

IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

1994 MTWCC 26

WCC No. 9304-6760

JONATHAN S. SANFORD

Petitioner

vs.

STATE COMPENSATION INSURANCE FUND

Respondent/Insurer for

BRANDON OWENS, INCORPORATED

Employer.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND JUDGMENT

The trial in this matter was held on October 12, 1993 in Kalispell, Montana. Petitioner, Jonathan Sanford (claimant or Sanford), was present and represented by Mr. Erik Rocksund. Respondent, State Compensation Insurance Fund (State Fund), was represented by Mr. Todd A. Hammer. Claimant and Dr. Randale Sechrest were sworn and testified. Exhibit Nos. 1 through 11 were admitted into evidence by agreement of the parties. Exhibit Nos. 12 through 15 were admitted over the objection of the State Fund. The parties stipulated the following depositions can be considered by the Court in reaching its decision: Jonathan Sanford, Renee Sanford, Dr. David F. Friedrich, Dr. Lonnie E. Paulos, and Dr. Lawrence Iwersen.

Claimant asks the Court to set aside a full and final compromise settlement with respect to a knee injury he suffered in 1989. He contends that there was a mutual mistake of fact regarding the nature and seriousness of his knee condition.

Having considered the Pretrial Order, the testimony presented at trial, the credibility of the claimant and Dr. Sechrest, the deposition testimony and the exhibits, the Court makes the following:

FINDINGS OF FACT

1. Claimant is presently 32 years old.

2. On December 30, 1989, he was injured while working as a skidder operator in Lincoln County, Montana for Brandon Owens, Inc. He slipped and fell backwards off the machinery he was operating, injuring his right knee.
3. At the time of injury, claimant's employer was insured by the State Fund, which accepted liability for the injury.
4. Claimant was initially examined by Dr. Mark Raine. Then on January 22, 1990, he was seen by Dr. Lawrence Iwersen, an orthopedic surgeon. (Ex. No. 1.) Dr. Iwersen assumed his care.
5. Claimant's medical history is significant in that he had a prior right knee injury and meniscectomy when he was 17 years old.
6. Dr. Iwersen's initial diagnosis was chondromalacia patella. He prescribed physical therapy. When the knee did not respond to that therapy, the doctor performed diagnostic arthroscopy on claimant on March 13, 1990. The arthroscopy did not identify any significant abnormality other than the old lateral meniscectomy. During the arthroscopy Dr. Iwersen visually observed, as well as probed, claimant's posterior cruciate ligament (PCL), noting that it was intact.
7. Following the March, 1990 arthroscopic surgery the claimant continued to experience pain in his knee.
8. A magnetic resonance image (MRI) performed in May 1990, also showed the PCL to be intact.
9. Claimant was seen in consultation by Dr. John Hilleboe, an orthopedic surgeon practicing with Dr. Iwersen, on May 30, 1990. Dr. Hilleboe could find "no crepitus, no ligamentous laxity associated with the cruciate testing or MCL or LCL testing. ("MCL" and "LCL" presumably refer to the medial and lateral collateral ligaments.) I looked at his MR[I] and I don't see any specific abnormality there either." (Ex. No. 1, May 30, 1990 report by Dr. John Hilleboe).
10. Claimant was also seen by Dr. Michael Sousa, another orthopedic surgeon, in the summer of 1990. In a July 3, 1990 letter, Dr. Sousa stated "that this patient has some **instability secondary to cruciate ligamentous laxity** and patellar symptoms, possibly secondary to a painful bipartite patella or chondromalacia patella." Dr. Sousa suggested claimant follow-up with Dr. Iwersen, and suggested claimant "may require a cruciate ligament reconstruction and/or a partial patellectomy to try to relieve his symptoms, but one cannot 100% guarantee the results of such surgery in view of the injury." (Ex. No. 1.)
11. When claimant's condition did not substantially improve, Dr. Iwersen undertook a second arthroscopic surgery on September 11, 1990, performing a partial patellectomy

[partial removal of the knee cap] due to a "painful bipartite patella." During the surgery the doctor visually observed and physically probed the posterior cruciate ligament, noting that it was intact. (Ex. No. 1, September 11, 1990 operative report; Iwersen Dep. 13 at 13-18.)

