WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **6495/20**
Applicant: **Kevin Mungoven**
Respondent: **Specialist Diagnostic Services Pty Ltd t/as Laverty Pathology**
Date of Determination: **12 January 2021**
Citation No: **[2021] NSWWCC 16**

The Commission determines:

1. The applicant sustained injury to his low back arising out of or in the course of his employment with the respondent on 21 August 2015 and 2 August 2018. The applicant's employment with the respondent was the main contributing factor to the aggravating injury he sustained to his low back on 21 August 2015 and 2 August 2018.

2. An award for the respondent in relation to allegation of low back injury sustained on 13 February 2020.

3. The applicant requires medical treatment and services as a consequence of the injury he has sustained to his low back on 2 August 2018. The surgical treatment proposed by Dr Ferch in the nature of an L3/4 interbody fusion is reasonably necessary treatment resulting from the injury the applicant sustained to his low back on 2 August 2018. The respondent is to pay the applicant's medical or related treatment under s 60 of the *Workers Compensation Act 1987* resulting from injury he sustained to his low back on 2 August 2018.

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

Jacqueline Snell
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 JACQUELINE SNELL, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

L Golic

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

STATEMENT OF REASONS

BACKGROUND

1. Kevin Mungoven (Mr Mungoven) is currently 55 years of age. He commenced employment with Specialist Diagnostic Services Pty Ltd t/as Laverty Pathology in or about July 2013, working as a courier driver. Mr Mungoven alleged that during the course of his employment with the respondent he sustained injury to his low back, making specific reference to incidents that occurred on 21 August 2015, 2 August 2018 and 13 February 2020.

2. Mr Mungoven's claim for compensation in these proceedings resulting from alleged injury to his low back involves a claim for medical or related treatment payable under s 60 of the *Workers Compensation Act 1987* (1987 Act), specifically surgical treatment in the nature of an L3/4 interbody fusion.

3. The respondent issued a notice in accordance with s 78 of the *Workplace Injury management and Workers Compensation Act 1998* (1998 Act) on 10 July 2019 [1], 16 January 2020 [2] and 25 June 2020 [3]. Following requests for review made by Mr Mungoven under s 287A of the 1998 Act, the respondent issued notices dated 28 November 2019 [4] and 23 September 2020 [5].

4. Mr Mungoven's claim for compensation resulting from alleged injury to his low back proceeded to an Arbitration hearing on 16 December 2020, conducted by telephone. Mr Greg Young of counsel appeared for Mr Mungoven instructed by Mr James Bartley, solicitor. Mr John Gaitanis of counsel appeared for the respondent, instructed by Mr Tom Murray, solicitor.

ISSUES FOR DETERMINATION

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

    (a) Alleged injury to the low back sustained on 21 August 2015, 2 August 2018 and 13 February 2020 during the course of employment with the respondent, with acknowledgment by the parties that it was the motor vehicle accident occurring on 2 August 2018 that was the most significant of the pleaded incidents, and

    (b) The requirement for medical or related treatment for the low back injury, specifically, the requirement surgical treatment in the nature of an L3/4 interbody fusion.

PROCEDURE BEFORE THE COMMISSION

6. 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.

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[1] Application to Resolve a Dispute (ARD) page 11
[2] ARD page 20
[3] ARD page 26
[4] ARD page 37
[5] ARD page 44

EVIDENCE

Documentary Evidence

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

    (a) The Application to Resolve a Dispute (the ARD) and attached documents, and

    (b) Reply and attached documents.

Oral Evidence

8. Neither party sought leave to adduce oral evidence or cross-examine any witnesses. Both counsel made oral submissions and a copy of the recording is available to the parties.

FINDINGS AND REASONS

Review of evidence

9. A brief summary of the evidence follows.

Mr Mungoven's statement

10. In his statement dated 6 July 2020 [6], Mr Mungoven relevantly explained that over time there had been a number of incidents in which he had sustained injury to his low back.

11. In or about 2007, he injured his low back when cleaning a fish tank at home and came under the specialist care of Dr Kuru and osteopathic care of Mr Wild. After receiving treatment throughout 2007, Mr Mungoven remained completely asymptomatic until 2015.

12. On 21 August 2015, while undertaking his courier driving duties with the respondent Mr Mungoven hit a number of "very large bumps", which caused pain in his low back. On the same day, he "jumped on the break" so as to avoid an accident, which again caused pain in his low back. Mr Mungoven came under the general medical care of Dr Adamski and specialist care of Dr Ferch. He received physiotherapy treatment. After receiving treatment during 2015, Mr Mungoven did not recall any further problems with his low back and said he "was asymptomatic for a number of years before the incident on 7 August 2018". Liability was initially accepted by the respondent for the injury Mr Mungoven sustained to his low back on 21 August 2015.

13. On 7 August 2018, while undertaking his courier driving duties with the respondent and stopped at traffic lights, Mr Mungoven's vehicle was "rear ended" by a large four-wheel drive vehicle. Mr Mungoven initially suffered from shock and a sore neck. Later the same day he developed pain in his left elbow and one week later he developed pain in his right hip, leg and foot. Diagnostic investigation confirmed a tear in his right hip, and Mr Mungoven believed he sustained this injury by "jamming my right leg down on the brake during the accident". Mr Mungoven said too that in this accident he aggravated the low back injury he had sustained in 2007 and 2015. Relevant to the injuries Mr Mungoven sustained to his right hip, leg and foot and back, he came under the general medical care of Dr Vijay and orthopaedic specialist care of Dr Salaria, Dr Kuru, Dr Ferch and Dr Rao. He again received physiotherapy treatment.

[6] ARD at page 1

14. As a result of the injuries he sustained in the accident on 7 August 2018, Mr Mungoven was placed on office-based duties and on 13 February 2020 he again aggravated his back injury while unloading stores from a courier van. Dr Vijay referred him for further physiotherapy treatment.

