WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **2462/20**
Applicant: **Michael McNamara**
Respondent: **Bevchain Pty Ltd**
Date of Determination: **4 September 2020**
Citation: **[2020] NSWWCC 301**

The Commission determines:

1. The applicant has suffered a consequential condition to his right hip by way of aggravation of a pre-existing condition.

2. The respondent is to pay for the applicant's proposed surgery.

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

E Beilby

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 E BEILBY, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

L Golic

Lucy Golic
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr Michael McNamara (the applicant) was employed by Bevchain Pty Ltd (the respondent) as a warehouse worker.

2. On 14 December 2016, the applicant was driving a pallet jack when it clipped a pallet that had an industrial fan positioned on top of it. The fan fell and the blade struck the applicant's right leg slicing his calf open. The applicant says he felt pain in his right hip at that time but it was not severe and he focused on the open wound on his leg.

3. The applicant was transferred to hospital by ambulance where he underwent emergency surgery and also had revisionary surgery in February 2018 due to scar tissue.

4. The applicant explains in his statement dated 17 February 2020[1] that he has experienced problems with the nerves in his right leg following the accident and in particular his peroneal nerve.

5. The applicant says he experiences significant pain and weakness in his right foot and has experienced several falls after the accident. The applicant also observes that he walks with an altered gait.

6. The applicant had further surgery on 24 April 2018 by way of a fascia release.

7. On 2 October 2018, the applicant underwent an MRI of his knee, pelvis and hip after a referral from his general practitioner.

8. On 23 October 2018, the applicant underwent an injection to his right hip which was unsuccessful in alleviating his symptomatology.

9. The applicant's treating surgeon, Dr Coffey has recommended the applicant undergo a right total hip replacement and the applicant wishes to undergo that surgery.

ISSUES FOR DETERMINATION

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

    (a) Did the applicant suffer a consequential condition to his right hip?

    (b) Is the proposed surgery recommended by Dr Simon Coffey, being a total right hip replacement, reasonably necessary?

PROCEDURE BEFORE THE COMMISSION

11. The parties attended an Arbitration on 29 July 2020. 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.

[1] Page 1 of the Application to Resolve a Dispute (the Application)

EVIDENCE

Documentary evidence

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

    (a) Application to Resolve a Disputeand attached documents , and
    (b) Reply to the Application to Resolve a Dispute.

Consideration

13. The applicant's case presented at Arbitration was that the applicant's limping or antalgic gait has aggravated an underlying hip condition.

14. The respondent conceded in the conciliation stage that if the applicant was successful in his claim so far as the aggravation was concerned, that a finding in his favour, so far as surgery was concerned, would follow.

15. I will now look to the medical evidence which both supports and challenges the applicant's case.

Medical evidence

16. The applicant underwent an MRI of the right hip on 1 October 2018.[2] The MRI disclosed degenerative changes predominantly through the lateral acetabular labrum with associated degenerative basal tear/chondrolabral separation with a cyst formation. The gluteus minimus tendon was also mildly tendinotic with no tear disclosed. There was mild to moderate insertional tendinosis of lateral band of gluteus medius with early fissuring. There was also likely a mild degree of bursitis in the maximum bursa.

17. The significance of the MRI is that there is some support for a pathological change in the applicant's hip. This of course does not mean that there has been a consequential condition that is compensable.

18. Dr Negus, orthopaedic surgeon, has prepared a report dated 21 September 2019[3] after a request from the applicant's solicitors. Dr Negus took a history that the applicant, following the incident, experienced a loss of sensation and tingling and redness in his limb. Further, Dr Negus understood the applicant had developed a limp.

19. Dr Negus was appraised of the neurological tests and report dated 5 February 2017 which demonstrated a right superficial peroneal nerve neuropathy. Dr Negus understood the MRI from October 2018 reported a labral tear and a chondrolabral separation in the right hip. The applicant told Dr Negus that he had suffered several falls with consequential injuries to his lower back and right hip, however, the right hip pain started from the time he walked in the moon-boot.

