WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **1948/19**
Applicant: **Mark Anthony Kennedy**
Respondent: **Manildra Meat Company Pty Limited**
Date of Determination: **31 July 2019**
Citation: **[2019] NSWWCC 260**

The Commission determines:

1. Pursuant to section 60 of the 1987 Act, the L4-S1 laminectomy, L4/5 and L5/S1 posterior interbody fusion, rhizolysis, L4-S1 pedicle screw internal fixation, posterolateral fusion and harvest bone graft surgery proposed by Dr Michael Ow-Yang is reasonably necessary treatment as a result of the injury sustained by the applicant in the course of his employment with the respondent on 24 May 2016.

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

Anthony Scarcella
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 ANTHONY SCARCELLA, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Jackson

Ann Jackson
Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Mr Mark Anthony Kennedy, is a 65-year-old man who was employed by Manildra Meat Company Pty Limited (the respondent) as a fulltime truck driver/forklift operator.

2. Mr Kennedy alleges that, in early May 2016, he noticed the onset of low back pain whilst carrying out his duties as a truck driver/forklift operator for the respondent. On 24 May 2016, whilst alighting from a work truck, his low back pain increased significantly.

3. On 29 May 2017, Mr Kennedy's treating neurosurgeon, Dr Michael Ow-Yang, recommended and sought approval for a L4-S1 laminectomy, L4/5 and L5/S1 posterior interbody fusion, rhizolysis, L4-S1 pedicle screw internal fixation, posterolateral fusion and harvest bone graft surgery pursuant section 60 of the *Workers Compensation Act 1987* (the 1987 Act).[1]

4. On 21 June 2017, EML issued a Dispute Notice pursuant to the former section 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) disputing liability for any ongoing or further medical treatment and for the spinal surgery proposed by Dr Ow-Yang.[2]

5. In or about August 2017, Mr Kennedy requested EML to review the decision contained in its Dispute Notice dated 21 June 2017.

6. On 22 August 2017, by way of a Dispute Notice issued under sections 74 and 287A of the 1998 Act, EML maintained its decision disputing liability for any ongoing or further medical treatment and for the spinal surgery proposed by Dr Ow-Yang.[3]

7. On 1 November 2018, Mr Kennedy, through his lawyers, served EML with a report by Dr Peter Endrey-Walder dated 25 September 2018 and requested EML to review the decisions contained in the Dispute Notices dated 21 June 2017 and 22 August 2017.[4]

8. On 18 March 2019, by way of a Dispute Notice issued under section 78 of the 1998 Act, EML maintained its decision disputing liability for any ongoing or further medical treatment and for the spinal surgery proposed by Dr Ow-Yang.[5]

9. The Application to Resolve a Dispute (ARD) dated 18 April 2019 was registered in the Commission.

10. The Reply dated 14 May 2019 was received in the Commission.

ISSUES FOR DETERMINATION

11. The parties agree that the following issue remains in dispute:

    (a) Whether the L4-S1 laminectomy, L4/5 and L5/S1 posterior interbody fusion, rhizolysis, L4-S1 pedicle screw internal fixation, posterolateral fusion and harvest bone graft surgery proposed by Dr Michael Ow-Yang is reasonably necessary treatment as a result of the injury sustained by Mr Kennedy on 24 May 2016 (deemed) within the meaning of section 60 of the 1987 Act.

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[1] ARD at page 11
[2] ARD at pages 16-19
[3] ARD at pages 20-24
[4] ARD at page 30
[5] ARD at pages 31-39

Matters previously notified as disputed

12. The issues in dispute were notified in a Dispute Notice pursuant to the former section 74 of the 1998 Act dated 21 June 2017; a Dispute Notice pursuant to sections 74 and 287A of the 1998 Act; and a Dispute Notice pursuant to section 78 of the 1998 Act.

Matters not previously notified

13. No other issues were raised.

PROCEDURE BEFORE THE COMMISSION

14. The parties attended a conciliation conference/arbitration in Wagga Wagga on 16 July 2019. Mr Timothy Abbott solicitor appeared for Mr Kennedy and Ms Lyn Goodman of counsel appeared for the respondent.

15. During the conciliation phase the parties agreed as follows:

    (a) Injury is not in dispute.

    (b) Due to the operation of section 59A of the 1987 Act, if there were a determination in favour of Mr Kennedy, it would have to be in the form of a declaration.

16. 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.

EVIDENCE

Documentary evidence

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

    (a) ARD dated 18 April 2019 and attached documents;

    (b) Reply dated 14 May 2019 and attached documents, and

    (c) Respondent's Application to Admit Late Documents dated 8 July 2019 and attached documents.

Oral evidence

18. Neither party sought leave to adduce oral evidence from or to cross-examine any witness.

AN ANALYSIS OF THE EVIDENCE

Mr Mark Anthony Kennedy

19. In evidence, there is a statement by Mr Kennedy dated 10 April 2019. I will now refer to the relevant parts of Mr Kennedy's statement.

20. Mr Kennedy described a solid work history, which included 32 years with NSW Railways as a truck driver and machine operator before commencing employment with the respondent in early 2012, where he initially worked in the freezer department for a short period of time and then worked as a truck driver/forklift driver.

21. Mr Kennedy stated that prior to commencing employment with the respondent, he had not experienced any "problems with my back".[6]

22. Mr Kennedy described his duties as a truck driver/forklift driver as follows:

> "6. There was a lot of getting in and out of the trucks and the forklift. The truck I was operating was old and had poor suspension and seating. I complained several times about the seat. I was given a terry towelling cover which of course did nothing to stop the jarring and bouncing caused by the faulty seat and lack of suspension.
>
> 7. When operating the forklift, I often had to use it on very uneven/potholed surfaces. I would bounce around in the machine which would jar my spine. The forklift itself was also an old machine and the seat was stiff. At times, I had to load skins. In order to do this, I had to get in and out of the forklift and lift steel gates to lock them in on the bin containing the skins. Whilst the gates were particularly heavy there [sic: was] some repetition work involved."[7]

23. Mr Kennedy stated that in early May 2016, whilst at work, he started to experience low back pain and complained about it to his workmates. The pain was located in the lower part of his back and the pain was referred into both legs behind his knees. He continued to work but struggled as the pain worsened.

24. Mr Kennedy stated that, on 24 May 2016, whilst alighting from a truck, the pain became much worse. He continued to work and reported it to his supervisor, Frank Austin, on the same day. After work, he went home and had a shower. The pain did not improve. On the following day, he was unable to get out of bed and his right leg was numb.

25. Mr Kennedy stated that, on 25 May 2016, he consulted his general practitioner, Dr Ranjan Perera. Dr Perera issued him with a Certificate of Capacity certifying him as having no work capacity for a period of two weeks. He also referred him for a CT scan, which was performed on 31 May 2016. Thereafter, Dr Perera certified Mr Kennedy fit for selected duties, which he continued to carry out in the respondent's offal room alternating each hour between light duties and resting (sitting) until the respondent made him redundant on 8 June 2018. He has not worked since.

26. Mr Kennedy stated that his pain persisted. He continued to take medication such as Voltaren and Panadeine Forte. As there was no improvement, Dr Perera referred him to Dr Ow-Yang, Neurosurgeon with whom he consulted on 25 January 2017.

27. On 9 March 2017, Dr Ow-Yang arranged for Mr Kennedy to undergo CT guided L4/5/S1 facet joint injections. The injections improved his pain for about a day and then returned to its previous levels.

28. Mr Kennedy stated that Dr Ow-Yang arranged for him to undergo an MRI scan and a bone scan on 3 May 2017 and 4 May 2017. In fact, the bone scan was performed on 3 May 2017 and reported on 4 May 2017.

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[6] ARD at page 40 at [8]
[7] ARD at page 40 at [6]-[7]

29. Mr Kennedy stated that, after reviewing the MRI scan, Dr Ow-Yang recommended a two-level posterior fusion to his lower back. EML declined approval for the proposed surgery.

30. Mr Kennedy stated that he continues to suffer severe pain which is made worse on activity. He was attempting to wean himself off the pain-relieving medication because he was concerned of becoming addicted to it.

31. In relation to the surgery proposed by Dr Ow-Yang, Mr Kennedy stated:

> "24. I want to have the surgery as otherwise I will be left with the chronic pain for the rest of my life. The pain affects all my daily activities, my social life, my ability to work and my ability to maintain my house.
>
> 25. None of the treatment I have received to date has improved my condition, all have failed. I am hoping that the surgical procedure recommended will give me a better standard of living."[8]

Dr Ranjan Perera, General Practitioner

32. Dr Ranjan Perera was Mr Kennedy's general practitioner. In evidence are Mr Kennedy's clinical records produced by Dr Perera.[9] The handwritten clinical notes are barely legible and lacking in detail. The printed clinical notes similarly lack the detail one would expect. The clinical records are not in chronological order. However, the earliest entry appears to be on an illegible date in November 2005 and the final entry is dated 29 May 2019. I will now refer to the relevant parts of those clinical records.

33. On 25 May 2016, Mr Kennedy consulted Dr Perera, who noted a "recurrent injury" to the right sacroiliac joint and tenderness.[10] Due to the brevity of the entries in Dr Perera's clinical notes, it is not clear what he meant by "recurrent injury". There are no legible references to complaints by Mr Kennedy of low back pain prior to 25 May 2016 in the clinical records produced by Dr Perera.

34. On 20 December 2016, Mr Kennedy consulted Dr Perera, who referred him to Dr Ow-Yang.[11]

Diagnostic imaging

35. On 31 May 2016, Mr Kennedy underwent a CT scan of his lumbosacral spine by Dr Kenneth Chuha, Radiologist on the referral of Dr Perera. In evidence, there is a CT scan report by Dr Chuha dated 31 May 2016.[12] Dr Chuha's report recorded the clinical notes as: "Right sciatica. ? L5/S1 disc."[13] The relevant findings included a mild to moderate diffuse disc bulge combining with moderate to severe bilateral facet osteoarthritis causing a moderate central canal stenosis and mild to moderate bilateral foraminal stenosis, worse on the right with contact on the right L4 nerve root at the L4/5 level.

36. On 3 May 2017, Mr Kennedy underwent a bone scan by Dr Andrew Watson, Radiologist on the referral of Dr Ow-Yang. In evidence, there is a bone scan report by Dr Watson dated 3 May 2017.[14] The clinical notes in the report referred to back pain and questioned the presence of lumbar facet arthropathy. Dr Watson reported a marked active facet joint arthropathy involving the right L4/5 facet joint, which correlated with the degenerative disease demonstrated in the 31 May 2016 CT scan of the lumbar spine.

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[8] ARD at page 42 at [24]-[25]
[9] Respondent's Application to Admit Late Documents dated 8 July 2019 at pages 1-62
[10] Respondent's Application to Admit Late Documents dated 8 July 2019 at page 9
[11] Respondent's Application to Admit Late Documents dated 8 July 2019 at page 2
[12] ARD at page 1-2
[13] ARD at page 1
[14] ARD at page 8

37. On 3 May 2017, Mr Kennedy underwent an MRI scan by Dr Ian Duncan, Radiologist on the referral of Dr Ow-Yang. In evidence there is an MRI scan report by Dr Duncan dated 4 May 2017.[15] Dr Duncan recorded the clinical indication as being one of low back pain and radiculopathy. Dr Duncan found no disc abnormality, canal or foraminal stenosis or facet arthrosis at L1-2 and L2-3. At L3-4, there was some disc desiccation; some differential use annular bulging but no focal disc protrusion or herniation; partial defacement of the lateral canal recesses (left greater than right); no exiting L3 nerve impingement; and no facet arthrosis. At L4-5, there was also disc desiccation with diffuse annular bulging; bilateral facet arthrosis and ligamentous hypertrophy with defacement of both lateral canal recesses and moderate to severe overall canal stenosis; and mild bilateral L4 foraminal stenosis. At L5-S1, there was no relevant disc abnormality; no canal or foraminal stenosis; all no facet arthrosis. Dr Duncan's conclusion was that of disc and facet degenerative changes at L4-5 resulting in moderate to severe canal stenosis.

