WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **2809/19**
Applicant: **Hassan Mojarad**
Respondent: **S&M Painting Services Pty Ltd**
Date of Determination: **27 September 2019**
Citation: **[2019] NSWWCC 315**

The Commission directs:

1. The Application to Resolve a Dispute (ARD) is amended to omit the claim for lump sum compensation pursuant to s 66 of the *Workers Compensation Act 1987* by:

   (a) omitting from the injury description at p 5 of the ARD the words, "consequential injury right shoulder"; and

   (b) omitting the claim for "Permanent Impairment / Pain and Suffering" at p 6 of the ARD.

The Commission determines:

1. The applicant sustained injury to his left knee on 8 February 2017 pursuant to s 4 of the *Workers Compensation Act 1987*.

2. The surgery proposed by Dr Kirsh is reasonably necessary as a result of the injury on 8 February 2017.

The Commission orders:

1. The respondent to pay the costs of and incidental to the left anterior cruciate ligament reconstruction and possible medial meniscal repair surgery proposed by Dr George Kirsh as per his reports dated 5 May 2017 and 29 May 2019, pursuant to s 60 of the *Workers Compensation Act 1987*.

2. The respondent to pay the applicant's reasonably necessary medical expenses incurred to date as a result of injury to the applicant's left knee on 8 February 2017 upon production of accounts, receipts and/or Medicare notice of charge, pursuant to s 60 of the *Workers Compensation Act 1987*.

A statement is attached setting out the Commission's reasons for the determination.

Rachel Homan
Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OF RACHEL HOMAN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr Hassan Mojarad (the applicant) was employed by S&M Painting Services Pty Ltd (the respondent) as a painter. On 8 February 2017, the applicant fell from a ladder and sustained an injury to his right elbow, liability for which was accepted by the respondent's insurer. The applicant claims that he also sustained injury to his left knee in the fall.

2. The respondent's insurer declined liability to pay compensation for the applicant's left knee condition in a notice issued pursuant to former s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) on 14 July 2017. The insurer relied on a report by Associate Professor Paul Miniter, who expressed the opinion that the condition in the applicant's left knee was the result of longstanding anterior cruciate ligament instability, a longstanding medial meniscal tear and the development of degenerative change, which were unrelated to the work injury.

3. On 15 January 2019, the applicant made a claim for lump sum compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act) in respect of permanent impairment resulting from injuries to the applicant's right elbow and left knee and consequential conditions affecting his right shoulder and skin. Liability to pay the compensation was disputed by notice issued pursuant to s 78 of the 1998 Act on 4 April 2019.

4. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) filed in the Commission on 7 June 2019. The applicant sought lump sum compensation as well as incurred and future medical expenses, including the costs of and incidental to a reconstructive surgery of the cruciate ligament at the applicant's left knee proposed by Dr George Kirsh.

PROCEDURE BEFORE THE COMMISSION

5. The parties appeared for conciliation conference and arbitration hearing on 2 September 2019. The applicant was represented by Mr Jon Trainor of counsel, instructed by Ms Mariana Sandoval. The respondent was represented by Mr John Gaitanis of counsel. The applicant was assisted by an accredited interpreter in the Farsi language.

6. During the conciliation conference, leave was granted to the applicant to withdraw the claim for lump sum compensation and the alleged consequential condition affecting the right shoulder by way of amendment to the ARD. It was agreed that a general order for the incurred s 60 expenses would suffice.

7. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

ISSUES FOR DETERMINATION

8. The parties agree that the following issues remain in dispute:

   (a) Whether the applicant sustained injury to his left knee on 8 February 2017 in accordance with s 4 of the 1987 Act, and

   (b) Whether the surgery proposed by Dr Kirsh is reasonably necessary as a result of the injury on 8 February 2017 for the purposes of s 60 of the 1987 Act.

EVIDENCE

Documentary evidence

9. The following documents were in evidence before the Commission and taken into account in making this determination:

    (a) ARD and attached documents;

    (b) Reply and attached documents, and

    (c) Full copy of a report of Procare, dated 27 March 2017, filed on 2 September 2019.

10. Neither party applied to adduce oral evidence or cross-examine any witness.

Applicant's evidence

11. The applicant's evidence is set out in a written statement dated 23 April 2019.

12. The applicant gave evidence that he was born in Iran and moved to Australia in 2013 when he was 23 years old. The applicant had been employed by the respondent for only a day and a half prior to his injury on 8 February 2017 and had no prior experience as a painter.

13. On 8 February 2017, the applicant was working, painting ceilings at an aged care facility in Matraville. After a break, the applicant returned to a foldable ladder he had been working on. With a paint bucket in his left hand, the applicant began to climb the ladder using his right hand. The applicant stood on the last step of the ladder with his paint bucket in his left hand and a paintbrush in his right hand and began to paint ceiling. The applicant went to secure his right foot by turning it slightly. As he did so, he saw the right leg of the ladder go up and he fell from the ladder, hitting the ground first with his right elbow then his chest.

