scarring), he differed from Dr Harrington's assessment for the right knee, explaining:

        > "(Dr Harrington) does, however, advise that two thirds of the condition of the right knee should be deducted for pre-existing degenerative change. As already advised, I am not persuaded that this is fair or reasonable since the degenerative changes of both knees are associated with his arduous occupation, particularly in a man of his age group".

PRELIMINARY REVIEW

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

Re-examination by an AMS Panel Member

52. The appellant employer seeks further examination by an AMS Panel member. However, the appellant does not challenge the overall assessments by the AMS based on his clinical findings and his interpretation of them. The only ground of appeal is based on matters relating to the nature of the injury referred to the AMS, and the application of s 323 of the 1998 Act to that question and the historical medical information before the AMS.

53. The Appeal Panel determined that nothing is to be achieved by further clinical examination of the worker. The examination findings and reasons expressed by the AMS are sufficiently clear and the evidence relevant to the issues is adequately set out in the materials before the AMS, and now the Panel. The Panel concludes that further examination is not necessary or desirable.

Hearing on the Papers

54. Neither party seeks an oral Assessment Hearing. In all the circumstances, the Panel considers there is sufficient evidence in the materials before the AMS and the Panel to deal with the appeal without such a hearing in accordance with the *Registrar's Guideline: Appeal Against Medical Assessment.*

EVIDENCE

55. The Panel has before it all the documents that were sent to the AMS for the original assessment and has taken them into account in making this determination. There is no application to adduce fresh evidence.

GROUNDS OF APPEAL

56. In *New South Wales Police Force v Registrar of the Worker Compensation Commission* [2013] NSWSC 1792 (*Police Force v Registrar)* at [52], Davies J held that the phrase "the grounds of appeal on which the appeal is made" in s 328(2) was "directed to greater particularity than simply categorising the appeal as being within one or more grounds in s 327(3)". Section 328(2) refers to the grounds restricted to those specified in the submissions accompanying the appeal (*Police Force v Registrar* at [49]). This approach was confirmed by His Honour in *The UGL Rail Services Pty Ltd (formerly United Group Rail Services Pty Ltd) v Attard* [2016] NSWSC 911; see also *Wilkinson v C & M Leussink Pty Ltd* [2015] NSWSC 69.

57. The identification of the grounds of appeal is dealt with in more detail below. It is apparent that the appeal is restricted to the following matters:

    (a) The nature of the injury referred to the AMS for assessment, and

    (b) The deduction of a proportion of impairment that was due to pre-existing injury, condition or abnormality pursuant to s 323 of the 1998 Act in relation to both the left and right lower extremities.

58. Both parties relied upon written submissions attached to the appeal application for the appellant and the opposition filed by the respondent. These will be dealt with below.

DISCUSSION and REASONS

59. The Appeal Panel is obliged to give reasons, the extent of which will vary from case to case: *Campbelltown City Council v Vegan* [2006] NSWCA 284. The power of review is far ranging but nonetheless confined to the matters set out in s 327(2) of the 1998 Act which can be the subject of appeal. The procedure on appeal is one of limited review, as set out in s 328.

60. In this matter, the Registrar has determined that at a ground of appeal under section 327(3) is made out.

Ground 1: Nature of the injury referred to the AMS

The appellant's submissions: nature of the injury referred to the AMS

61. The appellant notes and submits:

    (a) The ARD claimed injury "On 28 July 2011", in a frank injury when the worker "stepped onto a pod whilst carrying mesh when his leg gave way, causing injury to his left knee".

    (b) The right knee was claimed as "a consequential condition in the form of an aggravation of a pre-existing condition, of his right knee".

    (c) The respondent insurer accepted an injury with a date of 28 July 2011.

    (d) There is no agreement by the appellant the date of injury is to be a deemed date pursuant to s 15 or s 16 the *Workers Compensation Act 1987* (the 1987 Act).

    (e) The AMS's role was to assess WPI as a result of injury on 28 July 2011.

    (f) Dr Bodel, upon whom the worker relied for the claim, concluded "the gentleman suffered a tear of the posterior horn of the medial meniscus and an aggravation of the medial compartment osteoarthritis in the left knee because of the injury that occurred at work on 28 July 2011".

    (g) Dr Bodel made no reference to the nature and conditions of the injured worker's employment, to a deemed date of injury or any reference to a disease.