12. The medical history is interrupted here and will be picked up later in these findings.

13. In an agreement executed in March, 1991, and approved by an Order of the Department of Labor and Industry dated April 26, 1991, the claimant and State Fund entered into a Permanent Partial Wage Supplement Compromise and Release Settlement. The Settlement Agreement stated that "the parties to this matter have agreed to fully and finally conclude all compensation and/or rehabilitation payments due the claimant" in consideration of a \$29,000.00 lump sum payment and \$10,325.73 payable in bi-weekly payments. Claimant reserved medical and hospital benefits.

14. Claimant understood that he could not receive further benefits as the result of the settlement.

15. Claimant is now attempting to reopen the settlement agreement based on mutual mistake of fact. He contends that he and the State Fund were unaware that he had suffered a tear of his posterior cruciate ligament. He also contends that they erroneously believed that he could return to work.

16. Claimant's assertion that the parties were mistaken concerning his ability to return to work will be addressed first. Prior to the settlement, Dr. Iwersen approved his return to **sedentary work**. After the dust has cleared, and the final medical opinions are in, he is **still approved** to return to **sedentary work**. Dr. Lonnie Paulos, who is now treating claimant, testified that he can perform sedentary work. (Paulos Dep. at 50.) While claimant may dispute his own ability to work, he was medically approved for sedentary work both before and after the settlement.

17. Claimant's allegations concerning his torn posterior cruciate ligament rests on the testimony of Dr. Paulos, a respected knee surgeon, who performed further surgery on claimant's knee in the fall of 1992 and winter of 1993, and who testified by deposition. The State Fund's counter to that testimony is the deposition testimony of Dr. Iwersen and Dr. David F. Friedrich, an orthopedic surgeon retained by the State Fund as an expert witness, and the trial testimony of Dr. Randale Sechrest, an orthopedic surgeon. Dr. Sechrest was also retained by the State Fund as an expert witness. He performed a comprehensive review of medical records, the depositions of both Dr. Iwersen and Dr. Paulos, physical therapy records, Mr. Sanford's deposition and Dr. Iwersen's videotapes of his surgeries. Since he testified in person at trial, the Court had the opportunity to personally assess his testimony. I find his testimony to be credible, persuasive and convincing.

18. Continuing the medical chronology, Dr. Iwersen's post operative diagnosis after his September 11, 1990 arthroscopic surgery was "**posterolateral rotary instability**". (Ex. No.

1 at September 11, 1990 Operative Report; Iwersen Dep. at 14.) In a November 15, 1990 office note, Dr. Iwersen recorded that "[h]is lateral compartment is degenerated . . . and compromising his gait and power."

19. Dr. Iwersen reconfirmed his diagnosis in a December 20, 1990 office note, which stated:

The pt. was in today, long discussion and another exam. I think that basically, he has **lateral and posterolateral instability**. He has a difficult problem with this and we may be able to help him with a lateral reconstruction but I wouldn't mind getting an opinion from one of the knee surgeons in Salt Lake or Seattle as this is quite an unusual problem. He, on the other hand, would like to be rated and end all this. He has been helped with the brace and is tired with surgery, though I think we could help him with a reconstruction of his lateral collateral ligament[sic]. He does not wish this at this time, so I will rate him and see him on a PRN basis.

(Ex. No. 1, emphasis added.)

20. In discussions occurring prior to the April 1991 settlement, Dr. Iwersen told claimant that he had posterolateral instability, that the problem was a difficult one, and that additional surgery was likely. He told claimant that he had an unstable knee and that his ligaments were damaged. (Iwersen Dep. at 38-40.) He also recommended that claimant seek help from specialists in Salt Lake City or Seattle. (Iwersen Dep. at 36-37.)

21. In a December 20, 1990 letter to State Fund claims examiner Lisa Gray, Dr. Iwersen stated that he recommended reconstruction of the lateral collateral ligament, but that claimant did not wish to have this reconstructed and "feels at this time he can handle this himself and would just like to settle his case and get on with other things." (Ex. No. 1.)

22. At the time of settlement, the claimant did not want to submit to additional surgery and pressed for a final settlement of his claim. In his own testimony claimant acknowledged that at that time he was aware that his knee could require further surgery, and that Dr. Iwersen had suggested getting another opinion from a specialist in Salt Lake City or Seattle. He also acknowledged that he did not want to submit to the collateral ligament surgery suggested by Dr. Iwersen, and that he wanted to end it all and bring his claim to closure. (Sanford Dep. at 31-34.)