20. So far as treatment was concerned, the applicant related that he had undergone cortisone injections to both his hip and back which were unsuccessful and also had a nerve root sleeve injection to L5/S1 to rule out lumbar spine issues.

21. On examination, Dr Negus observed that the applicant walked with a painful antalgic gait. There was marked reduction in range of movement in the right hip when measured with a goniometer. Dr Negus also observed occasional inconsistency on examination in relation to movements of the knee and hips and in particular the foot power examination.

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[2] Page 31 of the Application.
[3] Page 17 of the Application.

22. Dr Negus opined the applicant had suffered a laceration of the right lower leg which divided his superficial peroneal nerve with subsequent loss of sensation. The applicant now had some motor weakness in the lower leg which is inconsistent on examination.

23. Dr Negus also opined the applicant had a very irritable and painful right hip joint which had been shown to have a labral tear and chondrolabral separation. There was grade 2/3 chondral degeneration and the altered gait arising from the moon-boot could have led to exacerbation of a pre-existing labral tear within the hip.

24. So far as the proposed surgery was concerned, Dr Negus had a guarded prognosis for the applicant with or without surgery as the applicant had had various interventions and had presented with atypical manner of symptoms. Nevertheless when directly asked about the reasonable necessity for the surgery Dr Negus thought that the request for the total right hip replacement was a reasonable medical expense arising from a consequential injury, the consequential injury being an aggravation of a pre-existing hip condition, labral tear and mild osteoarthritis.

25. The applicant was referred to Dr Andrew Keller, occupational physician at the request of the insurer in June 2017.[4] Dr Keller has prepared a report dated 8 June 2017 arising from that examination. The applicant complained to Dr Keller of having a constant burning feeling in his right lower leg which was aggravated by pushing hard with the right foot. Dr Keller did observe on examination a limp slightly favouring and putting weight on the left leg. Dr Keller was optimistic about the applicant's improvement at that time however does not appear to have turned his mind to the consequential claim in respect of the right hip (unsurprisingly as it was not part of the pleaded case).

26. The applicant was examined by Dr James Vote, orthopaedic surgeon, at the request of the insurer. Dr Vote has prepared a report dated 16 July 2019.[5] Dr Vote took a history of the applicant's injury and subsequent treatment. Dr Vote understood the applicant was discharged from hospital with a moon-boot and when the applicant resumed full weight bearing he noticed there was a loss of sensation and he was limping. Dr Vote had a history of the treatment the applicant had undergone and understood that Dr Coffey recommended a surgical intervention by way of arthroscopy of the hip or replacement of the hip. It was quite clear that Dr Vote was aware the applicant had right superficial peroneal neuropathy.

27. After performing a thorough examination of the applicant, Dr Vote opined that the applicant's main problem was his right hip however the findings were quite inconsistent. The applicant stated that it hurt on weight bearing but on recumbency it was still sore. The applicant resisted all movements of the hip in a passive sense and opposed to that could sit quite comfortably in an upright position on examination. Nevertheless Dr Vote described a positive physical finding of global restriction of hip movement.

28. After considering all the medical evidence that had been provided to him, Dr Vote described the applicant as a "difficult problem". The findings on examination were variable and it was unusual that following a relatively minor laceration to the right tibial region there would be functional limitation and motor weakness.

29. Dr Vote thought that the right hip pathology needed to be investigated further but could not see a direct link to the event 14 December 2016 and as such any proposed treatment would not be related to employment.

30. Dr Vote does not appear to turn his mind to the applicant's claim which is of a consequential injury arising from limping following his injury to the left lower extremity.

[4] Page 23 of the Application.
[5] Page 2 of the Reply.

31. The applicant was referred to Dr Con Kafataris, injury management consultant, in November 2019 at the request of the insurer.[6] At that stage the applicant had undergone surgical debridement after the injury, further exploration of the wound, physiotherapy, exercise therapy and hydrotherapy.

32. In the report prepared by Dr Kafataris, the applicant makes no complaint about pain in the right hip but complained of pain of the right shin, right achilles, right foot, right ankle as well as throughout the right buttock and groin.