Dr Michael Ow-Yang, Neurosurgeon

38. On 25 January 2017, Mr Kennedy first consulted Dr Michael Ow-Yang, Neurosurgeon on the referral of Dr Perera.

39. On 25 January 2017, Dr Ow-Yang reported to Dr Perera[16] that that Mr Kennedy had suffered an injury while at work in May 2016, when he developed a sudden onset of low back pain when getting out of a truck. He noted that Mr Kennedy's initial pain was severe and required admission to hospital. Dr Ow-Yang also noted that the low back pain was still significant and affected him during activity involving prolonged standing or when twisting or bending. Mr Kennedy had returned to work on light duties but, due to his ongoing back pain, he did not feel that he could perform his normal work activity of driving a truck and loading and unloading the truck. Mr Kennedy denied significant pain radiating into the lower limbs but did report intermittent numbness in the posterior thighs. Physiotherapy had not been of much benefit.

40. On reviewing Mr Kennedy's CT scan dated 31 May 2016, Dr Ow-Yang opined that it demonstrated severe L4/5 canal stenosis secondary to severe L4/5 facet hypertrophy and noted that there was also mild L5/S1 facet hypertrophy.

41. Dr Ow-Yang diagnosed low back pain secondary to L4/5 and L5/S1 lumbar facet arthropathy and mild symptoms relating to severe L4/5 lumbar canal stenosis. He recommended bilateral L4/5 and L5/S1 lumbar facet injections as the next step in escalating pain management, noting that any improvement in pain levels may be only temporary. If there was no improvement following the injections, then he proposed surgery in the form of an L5/S1 laminectomy, rhizolysis, posterior interbody fusion, pedicle screw internal fixation, posterolateral fusion and harvest of bone graft surgery.

42. On 9 March 2017, Mr Kennedy underwent CT guided bilateral L4/5 and LS/S1 steroid facet injections by Dr Ow-Yang.[17]

43. On 20 April 2017, Dr Ow-Yang reported to Dr Perera[18] that Mr Kennedy's recent lumbar steroid injections only partially and temporarily alleviated his low back pain. He noted that Mr Kennedy continued to experience significant and disabling mechanical low back pain. Dr Ow-Yang recommended definitive investigations in the form of an MRI of the lumbar spine and a SPECT CT of the lumbar spine prior to offering a surgical option.

[15] ARD at page 9
[16] ARD at pages 3-4
[17] ARD at pages 5-6
[18] ARD at page 7

44. On 18 May 2017, Dr Ow-Yang reported to Dr Perera[19] that Mr Kennedy had consulted him following the MRI of the lumbar spine and a SPECT CT of the lumbar spine referred to above. Dr Ow-Yang observed:

> "He [Mr Kennedy] failed to improve with maximal nonsurgical treatment involving lumbar facet radiofrequency denervation and several injections.
>
> Mark would like to escalate treatment to definitive surgery. I have offered a posterior approach to L5/S1 laminectomy, rhizolysis, posterior interbody fusion, pedicle screw internal fixation, posterolateral fusion and harvest of bone graft. There is a 70-80% chance of improving leg symptoms, and a 50% chance of improving back pain. As with any procedure to alleviate pain, there is the potential outcome of having no or only a partial response to surgery. There is a 1% risk of nerve injury or CSF leak, a 1% risk of infection, bleeding, DVT or PE, the risk of failure to fuse and the risk of adjacent segment degeneration. New technology using intraoperative CT stereotactic guidance is used to accurately place the pedicle screws."[20]

I note that there is no evidence that Mr Kennedy underwent lumbar facet radiofrequency denervation.

45. On 29 May 2017, Dr Ow-Yang wrote to EML seeking approval for Mr Kennedy to undergo a L4-S1 laminectomy, L4/5 and L5/S1 posterior interbody fusion, rhizolysis, L4-S1 pedicle screw internal fixation, posterolateral fusion and harvest bone graft procedure at the National Capital Private Hospital.[21] He also provided a quotation for the cost of the proposed surgery.[22]

46. On 7 June 2017, Dr Ow-Yang wrote to EML in response to its letter dated 6 June 2017 seeking further information in relation to Mr Kennedy's proposed surgery.[23] The EML letter dated 6 June 2017 is not in evidence. Amongst other things, Dr Ow-Yang made the following points:

> "
> - My recommendations are based purely on the patient's clinical presentation which is described in my letters. They are not influenced by whether or not the patient's condition is compensable.
> - The opinion of an Independent Medical Examiner or other consulting medical practitioner does not affect my recommendations. Any justification of my opinion is contained in the letters to the referring doctor. I would not comment on the recommendations of another doctor.
> - Surgical treatment is only offered to a patient when all reasonable conservative measures and treatment options have failed to improve the patient's symptoms."[24]

Dr Peter Endrey-Walder, General & Trauma Surgeon

47. On 25 September 2018, Mr Kennedy Consulted Dr Peter Endrey-Walder, General and Trauma Surgeon at the request of his lawyers.

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[19] ARD at page 10
[20] ARD at page 10
[21] ARD at page 11
[22] ARD at pages 12-14
[23] ARD at pages 14-15
[24] ARD at pages 14

48. In evidence, there is a report by Dr Endrey-Walder dated 25 September 2018.[25] I will now refer to the relevant parts of that report.

49. Dr Endrey-Walder took a history from Mr Kennedy which was largely consistent with the evidence and may be summarised as follows:

    (a) In early May 2016, Mr Kennedy complained to some workmates about some lower back ache, the like of which he had never experienced before.

    (b) On 24 May 2016, whilst alighting from the cabin of a truck at his work depot, Mr Kennedy suffered instant pain in his lower back but continued to work for the rest of the day. He reported the injury to his supervisor.

    (c) On 25 May 2016, Mr Kennedy was unable to get out of bed or get to work. His right leg went numb and he rated his back pain as a 9/10. He consulted Dr Perera who referred him for a CT scan of the lumbar spine on 31 May 2016 and placed him on selected duties at work.

    (d) On 25 January 2017, Mr Kennedy consulted Dr Ow-Yang, who recommended and then performed CT guided bilateral L4/5 and LS/S1 steroid facet injections on 9 March 2017.

    (e) Dr Ow-Yang arranged for Mr Kennedy to undergo a bone scan on 3 May 2017 and 4 May 2017.

    (f) On 18 May 2017, Dr Ow-Yang recommended that Mr Kennedy undergo a two-level posterior fusion.

    (g) In 2017, Mr Kennedy underwent about eight sessions of physiotherapy without much beneficial effect.

    (h) Mr Kennedy's pain-relieving and anti-inflammatory medications included Panadeine Forte and Voltaren.

50. Dr Endrey-Walder referred to the findings in Mr Kennedy's lumbar CT scan dated 31 May 2016; bone scan dated 3 May 2017; and lumbar MRI scan dated 4 May 2017.

51. Dr Endrey-Walder recorded Mr Kennedy's complaints as including constant pain down the middle of his lower back. He described the pain as a "gnawing" pain.[26] The pain became much worse with activity. Mr Kennedy also complained of a dull pain down the back of his leg to the knee. However, the back pain was more problematic than the leg pain.

52. On examination, Dr Endrey-Walder observed, amongst other things, well localised and quite marked tenderness over the right of midline at the L4/5 level; massive, both visible and palpable muscle spasm on both sides of the lumbar spine; difficulty straightening; no capacity to hyper-extend the back; the right thigh was 1 cm larger in circumference than the left thigh; 20° straight leg raising on the right; no clinical evidence of neurological deficit in the lower limbs.

53. Dr Endrey-Walder was critical of Dr Casikar's opinion that Mr Kennedy's problem was predominantly due to pre-existing pathology in the back and that he could not identify any specific work-related injury which could have caused the problem. In this regard Dr Endrey-Walder opined:

[25] ARD at pages 25-29
[26] ARD at page 27

> "Mr Kennedy became symptomatic in the course of his work at the lower back in early May 2016, a couple of weeks on developing acute pain that stopped him in his tracks.
>
> …
>
> It is certainly likely that the onset of the symptoms, when your client was 62 years of age, he had some spondylitic changes in the lower back, but this had not impacted on his life, nor on his work capacity as a Forklift Driver/Truck Driver over the years.
>
> Getting in and out of his truck and on and off the forklift would have to be considered as work that can impact on underlying silent degenerative changes, and this is exactly what happened to Mr Kennedy initially in a low-grade manner, on 24.5.2016 in a more acute and debilitation [sic] manner.
>
> …
>
> This man had no back pain until a couple of weeks prior to the acute injury, hence the much emphasised degenerative changes '*genetically determined*' had in no way impacted on his functionality.
>
> …
>
> … By far the most significant problem is the development of inflammatory changes in the right L4-5 facet joint, the symptoms clearly precipitated by work activity."[27]

54. Dr Endrey-Walder criticised Dr Casikar's reference to the advice he provided regarding non-surgical treatment of Mr Kennedy's condition. He was critical because such treatment had "clearly being proven to have failed over the past couple of years."[28]

55. In relation to the surgery proposed by Dr Ow-Yang, Dr Endrey-Walder opined:

> "It is the severity and the chronicity of this man's lower back pain that is the reason for offering the fusion procedure, the only surgical procedure which could have a long-term beneficial effect on his symptoms, even if it may not necessarily result in any significant improvement in his functional capacity.
>
> If Mr Kennedy is willing to undergo the operation, it would suggest to me that he is sufficiently troubled to do so, in which case such a procedure should be offered to him."[29]

Dr Vidyasager Casikar, Consultant Neurosurgeon

56. On 18 August 2016, Mr Kennedy consulted Dr Vidyasager Casikar, Consultant Neurosurgeon at the request of EML.

57. In evidence, there is a report by Dr Casikar dated 19 August 2016.[30] I will now refer to the relevant parts of that report.

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[27] ARD at pages 28-29
[28] ARD at page 29
[29] ARD at page 29
[30] Reply at pages 15-20

58. Dr Casikar took a history from Mr Kennedy which may be summarised as follows:

    (a) He had been a truck driver and forklift operator for four years. His job involved loading and unloading sheepskin from a truck with a forklift.

    (b) On 24 May 2016, at the end of the day during which he was involved in driving a truck, he developed a low back pain. There was no specific injury. The pain gradually developed on that day.

    (c) After work on 24 May 2016 he went home, had a hot shower and rested on the lounge. When he attempted to get up off the lounge, he found that his right leg had become numb. By the following morning, he could not get out of bed because of back and leg pain. Due to the severe pain in his right leg, he felt that he was unable to go to work and notified his supervisor.

