WORKERS COMPENSATION COMMISSION

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

Matter Number:	**M1-2396/19**
Appellant:	**A Noble & Son Limited**
Respondent:	**Leigh Naylor**
Date of Decision:	**11 October 2019**
Citation:	**[2019] NSWWCCMA 144**

Appeal Panel:	
Arbitrator:	**Marshal Douglas**
Approved Medical Specialist:	**Dr Drew Dixon**
Approved Medical Specialist:	**Dr David Crocker**

BACKGROUND TO THE APPLICATION TO APPEAL

1. On 18 July 2019, A Noble & Son Limited lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Ian Meakin, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 25 June 2019.

2. The appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act)

    - the MAC contains a demonstrable error.

3. The Registrar is satisfied that, on the face of the application, at least one ground of appeal has been made out. The Appeal Panel has conducted a review of the original medical assessment but limited to the ground(s) of appeal on which the appeal is made.

4. The Workers compensation medical dispute 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 Workers compensation medical dispute assessment guidelines.

5. The assessment of permanent impairment is conducted in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, 4th* ed 1 April 2016 (the Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5).

RELEVANT FACTUAL BACKGROUND

6. The respondent injured his knees on 19 October 2012 when he tripped over a pallet while working for the appellant. He subsequently came under the care of orthopaedic surgeon Dr Peter Walker, who on 11 April 2013 performed a left knee arthroscopy. On 21 November 2013, Dr Walker performed a right knee arthroscopy, following which the respondent continued to experience symptoms which resulted in a revision right knee arthroscopy in June 2014.

7. The respondent also had gastric bypass surgery in July 2014 that led to a reduction in his weight from 236 kilograms to 139 kilograms, although when examined by the AMS his weight was 150 kilograms.

8. The respondent's knees remained symptomatic. In 2016 Dr Walker performed a right total knee replacement. There was further surgery on his right knee on 1 June 2017 when the polyethylene tray was replaced with a larger tray. The respondent had left knee replacement arthroplasty done by Dr Walker on 4 October 2018.

9. A medical dispute arose between the parties regarding the degree of the respondent's permanent impairment resulting from the injury to his knees, and specifically whether the degree of his permanent impairment is more than 20%. He filed an application with the Commission for that dispute to be assessed by an Approved Medical Specialist and, on 27 May 2019, a delegate of the Registrar duly referred that to the AMS to assess.

PRELIMINARY REVIEW

10. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the Workers compensation medical dispute assessment guidelines.

11. As a result of that preliminary review, the Appeal Panel determined that it was not necessary for the respondent to undergo a further medical examination. This is because the Appeal Panel considers that the material before it is sufficient to enable it to re-assess the medical dispute that had been referred to the AMS to assess.

EVIDENCE

12. The Appeal Panel has before it all the documents that were sent to the AMS for the original medical assessment and has taken them into account in making this determination.

MEDICAL ASSESSMENT CERTIFICATE

13. The AMS examined the respondent on 17 June 2019. He noted within Part 4 of the MAC that he had obtained the following history relating to the occurrence of the respondent's injury and the treatment the respondent has had for his injury:

> "Mr Naylor is a 43-year-old Australian born man who is right handed. He started work with the current employer in 2009 and last worked there in December 2013. He worked as a Technical Sales Representative involving lifting and rigging equipment and including mobile cranes particularly servicing Army. Mr Naylor states that just prior to a fall at work on 19.10.2012 he was not experiencing discomfort in either the right or left knee. On that day he fell and injured both knees with continuing pain since that time. He was referred by his local practitioner to see Dr. Peter Walker, Orthopaedic Surgeon at Concord Hospital. Because of continuing symptoms, Mr Naylor underwent arthroscopic surgery to the right and left knee under the care of Dr. Peter Walker. He underwent an arthroscopic procedure on the left knee on 11.4.2013 and then arthroscopic surgery on the right knee in November of 2013 and further arthroscopic surgery on the right knee in June of 2014. During each surgery it was revealed there were arthroscopic findings of Grade II degenerative changes on the medial joint with small tears involving menisci. Further arthroscopic surgery to the right knee showed evidence of a loose body in the intercondylar notch and extensive Grade II and Grade III changes in the trochlear notch. Loose chondral flaps were debrided at surgery. Following the arthroscopic surgery on the left knee and two arthroscopic surgeries on the right knee, Mr Naylor remained symptomatic. Also, in that period of time, Mr Naylor was significantly obese. He states that he weighed 236kg prior to a gastric bypass surgery performed by Dr. Talbot at the Sydney Private Hospital in Ashfield in July 2014.