Treating medical evidence

Dr Kuru

15. Mr Mungoven first came under the orthopaedic care of Dr Kuru after he sustained injury to his low back in 2007. On 24 January 2007 [7] Dr Kuru reported complaint of low back pain with left leg pain, with left leg pain being his predominant problem. Dr Kuru provided opinion Mr Mungoven had long standing L3/4 spondylolsthesis, which had been acutely complicated by disc extrusion. Possible discectomy was raised. On review on 1 March 2007 [8] Dr Kuru described the MRI as confirming an extruded disc fragment at the L3/4 spondylolisthesis. Discectomy was again raised. On review on 29 March 2007 [9], with Mr Mungoven's leg pain remaining problematic, Dr Kuru said while the plan was to review him in six weeks, he would "probably proceed with discectomy".

16. Mr Mungoven subsequently returned to Dr Kuru for orthopaedic review on 3 April 2019 [10] at which time Dr Kuru noted him to have done "reasonably well" relevant to his earlier back complaint until he aggravated his low back in the accident occurring on 2 August 2018. Dr Kuru noted the MRI scan demonstrated L3/4 spondylolisthesis with some foraminal stenosis and degenerative disc changes at L4/5 but said he was unable to attribute Mr Mungoven's low back symptoms to change in pathology in the low back as "when compared to his scan in 2007 there has been limited, if any, change.

Dr Ferch

17. In his report dated 3 December 2019 [11] addressed to Mr Mungoven's solicitors, Dr Ferch, neurosurgeon, confirmed Mr Mungoven initially consulted with him on 28 September 2015 and continued to consult with him intermittently, with last review on 17 October 2019. Mr Ferch was aware of Mr Mungoven's previous episode of back and left leg pain, for which he said he received steroid injection with no further symptoms in his back and left leg.

18. Dr Ferch reported Mr Mungoven initially presented on 28 September 2015 with low back and left leg pain, which developed on 21 August 2015 while driving on a rough road while working as a pathology courier. At that time Mr Mungoven rated his back pain at 1/10 and his left leg pain at 3/10. Dr Ferch reported Mr Mungoven underwent steroid injection on 15 October 2015, with relief in his leg pain and while surgical treatment was discussed, Mr Mungoven "was happy to persevere with conservative treatment".

19. Mr Mungoven returned for review with Dr Ferch on 8 October 2019, which was after the accident occurring on 2 August 2018, with complaint of low back pain and bilateral leg pain. Dr Ferch reported a history of the accident occurring on 2 August 2018 following which Mr Mungoven developed increasing pain in his right leg, "characterised by a burning quality". At that time Mr Mungoven rated his back pain at 5/10 and his leg pain at 8/10. Dr Ferch said his findings on examination on 28 September 2015 and examination on 8 October 2019 "were similar". Dr Ferch provided diagnosis in terms of L3/4 spondylosis with bilateral leg pain and in response to specific questioning said there had been an acute deterioration in Mr Mungoven's symptoms due to the motor vehicle accidents he had experienced while working, and accordingly these accidents had been the main contributing factor to his

[7] ARD at page 79
[8] ARD at page 81
[9] ARD at page 82
[10] ARD at page 83
[11] ARD at page 63

persistent pain. He said the proposed surgical treatment in the nature of interbody distraction and fusion had a 70% chance of substantially improving his symptoms and was "reasonable and necessary".

20. In his contemporaneous report relevant to Dr Ferch's review of Mr Mungoven on 8 October 2019 [12], Dr Ferch noted the MRI undertaken in 2018 was similar to that undertaken in 2015, which confirmed spondylolisthesis at the L3/4 with associated left sided foraminal stenosis. He thought Mr Mungoven's right sided symptoms could be secondary to progressive right sided foraminal stenosis, to which he said Mr Mungoven would be vulnerable with spondylolisthesis.

Dr Vijay

21. In his report dated 13 August 2020 [13] addressed to Mr Mungoven's solicitors, Dr Vijay said Mr Mungoven had consulted with him on 7 August 2018 after the accident on 2 August 2018. Initial complaint was that of neck pain, headache and left elbow pain. On 3 September 2018, Mr Mungoven consulted with another doctor at the practice with complaint of right hip pain and was referred for ultrasound, which demonstrated trochanteric bursitis. Subsequent MRI of the right hip demonstrated gluteus medial avulsion and Mr Mungoven was referred for orthopaedic review by Dr Salaria who recommended MRI scan of the low back, which demonstrated degenerative changes in the lumbar spine, worse at L3/4. Mr Mungoven underwent steroid injection, with temporary relief. Relevant to his low back pain, Dr Vijay said Mr Mungoven first reported low back pain around the end of September or first week of October 2018 and since then he had suffered a progression of his symptoms with surgical treatment recommended by Dr Ferch. Dr Vijay is not of the view Mr Mungoven had recovered from the low back injury he sustained on 7 August 2018 and pointed out Mr Mungoven's symptoms continued to deteriorate. Dr Vijay supported Dr Ferch's recommended surgical treatment and expressed opinion the requirement for surgical treatment resulted from the accident occurring on 7 August 2018. He noted Mr Mungoven was asymptomatic at the time of the accident.

Dr Salaria

22. In his report dated 29 September 2018 [14], Dr Salaria confirmed Mr Mungoven came under his orthopaedic care and relevant to the accident occurring in August 2018 he noted of Mr Mungoven:

> "He had elbow pain and pins and needles in the foot which he thought would improve but over the next few days it exacerbated and he has been feeling weakness of the right ankle and pain in the lateral thigh and lateral calf. He has some groin pain but no pain over the lateral trochanteric region which would correlate with acute gluteus medius tendon injury. The hip range of movement itself is free and painless.
> …..
> Clinically, he seems to have L4 radiculopathy but I have organised the MRI scan for further evaluation.
>
> He has history of previous episode of back pain in 2014 or 2015 and was diagnosed with L4-5 spondylosis. He had symptoms on the left side which had settled down completely until this accident."