14. After the fall, the applicant tried to get up but when he went to move his right arm he realised his arm fell loose and he could not move it. The pain was excruciating and the applicant screamed. An ambulance was called and arrived after 10 to 15 minutes. The whole time the applicant was waiting for the ambulance he remained in the same position on his chest on the floor.

15. When the ambulance arrived, the applicant was given an injection of morphine which did not alleviate the pain. Another ambulance was called and after around 10 to 15 minutes, the applicant was given a second shot. After this, the applicant felt as though he was floating in and out of consciousness. The applicant was placed on a stretcher and taken to Prince of Wales Hospital. The applicant's arm was placed in a cast and he was taken for some scans and MRI. On 10 February 2017, Dr Wade Harper operated on the applicant's elbow. The applicant was discharged from hospital at 6.00 pm on the following day.

16. When the applicant returned home, his left ring finger and left knee were in pain. The applicant went to see his general practitioner. The applicant said he did not realise how painful his knee was until after he was discharged because when he was in hospital he had been lying on his back on the bed all the time.

17. The applicant's general practitioner, Dr Masoud Mohammadi referred the applicant for an x-ray for his finger and back and an MRI for his knee. The applicant underwent the x-rays the same day and the MRI the following day. The applicant was prescribed medication.

18. Dr Mohammadi referred the applicant to Dr George Kirsh after his MRI results came back. The applicant consulted Dr Kirsh on 5 May 2017. Dr Kirsh recommended surgery but it was not performed as the insurer did not approve it.

19. The applicant said his left knee hurt on a daily basis and he could not walk for a prolonged period of time. The knee swelled from time to time. The applicant said he never had a left knee problem before this.

20. A written statement prepared on 3 March 2017 as part of a factual investigation report for the insurer is also in evidence and is consistent with the evidence above.

Evidence from the applicant's treating practitioners

21. A triage form from Prince of Wales Emergency Department entered on 8 February 2017 at 11.12 am states:

> "pt presents [sic] post falling 1/2 m off a ladder (painter) landed on his r side, denies any head injury- denies any loc, gcs 15 peartl, pt initially distressed with pain· cda gave 25 mg morph & 30 mg ketamine"

22. A medication administration report from the hospital indicates that the applicant was given fentanyl, propofol, paracetamol and morphine on the day of the injury and continued to receive morphine, endone, paracetamol and ibuprofen up until 11 February 2017, when the applicant was discharged.

23. Clinical notes from Auburn Family Medical Centre in evidence commence on 20 February 2017. On that date, Dr Masoud Mohammadi noted:

> "Fractured right elbow following a fall from a ladder, ORIF to head of Radius has been done at POW Hospital. Has pain and affecting his sleep and activities. Says that has pain in lower back and left knee as well."

24. Dr Mohammadi noted that his examination showed:

> "Left knee Not swollen. Tender. No deformity. Movement restricted"

25. The applicant was given prescriptions for Endep and Targin and a referral to Auburn Medical Imaging for MRI scan of the left knee. The MRI referral stated,

> "Injury at work. Painful and restricted clicking and difficulty opening following bending."

26. Dr Mohammadi also issued a WorkCover certificate on 20 February 2017 giving a diagnosis of work-related injury/disease that included "left knee…pain".

27. The report of an MRI of the applicant's left knee performed on 21 February 2017 found:

> "Chronic complete rupture ACL, visualised scarred into the intercondylar notch. No other ligament injury is demonstrated.
>
> Bucket-handle tear of the entire medial meniscus, displaced into the intercondylar notch…
>
> Diminutive posterior horn and body of lateral meniscus with apical and surface fraying/tearing. This appears chronic in nature without displaced meniscal flap.
>
> Moderate lateral and early medial compartment cartilage wear…"

28. On 23 February 2017, Dr Mohammadi recorded that he had discussed the MRI of the left knee with the applicant and advised him to see a knee specialist. The applicant was given a referral to Dr George Kirsh which stated:

> "He is suffering from left knee pain and restrictions following a fall at work. His ACL has ruptured and also has a meniscal tear."

29. A letter from the applicant's physiotherapist, Michael Ward, to orthopaedic surgeon, Dr Wade Harper, dated 24 February 2017 indicates that he had consulted the applicant for the first time. The letter stated:

> "He was working as a Painter on the 8th of February when he had a fall from a ladder. Hassan sustained a Terrible Triad Injury to his right elbow, and he had surgery for this the following day.
>
> Hassan reports that he also injured his left knee and his left hand."

30. Dr Mohammadi issued a further WorkCover certificate on 13 March 2017. On this occasion, reference to the left knee was omitted.