33. On examination, Dr Kafataris did attempt to examine the applicant's right hip but the applicant would not allow any significant movement beyond 20 degrees of flexion. Dr Kafataris understood at that stage that it had been suggested the applicant have a right hip replacement and Dr Kafataris outlines a discussion he had with a return to work coordinator in respect of that proposal.

34. Dr Kafataris says that it was his view that the applicant would be unlikely to return to unrestricted to pre-injury duties either with or without a successful hip replacement. Dr Kafataris said that if the worker underwent the proposed hip surgery, then the goal of this would be to lead a relatively normal quality of life but not necessarily for him to return to duties that required climbing on or off forklifts, heavy and manual handling

35. The applicant was referred to see Dr Simon Coffey, orthopaedic surgeon, and first consulted with him on 17 September 2018. Dr Coffey understood that the applicant had had a number of falls as his leg gave way and Dr Coffey queried whether there were knee or ankle problems. Dr Coffey did not appear to take a history in respect of any pain or symptomatology in the right hip however he thought that the symptoms in the right lower limb may have been referred from the knee or the hip and further imaging was required of both those areas.

36. Dr Coffey wrote to the insurer on 25 September 2018[7] in respect to a series of questions asked of him in respect of Mr McNamara's condition. Dr Coffey diagnosed the applicant as having a right lower limb pain following a penetrating injury to the right leg and suggested further investigation with imaging of the right hip and right knee. Dr Coffey opined that the episodic right leg instability was likely caused by possible intra-articular damage or degeneration to the right hip or right knee.

37. On 11 October 2018, Dr Coffey wrote to Dr Jaffer[8] with a diagnosis of the applicant having a chondral labral injury to the right hip or an irritable right hip. Dr Coffey had the benefit of the MRI examination which confirmed a chondrolabral injury with a small segment of superolateral acetabular chondropathy and a small para-labral cyst. The MRI was described as being consistent with age-related changes with no specific osteoarthritic change. Dr Coffey then opined that the applicant's symptoms appeared to be coming from his hip rather than the knee or penetrating injury. Dr Coffey at that time recommended a corticosteroid injection of the hip.

38. Dr Coffey wrote to Dr Jaffer again on 20 November 2018 after the applicant had had the proposed injection. Unfortunately the applicant's symptoms had remained persistent and examination revealed persistent irritability of the right hip. It was observed at that time that the applicant continued to limp. Dr Coffey suggested there may be a future role for arthroscopic inspection of the hip however given his age it was not suggested to be appropriate at that time.

[6] Page 8 of the Reply.
[7] Page 38 of the Application.
[8] Page 39 of the Application.

39. Dr Coffey examined the applicant again on 20 December 2018[9] and observed that the applicant had not had any significant benefit after taking anti-inflammatory medication with the pain being fairly constant.

40. Dr Coffey opined at that stage that the applicant presented with ongoing hip trouble secondary to his injury. He did observe some inconsistencies in the presentation and as such a more proximal source of symptoms could be excluded by performing an MRI of the lumbar spine. Dr Coffey also suggested a repeat steroid injection to the hip joint and then if the symptoms were not reduced then an arthroscopy or arthroplasty may be indicated.

41. Dr Coffey then suggested that the applicant undergo an L5/S1 nerve root sleeve injection[10] which was performed however did not improve the applicant's symptoms at all.[11] It was at that stage that Dr Coffey, after having had no success with non-operative management and the persistence of ongoing disabling symptoms considered surgery in the form of a right total hip arthroplasty.

42. Dr Coffey has written a comprehensive report dated 25 October 2019 addressed to the applicant's solicitors.[12] Dr Coffey had the benefit of having read the opinions of Dr Negus and Dr Vote before preparing his report.

43. If was Dr Coffey's opinion that the applicant aggravated his right hip either as a result of the original injury or subsequently as a secondary response to altered gait as a result of the right leg laceration. Dr Coffey did observe inconsistencies in the applicant's presentation and the timing of the onset of the lower limb symptoms was unclear (Dr Coffey thought this was because of the distracting injury to the laceration).