[12] ARD at page 67
[13] ARD at page 74
[14] ARD at page 97

23. On review on 16 October 2018 [15], Dr Salaria reported continuing left leg pain and noted the MRI demonstrated L3/4 spondylosis and left foraminal stenosis, which he said would explain the left leg pain. On review on 4 December 2018 [16] Dr Salaria reported Mr Mungoven's back pain to be "a bit better".

Dr Rao

24. Mr Mungoven came under the orthopaedic care of Dr Rao on 27 November 2019 [17] relevant to the problem he experienced with his right foot going to sleep, which medical opinion did not connect with his low back injury.

Clinical records of Advanced Physiotherapy

25. These clinical records [18] demonstrated Mr Mungoven presented for treatment on 1 September 2015 with a two-week history of lower back pain resulting from driving incidents occurring while at work. Findings on examination were reported to be consistent with discogenic lumbar spine pain with possible nerve root involvement. On 18 September 2015, [19] Mr Mungoven's condition is reported to have "improved significantly".

Clinical records Charlestown Medical and Dental Centre

26. These clinical records [20] demonstrated Mr Mungoven was asymptomatic at the time of the accident occurring on 2 August 2018, with complaint of neck pain, headache and left elbow pain consequent on the accident. On review on 16 August 2018 and again on 23 August 2018 there is no mention of back pain, but on review on 3 September 2018 there is mention of right hip pain since 28 August 2018 without recent injury but with a history of the accident occurring on 2 August 2018. While again on 6 September 2018 there is no mention of back pain, Dr Vijay noted ongoing hip pain, with loss of two days' work due to same. With deterioration in right hip pain, Mr Mungoven is referred for diagnostic imaging, initially ultrasound and subsequently MRI which demonstrated "small tear/possible avulsion glute med". On 14 September 2018 Dr Vijay noted continuing right hip pain and a denial of back pain since the accident occurring on 2 August 2018. On examination there was no swelling or bruising, no tenderness and good range of movement without any discomfort. On review on 3 October 2018 however, Dr Vijay noted that in addition to right hip pain Mr Mungoven had "started to develop R sided lower back pain sometimes last week – informed physio last week – documented by physio" and that Mr Mungoven had consulted with Dr Salaria on 29 September 2018 who had recommended low back MRI. While over time Mr Mungoven's right hip pain settles down, his low back pain with bilateral leg involvement intermittently continued.

Clinical records of Body Worx Physiotherapy

27. These clinical records [21] relevant to treatment undertaken in 2018 and 2019 documented complaint by Mr Mungoven relevant to his lumbar spine and both legs, referral for review by Dr Salaria and recommended second opinion from Dr Ferch or Dr Hansen, both of who are neurosurgeons.

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[15] ARD at page 96
[16] ARD at page 95
[17] ARD at page 69
[18] ARD at page 564
[19] ARD at page 574
[20] ARD at page 128
[21] ARD at page 119

Independent medical evidence

Dr Harrington

28. Dr Harrington provided a number of independent medical examiner's reports relevant to Mr Mungoven's back condition.

29. In his initial report dated 14 November 2018 [22] Dr Harrington detailed the accident occurring on 7 August 2018 and noted the previous history of injury to Mr Mungoven's low back on two earlier occasions, the first having resolved and the second having resulted in a diagnosis of L4/5 spondylosis. Dr Harrington detailed the accident occurring on 7 August 2018, with initial neck and left elbow pain and subsequent low back and right hip pain.

30. At assessment, being only some three months after the accident, while Dr Harrington noted Mr Mungoven didn't experience pain in his low back as he had undergone a repeat CT epidural injection on 29 October 2018, current complaint included "funny pain" down the front of his left thigh, which Dr Harrington thought may be coming from the degenerative level and abnormal mechanics at L3/4. Dr Harrington had available to him MRI scans of the lumbosacral spine and MRI scan of the right hip. Following clinical examination Dr Harrington provided opinion in response to specific questioning about whether, with first complaint of low back pain being some time after 14 September 2018, the sequence of events were consistent with employment being the main contributing factor to Mr Mungoven's low back injury:

> "The diagnosis for his back pain would be an aggravation, including a recurrence of left leg pain. The appropriate timeframe for the aggravation would be three or four months".

31. Relevant to treatment, Dr Harrington considered the epidural injections at L3/4 had been appropriate but said he did not believe further treatment would be causally related to the accident, once the aggravation ceased, which he anticipated would be in December.

32. In his subsequent report dated 29 May 2019 [23], Dr Harrington noted Mr Mungoven had ongoing trouble with his low back and had returned to Dr Kuru for review, with significant pathology excluded. Dr Harrington noted diagnostic imaging of the lumbar spine showed degenerative changes "which haven't really changed". Following clinical examination on this occasion during which Dr Harrington noted movements of the lumbar spine to be "a little stiff", Dr Harrington provided diagnosis in terms of symptomatic degenerative changes in the lumbar spine and said:

> "The underlying degenerative changes have become symptomatic as a result of the rear-end collision during his courier run in August 2018. I believe ample time for the aggravation has now ceased and any ongoing symptoms are related to the pre-existing changes."

33. Dr Harrington did not consider Mr Mungoven required ongoing treatment relevant to the aggravating injury he sustained to his low back in the accident occurring on 2 August 2018 as he was of the view this aggravating injury had ceased.