31. Orthopaedic surgeon, Dr George Kirsh wrote to Dr Mohammadi on 5 May 2017 recounting the following history:

> "He fractured his right elbow and was taken to Prince of Wales Hospital but he had pain in the left knee at the time as well. As he was in bed all that time he did not notice whether the knee was bad or not and on discharge from the hospital when he was weight bearing he noticed pain and swelling in his knee. He now gets intermittent swelling with walking and the knee can give way. If he walks for a prolonged period he gets significant pain. He did not play any sport prior to this. He left the knee alone until his elbow was improving and now he has problems."

32. Dr Kirsh said that the applicant had full range of movement of the left knee and it was non-tender however there were positive signs indicating anterior cruciate insufficiency. The applicant's MRI scan confirmed tear of the anterior cruciate ligament and bucket-handle tear of the medial meniscus. Dr Kirsh considered that, as the knee was symptomatic, left anterior cruciate ligament reconstruction and possible medial meniscal repair or meniscectomy was recommended.

33. On the same date, Dr Kirsh faxed the insurer with a request for approval for a left anterior cruciate ligament reconstruction and possible medial meniscal repair, providing an estimate of fees.

34. A "L knee meniscal tear" was added to a WorkCover certificate issued by Dr Mohammadi on 22 May 2017 but on 23 June 2017, Dr Mohammadi indicated on a certificate that the left knee injury was not related to the work injury. Dr Mohammadi's subsequent certificates referred only to the right elbow fracture.

35. A Rehabilitation Progress Report issued by Rehabilitation Services by Altius for the period 21 June 2017 to 18 July 2017, records that a medical case conference was facilitated on 23 June 2017 with Dr Mohammadi. Dr Mohammadi and the applicant were provided with a summary of the outcomes of a report completed by Associate Professor Miniter on 15 May 2017 which found, amongst other things, that the applicant's left knee injury was a pre-existing, long-standing injury and unrelated to the work injury. The report notes:

> “Dr Mohammadi agreed with the recommendations. Mr Mojarad explained he was not able to recall a previous injury occurring to his left knee, with the only incident he can recall to have occurred on the 08.02.2017.”

36. In a letter to Dr Harper, dated 12 September 2017, Mr Ward reported that the applicant was about to commence a gym strengthening program.

37. In a letter, dated 21 September 2017, Dr Harper advised Dr Mohammadi that the applicant was recovering as expected from his difficult injury. Dr Harper said the applicant was able to perform strengthening exercises for simple activities of daily living but boxing or heavy weights may increase the wear within his damaged joint.

38. In a letter, dated 29 May 2019, to the applicant’s solicitors, Dr Kirsh gave the same history of injury and account of his findings on examination as appeared in his previous report to Dr Mohammadi. In addition, Dr Kirsh stated,

> “I feel there is no question that Mr. Mojarad's knee pathology relates to his fall from the ladder on 9.2.17. At the very least he requires resection of the medial meniscal tear and reconstruction of the knee as he is young and his knee is unstable. I enclose costings for this procedure.”

Dr James Bodel

39. The applicant relies on a medicolegal report prepared by orthopaedic surgeon, Dr James G Bodel, dated 3 January 2019.

40. Dr Bodel’s history relating to the injury was of the applicant losing balance and falling a distance in excess of 5 m. The applicant was not rendered unconscious but was aware of an immediate onset of severe pain and deformity in the region of the right elbow and also had an injury to the left knee which was later diagnosed as an ACL rupture. The applicant was in hospital for five to seven days. He was discharged home with his knee in a brace and his right arm in a sling.

41. Dr Bodel said that, over time, the pain in the applicant’s knee became worse. Dr Bodel noted that the applicant had been referred to a knee specialist but that surgical reconstruction of the ACL had not been accepted by the insurer as it took the view that this was an old injury unrelated to the fall. The applicant reported to Dr Bodel that he had no prior problems with the left knee before the fall.

42. Dr Bodel took a social history of the applicant enjoying playing soccer in Iran and but not being able to return to this. Dr Bodel noted also that the applicant did light gymnasium-based work and had tried to return to this as a means of exercise.

43. Dr Bodel’s examination revealed mild anterior cruciate ligament laxity and some tenderness over the medial joint line.

44. Dr Bodel said the MRI scan of the left knee showed evidence of anterior cruciate ligament injury but said he had not had the opportunity to view the films.

45. Dr Bodel gave the opinion that:

> “This gentleman does require further treatment principally in the region of the left knee where he needs an anterior cruciate ligament reconstruction.”

46. Dr Bodel said that the applicant had been offered surgery to the left knee but it had not been approved. Dr Bodel said the applicant had an unstable knee clinically and needed to have this repaired.

Associate Professor Paul Miniter

47. The respondent relies on medicolegal reports prepared by Associate Professor Paul Miniter dated 15 May 2017 and 6 March 2019.

48. In his first report, Associate Professor Miniter noted that in the hospital documentation there was no recollection of the applicant's left knee being injured. The applicant told Associate Professor Miniter that a number of days after he was discharged from hospital, probably or possibly up to a week, he began to experience some discomfort in his left knee. No subsequent investigations were undertaken.