    (h) As such, it was not open to the AMS to determine that the extensive degenerative changes of The [sic] heavy concreting occupation carried out by the injured worker as part of the impairment because it "is not subject to these proceedings, it is as a result of a specific incident that occurred on 28/07/2011." [sic]

    (i) "As such to dismiss a s323 deduction as a result of a pre-existing condition due to the heavy concreting occupation which he was pursuing was not open to the AMS to find." [sic]

    (j) The AMS clearly made direct reference to extensive degenerative changes of his knees, which should be assessed pursuant to s 323.

    (k) As such the appellant submits the AMS has made a demonstrable error in his interpretation of the deductions required under s 323.

    (l) These amount to demonstrable errors.

62. Boiling these submissions down, and allowing for the typographical errors an inelegance of language, it is clear that the appellant employer makes two points (which are considered the grounds of appeal):

    (a) The AMS assessed an injury that was not referred to him, by including in the assessment the contribution to the impairment from degenerative changes in his knees caused by the workers employment over many years, and

    (b) Because the evidence established, and the AMS acknowledged "extensive degenerative changes of his knees", he erred "in his interpretation of the deductions required under s 323".

The respondent's submissions: nature of the injury referred to the AMS

63. The respondent worker does not address the finding by the AMS that part of the degeneration in "his knees" was due to concreting work over years, rather than the personal injury to the left knee on 28 July 2011. No submissions assist in identifying the nature of the injury claimed by the worker, or the nature of the injury referred to the AMS.

64. Some submissions made in relation to the decision by the AMS not to deduct any proportion of impairment due to a pre-existing condition of abnormality may overlap this issue, and will be dealt with when considering the s 323 issue.

The Panel's conclusions: nature of the injury referred to the AMS

65. The gist of the appellant's complaint is that the AMS failed to properly categorise the nature of the subject injury, that being confined to a frank personal injury occurring on 28 July 2011 when the respondent worker suffered trauma to his left knee. Instead, he also considered the result of the heavy nature of the worker's employment over many years to be part of the referred injury, rather than treating that contributing cause as a "pre-existing injury, condition or abnormality" pursuant to s 323 of the 1998 Act.

66. The appellant does not directly address the submissions by the appellant in this regard, nor is the finding by the AMS that some of the degeneration was due to concreting work in general considered.

67. In *Bindah v Carter Holt Harvey Woodproducts Australia Pty Ltd* [2014] NSWCA 264 (*Bindah*), an Arbitrator made Consent Orders remitting the matter to the Registrar for referral to an AMS for assessment of impairment. The Orders stated simply that the "applicant suffered injury on 28 January 2009 to his right eye and the Respondent has liability in respect to injury", before remitting "the matter" to the Registrar for referral to an AMS.

68. The Court of Appeal considered the question as to whether the injury was a frank incident or as a gradual process (or disease) injury, Meagher JA said:

    "22. The principal issue raised by the proposed appeal concerns the meaning of the orders made on 21 November 2011 and in particular whether the 'injury' referred to in order 3 is the trauma injury which occurred on 28 January 2009. Those orders are to be construed taking into account the circumstances in which they were made, at least to the extent that those circumstances were known to the parties: see *Rogers v Wentworth* (Court of Appeal (NSW), 18 April 1988, unrep) per Mahoney JA at 6-7 and Hope JA (with whom Samuels JA agreed) at 18; *Beck v Weinstock* [2012] NSWCA 289 at [76] (per Campbell JA, McColl and Meagher JJA agreeing) and cases there cited. Those circumstances include the communications between the parties and their representatives which preceded the referral of the dispute to the Commission, and the terms of the Application which referred that dispute.

23. Turning first to the terms of the orders. Order 3 refers to an injury to the right eye suffered on 28 January 2009 and order 4 remits the applicant's disputed claim for lump sum compensation for permanent impairment to the Registrar for referral to an approved medical specialist for assessment. The applicant initially argued that the "injury" referred to was that described in the Application, namely the exacerbation or aggravation of the existing cataract condition and the giant retinal tear and retinal detachment resulting from surgery which was necessitated by that exacerbation. In oral argument, it was accepted that because the injury is described as suffered on 28 January 2009, any description of it could not include the retinal tear and detachment resulting from surgery which occurred subsequently. The question then became whether that injury referred only to an exacerbation of the pre- existing condition or, more generally, to the trauma injury received as a result of the direct blow to the right eye.