44. Because of the difficulty in establishing the exact onset of hip-related symptoms, Dr Coffey said it was not possible to tell whether the altered gait was the main contributing factor of the aggravation, or whether the original injury in which there was considerable distraction from the laceration was the cause of the symptom onset. Once again Dr Coffey recommended the applicant undergo a right hip arthroplasty.

45. The applicant was referred to Dr Darweesh Al-Khawaja by his general practitioner and consulted with him on 29 March 2019.[13] After examining the applicant Dr Al-Khawaja appeared to have concern that whilst the applicant complained of pain and weakness in the foot he did not have any dorsiflexion or plantar flexion of the foot. That is, the foot weakness symptoms could not be explained clearly. Dr Al-Khawaja referred the applicant to see Dr Michael Biggs who is a specialist in nerve injuries.

46. The applicant consulted Dr Michael Biggs on 3 April 2019.[14] Dr Biggs understood the applicant had had neuropathic pain in the distribution of the superficial peroneal nerve causing difficulty moving the right foot which had led to multiple falls.

47. On examination, Dr Biggs observed weakness of the foot in all movements. Dr Biggs diagnosed the applicant as having a superficial peroneal nerve injury and resultant neuropathic pain. Dr Biggs recommended appropriate anti-neuropathic medication and advised against surgical intervention.

[9] Page 41 of the Application.
[10] Page 42 of the Application.
[11] Page 43 of the Application.
[12] Page 45 of the Application.
[13] Page 47 of the Application.
[14] Page 49 of the Application.

48. The applicant was referred to Dr Ho, hip and knee surgeon, in April 2019 by his general practitioner. Dr Ho understood the applicant had had difficulties with his right shin laceration and had had seven or eight falls and was also seeing Dr Coffey. The applicant complained of buttock pain radiating down to the knee and to the foot.

49. Dr Ho on examination observed that the applicant walked with a limp on the right side, the hip was irritable and difficult to examine as was the right knee.

50. Dr Ho had the benefit of having an MRI scan which showed the paralabral cyst, labral tear and chondral wear of the weight bearing part of the hip.

51. Dr Ho considered the proposed hip surgery as recommended by Dr Coffey and opined that the applicant may benefit from right hip replacement surgery but because the applicant's symptoms were atypical, there was no guarantee that he could get a complete resolution of the symptoms following the surgery.

52. The applicant consulted Dr Zicat, hip and knee surgeon in November 2017.[15] At that time there does not appear to be any complaint in respect of a hip condition however there was a concern about a potential foreign body in the applicant's right leg. Fortunately, after reviewing the MRI, the doctor found that there was not any foreign body in the applicant's leg.

53. Dr Zicat understood the applicant continued to have difficulty with soft tissue pain following the injury and recommended the applicant undergo a bone scan. Dr Zicat did not recommend any particular surgical intervention at that stage.

54. The applicant saw Dr Zicat again in February 2018[16] after undergoing a bone scan. The bone scan showed that there was no evidence of osteomyelitis or any bony or soft tissue features about the leg that could be contributing to the applicant's pain. Dr Zicat could not provide a definitive diagnosis to the applicant's condition but was concerned about the significant levels of pain the applicant experienced which were not consistent with compartment syndrome or with a muscle herniation but may be due to abnormal mechanics within the anterior compartment around the area of his scar. Dr Zicat recommended exploration and scar tissue release.

55. The applicant once again saw Dr Zicat on 4 May 2018 following the wound exploration and fascia release as recommended by him.[17] Dr Zicat in the surgical procedure was able to find tethering of the muscle to the under-surface of the fascia which had been now completely released.