[22] Reply at page 1
[23] Reply at page 11

34. In a supplementary report dated 10 March 2020 [24] following review of the request for surgical treatment by Dr Ferch and Mr Mungoven's clinical records, while he accepted Mr Mungoven had sustained an aggravation of a pre-existing condition in his low back, Dr Harrington considered that the aggravation could be a slow deterioration of mechanical changes at L3/4 rather than a result of the accident on 7 August 2018. His reasoning was that if the aggravation was causally related to the accident, Mr Mungoven would have experienced symptoms almost immediately and the burning pain symptoms he experienced "related to pre-existing lumbar spondylosis and the natural history of slow deterioration". He did however accept it was possible Mr Mungoven sustained an aggravation injury in the accident but said "ample time has passed for such aggravation to have ceased". Relevant to the surgical treatment proposed by Dr Ferch, Dr Harrington said that when he assessed Mr Mungoven on 29 May 2019 he did not present with neurology in the lower limbs and accordingly was sceptical the proposed surgical treatment would make much difference.

Dr Bodel

35. Dr Bodel provided three independent medical examiner's reports.

36. In his initial report dated 25 September 2019 [25], Dr Bodel detailed the accident occurring on 7 August 2018 and as regard injury sustained in the accident, said:

> "The neck was initially okay but became increasingly sore over the next few days. He had pain in the left elbow as he had hit the elbow on the inside of the car. He also had pain in the lower part of the back on the right had side".

37. Dr Bodel noted Mr Mungoven had sustained injury to his back on two earlier occasions, the first at home, which "settled within a brief period of time" and the second on 21 August 2015 during the course of his employment with the respondent, which "improved with conservative care but never completely recovered".

38. At initial assessment, Dr Bodel noted current complaint that included increasing lower back pain with pins and needles radiating into the left leg. He had available to him a number of investigations, which included MRI scans of the lumbosacral spine that demonstrated disc pathology at L3/4 and L4/5 and an MRI scan of both hips that demonstrated minor degenerative change in the hips. Following clinical examination Dr Bodel provided opinion the disc injury Mr Mungoven had sustained at L3/4 and to a lesser extent L4/5 were in the nature of an aggravation, acceleration, exacerbation and deterioration of underlying degenerative disease in the lumber spine "as well as a frank injury at the L3/4 level". Dr Bodel explained the reasoning behind his opinion was the changes on the MRI scan that suggested long standing pathology "which had been asymptomatic prior to this event" while the pathology at the L3/4 level appeared to be new pathology. Dr Bodel considered the proposed surgical treatment was reasonably necessary treatment for the injury sustained in the accident in August 2018.

39. In his supplementary report dated 3 April 2020 [26] following review of a statement provided by Mr Mungoven's that is dated 22 January 2020 (which is not before the Commission) and reports of Dr Harrington that reportedly demonstrated an onset of back pain about one month after the accident, Dr Bodel accepted the injury sustained by Mr Mungoven to his low back in the accident in August 2018 was in the nature of an aggravation, acceleration, exacerbation and deterioration of the disease process at L3/4 rather than a frank injury as previously said. Dr Bodel confirmed his previously expressed opinion the proposed surgical treatment was reasonably necessary treatment for the injury sustained in the accident.

[24] Reply at page 22
[25] ARD at page 49
[26] ARD at page 56

40. In his further supplementary report dated 19 August 2020 [27], and following review of the statement provided Mr Mungoven dated 6 July 2020, Dr Bodel noted Dr Kuru's view the diagnostic imaging undertaken over the years since when he first had the opportunity to review him in 2007 demonstrated minimal change in pathology at the L3/4 level, and said:

> "I accept therefore that he was truly asymptomatic in the back prior to the motor vehicle accident that occurred during work on 07 August 2018".

41. Dr Bodel reiterated his previously expressed opinion Mr Mungoven sustained injury to his low back in the accident on 7 August 2018 and said:

> "It is probable that this injury was the aggravation, acceleration, exacerbation and deterioration of the disease process which was well established and well recognised at the L3/4 level. This had been asymptomatic at the time but the jarring nature of the injury has caused aggravation, acceleration, exacerbation and deterioration of that disease process and that is the main substantial contributing factor by way of aggravation, acceleration, exacerbation and deterioration."

42. Having noted that Dr Kuru had previously recommended surgical treatment following injury in 2007, Dr Bodel considered the currently proposed surgical treatment resulted from a combination of the original injury sustained in 2007 and the aggravating injury sustained on 7 August 2018.

Respondent's submissions

43. Through Mr Gaitanis of counsel, the respondent referred first to Mr Mungoven's statement and in particular his comment about the accident occurring in August 2018. He noted Mr Mungoven spoke of shock and a sore neck immediately after the accident but explained that one week following the accident he developed "pain and symptoms in his right hip and down his right leg and foot" and importantly said that he'd suffered an aggravation and deterioration of his lower back condition since his previous back injuries in 2007 and 2015.

44. Relevant to the history of injury Mr Mungoven sustained to his low back on 7 August 2018, Dr Bodel initially reported Mr Mungoven's neck was okay at first but became increasingly sore over the following few days, pain in his left elbow developed, and the lower part of his back on the right side also developed. Dr Bodel was subsequently prompted to the fact there was a delay of some significance between when the accident occurred and complaint to any doctor of symptoms and pain in his low back and Dr Bodel dealt with that delay in a further report. Dr Harrington reported that following the accident Mr Mungoven developed pain in his neck, low back and left elbow. While these independent medical examiners' reports and Mr Mungoven's statement indicated complaint relevant to the low back following the accident, the contemporaneous notes demonstrated there was no complaint relevant to the low back until some time after 7 August 2018. No explanation is provided by Mr Mungoven for this delay. Mr Gaitanis also referred to an absolute denial by Mr Mungoven he suffered back pain in the accident occurring on 7 August 2018. He pointed out the clinical records of Dr Vijay demonstrated Mr Mungoven's consultation with Dr Vijay that same day, with no mention of his back until consultation on 14 September 2018 when notation relevantly read "denies any back pain since the current injury" and examination demonstrated "Back no swelling/bruise. No tenderness. Good range of movement without any discomfort". An important feature for consideration in this matter was not only the evidenced delay in complaint of back injury but the evidenced denial of back injury sustained in the accident occurring on 7 August 2018.