49. Associate Professor Miniter said the applicant had occasional issues with his left knee and denied any recollection of his knee being injured in the past. The applicant did not give any history of instability but did speak of discomfort in the knee in certain positions and particularly with prolonged walking.

50. Associate Professor Miniter said his examination of the left knee revealed long-standing anterior cruciate ligament and stability. There was some subtle discomfort with full flexion. There were no suggestions of ligamentous instability other than the anterior cruciate ligament.

51. With regard to the MRI of the left knee, Associate Professor Miniter stated,

> "I have seen an MRI scan of the left knee which was taken on 20 February 2017. As far as I could determine, there are longstanding features here with a longstanding ACL tear and what appears to be a longstanding bucket handle tear of the medial meniscus. There are no features to suggest recent injury and by this, I mean that there are no features to suggest bone bruising. The features are in keeping with his physical examination. I note that there is also significant osteoarthritic disease identified in the lateral compartment and early osteoarthritic disease in the medial compartment of the knee."

52. Associate Professor Miniter concluded,

> "The injury to the left knee is unlikely to have been associated with the workplace. Despite his protestations to the contrary, the findings are those of longstanding pathology. He is not aware of the instability, he functions very well with an unstable knee, moving effortlessly around the room and he is unlikely to have had an injury to the left knee in the course of his fall in the workplace."

53. Associate Professor Miniter said the causal factors associated with the disease of the left knee were long-standing anterior cruciate ligament instability, "almost certainly" a long-standing medial meniscal tear, and the development of degenerative change.

54. In his supplementary report, Associate Professor Miniter said he had reviewed the applicant again on 15 February 2019. The history taken by Associate Professor Miniter included the following,

> "There was no issue in relation to his left knee until sometime after the matter and I note that he was seen by Dr George Kirsch in May 2017. The complaints were not clear but Dr Kirsch did recommend an ACL reconstruction and medial meniscal repair as well. Such surgery has not been performed as the features of the knee appear to be longstanding."

55. Associate Professor Miniter considered Dr Bodel's report but said he stood by his prior comments and could see no evidence of injury in the recent past to suggest that the applicant's knee was other than a long-standing problem. Associate Professor Miniter stated:

> "You will note in my own correspondence that the fall was associated with injury to the right elbow and to the finger in question but there was no mention at all of injury to the knee. Thus, I would not agree with the diagnosis from Dr Bodel for the reasons that I have previously given, namely that the symptoms relating to his knee have arisen prior to the injury in question and that its symptomatic nature has become a problem remote from the time of the fall in the workplace. Whilst Dr Bodel says that '*I am satisfied that the fall from a height has caused injury to both the right elbow, the left hand and the left knee for the reasons outlined above*' there is sufficient evidence presented to me both by way of history and by documentation to suggest that this is not the case. There is clear evidence of issues relating to his knee prior to the fall in question and the symptoms that he has developed relating to his knee after the fall have not been contemporaneous with the fall itself."

Applicant's submissions

56. Mr Trainor said there were two questions for determination, being: whether there was a compensable injury to the left knee; and if so, whether the surgery proposed by Dr Kirsh was reasonably necessary as a result of that injury.

57. Mr Trainor said that the fall from a ladder on 8 February 2017 involved the applicant falling from the top step and experiencing a violent, high energy impact causing a serious right elbow injury. Mr Trainor submitted that this mechanism of injury was consistent with the applicant's left knee being injured. Although the initial evidence did not mention injury to the applicant's knee, and only severe right elbow complaints, Mr Trainor submitted that as a matter of logic, if the applicant's chest had hit the ground there must have been some impact to his knees.

58. Mr Trainor noted that the evidence indicated that the applicant was given both morphine and ketamine by paramedics and remained at Prince of Wales Hospital until 11 February 2017. Throughout this period, he was being given morphine. Mr Trainor said there was a reasonable and plausible explanation for the absence of knee complaints whilst the applicant was in hospital. The primary focus had been on the applicant's serious right elbow fracture; the applicant was lying in bed on his back without any undue stress being placed on the knee; and he was receiving morphine.

59. Mr Trainor conceded that the first complaint of left knee pain had been made to Dr Mohammadi on 20 February 2017. The complaint was also recorded in the first WorkCover certificate and the referrals to Dr Kirsh and for MRI scan. Mr Trainor submitted that there was a mechanism of injury consistent with a left knee injury, a plausible explanation for the absence of complaints with regard to the left knee prior to 20 February 2017 and then unequivocal complaints of left knee pain thereafter. Mr Trainor said that *prima facie*, I would be satisfied on the balance of possibilities that there was an injury. In the circumstances, it was difficult to see the factual basis on which the insurer could dispute the knee injury.

60. With regard to the necessity for surgery, Mr Trainor submitted that Dr Kirsh had given the opinion that as the applicant's knee was symptomatic a left anterior cruciate ligament reconstruction and possible medial meniscal repair or meniscectomy was recommended. Dr Kirsh had seen the MRI scans and considered the surgery was reasonably necessary. Mr Trainor submitted that there was no medical evidence to challenge Dr Kirsh's view that the surgery was reasonably necessary.