24. It is at this point that it is necessary to take account of the circumstances in which the consent orders were made. They included the communications between the parties describing the essence of their dispute and the legal context relating to that dispute, as provided by the provisions of the *1987 Act* and the *WIM Act*.

25. The dispute was whether the injury to the applicant's eye, which undoubtedly occurred on 28 January 2009, also involved a material exacerbation of the cataract condition necessitating the surgery which occurred in June 2009. That dispute was as to the pathology of the injury which the applicant had sustained. In their exchanges, the parties did not treat the injury as consisting only in the acceleration of a disease within s 4(b)(ii) and s 16 of the *1987 Act*. There was good reason for that. In *Rail Services Australia v Dimovski* this Court (Handley JA, Hodgson JA and Young CJ in Eq) held, preferring and applying this Court's earlier decision in *Australian Conveyor Engineering Pty Ltd v Mecha Engineering Pty Ltd* [1998] NSWCC 51; (1998) 45 NSWLR 606, that s 16 applies if the relevant injury *only* 'consists in' the acceleration or exacerbation of a disease. Where, as in the present case, there is an event causing injury within s 4(a), the circumstance that the injurious event and injury included the aggravation of an existing disease does not mean that the injury, or some part of it, is an injury within s 16: *Dimovski* at [29] (Handley JA) and [68] (Hodgson JA). Rather the exacerbation or aggravation of the existing disease is part of the pathology of the injury within s 4(a).

26. The language of order 3 supports the conclusion that the 'injury' being referred to was the trauma injury and its pathology. In terms, it is a determination that the applicant 'suffered injury on 28 January 2009'. That injury was a trauma injury, aspects of the pathology of which were in dispute and remained to be assessed. The medical dispute as to that pathology was, by order 3, to be assessed under Pt 7 of Chapter 7 of the *WIM Act.*"

69. For the respondent worker in this case, the circumstances, as far as known on the evidence, includes the claim letter by his solicitors dated 6 March 2017. This makes the claim for "25% Whole Person Impairment in relation to the worker's left and right knees and scarring". The percentage impairment undoubtedly relies upon the report of Dr Bodel dated 9 November 2016 attached to the letter. However, the letter also had attached Dr Bodel's report dated 23 January 2014.

70. In the 2014 report, Dr Bodel concluded that the left knee injury was a medial meniscal tear and an aggravation of medial compartment osteoarthritis in the left knee *as a consequence of the injury that occurred at work on 28 July 2011.*

71. For the right knee, Dr Bodel said he "suffered an aggravation, acceleration, exacerbation and deterioration of an underlying degenerative condition in the region of the right knee which has been made worse by the leg length inequality *and his continued work in concreting*".

72. In the 2016, Dr Bodel confirms the nature of injury in the same terms for the left knee, and essentially the same for the right knee (adding that it "had been made worse by the leg length *inequality and his continued work in concreting*").

73. Dr Caldwell said the meniscal tear "substantially contributed" to the "current problems" and his requirement for this (left knee) surgery.

74. However, for the left knee, the wording of the claim in the ARD refers only to an injury to the left knee on 28 July 2011. On its face, this refers to a "personal injury" as described in the definition of injury in s 4(a) of the 1987 Act.

75. For the right knee, the ARD claimed "a consequential condition in the form of an aggravation of a pre-existing condition, of his right knee".

76. As implicitly acknowledged in *Bindah,* the Commission is not a jurisdiction of strict pleading, and some levity is often given to workers when presenting their case. While the circumstances surrounding the Consent Orders and the Referral to the AMS may be considered, that is principally a matter for the Commission, and not generally an Appeal Panel. However, this appeal raises the point, because it a fundamental issue to identify the nature of the injury claimed by the worker, and referred to the AMS for assessment.

77. Even considering the circumstances of the claim, before the filing of the ARD, the opinions of Dr Caldwell and Dr Bodel do no more than identify other factors at play. For Dr Caldwell, the frank injury was only a "substantial" factor "in the need for surgery". He did not implicate the nature of the worker's employment over the years. Dr Bodel, while implicating concreting work, did so only in respect of the worker's "continued work as a concreter*".* This is equally suggestive that his continued work *after* the injury (with the injured state of the left knee) was implicated, as it is to implicate the work in general *before* the trauma injury.