[27] ARD at page 59

45. Mr Gaitanis referred then to opinion provided by Mr Mungoven's treating orthopaedic specialist in 2007, Dr Kuru. Dr Kuru's reports in 2007 indicated Mr Mungoven suffered from longstanding L3/4 spondylosis, which was complicated by disc extrusion and significant leg pain, with surgical treatment discussed but not proceeded with. Dr Kuru's later reports following review of Mr Mungoven after the accident on 7 August 2018 indicated an inability to attribute Mr Mungoven's back symptoms to a change in pathology in his back as diagnostic imaging demonstrated "limited, if any change" to pathology noted on scan in 2007 and 2015. Dr Kuru also noted nerve conduction study demonstrated no peripheral process affecting the nerves in his legs, and suggested Mr Mungoven's right sided symptoms "may be secondary to progressive right-sided foraminal stenosis to which he would be vulnerable with spondylosis".

46. As regards opinion provided by Dr Ferch, Mr Gaitanis did not consider Dr Ferch provided reasoning necessary to enable a discharge of the onus or proof required of Mr Mungoven in that his explanation was "quite bare".

47. Mr Gaitanis pointed out while Mr Mungoven made a very good recovery from the injury he sustained in 2015, there appeared to be attribution by Dr Ferch of both motor vehicle accidents to an aggravation injury and thereby implication the proposed surgical treatment was reasonably necessary treatment as a result of both injury sustained in both accidents. Mr Gaitanis found it difficult to accept this opinion in circumstances where contemporaneous clinical records demonstrated a delay in reporting pain in the low back after the accident in 2018 and in fact a denial of back pain after the accident in 2018.

48. Mr Gaitanis returned to the opinions provided by the independent medical examiners Dr Bodel and Dr Harrington and in essence said Dr Bodel's opinion lacked significantly in explanation that would enable formation of the view of the cause of Mr Mungoven's low back pain because he first complained of it some time after the accident in August 2018, whereas Dr Harrington provided cogent explanation in that the diagnostic imaging between 2007 and 2018 did not demonstrate substantial deterioration or neurological compromise and Mr Mungoven's low back pain "is related to pre-existing lumbar spondylosis and the natural history of slow deterioration. If there was any aggravation this has now ceased".

49. In essence, Mr Gaitanis pressed that the clinical notes in this matter were important, particularly so where Mr Mungoven's statement and provided histories to Dr Bodel and Dr Harrington suggested symptoms shortly after the accident, whereas there was no report of symptoms close in time and in fact there was a denial of symptoms over one month later.

50. Relevant to anticipated submission by Mr Young as regards injury to Mr Mungoven's right hip, Mr Gaitanis said there did not appear to be any medical evidence to support suggestion that Mr Mungoven's right hip symptoms resulted from injury to his low back.

Mr Mungoven's submissions

51. Through Mr Young of counsel, Mr Mungoven confirmed that his claim was a claim made with reference to s 4(b)(ii) of the 1987 Act, being a claim for injury sustained in the nature of an aggravation, acceleration, exacerbation or deterioration of a disease injury. He said that he would demonstrate that Mr Mungoven's employment with the respondent was not only the main contributing factor but was the only contributing factor the aggravation injury that occurred in August 2018.

52. Relevant to Mr Gaitanis' submission about the importance of the clinical records in this matter and the notations made, Mr Young referred to the matter of *Davis v Council of the City of Wagga* [28] with caution by the Court of Appeal at [35]:

[28] [2204] NSWCA 34

> "Experience teaches that busy doctors sometimes misunderstand or mis-record histories of accidents, particularly in circumstances where their concern is with the treatment or impact of an indisputable frank injury".

53. Mr Young noted there was no dispute the motor vehicle accident occurred in August 2018 and there was no dispute Mr Mungoven injured his right hip as a result of that accident. Mr Young referred to the clinical records with notation on 3 September 2018 of complaint of right hip pain since 28 August 2018 and a history of the accident occurring on 7 August 2018, notation on 6 September 2018 of right hip pain and consequent incapacity for work, and notation on 14 September 2018 that MRI of the right hip demonstrated "small tear, possible avulsion gluteal medius".

54. Of significance explained Mr Young is while the respondent was excited about a history of previous low back injury in 2015 with complaint of low back pain and burning sensation in the left leg and MRI having demonstrated L3/4 pars defect with spondylolisthesis, it was significant after the accident in August 2018 there was a change in symptomology in that Mr Mungoven's prior problems had been left sided and now his problems included right sided problems. This is the key said Mr Young.

55. My Young canvassed a number of reports prepared by Dr Salaria, who was the specialist to who Mr Mungoven was referred relevant to his right hip pain. Dr Salaria essentially reported no more than two months after the accident occurring in August 2018 that Mr Mungoven's problems were not related to his right hip but rather were related to his low back and that Mr Mungoven had a history of low back pain in 2015, with diagnosis of L4/5 spondylitis and symptoms on the left side "which settled down completely until this accident". With Dr Salaria's involvement, the focus moved from Mr Mungoven's right hip to his low back and both Dr Kuru and Dr Ferch came back into the picture.