61. Mr Trainor referred to Dr Bodel's report but noted that as it was prepared 18 months after the accident there was a factual question as to the weight his retrospective analysis should be given. Mr Trainor submitted that the evidence provided by Dr Kirsh and Dr Mohammadi was sufficient to discharge the onus of proof.

Respondent's submissions

62. Mr Gaitanis submitted that there was a dispute as to whether the condition in the applicant's knee was the result of injury on 8 February 2017 or whether it involved long-standing pathology which was not related to work, consistently with the opinion of Associate Professor Miniter.

63. Mr Gaitanis noted the delay in the reporting of symptoms in the left knee until 20 February 2017 and the applicant's explanation for the delay. Mr Gaitanis submitted that the hospital notes did not contain any record of left knee discomfort. Although the applicant had asserted that he was lying on his back in bed during the entire period of his stay in hospital, the hospital records from 9 February 2017 referred to the applicant "independently walking in the ward" the day after the incident. Mr Gaitanis submitted that the applicant was walking in the ward and had doctors and nurses around him but failed to say anything about any injury to his left knee. Mr Gaitanis submitted that the hospital records thus contradicted the history taken by Dr Kirsh.

64. Mr Gaitanis noted that the MRI scans from 21 February 2017 were reviewed by Associate Professor Miniter and he formed the view that there was long-standing or chronic pathology. In contrast, Dr Bodel had conceded that he had not viewed the films. Mr Gaitanis submitted that Dr Bodel's opinion on causation consisted of a bare assertion that the fall had resulted in an injury. Mr Gaitanis submitted that Dr Bodel's report did not comply with the Expert Witness Code of Conduct, satisfy the criteria in *Dasreef Pty Ltd v Hawchar*[1] or consider whether there was any other possible explanation for the pathology.

65. Mr Gaitanis submitted that it was possible that the applicant had a pre-existing knee injury which he had decided to attribute to the fall. Mr Gaitanis noted that the applicant had told Dr Kirsh that he never played sport prior to the incident. Mr Gaitanis contrasted this with the history given to Dr Bodel of the applicant playing soccer in Iran and doing light gymnasium-based work. Mr Gaitanis submitted that the applicant had provided an incorrect history to Dr Kirsh and said it was common knowledge that playing soccer could cause knee injuries. Mr Gaitainis submitted that Dr Kirsh had drawn a conclusion that the condition was the result of the fall on the basis of that incorrect history.

66. Mr Gaitanis submitted that it was also possible that the applicant had pathology in his knee but that it did not trouble him, either before or after the accident. Mr Gaitanis noted that Dr Harper's reports referred to the applicant planning to return to work despite his ligament laxity. Mr Gaitanis submitted that it could be inferred from the letter of Dr Harper, dated 21 September 2017, that the applicant was planning to undertake boxing or lifting of heavy weights. Mr Gaitanis submitted that this suggested no aggravation of any pre-existing pathology in the applicant's knee. The applicant was able to live a normal life both before and after the injury. Mr Gaitanis submitted that it was feasible that the applicant was taking the opportunity to attribute a pre-existing pathology to the work incident. Mr Gaitanis further submitted that injury to the ACL would not be attributed to a knock on the knee but rather a twisting action.

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[1] (2011) 243 CLR 588; [2011] HCA 21.

67. Having regard to the deficiencies in Dr Bodel's report and the incorrect history given to Dr Kirsh, Mr Gaitanis submitted that Associate Professor Miniter's report was the only sensible report because he had viewed the MRI films. Associate Professor Miniter concluded that the pathology was long-standing in nature and not referable to the fall. Mr Gaitanis noted further that on 23 June 2017, Dr Mohammadi had certified that the left knee injury was not related to the work injury.

68. Mr Gaitanis submitted that the applicant was asking me to draw a conclusion that the fall resulted in an ACL injury by ignoring the incorrect history and the evidence of a long-standing, chronic condition. Mr Gaitanis submitted that the more likely explanation was that the applicant had confected a narrative to attribute an existing problem to the work injury.

Applicant's submissions in reply

69. Mr Trainor noted the inconsistencies in the WorkCover certificates issued by Dr Mohammadi with regard to the left knee. Mr Trainor said that the clinical notes referred to left knee pain on 20 February 2017. In the immediate aftermath of that consultation, Dr Mohammadi arranged an MRI scan, giving a brief history consistent with a work injury to the knee in the referral. The letter of referral to Dr Kirsh also attributed the knee symptoms to a work injury. The first WorkCover certificate included the left knee and on 22 May 2017, the relationship between the left knee and the work injury was again confirmed in a certificate by Dr Mohammadi.