    (d) He consulted Dr Perera, who admitted him to the Cootamundra Hospital for two nights. He was medicated appropriately and discharged home and advised to rest from work for two weeks.

    (e) As his condition had not resolved after two weeks, Dr Perera arranged for him to undergo a CT scan and thereafter, he was advised to have another week of rest.

    (f) He underwent five sessions of physiotherapy.

    (g) He then returned to work on light duties working normal hours.

    (h) Compared to the day he was admitted to Cootamundra Hospital, he felt a lot better. There were some days where the problem was worse than others. He was taking Voltaren when required.

    (i) He denied any previous history of similar problems.

59. On examination, Dr Casikar observed, amongst other things, that Mr Kennedy was able to walk on heels and toes without any difficulty; back flexion was possible up to 40°; lateral movements were normal; gait was normal; neurological examination of the lower limbs suggested straight leg raising (SLR) ranging between 60° and 80°; there was no evidence of dermatomal hyperaesthesia or motor weakness; and the deep tendon reflexes were normal.

60. Dr Casikar referred to the lumbar CT scan dated 31 May 2016 and initially provided a diagnosis of lumbar canal stenosis. Later in the report, Dr Casikar provided a diagnosis of L4/5 degenerative disease and lumbar canal stenosis and opined that the "injury is reasonably attributable to the alleged incident".[31] Dr Casikar also opined that Mr Kennedy's condition was an aggravation of a pre-existing condition, which whilst improving, had not yet completely resolved.

61. However, under the heading "opinion", Dr Casikar stated:

> "Mr Kennedy has lumbar canal stenosis which is due to a combination of short pedicles and thickening of the ligamentum flavum. The latter is a normal ageing process. The short pedicles are a congenital variation. Mr Kennedy's problems are not related to his work. There has been no specific injury. With canal stenosis,

[31] Reply at page 18

> it is not unusual to get frequent episodes of back pain and even sciatic pain. There is a significant lateral recess stenosis. With the kind of job that Mr Kennedy performs, twisting movements of the back and other kinds of aggravation are not unusual. When these types of injuries occur the already compromised nerve roots become oedematous and the problem lasts for a few weeks. Mr Kennedy has already shown significant improvement, mainly because the swelling around the nerve roots has improved.
>
> At this stage, Mr Kennedy does not require any surgery. He is significantly obese. He has got poor core muscles. I believe with reduction in the weight, regular home-based exercises and gym program under supervision, Mr Kennedy's medical problem would improve with reduced episodes of back pain. However, the degenerative process and the stenosis at the L4/5 segment is a progressive condition and it is likely to progress and Mr Kennedy may have problems in the future. He is now 62 years old. I believe with appropriate management of the back, he would be able to work until he reaches the age of retirement."[32]

62. Dr Casikar also opined that Mr Kennedy's employment was not a substantial contributing factor to his compensable condition and explained as follows:

> "His main problem is age-related degenerative disease of the lumbar spine and L4/5 stenosis. The nature of his work is such that it aggravated already compromised neural structures at this level. As I have explained above, the injury is improving because his symptoms are getting better. The probability that he would have had these injuries around this time in his life is very high because Mr Kennedy has significant degenerative disease and canal stenosis. He also has a poor physical condition. … Mr Kennedy has no previous history of back pain. This is not surprising. Even though the lumbar canal stenosis is a long-standing process, symptoms can occur at any time without any specific injury. Therefore, the fact that Mr Kennedy complained of the symptoms does not necessarily mean that there has been a specific workplace injury."[33]

63. Dr Casikar identified Mr Kennedy's congenital canal stenosis and age-related thickening of the ligamentum flavum as the main contributing factor to his condition.

64. In relation to the issue of Mr Kennedy's treatment, Dr Casikar opined that the treatment he had received to date have been appropriate and necessary in relation to his medical condition. It appeared that Mr Kennedy had made significant improvement. Dr Casikar recommended that the treatment should be continued and that, in addition, Mr Kennedy would benefit from regular home-based exercises to improve his core muscle strength. He also recommended a consultation with a dietician as being useful for weight reduction purposes. Dr Casikar did not have any alternative treatment to suggest.

65. In relation to the issue of further investigations, Dr Casikar opined:

> "If his symptoms persist and he is not recovering, perhaps an epidural injection at the L4/5 segment would be necessary. If all these procedures fail, Mr Kennedy might require a limited L4/5 decompression. In my opinion, this would be the last option. The surgery is not related to his employment. A non-surgical management of the problem is much better than any of the surgical treatments suggested."[34]

[32] Reply at page 17
[33] Reply at page 18
[34] Reply at page 20

66. On 9 February 2017, Mr Kennedy again consulted Dr Casikar at the request of EML.

67. In evidence, there is a report by Dr Casikar dated 9 February 2017.[35] I will now refer to the relevant parts of that report.

68. Dr Casikar took an updated history from Mr Kennedy which may be summarised as follows:

    (a) He attempted to return to his pre-injury duties of driving a truck and forklift but could not manage it. He was now working in the respondent's offal room in the packing and printing section working seven hours per day, five days per week.

    (b) Current medications were Panadeine Forte and Valium to control pain.

    (c) On 20 January 2017, Dr Ow-Yang recommended that he undergo facet injections and that if there were no improvement, he may require a posterior spinal fusion.

69. On examination, Dr Casikar observed, amongst other things, that Mr Kennedy was able to walk on his heels and toes without difficulty; gait was normal; back flexion was possible up to 30°; neurological examination of the lower limbs suggested SLR ranging between 40° and 50°; no evidence of dermatomal hyperaesthesia or motor weakness; and deep tendon reflexes were normal.

70. Dr Casikar confirmed his previous diagnosis of lumbar canal stenosis at L4/5. He also confirmed his opinion that the lumbar canal stenosis was due to a combination of short pedicles and thickening of the ligamentum flavum, which was predominantly due to Mr Kennedy's pre-existing back pathology. Dr Casikar was not able to identify any specific work-related injury which could have caused Mr Kennedy's problem.

71. Dr Casikar agreed with Dr Ow-Yang that facet joint injections would be useful treatment. In relation to Dr Ow-Yang's recommendation that, if the facet joint injections failed to relieve symptoms, the next procedure would be a spinal fusion, Dr Casikar stated:

> "I am not so sure if a spinal fusion is indicated. It is well recognised that non-surgical management of chronic degenerative disease has a better outcome than surgery or spinal fusion.
>
> Mr Kennedy has lumbar canal stenosis. He does not have any claudicating symptoms. If he had definite evidence of progressive claudicating symptoms, a limited laminectomy would have been appropriate. Since the symptoms are only back pain, in my opinion, conservative management has a better option than fusion.
>
> Mr Kennedy has two more years before he reaches his age of retirement. He is very keen to reach this stage. I believe that a spinal fusion is unlikely to make any spectacular difference to his work. On the contrary, he may not be able to get back to work at all after the spinal fusion."[36]

72. Dr Casikar confirmed his opinion that Mr Kennedy's employment was not a substantial contributing factor to his compensable condition. There was no specific injury and the fact that he developed back pain when he was driving the truck was purely incidental. Further, he opined:

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[35] Reply at pages 21-25
[36] Reply at pages 22-23

> "… Employment is not the cause of the problem. The commonly held opinion in the past that employment contributed significantly to the development and progression of the degenerative disease is no longer viable. The most substantial contributing factor to Mr Kennedy's condition it is lumbar canal stenosis in addition to age-related thickening of the ligamentum flavum."[37]

73. In relation to the issue of Mr Kennedy's treatment, Dr Casikar opined that the treatment recommended by Dr Ow-Yang seemed very appropriate as did the latter's proposed facet injections at the L4/5 segment. Dr Casikar opined that Mr Kennedy should undergo a few injections at that level to assess his response and perhaps even try facet denervation. Dr Casikar further opined that as Mr Kennedy's main complaint was only back pain and that he did not have any neurological symptoms and claudication (leg pain with walking) problem, spinal surgery was not recommended. He went on to state as follows:

> "It is well recognised that spinal fusion as far as back pain is concerned has a poor outcome. The Cochrane review committee has clearly indicated that non-surgical management of back pain or chronic degenerative disease has a better long-term outcome than a spinal fusion."[38]

74. Dr Casikar did not believe that Mr Kennedy required any further investigations at that stage. He had not noticed any change since his previous examination of Mr Kennedy. Mr Kennedy's neurological status remained the same. Dr Casikar's opinion and recommendations had not changed and he made the following observation:

> "I am more concerned about the fact that Mr Kennedy has only got two more years to function and it is reasonable to carry him on for another two years with appropriate suitable employment till he reaches the age of retirement. Forcing a spinal fusion will only create an additional burden and is unlikely to make any spectacular difference to his work capacity."[39]

75. In evidence, there is a supplementary report by Dr Casikar dated 9 June 2017 in response to a letter from EML posing certain questions arising from Dr Ow-Yang's recently proposed L4-S1 laminectomy, L4/5 and L5/S1 posterior interbody fusion, rhizolysis, L4-S1 pedicle screw internal fixation, posterolateral fusion and harvest bone graft surgery.[40] I will now refer to the relevant parts of that report.

76. In preparing the supplementary report, Dr Casikar did not re-examine Mr Kennedy.

77. The first question posed by EML was whether Dr Casikar was "still under the opinion" that the proposed surgery was "not reasonable or necessary for Mr Kennedy."[41] in response, Dr Casikar maintained that a non-surgical management of back pain would have a better outcome than the very extensive spinal fusion suggested by Dr Ow-Yang. He went on to state:

> "The evidence-based reports indicate that outcome of a spinal fusion on a background of Workers' Compensation has a very poor outcome as far as return to work and management of pain is concerned."[42]

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[37] Reply at page 23 at [2]
[38] Reply at page 24 at [9]
[39] Reply at page 25 at [10]
[40] Reply at pages 26-28
[41] Reply at page 26 at [1]
[42] Reply at page 26 at [1]

78. The second question posed by EML was whether Dr Casikar could provide a suggestion as to any conservative or surgical procedures as an alternative for the surgery proposed by Dr Ow-Yang.[43] In response, Dr Casikar opined that regular home-based exercises and simple analgesics could keep Mr Kennedy in his current suitable duties job at normal hours with a very good chance of reaching retirement.

79. The third question posed by EML requested Dr Casikar's professional opinion as to Mr Kennedy's capacity for work with conservative treatment or if he were to undergo the proposed spinal fusion. In response, Dr Casikar opined that driving a truck would not be an option due to the heavy lifting involved in such duties, which "would aggravate his back pain even further".[44]

80. The fourth question posed by EML sought Dr Casikar's opinion as to whether EML was liable for the cost of the surgery proposed by Dr Ow-Yang. In response, Dr Casikar stated:

> "As far as the liability of EML regarding the spinal fusion is concerned, this is likely to be very controversial. The initial management of back pain he required which included cortisone injection would be acceptable as a management of aggravation on a pre-existing degenerative disease. I do not believe the indications for spinal fusion are as a direct consequence of his workplace injury when he was driving the truck. Therefore, while the [sic] EML would be liable for the initial treatment he has had, I am not sure that EML would be liable for the spinal fusion suggested by Dr Ow-Yang."[45]

81. The fifth question posed by EML amounted to an invitation for "any further information and guidance to share on any aspect of Mr Kennedy's claim".[46] In response, Dr Casikar opined that the proposed surgical procedure was frequently performed to address problems related to degenerative disease of the lumbar spine. Enthusiasm for spinal fusions has gradually reduced as the outcomes have been very poor. He again referred to multiple evidence-based studies which indicated that spinal fusions on a background of workers compensation had poor outcome. Dr Casikar further opined:

> "Therefore, in my opinion, the effective management of Mr Kennedy to reach his age of retirement would be a nonsurgical management."[47]

82. The sixth question posed by EML sought an opinion as to any other investigative procedures that might be necessary in Mr Kennedy's situation. In response, Dr Casikar opined that he did not believe any further investigations were required. After having read Dr Ow-Yang's correspondence (presumably relating to the request for approval of the proposed surgery), somewhat surprisingly, stated:

> "I agree with his enthusiasm for spinal fusion. Unfortunately, this is not supported by evidenced-based studies."[48]

83. In evidence, there is a further supplementary report by Dr Casikar dated 5 July 2019 in response to a letter from EML's lawyers, Gair Legal, posing certain questions and enclosing further documentation.[49] I will now refer to the relevant parts of that report.