56. The applicant has undergone consistent physiotherapy under Jordan Baker from Glenmore Park Physiotherapy. The treating notes and reports back to the insurer and general practitioner have been annexed to the application. What is evident in the reports from the physiotherapist is the applicant's gait does appear to be uneven, for example on 21 May 2018[18] on examination the physiotherapist observed that the applicant lacked range of motion and strength, was limited in ankle dorsiflexion and during gait mobilised with a moderate limp due to decreased push off of his right foot. A further relevant entry, one of many in the notes, is seen on an entry dated 13 January 2019[19] where it was observed that the applicant walks with a limp, shifting weight off the foot through the gait.

[15] Page 55 of the Application.
[16] Page 56 of the Application.
[17] Page 58 of the Application.
[18] Page 89 of the Application.
[19] Page 122 of the Application.

DISCUSSION

57. The applicant's case is that the applicant has suffered a consequential condition to his right hip arising from an altered gait.

58. The applicant must establish that he suffered a condition in the right hip consequent on the laceration injury to the right leg, that is the hip condition "resulted from" the laceration injury. The test to be applied is in the principle set out by Kirby P in *Kooragang Cement Pty Ltd v Bates*[20] namely:

> "It has been well recognised in this jurisdiction that an injury can set in train a series of events. If the chain is unbroken and provides a relevant causative explanation of the incapacity or deaths on which the claim comes, it will be open to the Compensation Court to award compensation under the Act."

59. It is not necessary for the applicant to establish that he suffered an "injury" to the right hip within the meaning of section 4 of the *Workers Compensation Act 1987* (the 1987 Act), only that the symptoms and restrictions in the right hip resulted from the laceration injury.[21]

60. There is no issue that the applicant does indeed have a limp, that he is favouring putting weight on the left side. There is an abundance of evidence in the medical material which supports such a finding of fact. Indeed, the applicant helpfully provided an aide memoire which summarises the complaints in respect of altered gait and I have used that document as an aide memoire which is supported by the evidence before me in respect of that finding.

61. Many Doctors have observed limping including Dr Negus, Dr Ho and Dr Coffey. This is also observed and noted by the physiotherapist.

62. The respondent also does not dispute that the applicant has been diagnosed with a degree of affectation of the nerve as a result of the laceration.

63. The respondent does not accept the consequential condition as claimed. The respondent accepts that there is pathology or potential pathology in the applicant's right hip as identified in the MRI scan, that is, a partial thickness tear. The respondent reminds me that it is quite clear, as Justice Kirby has commented in *Kooragang Cement,* that simply because something occurs after an accepted injury does not satisfy the test. That is, just because the applicant limps does not automatically lead to a finding that is has caused a consequential condition in the applicants hip.

64. The applicant's case here is not that he injured his right hip as a result of the initial injury but further that he has had significant falls after the accident and also walks with an antalgic gait. This is supported by his treating orthopaedic surgeon Dr Coffey.

65. The respondent points out the inconsistencies found by doctors on examination which include Dr Negus, Dr Vote, Dr Coffey and Dr Al-Khawaja. I agree that the applicant, at times, did not present in a typical manner on examination. This however must be balanced against the fact that there is proven pathology, as found on MRI, in the applicant's right hip.

66. The respondent points out that Dr Negus only says that the altered gait arising from the moon-boot could have led to exacerbation of a pre-existing labral tear within the hip. That is, the doctor only raises this as a level of possibility by using the word "could" rather than a probability. I agree that this is indeed what Dr Negus says in his report. Dr Negus however is only one opinion in this dispute, and it should be observed that he agrees with the principle of altered gait (be it from wearing a moon boot) causing an aggravation to the hip condition.

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[20] (1994) 35 NSWLR 452 at 462 (*Kooragang Cement*)
[21] See Deputy President Roche in *Moon v. Conmah Pty Ltd* (2009) NSWWCCPD 134 at pars 45-46.

67. Dr Coffey holds a slightly different view to Dr Vote and others in this dispute. He has had the benefit of multiple recent consultations. To my mind he is in the best position to opine on causation in this matter.

68. The respondent also points out what it sees as a "logical problem with the case" is that the injury is to the applicant's right calf and his subsequent symptoms he complains of are on the right-hand side. Counsel for the respondent submitted "as a matter of logic, one would expect that if you were keeping the weight off the right leg because of those symptoms there would be less load on the right hip".