23. In a memo made contemporaneously with the settlement, the State Fund's claims examiner wrote:

Claimant has also been treated by Dr. Michael Sousa who also agreed with Dr. Iwersen that a reconstruction of his knee ligament would be in the best interest of the claimant. Due to the claimant having previous surgeries, he does not care to participate in another one.

(Ex. No. 5, March 28, 1991 memo of Lucinda Dixon.)

24. Dr. Paulos picked up claimant's care in the fall of 1992. He first saw claimant on September 23, 1992. He performed an arthroscopy on September 29, 1992 and a posterolateral reconstruction of the right knee on January 28, 1993. Dr. Paulos found claimant's posterior cruciate ligament to be partially torn. He testified he found scar fiber in the PCL, and that he believed when Dr. Iwersen saw an intact PCL, it had been torn but had healed to reestablish its physical presence. (Paulos Dep. at 36-37.)

25. Dr. Paulos gave his opinion that the PCL was the result of the claimant's 1989 injury and that he did not believe Dr. Iwersen "picked up the ligament damage" (*Id.* at 14) referring to claimant's PCL tear, lateral collateral ligament tear and posterolateral ligament complex tear. Dr. Paulos also felt Dr. Iwersen "did not appreciate the instability of Mr. Sanford's knee." (*Id.* at 18.)

26. Dr. Paulos had not read the deposition of claimant or claimant's wife, had not previously been informed that in January 1992 claimant had fallen downstairs, did not have the medical records of Dr. Sousa, did not have or review the videotapes of Dr. Iwersen's prior surgeries, and did not have any physical therapy records.

27. The Court finds Dr. Paulos' testimony unpersuasive.

a) Dr. Paulos' own post-surgical diagnosis was: "1. Right knee grade III **posterolateral rotational instability**. 2. Grade I PCL laxity." Compare this to Dr. Iwersen's December 1990 (pre-settlement) diagnosis of **lateral and posterolateral instability**.

b) While Dr. Iwersen may not have initially diagnosed instability of the knee, he did so by December 1990 prior to settlement, and his diagnosis did not change thereafter.

c) Dr. Iwersen explained that posterolateral instability, as diagnosed in December 1990, involves a "complex of ligaments that are incompetent. It's not just one particular thing that is incompetent." (Iwersen Dep. at 24.) He disputed the contention that it was crucial for him to specifically identify a tear of the posterior cruciate ligament in making the diagnosis or treating Sanford's instability.

[W]hether you have a complete tear of your posterior cruciate ligament to me doesn't -- That's not crucial. What is crucial is that he has this instability problem that is going to be disabling . . . [a]nd the posterior cruciate to me just -- It doesn't mean anything. What has happened is Dr. Paulos elected to reinforce that posterior cruciate ligament in order to take care of this posterolateral instability.

(*Id.* at 23:12-21). He went on to explain:

Q: Help us understand why the PCL is not the point, not the crux of this case.

A: Because there is more than one ligament involved in his instability.

Q: Go on.

A: And more than one soft tissue structure.

Q: Go on.

A: And they all need to be looked at and addressed, and even though you may not recognize one of the structures are damaged, if he has this instability, you need to address all of them. So, if the MRI shows that PCL is okay, you still may need to tighten up the PCL in order to -- because it may be just stretched from within.

Q: Okay. And so the diagnosis of posterolateral and lateral instability includes a complex of structures---

A: Ligaments.

Q: --within the knee; is that right?

A: Yes.

Q: And it may be necessary to tighten one, see if that works; if it doesn't work, go back and tighten another?

A: Yes.

Q: And that's why you remark, even if the MRI shows an intact posterior cruciate, as time goes on you may have to go back and reconstruct it or tighten it up.

A: Yes. (*Id.* at 62-63).