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[43] Reply at page 27 at [2]
[44] Reply at page 27 at [3]
[45] Reply at page 27 at [4]
[46] Reply at page 27 at [5]
[47] Reply at page 27 at [5]
[48] Reply at page 27 at [6]
[49] Respondent's Application to Admit Late Documents dated 8 July 2019 at pages 63-66

84. In preparing the further supplementary report, Dr Casikar did not re-examine Mr Kennedy.

85. After having reviewed Mr Kennedy's clinical records produced by Dr Perera, Dr Casikar stated that such records did not in any way alter the opinions previously expressed by him. He added that, if Mr Kennedy had claudication problems or bilateral verifiable neurological symptoms, then a decompression of the canal stenosis would be useful. As Mr Kennedy's symptoms were purely back pain, then the spinal fusion was not going to solve his problem.

86. As to whether the surgery proposed by Dr Ow-Yang was reasonably necessary as a result of Mr Kennedy's work injury, Dr Casikar opined that there was no evidence to indicate that it was reasonably necessary as a result of the workplace injury.

87. As to whether, on the updated evidence, Mr Kennedy had exhausted avenues of conservative treatment, Dr Casikar accepted that such avenues had been exhausted. However, he opined that the failure of medical treatment did not necessarily mean that there was a strong indication for surgery. He further opined that indications for surgery are usually where there is evidence of progressive neurological problems verified by clinical examination rather than, as in Mr Kennedy's case, merely based on complaints of back pain and radiological evidence of degenerative disease. The latter will often lead to a poor prognosis.

88. In response to the question as to whether the need for further treatment related to the work injury at work or the aggravation to a pre-existing condition sustained as a result of Mr Kennedy's employment activities, Dr Casikar responded that he accepted that Mr Kennedy had back pain but that such persistent back pain was due to constitutional degenerative disease and facet arthropathy and not as a result of his employment activities. However, he then added:

> "The injury at work has probably aggravated his pre-existing condition. The kind of aggravation he had would normally resolve in about 6 to 8 weeks. His persistent complaints of back pain due to the significant degenerative disease of the lumbar spine."[50]

89. Dr Casikar opined that if, despite his opinion, Mr Kennedy were to proceed with the surgery proposed by Dr Ow-Yang, he would likely continue to complain of back pain and his need for medical treatment would continue. Further, the probability of working until reaching retirement age would likely be prejudiced.

90. In relation to the opinions expressed by Dr Endrey-Walder, Dr Casikar's comments may be summarised as follows:

    (a) Degenerative disease is genetically determined. "Unfortunately, this is the latest opinion and is well-established."[51] Dr Casikar referred to a recent publication by the AMA Guides to the Evaluation of Disease and Injury Causation, second edition, where the author provides statistical evidence to indicate that degenerative disease is not work-related and is genetically determined.

    (b) Lumbar canal stenosis is age-related. The inflammatory changes in the facet joint were not precipitated by work. The kind of inflammatory reaction Dr Endrey-Walder alludes to normally resolves in about four to six weeks. The inflammatory reaction is based on calcium ion mechanism. It is not a permanent pathology. The only permanent cause for back pain is progressive degenerative disease. Injury has a finite period and injury does not produce indefinite pain.

[50] Respondent's Application to Admit Late Documents dated 8 July 2019 at page 64
[51] Respondent's Application to Admit Late Documents dated 8 July 2019 at page 65

(c) Dr Casikar agreed with Dr Endrey-Walder's opinion that the chronicity of Mr Kennedy's lower back pain was a reasonable indication for spinal fusion because it is one of the commonly performed surgical procedures for degenerative disease. However, he did not agree that it could have a long-term benefit on his symptoms because of the opinions he previously expressed in relation to the evidence-based studies that in a worker's compensation context, outcomes are very poor. Dr Casikar invited Dr Endrey-Walder to look into the reports and literature and, in particular, the Cochrane Review. The review indicates that spinal fusion is not an answer to all back pain and the outcome is generally very poor.

SUBMISSIONS

91. The parties made oral submissions at the arbitration hearing which were sound recorded. The sound recording is available to the parties.

The respondent's submissions

92. The respondent's submissions, through its counsel, Ms Goodman, may be summarised as follows:

(a) There is no issue about injury per se. The issue is whether the surgery recommended by Dr Ow-Yang in his reports dated 25 January 2017 and 18 May 2017 is reasonably necessary as a result of the injury.

(b) There is little evidence by way of clinical notes regarding day to day complaints by Mr Kennedy. In the respondent's Application to Admit Late Documents dated 8 July 2019 there are notes produced by Dr Perera, which are difficult to read and do not appear to deal with any back condition with the exception of one or two entries. The entry on 25 May 2016, refers to a recurrent injury to the sacroiliac joint and tenderness. Having reviewed the notes carefully, bearing in mind the difficulty in reading Dr Perera's handwriting, there appear to be no other entries in respect of the back prior to 25 May 2016. So, it is uncertain as to what Dr Perera meant by "recurrent". It matters little as injury is not in issue.

(c) Although Mr Kennedy consulted Dr Perera following 25 May 2016, there were no real complaints of back pain or any other pain recorded in the clinical notes. Most entries referred to form documents, presumably meaning certificates. At one point, it is recorded that Mr Kennedy's back is no better. Apart from that, one cannot make out any complaints about his back. There was no report in evidence from Dr Perera dealing with Mr Kennedy's back condition, treatment or his opinion on whether the proposed surgery is required or not.

(d) Mr Kennedy underwent a lumbar CT scan on 31 May 2016 on the referral of Dr Perera. He was later referred to Dr Ow-Yang.

(e) On 25 January 2017, Dr Ow-Yang seemed to obtain a consistent history from Mr Kennedy. He referred to the CT scan and provided a working diagnosis of low back pain secondary to L4/5 and L5/S1 lumbar facet hypertrophy and noted mild symptoms relating to severe L4/5 lumbar canal stenosis. Interestingly, there is no mention of pain radiating into Mr Kennedy's legs or as referred to by Dr Casikar, radicular pain or claudication. However, there was reference to no significant pain radiating into the lower limbs but there was intermittent numbness in the posterior thighs.

(f) Mr Kennedy then underwent bilateral L4/5 and L5/S1 facet injections by Dr Ow-Yang, which he later noted had a partial and temporary effect in alleviating low back pain. Dr Ow-Yang recommended that Mr Kenney undergo a bone scan and lumbar MRI scan on 3 and 4 May 2017 respectively. The bone scan showed marked active facet joint arthropathy involving the right L4/5 facet joint. The MRI scan demonstrated disc and facet degenerative changes at L4/5 resulting in moderate to severe canal stenosis.

(g) Dr Ow-Yang reviewed the results of the bone and MRI scans in consultation with Mr Kennedy and provided a working diagnosis of chronic mechanical low back pain secondary to L4/5 and L5/S1 facet arthropathy and L4/5 canal stenosis. The bilateral L4/5 and L5/S1 facet injections having failed to improve Mr Kennedy's condition, Dr Ow-Yang proposed a L4-S1 laminectomy, L4/5 and L5/S1 posterior interbody fusion, rhizolysis, L4-S1 pedicle screw internal fixation, posterolateral fusion and harvest bone graft surgery. Dr Ow-Yang sought approval to proceed with the proposed surgery but approval was declined.

(h) Dr Endrey-Walder reviewed and referred to the radiological investigations. He opined that Mr Kennedy became symptomatic in his lower back in the course of his work in early May 2016. The only evidence about early May 2016, that is, before 24 May 2016, comes from Mr Kennedy. Dr Endrey-Walder then referred to acute pain stopping him in his tracks a couple of weeks later (24 May 2016).

(i) Dr Endrey-Walder commented on Dr Casikar's evidence that Mr Kennedy's problem was predominantly due to pre-existing pathology in his back by stating that it was certainly likely that at the onset of the symptoms, at 62 years of age, he had some spondylitic changes in the lower back that did not impact on his life or work over the years. Dr Endrey-Walder opined that by far the most significant problem was the development of inflammatory changes in the right L4/5 facet joint, the symptoms of which were clearly precipitated by work activity. Dr Casikar opined that there would have been some inflammation but that it would have been very short lived.

(j) Clearly, there had been some sort of an aggravation or exacerbation of what was, predominantly, degenerative changes in Mr Kennedy's back.

(k) Dr Endrey-Walder took Dr Casikar to task in relation to his repeated advice regarding non-surgical treatment which had failed. However, Dr Casikar was referring to much more than just the facet joint injections. He referred to physiotherapy, a home exercise program and other treatment, none of which appears to have taken place. Mr Kennedy does not seem to have had any treatment other than the facet joint injections and some physiotherapy.

(l) Dr Endrey-Walder concluded by saying that it was the severity and chronicity of Mr Kennedy's low back pain that was the reason for offering the fusion procedure, being the only surgical procedure, which could have a long-term beneficial effect on his symptoms, even if it may not necessarily result in any significant improvement in his functional capacity. Here, Dr Endrey-Walder is admitting to what Dr Casikar had said, namely, at Mr Kennedy's age, he only has another couple of years to retirement and will be much more able to continue with work until retirement if he does not undergo the fusion.

(m) On 19 August 2016, Dr Casikar diagnosed lumbar canal stenosis. However, he also stated that the lumbar canal stenosis was due to a combination of short pedicles and thickening of the ligamentum flavum. The former was a congenital variation and the latter was a normal aging process. The problem is not work related. There has been no specific injury. With canal stenosis it is not unusual to get frequent episodes of back pain and even sciatic pain. With the kind of job that

Mr Kennedy performed, that is, twisting movements of the back and other kinds of aggravation are not unusual. It is for this reason that injury is not in issue. Dr Casikar also opined that when these types of injuries occur, the already compromised nerve roots become oedematous and the problem lasts for a few weeks. Mr Kennedy had already shown significant improvement, mainly because the swelling around the nerve roots had improved.

(n) Before Dr Ow-Yang proposed the fusion, Dr Casikar opined that Mr Kennedy did not require surgery. He believed that with reduction in weight, regular home-based exercises and gym program under supervision, Mr Kennedy's medical problem would improve with reduced episodes of back pain. There was no evidence that Mr Kennedy had undertaken any of these recommendations.

(o) Whilst injury itself is not in issue, it is important to note that Dr Casikar opined that Mr Kennedy's main problem as age-related degenerative disease of the lumbar spine and L4/5 stenosis. The injury was improving because his symptoms were getting better. The probability that he would have had these injuries around this time in his life was very high.