70. Mr Trainor conceded that on 23 June 2017, Dr Mohammadi disavowed a left knee injury. Mr Trainor submitted that the disavowal could be explained by reference to the Rehabilitation Services report in which it was recorded that Dr Mohammadi was provided with the outcomes of Associate Professor Miniter's report that same day. In the circumstances, Mr Trainor submitted that I should give little weight to what was recorded in Dr Mohammadi's certificate.

71. Mr Trainor noted that the respondent's submissions proceeded on the basis that there was a pre-existing injury. Mr Trainor said there was no evidence to that effect. The references to playing soccer in Iran and boxing were insufficient to lead to a conclusion that the applicant had a symptomatic knee problem prior to the fall.

72. Mr Trainor noted that two Directions for Production to treating practitioners pre-dating the accident had been returned but no further material had been placed in evidence by the respondent. Mr Trainor said it should be inferred that that material did not support the proposition that the applicant had a symptomatic knee condition prior to the accident. Mr Trainor submitted that it was irrelevant that the applicant played soccer in Iran prior to 2013. If there had been prior knee symptoms, one could expect there to be mention of such between 2013 and 2017.

73. With regard to the hospital records indicating that the applicant was ambulant in hospital on 9 February 2017, Mr Trainor noted that the same records showed that the applicant was given morphine that day. Mr Trainor submitted that the insurer was grasping at straws to find something to displace the claim.

74. Mr Trainor conceded that Dr Bodel had not seen the MRI images but submitted that he did not rely on the opinion of Dr Bodel in any event. Rather he relied on the opinion of the treating surgeon, Dr Kirsh.

75. Mr Trainor noted the respondent's submission, based on Associate Professor Miniter's report, that the pathology shown in the MRI was degenerative. Mr Trainor noted that the same opinion was not held by Dr Kirsh who in his supplementary report said there was no question that the applicant's knee pathology related to his fall. Mr Trainor noted that Dr Kirsh did see the MRI scans. Even if there was pre-existing pathology, Mr Trainor submitted in the alternative that it had been rendered symptomatic by the fall.

76. Mr Trainor submitted that the respondent's submission that an ACL injury could only occur through a twisting action should not be accepted on the basis that Mr Gaitanis was not a qualified medical practitioner. Mr Trainor submitted that in any event, it was conceivable that the fall did involve a twisting action given the nature of the accident and possible interaction with the ladder on the way down.

FINDINGS AND REASONS

77. Section 9 of the 1987 Act provides that a worker who has received an "injury" shall receive compensation from the worker's employer. The term "injury" is defined in s 4 of the 1987 Act as follows:

> **"4 Definition of 'injury'**
>
> In this Act:
> **injury:**
>
> (a) means personal injury arising out of or in the course of employment,
>
> (b) includes a disease injury, which means:
>
> (i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and
>
> (ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, and
>
> (c) does not include (except in the case of a worker employed in or about a mine) a dust disease, as defined by the *Workers' Compensation (Dust Diseases) Act 1942*, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined."

78. The Court of Appeal in *Nguyen v Cosmopolitan Homes*[2] has found that a tribunal of fact must be actually persuaded of the occurrence or existence of the fact before it can be found, summarising the position as follows:

> (a) A finding that a fact exists (or existed) requires that the evidence induce, in the mind of the fact-finder, an actual persuasion that the fact does (or at the relevant time did) exist;
>
> (b) Where on the whole of the evidence such a feeling of actual persuasion is induced, so that the fact-finder finds that the probabilities of the fact's existence are greater than the possibilities of its non-existence, the burden of proof on the balance of probabilities may be satisfied;
>
> (c) Where circumstantial evidence is relied upon, it is not in general necessary that all reasonable hypotheses consistent with the non-existence of a fact, or inconsistent with its existence, be excluded before the fact can be found, and

[2] [2008] NSWCA 246.

(d) A rational choice between competing hypotheses, informed by a sense of actual persuasion in favour of the choice made, will support a finding, on the balance of probabilities, as to the existence of the fact in issue.

79. There is no dispute that the applicant had a fall from a ladder on 8 February 2017, broadly in the circumstances claimed by the applicant in his evidence.

80. Although Mr Gaitanis made submissions suggesting that the applicant's knee may not be symptomatic, on my reading of the evidence, there is no medical dispute that the applicant has pathology in his left knee, in respect of which the surgery proposed by Dr Kirsh is reasonably necessary. Associate Professor Miniter did indicate in his first report that the applicant was unaware of the instability in his knee and functioned very well. He did not, however, indicate in either report that the proposed surgery was not reasonably necessary to address the pathology in the applicant's knee. Indeed, in his supplementary report, Associate Professor Miniter queried why the applicant had not sought to have his knee reconstructed in the public hospital system.

81. The disputes to be determined are therefore confined to whether the left knee was injured in the fall on 8 February 2017 pursuant to s 4(a) of the 1987 Act and the casual question of whether the surgery proposed is reasonably necessary "as a result of" that injury.