Dr. Iwersen testified that his diagnosis of claimant's lateral and posterolateral instability was the same diagnosis or problem that Dr. Paulos addressed. (*Id.* at 41:19-22).

d) Dr. Sechrest's in-court testimony, which the Court finds credible and persuasive, confirmed that knee instability, and particularly posterolateral instability, is usually the result of a combination of injuries and is described in terms of a functional diagnosis. He further testified that specific identification of a tear to the PCL may be important in determining a specific surgical remedy but is not significant in determining the nature and significance of the injury. The Court finds that testimony persuasive.

e) It is more likely than not that the PCL tear identified by Dr. Paulos was caused by Sanford's January 1992 fall down the stairs at home. Both Dr. Sechrest and Dr. Friederick reviewed videotapes of Dr. Iwersen's first two surgeries as well as a physical therapy report following Sanford's January 1992 fall. Based on their review of those items, as well as other records and depositions, they testified that it was more probable than not that the PCL damage occurred as a result of the January 1992 fall down the stairs. Prior to the fall down the stairs, claimant's knee popped out "hundreds of times." (Sanford Dep. at 61.) The fall down the stairs, however, was different in degree. Claimant described his fall as follows:

A: That's the worst time because the knee -- the knee popped quite a ways out. It wasn't just a little. It wasn't just a slide. It was an out.

Q: And that one really put you down?

A: Yes.

(Sanford Dep. at 65-66.)

Dr. Friedrick observed videotapes of the 1990 arthroscopies and opined that Dr. Iwersen's probings of the PCL were inconsistent with the existence of a PCL tear at that time. (Friedrick Dep. at 11-12.) Dr. Iwersen did not express an opinion but pointed out that falling down the stairs did not cause Sanford's instability, which already existed, and that the fall could have caused a PCL tear or further tear.

28. Through Dr. Iwersen's letter to claims examiner Lisa Grey, the State Fund was informed that Sanford had an unstable knee and was suffering from posterolateral instability. State Fund was also informed of Dr. Iwersen's recommendation of surgery and further evaluation.

29. The nature of Sanford's knee instability did not change following the settlement agreement. Claimant testified in his deposition that the instability of his knee had not substantially changed between 1990 and Dr. Paulos' January 1993 surgery. Dr. Paulos' surgery has helped but has not eliminated the instability.

CONCLUSIONS OF LAW

1. This Court has jurisdiction over this proceeding pursuant to section 39-71-2905, MCA.
2. The claimant is seeking to set aside an April 26, 1991 settlement agreement on the basis of mutual mistake of fact. He alleges two mistakes. First, he claims that both he and the State Fund were mistaken as to his ability to return to any sort of employment. Second, he asserts that his knee condition was misdiagnosed and that the parties were unaware that he had torn his PCL.

Numerous decisions of the Montana Supreme Court have held that a full and final compromise settlement agreement made when the parties are operating under a mutual mistake of fact must be set aside or reopened. The cases are discussed in this Court's recent decision in ***Pettit v. State Compensation Insurance Fund***, WCC No. **9305-6781 (December 29, 1993)**, wherein a settlement agreement was set aside for mutual mistake of fact based on a misunderstanding of the nature of claimant's condition, which had been diagnosed as a low-back condition but later determined to be a sacroiliac joint condition.

For completeness of this opinion, the Court will again review the basic law governing the reopening of full and final compromise settlement agreements. The cases in which agreements have been set aside are ***Kienas v. Peterson***, 191 Mont. 325, 624 P.2d 1 (1981); ***Weldele v. Medley Development***, 227 Mont. 257, 738 P.2d 1281 (1987); ***Kimes v. Charlie's Family Dining & Donut Shop***, 233 Mont. 175, 759 P.2d 986 (1988); ***Wolfe v. Webb***, 251 Mont. 217, 824 P.2d 240 (1992). Cases in which reopening has been denied are ***Solie v. Peavey Co.***, 212 Mont. 197, 686 P.2d 920 (1984); ***Whitcher v. Winter Hardware Co.***, 236 Mont. 289, 769 P.2d 1215 (1989) and ***Hartfield v. City of Billings***, 246 Mont. 259, 805 P.2d 1293 (1990). The standard applied in these cases is based on contract law. ***Wolfe*** at 227. "General contract law gives courts the right to reopen a compromise settlement when there has been a non-negligent mutual mistake of material fact." ***Kimes*** at 177. The more particular legal test, applied in such cases is articulated by the seminal case, and is whether "[t]he parties were laboring under a **material mistake as to the nature of and the extent of claimant's injuries.**" ***Kienas***, 191 Mont. at 330 (*emphasis added*) accord ***Wolfe***, 251 Mont. at 227-228.