(p) On 9 February 2017, Dr Casikar opined that Mr Kennedy did not have any neurological symptoms. The problem was predominantly due to pre-existing pathology in the back. He agreed with Dr Ow-Yang that facet joint injections would be a useful way of dealing with the problem. He was not so sure that a spinal fusion was indicated. He stated that it is well recognised that non-surgical management of chronic degenerative disease has a better outcome than surgery or spinal fusion. He noted the absence of claudication and that if there was evidence of claudication symptoms, then a limited laminectomy would have been appropriate. Dr Casikar opined that a spinal fusion was unlikely to make any spectacular difference to his work and, on the contrary, he may not be able to get back to work at all after the fusion.

(q) On 9 June 2017, Dr Casikar maintained his position that non-surgical management of Mr Kennedy's back pain would have a better outcome than the very extensive spinal fusion proposed by Dr Ow-Yang. In this regard, Dr Casikar referred to the Cochrane Review in support of his position. He opined that as long as Mr Kennedy performed regular home-based exercises and took simple analgesics, he would be able to maintain his present job until retirement.

(r) On 5 July 2019, Dr Casikar repeated much of what he had said in his previous reports. He confirmed that, if Mr Kennedy had claudication problems or bilateral verifiable neurological symptoms, then a decompression of the canal stenosis would be useful. As Mr Kennedy's symptoms were purely back pain, then the spinal fusion was not going to solve his problem. Dr Casikar opined that there was no evidence to indicate that the proposed surgery was reasonably necessary as a result of the workplace injury. He further opined that indications for surgery are usually where there is evidence of progressive neurological problems verified by clinical examination rather than, as in Mr Kennedy's case, merely based on complaints of back pain and radiological evidence of degenerative disease. The latter will often lead to a poor prognosis.

(s) Mr Kennedy has undergone the cortisone injections but there is no evidence that he has reduced his weight or undertaken home-based exercises under the guidance of a physiotherapist as recommended by Dr Casikar for the purpose of improving his symptoms of back pain.

(t) One would not be satisfied that the very extensive surgery suggested by Dr Ow-Yang is reasonably necessary as a result of injury on 24 May 2016.

Mr Kennedy's submissions

93. Mr Kennedy's submissions, through his solicitor, Mr Abbott, may be summarised as follows:

(a) There is no evidence that Mr Kennedy has not undergone any treatment options that have been made available to him.

(b) In terms of medical opinions, it is clear that a contest remains between Dr Casikar on the one hand and the treating neurosurgeon, Dr Ow-Yang, and Dr Endrey-Walder on the other.

(c) Dr Casikar's opinions should not be accepted for a number of reasons. Firstly, Dr Casikar's reports are "all over the place". There are problems in the way he formulates his opinions. One of those problems is the notion that Mr Kennedy does not have leg pain, when it is clearly referred to in the treating doctors' reports and his statement. The absence of leg pain underlies some of Dr Casikar's opinions. Dr Casikar also seems to be terribly concerned with the notion that, even if Mr Kennedy's surgery was successful, he would not get back to work and at the age of 63, what would be the purpose of the operation? That is not the point, nor is it the test.

(d) In Dr Casikar's report dated 19 August 2016, he took a history from Mr Kennedy that on 24 May 2016 he was involved in driving a truck and developed low back pain, without any specific injury. It was a problem that gradually developed on the day. Mr Kennedy went home, had a hot shower and rested on the lounge. When he tried to get up, he found that his right leg had become numb. By the following morning, he could not get out of bed because of pain in the back and severe pain in the right leg. It is submitted that, thereafter, the right leg pain has continued.

(e) In his report dated 19 August 2016, Dr Casikar seemed to cavil with himself in relation to the issue of injury. Initially, he opined that the injury was reasonably attributable to the alleged incident. However, later in the report, he seemed to cavil with that opinion when he stated that employment was not a substantial contributing factor to his compensable condition. It is uncertain what Dr Casikar is trying to say. If the injury happened at work, it must follow that work was a substantial contributing factor to his injury.

(f) Later in the report dated 19 August 2016, Dr Casikar opined that Mr Kennedy's condition is an aggravation of a pre-existing condition and that the aggravation was improving but had not resolved yet. In his subsequent reports, Dr Casikar did not provide an opinion as to when or if the aggravation of the pre-existing condition he referred to had completely resolved. It is curious that in the report, Dr Casikar regularly referred to Mr Kennedy's condition as improving, when it was clear from Mr Kennedy's evidentiary statement, Dr Ow-Yang's reports and Dr Endrey-Walder's report, that it was not improving.

(g) In his report dated 19 August 2016, Dr Casikar opined that if Mr Kennedy's symptoms persisted and he was not recovering, then perhaps an epidural injection at the L4/5 segment would be necessary. If all procedures failed, then he might require a limited L4/5 decompression as the last option. However, he opined that such surgery was not related to his employment but did not explain why.

(h) In Dr Casikar's report dated 9 February 2017, he seems to be at odds with his previous conclusion that there was an injury at work because he was not able to identify any specific work-related injury which could have caused Mr Kennedy's problem. Further, he was now unsure as to whether a spinal fusion was indicated because it was well-recognised that non-surgical management of chronic degenerative disease had a better outcome than surgery or spinal fusion. In this regard, Dr Casikar seemed to be backing away from his previous view that surgery would be an option of last resort. Dr Casikar referred to Mr Kennedy not having any claudication symptoms and, if that were a reference to Mr Kennedy of not suffering from leg pain, then it was clearly wrong. Dr Casikar commented that forcing a spinal fusion would only create an additional burden and was unlikely to make any spectacular difference to his work capacity. The comment is curious, firstly, because there is no suggestion that Dr Ow-Yang was forcing Mr Kennedy to have a spinal fusion; and secondly, the issue of work capacity is not what should be considered in relation to the question as to whether the proposed surgery is reasonable.

(i) In Dr Casikar's report dated 9 June 2017, he firmed up his view that non-surgical management of back pain had a better outcome than the very extensive spinal fusion proposed by Dr Ow-Yang. Dr Casikar referred to home-based exercises. It is not clear what he meant by home-based exercises, but it is submitted that any such exercises on their own would provide little assistance. Another curious comment was Dr Casikar's agreement with Dr Ow-Yang's enthusiasm for spinal fusion but qualified that comment by stating that the spinal fusion was not supported by evidence -based studies. Dr Casikar seemed to be saying that surgery was a good option, but it was not supported by evidence-based studies, which are not referenced or attached to his report.

(j) Dr Casikar's opinions should not be accepted for the reasons referred to above. It is not clear what he is saying.

(k) In Dr Ow-Yang's report dated 25 January 2017, he referred to Mr Kennedy complaining of intermittent numbness in the posterior thighs. It was curious that Dr Ow-Yang recorded that Mr Kennedy denied significant pain radiating into the lower limbs when such pain was referred to in later reports. Dr Ow-Yang also reported that physiotherapy had not provided Mr Kennedy with much benefit. Dr Ow-Yang did refer to his proposed surgery as representing the definitive surgical option for managing Mr Kennedy's pain, if his condition did not improve following the lumbar facet injections. Dr Ow-Yang took a conservative approach.

(l) In Dr Ow-Yang's report dated 20 April 2017, he reported that Mr Kennedy still had significant ongoing in disabling mechanical low back pain and noted that Mr Kennedy would like to consider a definitive surgical option for pain management by way of lumbar fusion. Dr Ow-Yang requested an MRI scan and SPECT CT of the lumbar spine prior to offering a surgical option. Again, Dr Ow-Yang continued to take a conservative approach and did not resort to surgery too early.

(m) In Dr Ow-Yang's report dated 20 April 2017, he referred to the outcomes of the SPECT CT scan and MRI scan of Mr Kennedy's lumbar spine. Dr Ow-Yang provided a working diagnosis of chronic mechanical low back pain secondary to L4/5 and L5/S1 facet arthropathy and L4/5 canal stenosis. He reported that Mr Kennedy wished to escalate treatment to definitive surgery and Dr Ow-Yang offered the proposed surgery which is the subject of these proceedings. Importantly, he opined that with the proposed surgery, there was a 70% to 80% chance of improving leg symptoms. So, clearly there were leg symptoms. He opined that there was also a 50% chance of improving back pain.

(n) In Dr Ow-Yang's report dated 7 June 2017 and consistent with his conservative management to that point, he stated that surgical treatment was only offered to a patient when all reasonable conservative measures and treatment options had failed to improve the patient's symptoms. Dr Ow-Yang would not make such a statement unless he felt that all reasonable conservative measures had failed in Mr Kennedy's case. There is evidence that Mr Kennedy underwent physiotherapy and the lumbar facet joint injections.

(o) Dr Endrey-Walder opined that it was the severity and chronicity of Mr Kennedy's lower back pain that was the reason for offering the fusion procedure, being the only surgical procedure, which could have a long-term beneficial effect on his symptoms, even if it may not necessarily result in any significant improvement in his functional capacity.

(p) Mr Kennedy desperately wishes to undergo the surgical procedure proposed by Dr Ow-Yang to improve his quality of life, which is a very important factor to consider. On the relevant life tables, Mr Kennedy has another 25 years of life.

(q) Reference was made to the principles referred to in *Rose v Health Commission (NSW)*[52] (*Rose*), in *Diab v NRMA Ltd*[53] (*Diab*) and *Murphy v Allity Management Services Pty Ltd*[54] (*Murphy*).

(r) The test is not necessarily whether the treatment will be effective. Effectiveness is not a definitive matter. Based on Dr Ow-Yang's opinion, it is likely that the treatment would be effective.

The respondent's submissions in reply

94. The respondent's submissions in reply may be summarised as follows:

(a) The submission that Mr Kennedy continued to have severe leg pain, was not borne out by the evidence.

(b) Clearly, there was mention of leg pain initially.

(c) Both Dr Ow-Yang and Dr Endrey-Walder refer to Mr Kennedy's severe back pain without there being any mention of leg pain. Dr Perera's clinical notes make no reference to leg pain.

[52] *Rose v Health Commission (NSW)* (1986) 2 NSWCCR 32
[53] *Diab v NRMA Ltd* [2014] NSWWCCPD 72
[54] *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49

(d) In his report dated 18 May 2017, Dr Ow-Yang referred to disabling low back pain. There is no mention of leg pain. The reference by Dr Ow-Yang to the 70% to 80% chance of improving leg symptoms was not referring specifically to Mr Kennedy but rather, an overview of the results this surgical procedure may achieve.

(e) Dr Casikar seems to have been unaware of the eight sessions of physiotherapy Dr Endrey-Walder referred to in his report.

(f) Dr Endrey-Walder opined that it was the severity and the chronicity of Mr Kennedy's lower back pain that was the reason for offering the fusion procedure.