82. I accept that there was a delay in the reporting of knee symptoms after the fall on 8 February 2017. There is no record, and the applicant does not claim, that he complained of knee symptoms immediately following the fall or during the period in which he was hospitalised. The applicant explained the delay to Dr Kirsh in May 2017, saying that he was in bed all the time whilst he was in hospital. This explanation is repeated in the applicant's written statements.

83. Mr Gaitanis sought to discredit this explanation by reference to the hospital records which do refer to the applicant moving independently in the ward as soon of the day after the injury. The hospital records do not, however, suggest that the applicant was on his feet and walking for prolonged periods whilst in hospital. The nature of the applicant's elbow injury and the treatment it required would tend to indicate that he would not have been very active. The hospital records also confirm that the applicant was receiving strong pain relief in the form of morphine and endone throughout the period of his hospital stay. It has also not been suggested by the applicant that the knee symptoms are persistently debilitating. As noted above, Associate Professor Miniter found the applicant able to function well. The complaints made to the applicant's treating practitioners were of intermittent symptoms becoming worse with prolonged activity. In the circumstances, I am satisfied that a reasonable and plausible explanation has been provided for the applicant's failure to report knee symptoms whilst in hospital.

84. The first complaint of knee symptoms appears in the evidence 12 days after the fall in the clinical records of Dr Mohammadi. Dr Mohammadi's clinical records confirm that the applicant attributed the knee symptoms to the fall on this occasion. Dr Mohammadi appears to have considered this plausible as he made reference to a work injury to the knee in his referrals for MRI and to Dr Kirsh and included the left knee in the first WorkCover certificate of capacity issued by him.

85. The delay in reporting knee symptoms and attributing it to the work injury is not so significant as is suggested by Associate Professor Miniter's reports. It appears Associate Professor Miniter was not in possession of Dr Mohammadi's clinical records or at least misapprehended their effect, as his reports suggest that the first reporting of symptoms was to Dr Kirsh in May 2017. In his supplementary report, Associate Professor Miniter states,

> "There was no issue in relation to his left knee until sometime after the matter and I note that he was seen by Dr George Kirsch in May 2017."

86. Rather confusingly, Associate Professor Miniter says later in the same report, as part of his explanation for why he disagrees with Dr Bodel:

> "You will note in my own correspondence that the fall was associated with injury to the right elbow and to the finger in question but there was no mention at all of injury to the knee. Thus, I would not agree with the diagnosis from Dr Bodel for the reasons that I have previously given, namely that the symptoms relating to his knee have arisen prior to the injury in question and that its symptomatic nature has become a problem remote from the time of the fall in the workplace."

87. There are several difficulties with this comment. First, complaints of symptoms in the finger were first made at the same time as complaints of symptoms in the knee, that is to Dr Mohammadi on 20 February 2017. Associate Professor Miniter appears to accept that the finger was injured in the fall but not the knee. Secondly, Associate Professor Miniter appears to regard the knee as having become problematic "remotely from the time of the fall". To the extent that this suggests a delay of more than 12 days, it is incorrect as shown by Dr Mohammadi's evidence. Thirdly, Associate Professor Miniter appears to apprehend that the knee was symptomatic prior to the fall, which is not a proposition supported by any evidence other than, perhaps, the evidence in the MRI of pre-existing pathology. The presence of pathology, however, does not necessarily mean that the knee was symptomatic.

88. Mr Gaitanis strongly suggested in his submissions that there may have been a previous knee injury pointing to Dr Bodel's history of the applicant playing soccer in Iran and undertaking gymnasium work. I am unable, however, to accept this submission as anything other than speculation. There is no evidence to suggest a prior knee injury or prior knee symptoms. As Mr Trainor noted, leave was granted to the respondent at teleconference to issue directions for production to two general practices attended by the applicant prior to the fall yet no additional evidence has been filed. An inference is available that the records produced did not assist the respondent's case. The applicant has consistently denied any recollection of prior knee injury throughout the claims process and to his treating practitioners. The applicant has also consistently attributed the onset of symptoms to the fall, from a relatively early date, to his general practitioner, orthopaedic surgeon, physiotherapist and the independent medical examiners.

89. Mr Gaitanis submitted that the failure to give Dr Kirsh a history of having played soccer in Iran was sufficient to compromise the reliability of Dr Kirsh's opinion. In *NSW Police Force v Hahn*[3], Deputy President Larry King SC commented:

> "The argument that Dr Smith did not have a proper basis upon which to express his views cannot be accepted for additional reasons. First, to my mind the appellant endeavours to impose too exacting a standard of comparison between the evidence and the history relied upon by Dr Smith. Quite apart from the fact that I think the detail set out in his final two reports is satisfactory by way of history, the decision of the High Court in *Paric v John Holland (Constructions) Pty Ltd*, reinforces that view. In that case the High Court made it clear that exact correspondence between the history in a medical report and what is proved in evidence is not necessary for the validity of the medical opinion. All that is required both as a matter of principle and common sense is that there be real correspondence between the two. Put perhaps more bluntly, near enough is good enough, and the histories in Dr Smith's reports amply pass that test. Secondly, the appellant's criticisms of the reasoning of Dr Smith set out in his reports also puts the standard too high. It is a criticism which depends squarely upon the judgment of Heydon J, as his Honour then was,

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[3] [2017] NSWWCCPD 51 at [60].