56. According to Mr Young, Dr Ferch's opinion is really important in this matter in that he had the opportunity to review Mr Mungoven both before and after the accident occurring in August 2018. Following review of Mr Mungoven after the incident occurring on 21 August 2015, on 28 September 2018 Dr Ferch recorded Mr Mungoven as suffering low back pain and left leg pain and following review of Mr Mungoven after the incident occurring on 7 August 2018 Dr Ferch recorded him as suffering low back pain and bilateral leg pain. He recorded too that following the accident on 7 August 2018 Mr Mungoven "developed increasing pain in his right lower limb". Mr Young argued that with the change in symptomatology and pathology following the accident on 7 August 2018, there has been an aggravation of the disease injury that Mr Mungoven, being L3/4 spondylolisthesis, and Mr Mungoven's employment with the respondent is the only contributing factor to injury. Mr Young said while Dr Kuru's opinion was important, he only had the opportunity to review Mr Mungoven on one occasion after the accident on 7 August 2018, whereas Dr Ferch had the opportunity to review him on more occasions both before and after the accident and should be accepted as regards diagnosis, causation and recommended surgical treatment.

57. In dealing briefly with the opinion of Dr Bodel, Mr Young said that it was really Dr Salaria who was the key clinical explanation and finding that Mr Mungoven's problem had always been his low back and the right hip had been the red herring. In essence, he said the other specialists, Dr Ferch in particular, spring boarded off the work that Dr Salaria did, and one would accept the opinion of Dr Bodel in terms of causation.

58. Dr Harrington, Mr Young said, posed an interesting problem for the respondent in that he initially accepted Mr Mungoven had sustained an aggravation of his low back, which ceased notwithstanding the fact Mr Mungoven remained symptomatic, and one would not accept the opinion of Dr Harrington.

59. With reference to *Murphy v Allity Management Services Pty Ltd* [29] Mr Young said the opinions of Dr Ferch, Dr Vijay, Dr Bodel and even Dr Harrington's finding of the burning sensation he attributes to Mr Mungoven's spondylosis supported requirement the injury Mr Mungoven sustained to his low back in the accident occurring on 7 August 2018 materially contributed to the need for the proposed surgical treatment in the nature of L3/4 interbody fusion.

Respondent's submissions in reply

60. Regarding the interplay between Mr Mungoven's historical left-sided problem and the emanating right-sided problem, Mr Gaitanis understood inference from Mr Young that the symptoms of right hip burning sensations (and the like) were an aggravation of the lumbar spondylolisthesis and there had been pathological change, but said the MRI of the right hip of 11 September 2018 took away any such argument submitted as it demonstrated a right hip small tear, particularly in circumstances where in providing opinion relevant to Mr Mungoven's low back injury, Dr Bodel, Dr Kuru and Dr Ferch failed to mention the MRI of the right hip. Mr Gaitanis pointed out there was no medical commentary on the relationship between the right hip and the cause of the low back symptoms and said the evidence on which Mr Mungoven relied in this regard is deficient.

Determination

Low back injury

61. Mr Mungoven has the onus of proving he sustained injury to his back during arising out of or during the course of his employment with the respondent. This is a question of fact in his matter and consideration of his statement and all of the medical evidence is required. In *Nguyen v Cosmopolitan Homes (NSW) Pty Limited* [30] McDougall J stated at [44]:

> "A number of cases, of high authority, insist that for a tribunal of fact to be satisfied, on the balance of probabilities, of the existence of a fact, it must feel an actual persuasion of the existence of that fact. See Dixon J in *Briginshaw v Briginshaw* [1938] HCA; (1938) 60 CLR 336. His honour's statement was approved by the majority (Dixon, Evatt and McTiernan JJ) in Helton v Allen [1940] HCA 20; (1940) 63 CLR s91 at 712."

62. Section 4 of the 1987 Act relevantly defines injury as a personal injury arising out of or in the course of employment, including the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation of the disease.

63. Relevant to the issue of causation in *Kooragang Cement Pty Ltd v Bates* [31], Kirby J said:

> "The result of the cases is that each case where causation is in issue in a workers compensation claim must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate case by the use of the phrase 'results from' is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a commonsense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation."

[29] [2105] NSWWCCPD 49
[30] [2008] NSWCA 246
[31] (1994) 35 NSWLR 452; 10 NSWCCR 796 at [463] (*Kooragang*)

64. As to what constitutes an aggravation of a disease process in *Federal Broom Co Pty Ltd v Semlitch* [32] there is discussion by Windeyer J:

> "The question that each poses is, it seems to me, whether the disease has been made worse in the sense of more grave, more grievous or more serious in its effects upon the patient."

65. In *AV v AW* [33] the Commission considered the meaning of 'main contributing factor' and following analysis of the authorities relevantly concluded that the test of 'main contributing factor' is one of causation, which involves consideration of the evidence overall and in a matter involving s 4(b)(ii) it is necessary that the employment be the main contributing factor to the aggravation, not the underlying disease process as a whole.

66. Mr Young explained that in essence Mr Mungoven relied on s 4 (b)(ii) of the 1987 Act, being an aggravation, acceleration, exacerbation or deterioration in the course of employment of the degenerative disease in his lumbar spine, and it is true he must establish his employment with the respondent was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease.

67. Although Mr Mungoven relied on three alleged injurious incidents occurring during the course of his employment with the respondent, the parties agreed it was the motor vehicle accident occurring on 2 August 2018 that was the most significant of the incidents, and counsels' submissions certainly focussed on this incident.

68. There is no dispute that prior to the accident occurring on 2 August 2018, Mr Mungoven had sustained injury to his low back. In his statement Mr Mungoven explained he had sustained injury to his low back in or about 2007 but after receiving treatment during 2007 he remained completely asymptomatic until the incident occurring in 2015 in which he aggravated his low back injury. He explained too that after receiving treatment during 2015 he was again asymptomatic until the accident on 2 August 2015 in which he again aggravated his low back injury. Mr Mungoven also added that while undertaking office-based duties he again aggravated his low back injury while unloading stores from a courier van on 13 February 2020.