FINDINGS AND REASONS

95. I have carefully considered the evidence and the oral submissions made by the parties.

96. Section 59A of the 1987 Act provides:

> "(1) Compensation is not payable to an injured worker under this Division in respect of any treatment, service or assistance given or provided after the expiry of the compensation period in respect of the injured worker.
>
> (2) The compensation period in respect of an injured worker is:
>
> (a) if the injury has resulted in a degree of permanent impairment assessed as provided by section 65 to be 10% or less, or the degree of permanent impairment has not been assessed as provided by that section, the period of 2 years commencing on:
>
> (i) the day on which the claim for compensation in respect of the injury was first made (if weekly payments of compensation are not or have not been paid or payable to the worker), or the day on which weekly payments of compensation cease to be payable to the worker (if weekly payments of compensation are or have been paid or payable to the worker), or
>
> (b) if the injury has resulted in a degree of permanent impairment assessed as provided by section 65 to be more than 10% but not more than 20%, the period of 5 years commencing on:
>
> (i) the day on which the claim for compensation in respect of the injury was first made (if weekly payments of compensation are not or have not been paid or payable to the worker), or
>
> (ii) the day on which weekly payments of compensation cease to be payable to the worker (if weekly payments of compensation are or have been paid or payable to the worker).

(3) If weekly payments of compensation become payable to a worker after compensation under this Division ceases to be payable to the worker, compensation under this Division is once again payable to the worker but only in respect of any treatment, service or assistance given or provided during a period in respect of which weekly payments are payable to the worker.

(4) For the avoidance of doubt, weekly payments of compensation are payable to a worker for the purposes of this section only while the worker satisfies the requirement of incapacity for work and all other requirements of Division 2 that the worker must satisfy in order to be entitled to weekly payments of compensation.

(5) This section does not apply to a worker with high needs (as defined in Division 2).

(6) This section does not apply to compensation in respect of any of the following kinds of medical or related treatment:

(a) the provision of crutches, artificial members, eyes or teeth and other artificial aids or spectacles (including hearing aids and hearing aid batteries),

(b) the modification of a worker's home or vehicle,

(c) secondary surgery.

(7) Surgery is **'secondary surgery'** if:

(a) the surgery is directly consequential on earlier surgery and affects a part of the body affected by the earlier surgery, and

(b) the surgery is approved by the insurer within 2 years after the earlier surgery was approved (or is approved later than that pursuant to the determination of a dispute that arose within that 2 years).

(8) This section does not affect the requirements of section 60 (including, for example, the requirement for the prior approval of the insurer for secondary surgery)."

97. The parties agreed that due to the operation of section 59A of the 1987 Act, if there were a determination in favour of Mr Kennedy in this case, it would have to be in the form of a declaration rather than in an order to pay the costs of and ancillary to the surgery proposed by Dr Ow-Yang at the appropriate gazetted rates.

98. Section 60(1) of the 1987 Act relevantly provides:

"If as a result of an injury received by a worker, it is reasonably necessary that:

(a) any medical or related treatment (other than domestic assistance) be given, or

(b) any hospital treatment be given, or

(c) any ambulance service be provided, or

(d) any workplace rehabilitation service be provided,

the worker's employer is liable to pay, in addition to any other compensation under this Act, the cost of that treatment or service and the related travel expenses specified in subsection (2)."

99. Section 60(5) of the 1987 Act relevantly provides:

> "The jurisdiction of the Commission with respect to a dispute about compensation payable under this section extends to a dispute concerning any proposed treatment or service and the compensation that will be payable under this section in respect of any such proposed treatment or service. Any such dispute may be referred by the Registrar for assessment under Part 7 (Medical assessment) of Chapter 7 of the 1998 Act."

100. There are two elements to section 60(1) of the 1987 Act that must be considered. The first element is "as a result of an injury received by a worker". The second element is that of "reasonably necessary".

101. Dealing with the first element, namely, "as a result of injury received by a worker", I am required to conduct a commonsense evaluation of the causal chain, as referred to in *Kooragang Cement Pty Ltd v Bates*[55] (*Kooragang*), to determine whether the L4-S1 laminectomy, L4/5 and L5/S1 posterior interbody fusion, rhizolysis, L4-S1 pedicle screw internal fixation, posterolateral fusion and harvest bone graft proposed by Dr Ow-Yang is reasonably necessary treatment "as a result of" the injuries Mr Kennedy sustained in the course of his employment with the respondent on 24 May 2016.

102. *Murphy* referred to *Kooragang* and is authority for the proposition that an injured worker must establish that the injury materially contributed to the need for the treatment or the surgery. The need for surgery can arise from multiple causes. In *Murphy* Roche DP stated:

> "...That is because a condition can have multiple causes (*Migge v Wormald Bros Industries Ltd* (1973) 47 ALJR 236; *Pyrmont Publishing Co Pty Ltd v Peters* (1972) 46 WCR 27; *Cluff v Dorahy Bros (Wholesale) Pty Ltd* (1979) 53 WCR 167; *ACQ Pty Ltd v Cook* [2009] HCA 28 at [25] and [27]; [2009] HCA 28; 237 CLR 656). The work injury does not have to be the only, or even a substantial, cause of the need for the relevant treatment before the cost of that treatment is recoverable under s 60 of the 1987 Act.
>
> Ms Murphy only has to establish, applying the common sense test of causation (*Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796), that the treatment is reasonably necessary 'as a result of' the injury (see *Taxis Combined Services (Victoria) Pty Ltd v Schokman* [2014] NSWWCCPD 18 at [40]-[55]). That is, she has to establish that the injury materially contributed to the need for the surgery (see the discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716)."[56]

103. I accept Mr Kennedy as a witness of truth, who did his best to provide a history of his injuries, his treatment and his complaints to his various treating doctors and the forensic medical specialists. The histories he provided of injury, treatment and complaints of symptoms were, in the main, consistent over a period of three years. He impressed me as a stoic man with a strong work ethic. He returned to work on suitable duties following injury until he was made redundant by the respondent on 8 June 2018. He has not worked since.

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[55] *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796
[56] *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49 at [57]

104. The unchallenged evidence is that, prior to commencing employment with the respondent, Mr Kennedy had not experienced any problems with his back. In early May 2016, Mr Kennedy noticed the onset of low back pain whilst carrying out his duties as a truck driver/forklift operator for the respondent. On 24 May 2016, whilst alighting from a work truck, his low back pain increased significantly. On 25 May 2016, he consulted his general practitioner, Dr Perera, who issued him with a Certificate of Capacity certifying him as having no work capacity for a period of two weeks and had him admitted to Cootamundra Hospital due to the severity of the pain. Dr Perera also referred Mr Kennedy for a CT scan, which was performed on 31 May 2016. Thereafter, Dr Perera certified Mr Kennedy fit for selected duties, which he continued to carry out in the respondent's offal room alternating each hour between light duties and resting (sitting) until the respondent made him redundant on 8 June 2018.

105. I agree with Mr Kennedy's submission that, in terms of medical opinions, it is clear that, generally the contest is between Dr Casikar on the one hand and the treating neurosurgeon, Dr Ow-Yang, and Dr Endrey-Walder on the other.

106. On 31 May 2016, Mr Kennedy underwent a CT scan of his lumbosacral spine, the relevant findings of which included a mild to moderate diffuse disc bulge combining with moderate to severe bilateral facet osteoarthritis causing a moderate central canal stenosis and mild to moderate bilateral foraminal stenosis, worse on the right with contact on the right L4 nerve root at the L4/5 level.

107. On 25 January 2017, Mr Kennedy first consulted Dr Ow-Yang on the referral of Dr Perera. On reviewing Mr Kennedy's CT scan dated 31 May 2016, Dr Ow-Yang opined that it demonstrated severe L4/5 canal stenosis secondary to severe L4/5 facet hypertrophy and noted that there was also mild L5/S1 facet hypertrophy. Dr Ow-Yang diagnosed low back pain secondary to L4/5 and L5/S1 lumbar facet arthropathy and mild symptoms relating to severe L4/5 lumbar canal stenosis. He noted that physiotherapy had not provided relief from symptoms. He recommended bilateral L4/5 and L5/S1 lumbar facet injections as the next step in escalating pain management, noting that any improvement in pain levels may be only temporary. In his report dated 9 February 2017, Dr Casikar agreed that the lumbar facet injections were appropriate treatment.

108. On 9 March 2017, Mr Kennedy underwent CT guided bilateral L4/5 and LS/S1 steroid facet injections by Dr Ow-Yang, which only partially and temporarily alleviated his low back pain. On 20 April 2017, Dr Ow-Yang noted that Mr Kennedy continued to experience significant and disabling mechanical low back pain. Dr Ow-Yang recommended definitive investigations in the form of an MRI of the lumbar spine and a SPECT CT of the lumbar spine prior to offering a surgical option.

109. On 3 May 2017, Mr Kennedy underwent a bone scan by Dr Watson, who reported a marked active facet joint arthropathy involving the right L4/5 facet joint, which correlated with the degenerative disease demonstrated in the 31 May 2016 CT scan of the lumbar spine.

110. On 3 May 2017, Mr Kennedy underwent an MRI scan by Dr Duncan, whose conclusion was that of disc and facet degenerative changes at L4-5 resulting in moderate to severe canal stenosis.

111. On 18 May 2017, Mr Kennedy consulted Dr Ow-Yang following the MRI of the lumbar spine and a SPECT CT of the lumbar spine referred to above. Dr Ow-Yang observed that Mr Kennedy had failed to improve with maximal nonsurgical treatment and proposed surgery in the form of a posterior approach to L5/S1 laminectomy, rhizolysis, posterior interbody fusion, pedicle screw internal fixation, posterolateral fusion and harvest of bone graft. He stated that there was a 70% to 80% chance of improving leg symptoms and a 50% chance of improving back pain. He noted that Mr Kennedy wished to proceed with the proposed surgery.

112. On 29 May 2017, Dr Ow-Yang wrote to EML seeking approval for Mr Kennedy to undergo a L4-S1 laminectomy, L4/5 and L5/S1 posterior interbody fusion, rhizolysis, L4-S1 pedicle screw internal fixation, posterolateral fusion and harvest bone graft procedure and provided a quotation for the cost of the proposed surgery. EML declined to approve the proposed surgery.

113. On 7 June 2017, Dr Ow-Yang wrote to EML in response to its letter dated 6 June 2017 seeking further information in relation to Mr Kennedy's proposed surgery. Amongst other things, Dr Ow-Yang stated that his recommendations for surgery were based purely on Mr Kennedy's clinical presentation as described in his reports and were not influenced by whether or not Mr Kennedy's condition was compensable; that his recommendations are not affected by the opinion of an Independent Medical Examiner or other consulting medical practitioner; and, that surgical treatment was only offered to a patient when all reasonable conservative measures and treatment options had failed to improve the patient's symptoms.

114. On 25 September 2018, Mr Kennedy consulted Dr Endrey-Walder, who referred to the findings in Mr Kennedy's lumbar CT scan dated 31 May 2016; bone scan dated 3 May 2017; and lumbar MRI scan dated 4 May 2017. On examination, Dr Endrey-Walder observed, amongst other things, well localised and quite marked tenderness over the right of midline at the L4-5 level; massive, both visible and palpable muscle spasm on both sides of the lumbar spine; difficulty straightening; no capacity to hyper-extend the back; the right thigh was 1 cm larger in circumference than the left thigh; 20° straight leg raising on the right; no clinical evidence of neurological deficit in the lower limbs. Dr Endrey-Walder was critical of Dr Casikar's opinion that Mr Kennedy's problem was predominantly due to pre-existing pathology in the back and that he could not identify any specific work-related injury which could have caused the problem. Dr Endrey-Walder opined that by far the most significant problem was the development of inflammatory changes in the right L4-5 facet joint, the symptoms of which were clearly precipitated by work activity. He also opined that the severity and the chronicity of Mr Kennedy's low back pain that was the reason for offering the fusion procedure, the only surgical procedure which could have a long-term beneficial effect on his symptoms, even if it may not necessarily result in any significant improvement in his functional capacity.