78. Considering these matters, and the fact that the ARD specifically identified only the incident on 28 July 2011, apparently eschewing any notion of a disease type condition for the left knee (while embracing the notion for the right knee), the Panel is satisfied that the claim was based solely on the injury simpliciter to the left knee pursuant to s 4(a) of the 1987 Act. More importantly, the Panel is satisfied that the left knee injury dealt with in the Consent Certificate of Determination and the Referral was the trauma incident on 28 July 2011, and that alone.

79. In addition, cl 2.2 of the *Workers Compensation Medical Dispute Assessment Guidelines* published by the State Insurance Regulatory Authority (SIRA) requires the Registrar to give the parties notice of the referral.

80. The Commission's *Practice Direction No 11 - Permanent impairment disputes* also provides:

> "14. The parties will be issued with a copy of the referral to the AMS. A party must raise any deficiency with the referral in writing to the Registrar and the other party. The Registrar will resolve the issue."

81. In *Comensoli v NSW Department of Juvenile Justice* [2006] NSWWCCPD 138 Fleming DP said (at [36]) that:

> "The referral of a medical dispute to an AMS pursuant to section 321 of the 1998 Act is a critical step in the determination of the rights and liabilities of parties to a workers compensation claim for lump sum compensation for permanent impairment (*Jopa Pty Limited t/as Tricia's Clip-n-Snip v Evenden* [2004] NSWWCCPD 50). It is a matter that should be given careful attention. The content of the referral should be carefully checked by the Commission and the parties to ensure it is in accordance with the issues in dispute and in accordance with any findings of the Arbitrator or the Registrar."

82. The presumption of regularity would suggest that these steps were taken. The appellant had every opportunity to make submissions as to the terms of the Referral, if it was suggested that it did not reflect the claim actually made, or the result of any communications before or after the filing of the ARD.

83. Therefore, the Panel accepts the employer's submissions that it was not open to the AMS to assess, as part of the injury referred, any contribution to the impairment from the left knee that was due to something other than the injury referred. His role was to assess "the degree of permanent impairment of the worker as a result of an injury" (s 319(c) of the 1998 Act); and "whether any proportion of permanent impairment is due to any previous injury or pre-existing condition or abnormality, and the extent of that proportion" (s 319(d) of the 1998 Act).

84. Accordingly, the AMS erred by including in the injury-related impairment, impairment that he obviously considered was due to "the extensive degenerative changes of his knees (which he said was) almost certainly a reflection of the heavy concreting occupation which he was pursuing".

85. On this ground alone, the Panel must assess the impairment in the left knee as a result of injury according to law: *Drosd v Workers Compensation Nominal Insurer* [2016] NSWSC 1053.

86. However, it is noted that neither party suggests the AMS did not assess the impairment according to law, and the overall examination findings and assessments by the AMS are not in question. Furthermore, the Panel considers the AMS's findings and assessments have been performed without error. The only question is how much of that is "as result of the injury". Part of that is the statutory consideration of s 323 of the 1998 Act. The Panel is of the view that nothing is to be served by further examination, and consideration of the injury-related impairment may be properly made on the basis of the AMS's overall assessments and the material before the Panel.

Ground 2(a): The left knee: The deduction of a proportion of impairment that was due to pre-existing injury, condition of abnormality pursuant to s 323 of the 1998 Act

87. Before dealing with the submissions, some general principles are reviewed. Section 323(1) of the 1998 Act requires a deduction for any proportion of the impairment that is due to any previous injury or that is due to any pre-existing condition or abnormality.

88. The exception is in accordance with s 323(2), under which the contribution can be assumed to be 10% but only if the proportion would be difficult or costly to determine, and the 10% deduction assumption is not at odds with the available evidence.

89. The approach is set out in *Cole v Wenaline* [2010] NSWCS 78 (*Cole*). The assessment of the extent to which a prior injury or pre-existing condition contributes to impairment must be based on evidence relevant to the likely effects of that condition or injury to the worker's present impairment. Any deduction under s 323(1) for the proportion of impairment due to prior factors must be based on evidence and not hypothesis or assumption.