He currently weighs 150kg but he has been down to 139kg. Dr. Walker at that time suggested that the gastric surgery would allow Mr Naylor to proceed with some confidence towards bilateral total knee replacement. Mr Naylor underwent a right total knee replacement at Concord District Hospital in 2016. Because of continuing instability Dr. Walker again operated on 1.6.2017 and replaced the polyethylene tray with a larger tray to achieve stability. As a result of this, the right knee then felt stable and he was able to do away with his stabilisation brace. Left knee replacement arthroplasty was performed by Dr. Walker on 4.10.2018. He continues to mobilise with the aid of a Canadian crutch but reports continuing discomfort in both knees particularly on the left side. All surgeries have been performed under the care of Dr. Walker and his team. Mr Naylor continued to see his local practitioner, Dr. Priya Pillay of Newington. Mr Naylor last saw Dr. Walker on 4.10.2018, some months ago."

14. The AMS also noted within Part 4 of the MAC that the respondent had injured his left knee as a teenager and that the treatment he then received for that injury included two arthroscopies.

15. The AMS noted that the respondent presently experiences discomfort in both his knees and wears a brace on his left knee. The AMS noted that the respondent uses a Canadian crutch to walk distances and that the respondent requires assistance to do heavier tasks around his home.

16. The AMS recorded the following findings from his examination of the respondent:

"Mr Naylor states that he stands 6' 1" and weighs 150kg. He uses a Canadian crutch. He has tattoos present on both arms. There is an old scar associated with the left shoulder anteriorly referencing the deltoid pectoral group.

The surgical arthroscopic portal scars are consistent with the multiple scars as well as the knee replacement scars which are anterior longitudinal scars which are well healed. The scars are not tethered to deeper structures. The scars are mildly atrophic and both scars measure 15cm in length. The scars are consistent with bilateral knee replacement.

When standing erect, Mr Naylor states that he has discomfort over the anterior aspect of both knees but particularly on the left side. He is unable to squat. On standing erect, I measure a 5° valgus alignment of both the right and left knee. There is no local heat or redness associated with either knee and no intra-articular effusion at the time of today's assessment.

When measured with a goniometer, the right and left knee demonstrate the following range of motion.

	Right	Left
Flexion	90^0	80^0
Extension	0^0	0^0

There is a less than 5mm antero-posterior movement on formal assessment. There is a 5° medial to lateral movement on testing stability. There is no flexion contracture on the right or left knee with the ability to extend to 0°. There is a less than 10° evidence of extension lag on the right and left side.

Mr Naylor states that the pain in the right knee is a significant pain occurring intermittently. The left knee demonstrates a moderate pain which is continual. Mr Naylor states that the pain is experienced over the anterior aspect of both knees. It is almost as significant as that prior to the operations."

17. The AMS had regard to an MRI scan of the respondent's right knee done on 11 September 2014, a CT scan of the respondent's right leg done on 5 February 2017 and x-rays of the respondent's left and right knees done on 28 November 2017. In the MAC at part 6, the AMS summarised the relevant content of those investigations.

18. The AMS provided the following diagnosis and summary of the respondent's injury in Part 7 of the MAC:

> "I am historically satisfied that Mr Naylor's left knee was asymptomatic prior to the work accident. There were two arthroscopies performed in his teenage years on the left knee. The work injury on 19.10.2012 resulted in both the right and left knee becoming symptomatic with a significant number of arthroscopies and subsequent knee replacement, although the right knee required a revision of the tibial plateau. Mr Naylor continues to describe discomfort in both knees with some limitation of range of motion but full extension and no evidence of flexion contracture."