115. With respect, I found the reasoning in Dr Casikar's four reports difficult to follow, unconvincing and not borne out by the evidence in parts. In his report dated 19 August 2016, Dr Casikar provided a diagnosis of L4/5 degenerative disease and lumbar canal stenosis and opined that Mr Kennedy's injury was reasonably attributable to the alleged incident at work. Dr Casikar also opined that Mr Kennedy's condition was an aggravation of a pre-existing condition, which whilst improving, had not yet completely resolved. However, later in the same report, he opined that Mr Kennedy's main problem was age-related degenerative disease of the lumbar spine and L4/5 stenosis and that the nature of his work was such that it aggravated already compromised neural structures at this level and that such aggravation lasts for a few weeks. He opined that the injury was improving because his symptoms were getting better. He accepted and expressed no surprise that Mr Kennedy had no previous history of back pain, because even though the lumbar canal stenosis was a long-standing process, symptoms could occur at any time without any specific injury. Therefore, the fact that Mr Kennedy complained of the symptoms did not necessarily mean that there had been a specific workplace injury.

116. I found the opinions expressed by Dr Casikar in his report dated 19 August 2016 somewhat contradictory. He opined that the aggravation of Mr Kennedy's pre-existing condition was related to his work. He then stated that there was no specific injury. Further, he stated that Mr Kennedy's condition was improving, which was not borne out by the evidence of Mr Kennedy, Dr Ow-Yang and Dr Endrey-Walder. Dr Casikar stated that the aggravation of Mr Kennedy's pre-existing condition typically lasted a few weeks. Yet, by the time he examined Mr Kennedy on 18 August 2016, over 11 weeks had already passed since the incident on 24 May 2019 and he opined that the aggravation had not yet completely resolved.

117. On 9 February 2017, Dr Casikar confirmed his previous diagnosis of lumbar canal stenosis at L4/5. He also confirmed his opinion that the lumbar canal stenosis was due to a combination of short pedicles and thickening of the ligamentum flavum, which was predominantly due to Mr Kennedy's pre-existing back pathology. Dr Casikar was not able to identify any specific work-related injury which could have caused Mr Kennedy's problem. Again, the latter contradicts his earlier opinion that Mr Kennedy's condition was an aggravation of a pre-existing condition, which whilst improving, had not yet completely resolved. He did not state whether the aggravation he had referred to in his earlier report had ceased or not. Dr Casikar also opined that the most substantial contributing factor to Mr Kennedy's condition was lumbar canal stenosis in addition to age-related thickening of the ligamentum flavum. He was not so sure if a spinal fusion was indicated as it was well recognised that non-surgical management of chronic degenerative disease has a better outcome than surgery or spinal fusion. He noted that Mr Kennedy did not have any claudication symptoms and if he did, a limited laminectomy would be appropriate. He concluded that, since the symptoms were only back pain, conservative management was a better option than fusion. Dr Casikar's conclusion in this regard was not borne out by the evidence. Dr Casikar again opined that employment was not the cause of the problem and that the most substantial contributing factor to Mr Kennedy's condition was lumbar canal stenosis in addition to age-related thickening of the ligamentum flavum.

118. On 9 June 2017, Dr Casikar stated that, as far as the liability of EML regarding the spinal fusion was concerned, the issue was likely to be very controversial. He opined that the initial management of back pain provided to Mr Kennedy, which included cortisone injections, was acceptable management of aggravation on a pre-existing degenerative disease. However, he did not believe the indications for spinal fusion were as a direct consequence of his workplace injury when he was driving the truck. He then stated that he was not sure that EML would be liable for the spinal fusion suggested by Dr Ow-Yang. Dr Casikar further opined that the proposed surgical procedure was frequently performed to address problems related to degenerative disease of the lumbar spine and that enthusiasm for spinal fusions has gradually reduced as the outcomes have been very poor. Somewhat surprisingly, he agreed with Dr Ow-Yang's enthusiasm for spinal fusion but again referred to multiple evidence-based studies which indicated that spinal fusions on a background of workers compensation had poor outcome. He did not provide the reasoning behind the latter proposition.

119. On 5 July 2019, after having reviewed Mr Kennedy's clinical records produced by Dr Perera, Dr Casikar stated that such records did not in any way alter the opinions previously expressed by him. He added that, if Mr Kennedy had claudication problems or bilateral verifiable neurological symptoms, then a decompression of the canal stenosis would be useful. As Mr Kennedy's symptoms were purely back pain, then the spinal fusion was not going to solve his problem. Dr Casikar opined that there was no evidence to indicate that it was reasonably necessary as a result of the workplace injury. As to whether the need for further treatment related to the work injury at work or the aggravation to a pre-existing condition sustained was a result of Mr Kennedy's employment activities, Dr Casikar responded that he accepted that Mr Kennedy had back pain but that such persistent back pain was due to constitutional degenerative disease and facet arthropathy and not as a result of his employment activities. He also opined that the injury at work had probably aggravated his pre-existing condition and that the kind of aggravation Mr Kennedy had suffered would normally resolve in about six to eight weeks. Dr Casikar was of the view that Mr Kennedy's persistent complaints of back pain were due to the significant degenerative disease of the lumbar spine. He did not explain the reasoning behind such conclusion. If his reasoning was related to the absence of lower limb symptoms, then that was not in accord with the preponderance of the evidence, namely, that Mr Kennedy continues to suffer lower limb symptoms, albeit that his lower back symptoms are more of an issue.

120. I prefer the evidence of Dr Ow-Yang as the treating neurosurgeon and Dr Endrey-Walder over the evidence of Dr Casikar for the reasons referred to above. Dr Endrey-Walder engaged with the evidence and opined that by far the most significant problem was the development of inflammatory changes in the right L4-5 facet joint, the symptoms of which were clearly precipitated by work activity. The inflammatory changes were still present, contrary to the opinion of Dr Casikar. Dr Ow-Yang's diagnosis was chronic low mechanical back pain secondary to L4/5 and L5/S1 facet arthropathy and L4/5 canal stenosis.

121. The work injury does not have to be the only, or even a substantial, cause of the need for the relevant treatment before the cost of that treatment is recoverable under section 60 of the 1987 Act. Mr Kennedy only has to establish, applying the common sense test of causation, that the proposed surgical treatment is reasonably necessary 'as a result of' the injury. That is, he has to establish that the injury materially contributed to the need for the surgery. On the preponderance of the evidence, I am satisfied that Mr Kennedy has established that the injury materially contributed to the need for the proposed surgery.

122. Accordingly, I find that the surgical treatment proposed by Dr Ow-Yang is as a result of injury on 24 May 2016.

123. Turning to the "reasonably necessary" element, Roche DP in *Diab* set out the "standard" test adopted for determining if medical treatment is reasonably necessary in *Rose*:

> "3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of the injury.
>
> 4. It is reasonably necessary that such treatment be afforded a worker if this Court concludes, exercising prudence, sound judgement and good sense, that it is so. That involves the Court in deciding, on the facts as it finds them, that the particular treatment is essential to, should be afforded to, and should not be forborne by, the worker.
>
> 5. In so deciding, the Court will have regard to medical opinion as to the relevance and appropriateness of the particular treatment, any available alternative treatment, the cost factor, the actual or potential effectiveness of the treatment and its place in the usual medical armoury of treatments for the particular condition."

124. Roche DP noted subsequent appellate authority with respect to the use of the words "reasonably necessary" and said:

> "86. Reasonably necessary does not mean 'absolutely necessary' (*Moorebank* at [154]). If something is 'necessary', in the sense of indispensable, it will be 'reasonably necessary'. That is because reasonably necessary is a lesser requirement than 'necessary'. Depending on the circumstances, a range of different treatments may qualify as 'reasonably necessary' and a worker only has to establish that the treatment claimed is one of those treatments. A worker certainly does not have to establish that the treatment is 'reasonable and necessary', which is a significantly more demanding test that many insurers and doctors apply. …
>
> 88. In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in *Rose* (see [76] above), namely:

(a) the appropriateness of the particular treatment;
(b) the availability of alternative treatment, and its potential effectiveness;
(c) the cost of the treatment;
(d) the actual or potential effectiveness of the treatment, and
(e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.

89. With respect to point (d), it should be noted that while the effectiveness of the treatment is relevant to whether the treatment was reasonably necessary, it is certainly not determinative. The evidence may show that the same outcome could be achieved by a different treatment, but at a much lower cost. Similarly, bearing in mind that all treatment, especially surgery, carries a risk of a less than ideal result, a poor outcome does not necessarily mean that the treatment was not reasonably necessary. As always, each case will depend on its facts.

90. While the above matters are 'useful heads for consideration', the 'essential question remains whether the treatment was reasonably necessary' (*Margaroff v Cordon Bleu Cookware Pty Ltd* [1997] NSWCC 13; (1997) 15 NSWCCR 204 at 208C). Thus, it is not simply a matter of asking, as was suggested in *Bartolo*, is it better that the worker have the treatment or not. As noted by French CJ and Gummow J at [58] in *Spencer v Commonwealth of Australia* [2010] HCA 28, when dealing with how the expression 'no reasonable prospect' should be understood, '[n]o paraphrase of the expression can be adopted as a sufficient explanation of its operation, let alone definition of its content' ''.

125. Dr Casikar opined that there was no evidence to indicate that the surgery proposed by Dr Ow-Yang was reasonably necessary as a result of the workplace injury. Further, he opined that as Mr Kennedy's symptoms were purely back pain, then the spinal fusion was not going to solve his problem. There was no reference to leg pain in Dr Perera's clinical notes. However, the handwritten clinical notes are barely legible and lacking in detail. The printed clinical notes similarly lack the detail one would expect.

126. Histories in medical records are often used to attack the credit of a worker. Reference is made either to a failure to mention relevant matters, or a description in a medical record which is different to what the worker now says in evidence. Care should be taken when considering such evidence, not to place too much weight on the clinical notes of treating doctors, given their primary concern with treatment. Experience demonstrates that busy doctors sometimes misunderstand, omit or incorrectly record histories of accidents or complaints by a patient, particularly in circumstances where their concern is with the treatment or impact of an obvious frank injury: *Davis v Council of the City of Wagga Wagga*[57]; and applied in *King v Collins*[58] and *Mastronardi v State of New South Wales*[59].

127. The caution referred to above was confirmed by Roche DP in *Winter v NSW Police Force*[60] as follows:

> "It is important to remember that clinical notes are rarely (if ever) a complete record of the exchange between a patient and a busy general practitioner. For this reason, they must be treated with some care (*Nominal Defendant v Clancy* [2007] NSWCA 349; *Davis v Council of the City of Wagga Wagga* [2004] NSWCA 34; *King v Collins* [2007] NSWCA 122 at [34-36])."[61]

[57] *Davis v Council of the City of Wagga Wagga* [2004] NSWCA 34
[58] *King v Collins* [2007] NSWCA 122
[59] *Mastronardi v State of New South Wales* [2009] NSWCA 270
[60] *Winter v NSW Police Force* [2010] NSWCCPD 12
[61] *Winter v NSW Police Force* [2010] NSWCCPD at [183]

128. Dr Perera's clinical notes should not be overly scrutinised; they were not compiled with this claim in mind. The concerns raised in the above-mentioned authorities would seem to be of relevance in this case. In my view, little information can be obtained from the clincal records of Dr Perera and therefore, they are of minimal probative value. There is generally no record of any history, no details regarding the reason for each consultation and no mention of the complaints made by Mr Kennedy. The clinical records merely record the time, date of the consultation and medication prescribed. At times, there is a brief history, but in general, there is minimal, if any, record of Mr Kennedy's complaints and symptoms. I acknowledge that caution must be taken when relying upon clinical records. I have exercised caution in this regard and considered all the evidence.