> *in Makita (Australia) Pty Ltd v Sprowles*, but which overlooks the line of authority which has come into existence since that decision and which starts with *Sydneywide Distributors Pty Ltd v Red Bull Australia Pty Ltd*. This line of authority makes it clear that Heydon J in *Makita* should be regarded as having enunciated a counsel of perfection and that doctors, in expressing an opinion, rely, on more than histories, the results of investigations and their training and expertise. Often, they use their experience and medical intuition as well, and when they arrive at an opinion it cannot always be elaborated and explained at length (see also *Dasreef Pty Ltd v Hawchar*). This common sense approach also leads to the view that Dr Smith's opinion is a satisfactory one and in any event to my mind it is expressed as much more than an ipse dixit."

90. Had there been any other record of knee symptoms or knee injury I would be inclined to accept Mr Gaitanis' submission. In the absence of such, and in view of the Deputy President's comments above, I am not satisfied that this omission rendered Dr Kirsh's opinion unsatisfactory.

91. Like Associate Professor Miniter, Dr Kirsh did have the benefit of having viewed the MRI scans. Notwithstanding that the MRI report on its face suggests chronic and degenerative pathology of a long-standing nature, Dr Kirsh, being appropriately qualified to assess the scans and provide an opinion on causation, has expressed the view that he was in no doubt that the knee pathology related to the fall from the ladder. Although Dr Kirsh does not elaborate on why he has reached the view, I am satisfied that he was in possession of the relevant history and investigations and had examined the applicant. Dr Kirsh was entitled to use his medical knowledge, experience and intuition in arriving at his opinion.

92. In contrast, as indicated above, Associate Professor Miniter appears to have expressed his opinion whilst under a misapprehension as to the timing of the first complaints of knee symptoms following the fall and the existence of knee symptoms prior to the fall. In weighing the opinions of Dr Kirsh and Associate Professor Miniter, I prefer that of Dr Kirsh for these reasons.

93. I have found Dr Bodel's report to be of little assistance in determining this matter. Dr Bodel's history appears to contain some details which are inconsistent with the remainder of the evidence before me. Dr Bodel suggests the fall was from a height of 5 m and that the applicant left the hospital in a knee brace (suggesting symptoms were reported more contemporaneously than was the case.) Dr Bodel does not give a clear opinion on causation let alone any reasoning to support such an opinion but appears simply to assume that injury did occur in the fall as claimed.

94. Finally, I have considered the disavowal of the left knee condition being related to work injury by Dr Mohammadi on 23 June 2017. This disavowal is at odds with Dr Mohamaddi's clinical notes, referrals and earlier WorkCover certificates. It can also be explained by the Rehabilitation Services report. Dr Mohammadi appears to have simply adopted the opinion of Associate Professor Miniter which was communicated to him that day by the rehabilitation services provider. For these reasons, I do not find that certificate to be of assistance in making my determination.

95. After carefully reviewing all the evidence, I am satisfied on the balance of probabilities that the applicant injured his left knee when he fell from a ladder whilst in the course of employment on 8 February 2017 and that employment was a substantial contributing factor to the injury. I am satisfied that the applicant has a compensable knee injury pursuant to ss 4(a) and 9A of the 1987 Act.

96. I am also satisfied that the need for surgery results from that injury. I am not satisfied on the evidence before me that there was a previous knee injury or knee symptoms prior to the fall. Whilst the MRI report is suggestive of some pre-existing chronic or degenerative pathology, I am satisfied on the basis of Dr Kirsh's opinion that the fall caused the applicant's knee to become symptomatic and that there is pathology in the applicant's knee, caused by the injury, rendering the surgery proposed by Dr Kirsh reasonably necessary. I am satisfied that as a result of the injury on 8 February 2017 it is reasonably necessary that the applicant undergo the surgical treatment recommended by Dr Kirsh for the purposes of s 60 of the 1987 Act.

SUMMARY

97. The applicant sustained injury to his left knee on 8 February 2017 pursuant to s 4 of the 1987 Act.

98. The surgery proposed by Dr Kirsh is reasonably necessary as a result of the injury on 8 February 2017.

99. The respondent to pay the costs of and incidental to the left anterior cruciate ligament reconstruction and possible medial meniscal repair surgery proposed by Dr George Kirsh as per his reports dated 5 May 2017 and 29 May 2019, pursuant to s 60 of the 1987 Act.

100. The respondent to pay the applicant's reasonably necessary medical expenses incurred to date as a result of injury to the applicant's left knee on 8 February 2017 upon production of accounts, receipts and/or Medicare notice of charge.