Kienas involved a back injury. The settlement was set aside because it was based on a medical assessment which did not take into consideration the effect of the injury on the claimant's pre-existing cerebral palsy. The pre-settlement impairment rating was based solely on the back injury, and neither party was aware at the time that the injury could aggravate or accelerate the cerebral palsy. In ***Kimes*** "a new and different medical problem was discovered after the settlement." ***Whitcher***, 236 Mont. at 294. Since the injury in ***Kimes*** involved the knee, a more detailed discussion of that case will follow. In ***Weldele*** the Supreme Court "allowed a reopening of the settlement where the claimant's initial condition deteriorated substantially and the treating physician's initial assessment was a misdiagnosis of the actual extent of the injury." ***Whitcher***, *Id.* at 294. The pre-settlement diagnosis was carpal tunnel syndrome and a rotator cuff injury. After the settlement claimant's physicians determined that he was in fact suffering from thoracic outlet syndrome. In ***Wolfe*** the claimant suffered an injury to his right clavicle. After settlement his physicians discovered that he also suffered from previously undiagnosed damage to his right shoulder.

Kimes warrants further discussion here because it involved a knee injury and a reopening of the settlement. Pre-settlement, the claimant had undergone surgery for a torn cruciate

ligament. Post-settlement, it was discovered that he had also suffered a torn meniscus, which is the cartilage which protects the knee joint. The torn meniscus was especially significant because it created the conditions for "probable degenerative changes in his knee joint," 233 *Mont. at 178*, adding a new dimension to the prognosis for claimant's knee.

In the present case claimant had multiple knee problems, all of which were recognized prior to the settlement agreement. He had his meniscus removed in 1979, thus predisposing his knee to degenerative changes. He had a painful patella. Finally, his physicians had identified, and he was aware that he had, instability due to lax ligaments which had been torn or stretched. While his treating physicians may not have identified all of the specific ligaments involved, the basic nature of his condition was recognized. In this regard, this case differs from ***Kimes***, where the involvement of the meniscus was not identified prior to settlement. Sanford's need for ligamental surgery was also recognized prior to the settlement, although his physician recommended addressing a different ligament than did Dr. Paulos. It is also more likely than not that the PCL tear ultimately found by Dr. Paulos was the immediate result of claimant's fall down the stairs in January 1992. On the other hand, the PCL tear did not change his basic condition. His knee was already unstable and popping out.

Mr. Sanford also should not be allowed to complain of any failure to more particularly identify the anatomical components of his knee problems since he refused advice that he seek further evaluation and surgery. It was, after all, he who refused Dr. Iwersen's recommendations and insisted on settlement.

Claimant's employment prognosis has not changed. He offered testimony that he has tried to obtain employment at "quite a few places" but has been unable to get a job. However, his inability to secure a job does not mean that he is medically unable to return to work. The medical testimony by Dr. Paulos and Dr. Iwersen is that claimant is capable of returning to sedentary employment.

Claimant has the burden of proving his case by a preponderance of the evidence. ***Dumont v. Aetna Fire Underwriters***, 183 *Mont. 190*, 598 P.2d 1099 (1979). He has failed to sustain that burden. Based on an application of case law to the facts of this case, we find that there was no mutual mistake of fact warranting a reopening of the April 26, 1991 settlement agreement.

3. Claimant is not entitled to attorney fees or costs.

JUDGMENT

1. This Court has jurisdiction over this matter pursuant to section 39-71-2905, MCA.

2. Claimant has failed to establish that the Compromise and Release Settlement approved on April 26, 1991 was based on mutual mistake of fact. There is no basis to set the agreement aside. Claimant's petition is therefore dismissed.

3. Petitioner is not entitled to attorney fees and costs.

4. The JUDGMENT herein is certified as final for purposes of appeal pursuant to ARM 24.5.348.

5. Any party to this dispute may have 20 days in which to request a rehearing from these Findings of Fact and Conclusions of Law and Judgment.

DATED in Helena, Montana, this 16th day of March, 1994.

(SEAL)

/S/ Mike McCarter

JUDGE

c: Mr. Erik Rocksund

Mr. Todd A. Hammer