90. In *Vitaz v Westform New South Wales Pty Limited* [2011] NSWCA 254, (*Vitaz*) Basten JA (McColl JA and Handley AJA agreeing), said, following the approach adopted in *D'Aleo v Ambulance Service of New South Wales* (NSWCA, 12 December 1996, unrep) (quoted by Giles JA, Mason P and Powell JA agreeing, in *Matthew Hall Pty Ltd v Smart* [2000] NSWCA 284; 21 NSWCCR 34 at [30]- [32] and by Schmidt J in *Cole:*

> *"*The resulting principle is that if a pre-existing condition is a contributing factor causing permanent impairment, a deduction is required even though the pre-existing condition had been asymptomatic prior to the injury. In the absence of any medical evidence establishing a contest as to whether the pre-existing condition did contribute to the level of impairment, the complaint about a failure to give reasons must fail. An approved medical specialist is entitled to reach conclusions, no doubt partly on an intuitive basis, and no reasons are required in circumstances where the alternative conclusion is not presented by the evidence and is not shown to be necessarily available." at [43].

91. The first task for the AMS, as Campbell J noted in *Greater Western Area Health Service v Austin* [2014] NSWSC 604 is to assess the body parts referred,

> "An Approved Medical Specialist's task is to assess the whole person impairment with which the injured worker presents. Whether it be caused by the injury or whether its cause is from an unrelated source, nonetheless the impairment should be recorded. If it is the opinion of the AMS that the losses, or part of them, had been caused for other reasons then an AMS has the power to make an appropriate deduction under s.323 of the 1998 Act, or to vary his assessment as provided at [8(g)] of the MAC."

92. In *Fire & Rescue NSW v Clinen* [2013] NSWSC 629 Campbell J said:

> "As Schmidt J pointed out in *Cole and Elcheikh*, it is necessary to find a pre-existing abnormality or condition, here the latter, actually contributing to the impairment before s. 323 WIM is engaged. This conclusion has to be supported by evidence to that effect. Assumption will not suffice."

93. In *Ryder v Sundance Bakehouse* [2015] NSWSC 526*,* Campbell J said at [54]:

> "Section 323 as I have already said, requires there to be a deduction for any proportion of the impairment that is *due to* any pre-existing condition. This is an essential element of the section; indeed, it is the pith of it. It is not enough to simply identify that there is a pre-existing condition and that there has been a subsequent impairment and therefore make a deduction under this section because of the existence of the pre-existing condition. Such reasoning fails to consider a necessary condition of the operation of the section; that a proportion of the permanent impairment is *due to* the pre-existing condition."

94. In *Cullen v Woodbrae Holdings Pty Ltd* [2015] NSWSC 1416 (*Cullen*), Beech-Jones J reiterated the need for evidence of an actual pre-existing condition rather than a predisposition or susceptibility, saying: “Thus to establish a pre-existing condition for the purposes of s 323(1) there must, at the relevant date, be an actual condition although it may be asymptomatic. A mere predisposition or even a susceptibility is not sufficient to constitute a condition.” (at [46].

The appellant employer’s submissions: The left knee - s 323

95. The employer submits that as the contribution to any impairment that was due to the worker’s heavy concreting occupation it was not open to the AMS to find and include that part of the impairment as impairment that was due to the injury referred.

96. Further, because the AMS clearly made direct reference to extensive degenerative changes of the worker’s knees, he should have assessed the proportion for deduction pursuant to s 323.

97. No submissions as to the appropriate deduction are made.

The respondent’s submissions: The left knee - s 323

98. The respondent submits:

    (a) All of the matters that contributed to the need for the osteotomy were a consequence of the frank incident, presumably relying upon Dr Caldwell’s opinion.

    (b) The worker’s impairments “are largely assessed by reference to the outcome following the high tibial osteotomy” and those osteotomies were “a consequence of the work injury”.

    (c) If “some indeterminate amount of degenerative change prior to 28 July 2011 has not contributed to the matters taken into account when making the assessment” (that is, the surgery and the result thereof), it cannot be said that the presence of that degenerative change has resulted in a greater impairment than would otherwise have been the case.

    (d) It is also clear that a portion of the arthritis which was present at the time of each operation could also be attributed to the incident of 28 July 2011, but it is unclear whether there is in fact any pre-existing arthritis. This is because the incident and its aftermath have contributed to the development of the arthritis.