69. I accept that at the time of the accident on 2 August 2018 Mr Mungoven was asymptomatic. At review by his treating neurosurgeon Dr Ferch following steroid injection on 15 October 2015 while surgical treatment was discussed Mr Mungoven was reportedly "happy to persevere with conservative treatment" and did not return to consult with Dr Ferch until after the accident on 2 August 2018. The clinical records of Advanced Physiotherapy to who Mr Mungoven was referred for treatment on 1 September 2018 demonstrated that by 18 September 2015 his condition had improved significantly and Mr Mungoven appeared to have ceased treatment on 2 November 2015. The clinical records of Charlestown Medical and Dental Centre demonstrated that until after the incident occurring on 2 August 2018, there had been no complaint of back pain since 20 March 2016.

70. It is not disputed that it was not until some time after the accident occurring on 2 August 2018 that Mr Mungoven complained of low back pain, but it is disputed that Mr Mungoven's low back symptoms resulted from an aggravating injury sustained to his low back in the accident on 2 August 2018 and that his employment with the respondent was the main contributing factor to that injury.

[32] [1964] HCA 34; 110 CLR 626 at [369]
[33] [2020] NSWWCCPD 9

71. While Mr Mungoven reported no back pain at initial consultation with Dr Vijay on 16 August 2018 and there is a subsequent denial on 14 September 2018 of low back pain since the accident occurring on 2 August 2018 with no abnormality noted on examination, it is evident that by 3 September 2018 Mr Mungoven had begun experiencing significant right hip pain, for which he had lost time off work and for which he was in part referred for orthopaedic review by Dr Salaria on 29 September 2018. I consider it of some significance that
Dr Hasan, with whom Mr Mungoven consulted on 3 September 2018 about his right hip pain, took a history that included reference to the accident occurring on 2 August 2018. Although on review Dr Salaria did not appear much concerned with Mr Mungoven's right hip, he was concerned about Mr Mungoven's low back and referred him for MRI that demonstrated L3/4 spondylosis and left leg pain, which Dr Salaria accepted explained Mr Mungoven's left leg symptoms. It was after Mr Mungoven's initial review with Dr Salara that Mr Mungoven first complained to Dr Vijay about low back pain and despite this delay in complaint, Dr Vijay accepted Mr Mungoven sustained low back injury in the accident occurring on 2 August 2018, without recovery and ongoing deterioration of symptoms. As Mr Mungoven's treating general practitioner, I consider Dr Vijay's opinion on causation to be persuasive.

72. Dr Kuru had the opportunity to review Mr Mungoven following injury sustained in 2007 and on a couple of occasions following the accident occurring on 2 August 2018. Dr Kuru accepted Mr Mungoven aggravated his low back in the accident occurring on 2 August 2018 but said he was unable to attribute his current symptoms to a change in pathology in his low back as "when compared to his scan in 2007 there has been limited, if any change".
Dr Ferch too had the opportunity to review Mr Mungoven following injury sustained in 2015 and also on a couple of occasions following the accident occurring on 2 August 2018.
Dr Ferch said his findings on examination on 28 September 2015 after the first work related incident and his findings on examination on 8 October 2019 after the second work related incident "were similar" and accepted there had been an acute deterioration in Mr Mungoven's low back symptoms as a result of these work related incidents with his employment with the respondent were the main contributing factor to his persistent pain. As Dr Ferch's treating neurosurgeon with considerable involvement in Mr Mungoven's treatment I consider Dr Ferch's opinion on causation to also be persuasive.

73. The independent examiners Dr Bodel and Dr Harrington both reported a previous history of injury occurring in 2007 and 2015, and both are acutely aware of the delay in the reporting by Mr Mungoven of low back symptoms after the accident on 2 August 2018. Both Dr Bodel and Dr Harrington accepted Mr Mungoven was asymptomatic at the time of the accident on 2 August 2018. Dr Bodel provided opinion Mr Mungoven sustained an aggravating injury to his low back in the accident on 2 August 2020 with his employment being the main contributing factor to injury, and while Dr Harrington appeared to be less convinced, he too appeared to have accepted Mr Mungoven sustained an aggravating injury to his low back in the incident on 2 August 2020. He said however that the aggravation had ceased and ongoing symptoms resulted from Mr Mungoven's pre-existing condition. Dr Harrington's reasons for resolution of the aggravation are based on the passing of time only and I am not of the view the respondent has adduced sufficient evidence to establish that Mr Mungoven's ongoing symptoms were wholly the consequence of his pre-existing condition (see *Purkiss v Crittenden* [34] and *Watts v Rake*[35]).

74. I am of the view Mr Mungoven provided a credible history regarding development of his low back symptoms with bilateral leg involvement after the accident occurring on 2 August 2018 and the delay in reporting his symptoms is adequately canvassed by a number of doctors, including Dr Vijay, who noted that following referral to Dr Salaris relevant to reported right hip pain, Mr Mungoven's low back was diagnostically investigated and accepted Mr Mungoven

[34] (1960) 114 CLR 164
[35] (1960) 108 CLR 158

sustained low back injury in the accident occurring on 2 August 2018 from which he had not yet recovered, and the independent medical examiners Dr Bodel and Dr Harrington, who accepted Mr Mungoven had sustained an aggravating injury to his low back in the accident occurring on 2 August 2018.

75. Considering the explanation given by Mr Mungoven as to the development of his low back symptoms with bilateral leg involvement after the accident occurring on 2 August 2018 and the support afforded in particular by Mr Mungoven's treating general practitioner and treating neurosurgeon, and also that afforded by Dr Bodel who had the opportunity to review the opinions provided over time by Dr Harrington, I am of the view Mr Mungoven suffered an aggravating injury to his low back as a result of the incidents occurring on 21 August 2015 (for which liability was initially accepted by the first respondent) and on 2 August 2018 and his employment with the respondent was the main contributing factor to such aggravating injuries. I accept Mr Mungoven has discharged the onus of proof required of him relevant to these alleged aggravating injuries.