129. I do not accept that Mr Kennedy's symptoms were purely back pain. Mr Kennedy's evidentiary statement referred to leg symptoms, including right leg numbness. Dr Ow-Yang took an initial history involving leg symptoms as intermittent numbness in the posterior thighs and referred to a denial of significant pain radiating into the lower limbs. The clear inference to be drawn is that there was some lower limb pain, but it was not significant. He later referred to how the proposed surgery had a 70% to 80% chance of improving Mr Kennedy's leg symptoms. On 25 September 2018, Dr Endrey-Walder reported Mr Kennedy's complaints as including constant "gnawing" pain down the middle of his lower back, which was worse with activity. He also reported Mr Kennedy complaining of a dull pain down the back of his leg to the knee. However, the back pain was more problematic than the leg pain. The CT scan report by Dr Chuha dated 31 May 2016 recorded the clinical notes as being right sciatica. Dr Duncan in the MRI scan report dated 3 May 2017, recorded the clinical indication as being one of low back pain and radiculopathy.

130. Another focus of Dr Casikar's opinion as to whether the proposed surgery was reasonably necessary was that, even if Mr Kennedy were to proceed to surgery proposed by Dr Ow-Yang, the probability of him working until reaching retirement age would likely be prejudiced and that would be another reason not to proceed with the surgery. With respect, it is not a matter to be considered in relation to whether the surgery is reasonably necessary.

131. Dr Casikar agreed with Dr Endrey-Walder's opinion that the chronicity of Mr Kennedy's lower back pain was a reasonable indication for spinal fusion because it is one of the commonly performed surgical procedures for degenerative disease. However, he did not agree that it could have a long-term benefit on his symptoms because of the opinions he previously expressed in relation to the evidence-based studies that in a workers compensation context, outcomes are very poor. He stated that the Cochrane Review indicated that spinal fusion is not an answer to all back pain and the outcome is generally very poor. Somewhat curiously, Dr Casikar agreed with Dr Ow-Yang's enthusiasm for spinal fusion but stated that, unfortunately, it was not supported by evidenced-based studies. Whilst he referred to the Cochrane Review, he did not reference any of the other evidence-based studies. Further, he did not provide the reasoning behind the conclusions of the evidence-based studies, namely, why outcomes were generally very poor in a workers compensation context.

132. Rule 15.2(3) of the Workers Compensation Commission Rules 2011 provides that "evidence based on speculation or unsubstantiated assumptions is unacceptable." Further, it is well established in the authorities such as *Paric v John Holland (Constructions) Pty Ltd*[62] (*Paric*); *Makita (Australia) Pty Ltd v Sprowles*[63] (*Makita*); *South Western Sydney Area Health Service v Edmonds*[64] (*Edmonds*); and *Hancock v East Coast Timbers Products Pty Ltd*[65] (*Hancock*); that there must be a "fair climate" upon which a doctor can base an opinion. Whilst it is

[62] *Paric v John Holland (Constructions) Pty Ltd* [1985] HCA
[63] *Makita (Australia) Pty Ltd v Sprowles* [2001] NSWCA 305; 52 NSWLR 705
[64] *South Western Sydney Area Health Service v Edmonds* [2007] NSWCA 16; 4 DDCR 421
[65] *Hancock v East Coast Timbers Products Pty Ltd* [2011] NSWCA 11; 80 NSWLR 43

accepted that a doctor does not need to provide elaborate or detailed explanations for his conclusion, one needs more than a mere “ipse dixit” (an assertion without proof) and that seems to be precisely what Dr Casikar has done in relation to the assertion that evidence-based studies demonstrate that a spinal fusions in a worker’s compensation context generally had very poor outcomes.

133. Dr Ow-Yang and Dr Endrey-Walder supported the proposed surgery as being reasonably necessary and likely to be beneficial in the circumstances of Mr Kennedy’s case. I prefer the evidence of Dr Ow-Yang and Dr Endrey-Walder over the evidence of Dr Casikar for the reasons already stated above.

134. Mr Kennedy has expressed the desire to proceed with the surgery proposed by Dr Ow-Yang.

135. Applying the principles referred to in *Diab* above, different treatments may qualify as ‘reasonably necessary’ and Mr Kennedy only has to establish that the treatment claimed is one of those treatments. The L4-S1 laminectomy, L4/5 and L5/S1 posterior interbody fusion, rhizolysis, L4-S1 pedicle screw internal fixation, posterolateral fusion and harvest bone graft surgery proposed by Dr Michael Ow-Yang is one of those treatments and I find as follows:

    (a) The alternative treatment by way of conservative management, including physiotherapy, bilateral L4/5 and L5/S1 lumbar facet injections and anti-inflammatory and pain-relieving medications which have failed to alleviate symptoms over the last three years, are unlikely to be effective and on the balance of probabilities, will result in Mr Kennedy continuing to suffer the ongoing chronic pain and restrictions referred to in the evidence. Whilst there is no evidence that Mr Kennedy participated in any regular home-based exercises to improve his core muscle strength or that he lost weight as recommended by Dr Casikar, based on the evidence of Dr Ow-Yang and Dr Endrey-Walder it is unlikely to have had any positive impact on the improvement of symptoms. Without the proposed surgery, Mr Kennedy will continue to have disabling low back pain, whilst he continues to experience mechanical low back pain secondary to L4/5 and L5/S1 facet arthropathy and L4/5 canal stenosis. Home-based exercises, medication and weight loss are unlikely to have any positive impact on the improvement of symptoms. Dr Ow-Yang confirmed that he only offered surgical treatment to a patient when all reasonable conservative measures and treatment options had failed to improve the patient's symptoms. Dr Casikar accepted that all avenues of conservative management had been exhausted. However, he opined that the failure of medical treatment did not necessarily mean that there was a strong indication for surgery. I prefer the evidence of Dr Ow-Yang and Dr Endrey-Walder over the evidence of Dr Casikar for the reasons already stated above. Accordingly, I find that the surgery proposed by Dr Ow-Yang is appropriate treatment.

    (b) The alternative treatment of physiotherapy, bilateral L4/5 and L5/S1 lumbar facet injections and anti-inflammatory and pain-relieving medications which have failed to alleviate symptoms over the last three years, are unlikely to be effective and on the balance of probabilities, will result in Mr Kennedy continuing to suffer the ongoing chronic pain and restrictions referred to in the evidence. Treatment by way of physiotherapy provided no benefit to Mr Kennedy. The bilateral L4/5 and L5/S1 lumbar facet injections and anti-inflammatory only provided very short-term relief. Mr Kennedy’s anti-inflammatory and pain-relieving medications have not improved his symptoms.

Accordingly, I find that further physiotherapy and further bilateral L4/5 and L5/S1 lumbar facet injections do not have the potential of being effective. Further, I find that the consumption of ongoing anti-inflammatory and pain-relieving medications, home-based exercises and weight loss do not have the potential of being effective.

(c) There was no issue raised by the respondent as to the cost of the proposed surgery as set out in Dr Ow-Yang's quotation dated 29 May 2017.

(d) The potential effectiveness of the proposed surgery is the best chance Mr Kennedy has of improving his current and longstanding symptoms, improving his quality of life and resuming suitable employment. Dr Ow-Yang opined that there was a 70% to 80% chance of improving Mr Kennedy's leg symptoms, and a 50% chance of improving back pain. I disagree with the respondent's submission that the latter opinion was not specifically addressing Mr Kennedy's situation but rather, was a general overview of the results the proposed surgical procedure may achieve for patients in general. Clearly, Dr Ow-Yang was responding to a letter from EML dated 6 June 2017 requesting further particulars of the proposed surgery to Mr Kennedy referred to in Dr Ow-Yang's letter and quotation both dated 29 May 2017. Dr Endrey-Walder opined that surgery proposed by Dr Ow-Yang was the only surgical procedure which could have a long-term beneficial effect on his symptoms, even if it may not necessarily result in any significant improvement in his functional capacity. Dr Casikar opined that because Mr Kennedy's symptoms were purely back pain, then the spinal fusion was not going to be effective. I prefer the evidence of Dr Ow-Yang and Dr Endrey-Walder over the evidence of Dr Casikar for the reasons stated above.

(e) The purpose and potential effect of the proposed surgery is to alleviate the consequences of the injury as far as possible.

(f) The evidence of Dr Ow-Yang and Dr Endrey-Walder supported the proposed surgery as being reasonably necessary and likely to be beneficial in the circumstances of this case. I prefer the evidence of Dr Ow-Yang and Dr Endrey-Walder over the evidence of Dr Casikar for the reasons stated above.

136. Accordingly, I find that Mr Kennedy has discharged the onus of proving that the L4-S1 laminectomy, L4/5 and L5/S1 posterior interbody fusion, rhizolysis, L4-S1 pedicle screw internal fixation, posterolateral fusion and harvest bone graft surgery proposed by Dr Ow-Yang is reasonably necessary treatment as a result of the injury sustained by Mr Kennedy in the course of his employment with the respondent on 24 May 2016.

137. I do not have the power to order the respondent to pay the cost of L4-S1 laminectomy, L4/5 and L5/S1 posterior interbody fusion, rhizolysis, L4-S1 pedicle screw internal fixation, posterolateral fusion and harvest bone graft surgery proposed by Dr Ow-Yang at this time due to the operation of section 59A of the 1987 Act. Liability for the payment of the expense of the surgery would occur once Mr Kennedy enters hospital to undergo the treatment and any entitlement to weekly payments is revived. It would be expected that the respondent would pay for the cost of the surgery without the need for further litigation as envisaged by DP Roach in *Flying Solo Properties Pty Ltd t/as Artec Signs v Collett*[66] (*Collett*).

[66] *Flying Solo Properties Pty Ltd t/as Artec Signs v Collett*[66] (2015) NSWWCCPD 14

SUMMARY

138. Pursuant to section 60 of the 1987 Act, the L4-S1 laminectomy, L4/5 and L5/S1 posterior interbody fusion, rhizolysis, L4-S1 pedicle screw internal fixation, posterolateral fusion and harvest bone graft surgery proposed by Dr Ow-Yang is reasonably necessary treatment as a result of the injury sustained by Mr Kennedy in the course of his employment with the respondent on 24 May 2016.

139. The Commission does not have the power to order the respondent to pay the cost of the L4-S1 laminectomy, L4/5 and L5/S1 posterior interbody fusion, rhizolysis, L4-S1 pedicle screw internal fixation, posterolateral fusion and harvest bone graft surgery proposed by Dr Ow-Yang at this time due to the operation of section 59A of the 1987 Act. Liability for the payment of the expense of the surgery would occur once Mr Kennedy enters hospital to undergo the treatment and any entitlement to weekly payments is revived. It would be expected that the respondent would pay for the cost of the surgery without the need for further litigation as envisaged by DP Roach in *Collett*.