69. The respondent complains that Dr Negus does not explain the mechanism by which this aggravation, as he puts it, would occur in the right hip in those circumstances. I do not accept this submission. It could be said to the contrary that the altered gait causes irritability of the hip because of the change in biomechanical movement.

70. Nevertheless I, like counsel for the respondent, am not a doctor. There is no medical opinion before me that raises as an issue that favouring right hand leg does not cause irritability in the right hip. Quite clearly the applicant's case is not that there was extra load going to the right hip but that there is an antalgic gait and altering of the mechanics of the hip causing irritability. This is supported by Dr Coffey and to a lesser extent Dr Negus.

71. In making a finding in the applicant's favour, I accept that there are challenges in accepting the applicant's case, such as the abnormal findings on examination. These matters were well ventilated by Counsel for the respondent. At the end of the day, it must be borne in mind that the applicant doesn't need to present a 'perfect case' but must discharge the burden of proof. In this dispute, the applicant has discharged the burden to the required standard.

72. In this case I accept the applicant has sustained a consequential condition of his right hip. I accept that he has an altered gait arising from the accepted injury to the right shin and that has aggravated an underlying condition in the right hip.

Reasonableness as to the surgery

73. No submissions were made by the respondent as to the reasonable necessity for the proposed surgery though a formal concession was not made. This is not surprising as the main issue was the liability issue, that is whether the applicant had suffered a consequential condition.

74. Section 60 of the 1987 Act provides:

> "(1) If, as a result of an injury received by a worker, it is reasonably necessary that--
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> (a) any medical or related treatment (other than domestic assistance) be given, or
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> (b) any hospital treatment be given, or
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> (c) any ambulance service be provided, or
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> (d) any workplace rehabilitation service be provided,
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> 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)."

75. Burke CCJ in *Rose*[22] considered what reasonably necessary treatment was in the context of section 10 of the *Workers Compensation Act 1926*[23]:

> "Treatment, in the medical or therapeutic context, relates to the management of disease, illness or injury by the provision of medication, surgery or other medical service designed to arrest or abate the progress of the condition or to alleviate, cure or remedy the condition. It is the provision of such services for the purpose of limiting the deleterious effects of a condition on restoring health. If the particular 'treatment' cannot, in reason, be found to have that purpose or be competent to achieve that purpose, then it is certainly not reasonable treatment of the condition and is really not treatment at all. In that sense an employer can only be liable for the cost of reasonable treatment."

76. In *Diab v NRMA Ltd*[24] Deputy President Roche cited *Rose* with approval. He summarised the principles as follows:

> "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 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."

77. Of some assistance in determining disputes such as the present one, Deputy President Roche helpfully stated:

> "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."

78. It is accepted that a condition can have multiple causes, but the applicant must establish that the injury materially contributed to the need for surgery. This was confirmed by Deputy President Roche in *Murphy v Allity Management Services Pty Ltd*[25], where he stated:

> "Moreover, even if the fall at Coles contributed to the need for surgery, that would not necessarily defeat Ms Murphy's claim. That is because a condition can have 'multiple causes'…… 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."

79. I accept that the surgery is reasonably necessary, for short reasons which I will now outline.

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[22] *Rose v Health Commission NSW* (1986) 2 NSWCCR 32 (*Rose*).
[23] Par 42.
[24] [2004] NSWCCPD 72 (*Diab*).
[25] [2015] NSWCCPD 49 (*Murphy)*.

80. Applying the relevant factors from *Diab,* the applicant has undergone various alternate treatments with no success. This include injections and extensive physiotherapy.

81. There is support from various doctors that the surgery could alleviate the applicant's pain. This includes Dr Negus, Dr Ho and of course Dr Coffey. This to my mind is very important when finding that the surgery is reasonably necessary.

82. There is no evidence that the cost of the treatment is prohibitively expensive, when weighed against the applicant's symptomatology.

83. I therefore find that the proposed surgery is reasonably necessary