19. The AMS advised within Part 10 of the MAC that he had assessed the respondent's permanent impairment by reference to Table 17-35 of AMA 5, but as corrected in accordance with the note under [3.30] of the Guidelines. He reported his scores for the respondent's right knee, as rated under Table 17-35, totalled 58 points. He noted that correlated with a fair result for the respondent's right knee replacement, which attracted a rating of 20% whole person impairment. He noted that his scores for the respondent's left knee replacement totalled 46 points, which correlated with a poor outcome and a rating of 30% whole person impairment. He advised that those ratings combined to 44% whole person impairment.

20. The AMS recorded the following at Part 11 of the MAC relating to whether any proportion of the respondent's permanent impairment is due to any previous injury or pre-existing condition or abnormality:

> "a. In my opinion the worker suffers from the following relevant previous injuries, pre-existing conditions or abnormalities:
>
> (i) Nil
>
> b. The previous injury, pre-existing condition or abnormality directly contributes to the following matters that were taken into account when assessing the whole person impairment that results from the injury, being the matters taken into account in 10a, and in the following ways:
>
> (i) Nil"

21. The AMS also made brief comment within Part 10c of the MAC on a forensic medical report of general surgeon Dr W Patrick dated 28 March 2019, a forensic medical report of orthopaedic surgeon Associate Professor Paul Miniter dated 6 December 2018, a Medical Assessment Certificate of AMS Dr Gregory Burrows issued on 5 November 2015 and several treating reports from Dr Walker.

SUBMISSIONS

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

23. The appellant's submissions are, in substance, that the AMS erred by not concluding that a proportion of the respondent's permanent impairment was due to a previous injury or pre-existing condition. The appellant submits that the AMS failed to provide any reason as to why he did not consider there was any proportion "of pre-existing loss". The appellant highlights that Dr Patrick had made a deduction of one-fifth with respect to the respondent's right knee and one-half with respect to the respondent's left knee for the extent to which pre-existing

degeneration contributed to the respondent's permanent impairment. Further, the appellant also highlighted that Associate Professor Miniter, although of the view that the respondent had not achieved maximum medical improvement, had made a deduction of 50% with respect to both knees on account of that. The appellant submits that the AMS failed to consider the deductions that Dr Patrick and Associate Professor Miniter had made when they each assessed the respondent's impairment.

24. In reply, the respondent submits that there was no requirement on the "AMS to accept other specialist's assessments". The AMS obtained a correct history and examined the respondent in accordance with the Guidelines. The AMS read the relevant material that had been referred to him. In those circumstances there is no demonstrable error in the MAC.

FINDINGS AND REASONS

25. The procedures on appeal are contained in s 328 of the 1998 Act. The appeal is to be by way of review of the original medical assessment but the review is limited to the grounds of appeal on which the appeal is made.

26. In *Campbelltown City Council v Vegan* [2006] NSWCA 284 the Court of Appeal held that the Appeal Panel is obliged to give reasons.

27. The authorities are clear and consistent with respect to what s 323(1) of the 1998 Act requires. Firstly, the level of a worker's post-injury impairment at the time of assessment must be determined. Secondly, a prior injury or pre-existing condition or abnormality must be identified. Thirdly, it must be determined whether a proportion of the worker's post-injury impairment is due to that prior injury or pre-existing condition. If so, then lastly, the extent to which the worker's post-injury impairment is due to the prior injury or pre-existing condition or abnormality must be determined[1].

28. The third and fourth stages of that process cannot be done based on assumption or hypothesis[2]. That is to say, it cannot be assumed from the fact that a worker has a pre-existing condition or has had a previous injury that a proportion of the worker's impairment is due to that pre-existing condition or prior injury. Similarly, a pre-existing condition that is asymptomatic at the time a worker suffers injury may still contribute to an impairment a worker has from an injury[3], and so it cannot be assumed from the fact that the pre-existing condition is asymptomatic that it does not contribute to the worker's impairment from the injury. As was held in *Ryder v Sundance Bakehouse* [2015] NSWSC 526, the pre-existing condition that a worker has or the worker's prior injury must make a difference to the outcome in order for a worker's impairment to be due to it. If it makes a difference then, to the extent that it does, a deduction must be made.