76. There is however minimal evidence available relevant to the alleged injury Mr Mungoven sustained to his low back on 13 February 2020 and counsel made no submissions relevant to this alleged injury. While in his statement Mr Mungoven explained that as a result of injuries sustained on 7 August 2020 he was placed on office based duties and again aggravated his low back injury while unloading stores from a courier van and that he sought treatment from Dr Vijay and was referred for physiotherapy treatment, there is no medical evidence that canvassed the alleged injury to the low back in this particular incident. I am not of the view Mr Mungoven suffered an aggravating injury to his low back as a result of the incident occurring on 13 February 2020 as I do not accept Mr Mungoven has discharged the onus of proof required of him relevant to this alleged injury.

Treatment

77. As I accept Mr Mungoven suffered an aggravating injury to his low back arising out of or in the course of his employment with the respondent on 21 August 2015 and 2 August 2018 and that his employment with the respondent was the main contributing factor to injury, it follows he has an entitlement to compensation for the cost of medical or related treatment payable under ss 59 and 60 of the 1987 Act for that aggravating injury.

Is the proposed surgical treatment in the nature of an L3/4 interbody fusion reasonably necessary as a result of injury sustained by Mr Mungoven arising out of or during the course of his employment with the respondent on 21 August 2015, 2 August 2018 and 13 February 2020?

78. Section 60 of the 1987 Act provides:

> "60 (1) 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)".

79. What constitutes reasonably necessary treatment was considered in the context of what is now s 60 of the *Workers Compensation Act 1926* in *Rose v Health Commission (NSW)*[36]. Burke CCJ said:

> "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 and 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."

80. His Honour added:

> "1. Prima facie, if the treatment falls within the definition of medical treatment in section 10(2), it is relevant medical treatment for the purposes of this Act. Broadly then, treatment that is given by, or at the direction of, a medical practitioner or consists of the supply of medicines or medical supplies is such treatment.
>
> 2. However, although falling within that ambit and thereby presumed reasonable, that presumption is rebuttable (and there would be an evidentiary onus on the parties seeking to do so). If it be shown that the particular treatment afforded is not appropriate, is not competent to alleviate the effects of injury, then it is not relevant treatment for the purposes of the Act.
>
> 3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.
>
> 4. It is reasonably necessary that such treatment be afforded a worker if this Court concludes, exercising prudence, sound judgment 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.
>
> 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."

81. In *Diab v NRMA Ltd* [37], Deputy President Roche cited *Rose* with approval and provided a summary of 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;

[36] (1986) 2 NSWCCR 32 (*Rose*).
[37] [2014] NSWWCCPD 72 (*Diab*).

(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.

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".

82. Whether the need for reasonably necessary treatment arises from an injury is a question of causation and must be determined based on the facts in each case as discussed in *Kooragang*. In this matter Mr Mungoven must establish that the injury he sustained to his low back while working with the respondent materially contributed to the need for the proposed surgical treatment. This requirement was confirmed by former Deputy Roche in *Murphy v Allity Management Services Pty Ltd* [38] 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 (*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 at [25] – [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' 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 surgery (see discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716."

83. After Mr Mungoven sustained injury to his low back in 2007, Dr Kuru canvassed possible surgical treatment but Mr Mungoven's preference was for conservative care. After Mr Mungoven sustained aggravating injury to his low back in 2015, Dr Ferch canvassed possible surgical treatment but again Mr Mungoven's preference was for conservative care. It was not until Mr Mungoven sustained aggravating injury to his low back in 2018 and Dr Ferch again discussed surgical treatment with him that Mr Mungoven decided to proceed with surgery.

84. Dr Ferch provided opinion the requirement for the current proposed surgical treatment in the nature of interbody distraction and fusion was "reasonable and necessary" treatment for the acute deterioration in Mr Mungoven's symptoms due to the motor vehicle accidents occurring during the course of his employment with the respondent. Dr Vijay supported the proposed surgical treatment and provided opinion the requirement for the proposed surgical treatment resulted from the aggravating injury he sustained in the accident on 2 August 2018. Dr Bodel also supported the proposed surgical treatment but provided opinion the requirement for the proposed surgical treatment resulted from the injury Mr Mungoven sustained to his low back in 2007 and the aggravating injury sustained in the accident on 2 August 2018. Dr Harrington did not support the proposed surgical treatment as he was sceptical it would make much difference to Mr Mungoven.

[38] [2015] NSWWCCPD 49.

85. Although Dr Harrington expressed scepticism about the outcome of the proposed surgical treatment, Dr Ferch recommended it and both Dr Vijay and Dr Bodel support it. As before, I accept the opinions expressed by Mr Mungoven's treating neurosurgeon and general practitioner because of their day to day involvement of his treatment.

86. While it may be true surgical treatment had previously been discussed with Mr Mungoven in 2007 and again in 2015, Mr Mungoven's preference at that time was for conservative care. Although medical opinion differs as to the incidents contributing to the current requirement for surgical treatment, I am mindful Mr Mungoven was asymptomatic at the time of the accident on 2 August 2018 and with an acute deterioration in his symptoms since that time conservative treatment is not now Mr Mungoven's preference. Applying the common sense test of causation I accept the aggravating injury Mr Mungoven sustained in the accident on 2 August 2018 materially contributed to the need for the surgical treatment now recommended by Dr Ferch.

SUMMARY

87. Mr Mungoven sustained injury to his low back arising out of or in the course of his employment with the respondent on 21 August 2015 and 2 August 2018. Mr Mungoven's employment with the respondent was the main contributing factor to these aggravating injuries he sustained to his low back.

88. Mr Mungoven did not sustain injury to his low back as a result of an alleged incident occurring on 13 February 2020.

89. Mr Mungoven requires medical treatment and services as a consequence of the injury he has sustained to his low back. The surgical treatment proposed by Dr Ferch in the nature of an L3/4 interbody fusion is reasonably necessary treatment resulting from the injury Mr Mungoven sustained to his low back on 2 August 2018.