    (e) “Prior to 28 July 2011, the Respondent worker was asymptomatic. This would be inconsistent with a conclusion that if there was any arthritis already existing at that stage, it was only minimal. By itself, it was not contributing to any impairment” [sic].

    (f) The authorities require the AMS to be satisfied that, firstly, there was an identifiable pre-existing condition; and secondly, that that pre-existing condition contributes to the impairment: *Ryder*. The panel “must be satisfied that but for the pre-existing abnormality the degree of impairment resulting from the work injury would not have been as great": *Ryder*.

    (g) The appellant’s submissions merely assert that there was pre-existing degenerative change, without explaining how that condition contributes to the impairment: *Cole*.

(h) There were no investigations prior to the injury, so it is therefore not possible to know how much of the arthritis was pre-existing. In the circumstances, a deduction of one tenth would be consistent with the medical evidence.

The Panel's conclusions: The left knee - s 323

99. It is clear to the Panel that the AMS, based upon his conclusion that part of the impairment was due to the general nature of the respondent worker's work over the years, that a deduction for pre-existing contribution was warranted.

100. The AMS was correct to so conclude, whether or not the pre-existing condition was due to his work or otherwise. This is so because it is also reasonably clear to the Panel, contrary to the respondent worker's submissions, that there was some degree of arthritis in the knees before the date of injury. The left knee MRI on 1 August 2011 (seven days after the frank injury) was described by the radiologist as showing "intermediate grade chondromalacia of the patella and medial femoral condyle". Dr Bodel described it as "…. moderate medial compartment osteoarthritis, particularly involving the articular cartilage of the medial femoral condyle. There is some mild articular cartilage damage in the retropatellar region." Additionally, the weight bearing x-rays in October 2011 showed medial compartment narrowing of the knees on both sides, indicative of significant degenerative change at the time. It is most unlikely that these changes developed as a result of the injury only months before.

101. The Panel does not accept the worker's assertion that the pre-existing degeneration was "some indeterminate amount". Further it is not accepted that "it cannot be said that the presence of that degenerative change has resulted in a greater impairment than would otherwise have been the case".

102. The respondent's assertion that the worker was asymptomatic in both knees prior to 28 July 2011 is not determinative: *Cole; Vitaz.* The issue is whether any proportion of the assessed impairment is "due to" whatever was pre-existing: *Ryder*. Contrary to the worker's submission, the pre-injury lack of symptoms, or impairment is not inconsistent with a conclusion that there was pre-existing changes in the left knee.

103. The worker's submission that the need for the osteotomy was a consequence of the frank incident is relevant but not conclusive. Clearly, the question of whether a proportion of the impairment is due to a pre-exiting condition is different to whether the surgery was "a result of" the injury. For the latter, the injury need only have materially contributed to the need for the surgery for it to be necessary "as a result of" the injury: s 60 of the 987 Act; *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49 Roche DP at [58]. For s 323 to be enacted, however, an apportionment is clearly required, and that does not undermine the relevant causal relationship between the injury and the surgery.

104. While, as the worker submits in this case, impairments "are largely assessed by reference to the outcome following the high tibial osteotomy" there must still be a deduction for the impairment due to a pre-existing condition if the evidence requires it.

105. Accordingly, the Panel is satisfied that there was an identifiable pre-existing condition, and that that condition contributes to the impairment assessed: *Ryder*. That is but for the pre-existing abnormality the degree of impairment resulting from the work injury would not have been as great: *Ryder*. Nevertheless, the trauma of the frank injury and the consequent meniscectomy in the left knee have been the major contributor to the applicant's impairment in the left knee.

106. When it comes down to actually assessing the proportion to be deducted, however, the Panel acknowledges that there is a broad area for personal judgement in the application of s 323. Scientific precision is not achievable and inevitably, judgement is required.

107. In this case the Panel concludes that it is difficult to assess the proportion of the impairment in the left knee which is due to the pre-existing impairment, and the "default" 1/10th deduction pursuant to s 323(2) is not at odds with the evidence.

108. The assessment of 11% WPI in the left lower extremity is therefore reduced to 10% WPI.

Ground 2(a): the right knee: The deduction of a proportion of impairment that was due to pre-existing injury, condition of abnormality pursuant to s 323 of the 1998 Act

The appellant's submissions: the right knee - s 323

109. The appellant employer does not make any further or different submissions regarding the right knee. The general submissions in respect of the left knee will be considered.