29. In the Appeal Panel's view, the evidence demonstrates clearly that at the time the respondent suffered injury on 19 October 2012 he had degeneration in both his knees, more so in the left knee than the right knee. The arthroscopy of the respondent's left knee of 11 April 2013 revealed significant trochlear, medical femoral condyle and lateral femoral condyle cartilage wear. The right knee arthroscopy done on 21 November 2013 revealed significant cartilage wear of the medial femoral condyle and trochlear. AMS Dr Burrows in the Medical Assessment Certificate he issued on 5 November 2015 noted that the x-ray done on 10 December 2012 revealed cartilage wear of the medical compartment with a 1 millimetre cartilage interval and that an x-ray was one of the respondent's right knee on 21 June 2013 revealed medical compartment cartilage interval that was narrowed to 4 millimetres.

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[1] See for example *Cole v Wenaline Pty Ltd* [2010] NSWSC78, *Ryder v Sundance Bakehouse* [2015] NSWSC526 and Pereira v Siemens Ltd [2015] NSWSC 1133.
[2] ibid
[3] See *Vannini v World Wide Demolitions Pty Ltd [2018]* NSWCA 324 and *Vitaz v Westform (NSW) Pty Ltd* [2011] NSWCA 254

30. These arthroscopic and x-ray investigations were all done within a period of 2 to 13 months after the respondent suffered the injury to his knees. Given that, and noting too the respondent's weight, which was likely to have contributed to the respondent's degenerative changes in his knees, it is the Appeal Panel's view that the extensive degeneration revealed by the investigations was present at the time the respondent suffered his injury. The injury of itself could not have caused such extensive degeneration.

31. As the Appeal Panel has indicated in its discussion above at [28], it cannot be assumed from the fact that the degenerative changes in the respondent's knees were asymptomatic at the time he suffered injury, that the changes do not contribute to the respondent's permanent impairment. What is relevant is whether, based on the evidence, it can be concluded that that pre-existing degeneration contributes to the respondent's permanent impairment in terms of making a difference to the outcome.

32. The respondent's impairment in this case relates to his having artificial knees. The respondent's surgery in the form of total knee replacements, by which he obtained his artificial knees, was due to a combination of the pre-existing degeneration in his knees and that degeneration being aggravated and, in all likelihood, worsened slightly by his injury and the physiotherapy he had for his injury, which included his doing lunges and squats. In that circumstance, and notwithstanding that the respondent's pre-existing degeneration in his knees was at the time of his injury asymptomatic, the Appeal Panel considers that the pre-existing degeneration has contributed to the impairment the respondent has as a consequence of the artificial knees he now has.

33. Saying that another way, it cannot be assumed from the fact that the respondent's existing degeneration in his knees was not causing any symptoms or any significant symptoms in his knees at the time he suffered injury, that the degeneration that was existing in his knee did not contribute to the need for him to have knee replacements and thereby contribute to his present impairment relating to those knee replacements. The respondent's pre-existing degeneration in his knees was a material and contributing factor to his need for total knee replacements. It was the symptoms from the existing degeneration of his knees that were precipitated by his injury and the slight worsening of that degeneration due to his injury that ultimately made his knee replacements necessary.

34. The Appeal Panel therefore is of the view that the AMS was wrong to conclude that the respondent did not suffer from "relevant previous injuries, pre-existing conditions or abnormalities". As a consequence of the AMS making that error, the MAC contains a demonstrable error and must be revoked.

35. As the MAC contains a demonstrable error, the Appeal Panel revokes it. The Appeal Panel accordingly must reassess the medical dispute that was referred for assessment.

36. The Appeal Panel observes that neither party took issue with the scores the AMS assigned in accordance with Table 17.35 of AMA 5 relating to the respondent's knees.

37. In the Appeal Panel's view the AMS's examination of the respondent was sound and the AMS's findings from his examination of the respondent are therefore reliable. The Appeal Panel adopts the AMS's findings from his examination. The Appeal Panel also has regard to the history the AMS obtained. Based on that, the Appeal Panel also comes to the same scores as that which the AMS did. Consequently, the Appeal Panel considers that the respondent had a fair result from his right knee replacement. The Appeal Panel therefore assesses the respondent to have 20% whole person impairment relating to his right knee. The Appeal Panel also concludes that the respondent had a poor result from his left knee replacement and assesses him to have 30% whole person impairment due to that.

38. As mentioned above, the Appeal Panel is of the view that the respondent had degeneration in his knees at the time he suffered injury. The degeneration in his left knee was extensive, based on what the arthroscopy on 11 April 2013 and the x-ray of 10 December 2012 revealed. As also indicated above, the Appeal Panel considers that the injury the respondent suffered to his left knee on 19 October 2012 caused an aggravation of that existing degeneration in his knee with symptoms manifesting and also caused, in all likelihood, a worsening of the degeneration. This ultimately led to the respondent having treatment in the form of a total left knee replacement. In the Appeal Panel's view the contribution of the pre-existing degeneration in the respondent's left knee at the time of his injury and contribution of the injury itself to the need for his having a total left knee replacement is equal. In other words, the extent of the respondent's degeneration in his left knee as at the time he suffered injury, as revealed by the radiological and arthroscopic investigations done respectively on 11 December 2012 and 11 April 2013, was as a significant factor to his ultimate need for surgery as was the injury he actually suffered on 19 October 2012.

39. With respect to the respondent's right knee, the extent of his degeneration in his knee, as revealed by the arthroscopy on 21 November 2013 and the x-ray on 21 June 2013, was not as great as that which was present in his left knee. That degeneration, whilst a material factor in the respondent's need for a knee replacement, was not as significant factor as the injury itself. In the Appeal Panel's view, it is too difficult to determine exactly what contribution the pre-existing degeneration in the respondent's right knee made to the respondent's need for a right knee replacement. However, in the Appeal Panel's view, because it was a material factor in the need for the respondent's surgery, a proportion of the respondent's impairment is due to it. It has made a difference to the outcome for the respondent. The Appeal Panel therefore, in accordance with s 323(2) of the Act assumes the deduction to be made under s 323(1) of the Act is 10%, which in the Appeal Panel's view is not at odds with the evidence.

40. That means therefore that the degree of the respondent's permanent impairment due to his injury with respect to the left knee is 10% whole person impairment and with respect to the right knee it is 27% whole person impairment, which combines to 34% whole person impairment. The Appeal Panel assesses the respondent's degree of permanent impairment accordingly.

41. For these reasons, the Appeal Panel has determined that the MAC issued on 25 June 2019 should be revoked, and a new MAC should be issued. The new certificate is attached to this statement of reasons.

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

G De Paz

Glicerio De Paz
Dispute Services Officer
As delegate of the Registrar

WORKERS COMPENSATION COMMISSION

APPEAL PANEL
MEDICAL ASSESSMENT CERTIFICATE

Injuries received after 1 January 2002

Matter Number: **2396/19**
Applicant: **Leigh Naylor**
Respondent: **A Noble & Son Limited**

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 Ian Meakin 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 the Guidelines**	**Chapter, page, paragraph, figure and table numbers in AMA 5 Guides**	**% WPI**	**Proportion of permanent impairment due to pre-existing injury, abnormality or condition**	**Sub-total/s % WPI (after any deductions in column 6)**
1. Right lower extremity-knee	19/10/12	Chapter 3 Pages 13-23	Chapter 17 Pages 523-564	20%	1/2	10%
2. Left lower extremity-knee	19/10/12	Chapter 3 Pages 13-23	Chapter 17 Pages 523-564	30%	1/10	27%
Total % WPI (the Combined Table values of all sub-totals)						**34%**

Marshal Douglas
Arbitrator

Dr Drew Dixon
Approved Medical Specialist

Dr David Crocker
Approved Medical Specialist

11 October 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*.

G De Paz

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Dispute Services Officer
As delegate of the Registrar