The respondent's submissions: the right knee - s 323

110. The respondent asserts:

    (a) The right knee degeneration (osteoarthritis) was a consequence of the leg length discrepancy caused by the high tibial osteotomy in the left leg. It is submitted that this length accelerated and accentuated the progression of the degenerative changes (relying on Dr Dunkley).

    (b) It is also clear that a portion of the arthritis which was present at the time of each operation could also be attributed to the incident of 28 July 2011, but it is unclear whether there is in fact any pre-existing arthritis. This is because the incident and its aftermath have contributed to the development of the arthritis.

    (c) It is known that there was osteoarthritis in the right knee two years after the event, and that may have been due to the effects of the left knee injury anyway. Any arthritis in 2013 would be much greater than that present in July 2011. This ignores the weight bearing x-rays in October 2011 showed medial compartment narrowing of the knees on both sides, indicative of significant degenerative change at the time. It is most unlikely that these changes developed as a result of the injury only months before.

    (d) If there is to be a deduction under s 323, it should only be in respect of the right knee. If the Panel is satisfied that the right knee arthritis was pre-existing then it may be of the view that it has contributed to the impairment to some extent. However, the deduction pursuant to s 323 should not be greater than one-tenth because it is unclear how much if any degenerative change there was in the right knee prior to 28 July 2011.

    (e) Accordingly, the "need for the high tibial osteotomies in left leg is directly attributable to the incident of 28 July and indirectly attributable to that incident in respect of the right leg".

The Panel's conclusions: the right knee - s 323

111. It is initially noted that the way the worker has framed his claim regarding the right knee largely undermines his submissions that any arthritis in the right knee may have been due to the effects of the left knee injury anyway. The claim for the right knee is specifically for a "consequential condition in the form of an aggravation of a pre-existing condition".

112. The worker's submission that there is no contemporaneous evidence to show the presence of osteoarthritis in the right knee at around the time of injury in 2011 also ignores the weight bearing x-rays in October 2011 showing medial compartment narrowing in both knees, indicative of significant degenerative change at the time. As for the left knee, it is most unlikely that these changes developed as a result of the injury only months before.

113. Having noted that, however, the Panel accepts that any arthritis in 2013 would be much greater than that present in July 2011.

114. The respondent's submission that the leg length discrepancy caused by the left high tibial osteotomy accelerated and accentuated the progression of the degenerative changes in the right knee is obviously accepted. The way the claim is made, and has been referred to the AMS accepts that fact.

115. The Panel does not accept that the assessment for the right knee should not be the subject of a deduction under s 323. The question is, what is the deduction?

116. Factors relevant to this question include: the previous surgery for a Baker's cyst in the right knee (indicative of degeneration); and the presence of arthritis in the weight bearing x-rays within months of the frank injury. The possible contribution of the pre-injury and post-injury employment, as concluded by the AMS and endorsed by the worker in submissions is also noted.

117. Given the previous surgery and the early weight bearing x-rays the Panel agrees with the worker's submissions that the contribution from pre-existing conditions in the right knee deduction is probably greater that that in the left. The Panel concludes that these factors together make a deduction of 1/5th appropriate.

118. This reduces the total impairment in the right lower extremity from 15% WPI to 12% WPI.

DECISION

119. For the reasons set out in this statement of reasons, the decision in this matter is that the Medical Assessment Certificate given in this matter is revoked and a new Certificate is issued.

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE REASONS FOR DECISION OF THE MEDICAL APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT* 1998.

REGISTRAR

Ann Macleod
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **6736/18**
Applicant: **Daniel Joester**
Respondent: **Cannavale Constructions Pty Ltd**

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 Tim Anderson 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 AMA5 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.Left Lower Extremity (knee)	28/07/2011	Ch 3	Table 17-33, p 547	11	1/10	10
2. Right Lower Extremity (knee)	28/07/2011	Ch 3	Table 17-33, p 547	15	1/5	12
Total % WPI (the Combined Table values of all sub-totals)					**21%**	

Gerard Egan
Arbitrator

Dr David Crocker
Approved Medical Specialist

Dr Tom Mastroianni
Approved Medical Specialist

16 July 2019

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.*

A MacLeod

Ann MacLeod
Dispute Services Officer
As delegate of the Registrar