WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**3813/19**
Applicant:	**DONNA JARMAN**
Respondent:	**VINCENTIA GOLF CLUB LIMITED**
Date of Determination:	**28 November 2019**
Citation:	**[2019] NSWWCC 378**

The Commission determines:

1. The need for proposed surgery comprising total disc replacement at L3/4 and L4/5 and anterior lumbar interbody fusion at L5/S1 results from the applicant's work injury on 22 August 1999.

2. The proposed surgery is reasonably necessary for the compensable injury.

3. Respondent to pay the applicant's section 60 of the *Workers Compensation Act 1987* expenses on production of accounts/receipts, including lumbar surgery comprising total disc replacement at L3/4 and L4/5 and anterior lumbar interbody fusion at L5/S1, and associated costs.

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

Ross Bell
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 ROSS BELL, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. This Application to Resolve a Dispute (the Application) registered on 31 July 2019 is in respect of a claim for injury to the lumbar spine on 22 August 1999. The insurer denied the claim in a Notice issued under s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act) dated 6 June 2019. The Application is for section 60 of the *Workers Compensation Act 1987* (the 1987 Act) medical expenses for lumbar surgery proposed by Dr McEntee.

ISSUES FOR DETERMINATION

2. The following issues remain in dispute:

   (a) Do Ms Jarman's s 60 medical expenses, including the need for proposed L3/4, L4/5 and L5/S1 disc replacement and fusion surgery, result from the injury on 22 August 1999?

   (b) Is the proposed lumbar surgery reasonably necessary for the injury on 22 August 1999?

PROCEDURE BEFORE THE COMMISSION

3. The parties attended a conciliation conference and arbitration hearing on 1 November 2019. 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

Oral evidence

4. There was no oral evidence adduced.

Documentary evidence

5. The following documents were in evidence before the Commission and I have taken them into account in making this determination:

   (a) The Application with annexed documents.

   (b) Reply with annexed documents.

   (c) Application to Admit Late Documents with annexures filed for Vincentia Golf Club Limited (the respondent) on 2 October 2019 comprising clinical notes of Medicross Helensvale Surgery; and a supplementary report of Dr Machart dated 20 September 2019.

SUBMISSIONS

6. The representatives made oral submissions at the arbitration hearing. As they were recorded they will not be repeated here, but I have taken them into account, and they are referred to in the discussion below.

Relevant evidence

Ms Jarman's statement

7. Ms Jarman outlines the background and circumstances of the injury in her statement of 1 June 2019. After concentrating on her children in a domestic life, in 1997 Ms Jarman obtained employment as a cleaner with the respondent at 28 hours per week.

8. On 22 August 1999 she was filling a metal mop bucket with boiling water when the grate it was sitting on detached from the wall. She was squatting down below the bucket opening the tap on a 20 litre container of bleach when she saw this happening. To avoid boiling water pouring over her head she was obliged to grab the bucket to prevent it falling and in the process "had to twist very awkwardly". She then fell to the ground and landed on her left hip.

9. She felt severe pain to her lower back. She "went home in agony", then the next day attempted to work but was unable and went home to bed. The following day she was still in severe pain and attended her general practitioner Dr J Jackson. She had injured her back, hip and pelvis.

10. In 2002 she had surgery by Dr I Davidson on her ruptured pubic bone involving a plate and four screws. She has not worked since the incident. Her back pain has become worse in the months before her statement in June 2019 which has affected her quality of life. She wishes to have the three-level lumbar surgery proposed by Dr McEntee because she "can never get comfortable" and is in constant pain, taking Oxycontin, Panadeine Forte, Tramadol and Endone, plus anti-depressants.

Medical evidence

Dr McKee

11. Dr McKee in his report of 4 October 2018 takes the history of the incident causing pain in the pelvic area, the lumbar spine and the hip. He notes the imaging studies including x-rays which had been essentially normal and a CT scan on 14 September 1999 revealing mild diffuse bulging of the L5/S1 disc with no discrete left sided disc herniation detected, a normal canal and no spondylolisthesis.

12. He notes the referral to Dr John Stephen with the major complaint being pain in the trochantic region and groin, and how Dr Stephen had suspected a possible upper lumbar disc proplapse. He goes on to note that an MRI of 9 November 1999 had shown no disc proplapse in the upper lumbar region or any foriminal disc prolapse. Dr McKee also notes the bone scan on 7 January 2000 which showed no significant trochanteric bursitis, but minor evidenc of enthesitis involving the body of the pubic bone.

13. Dr McKee goes on to give a detailed account of the pubis symphysis fusion and subsequent treatment, and the apparent failure of the fusion. He notes the return to see Dr Davison on 4 March 2008 which confirmed, from progress x-rays, the failure of the union, but with the internal fixation in place, and that Dr Davison thought the symptoms would be permanent. Dr McKee notes the referral by general practitioner Dr Raju to Dr McEntee for continuing back pain and sciatica.

14. Dr McKee notes the history of ongoing pain since the time of the surgery including the pubic bone, low back ache and associated sciatic symptoms in both legs, with radiation down to the feet from time to time, with "numbness and pins and needles". He notes that the symptoms had become worse over the previous few years.

15. Dr McKee refers to the imaging in detail, including the MRI of 11 December 2017 and the EMG of 14 December 2017 which revealed multi-level degenerative changes throughout the mid and lower lumbosacral spine most marked at L3/4 and L4/5, with neurophysiological features of chronic left L5 nerve root dysfunction.

16. Dr McKee disagrees that there was pre-existing spondylarthrosis before the 1999 incident, because it did not appear on the imaging at the time, including the MRI obtained for Dr Stephen. Dr McKee says,

> "In my opinion that severe twisting injury when crouching could have initiated disc injury and it may not have been revealed until further MRI scans during the intervening 19 years."

17. Dr McKee disagrees with Dr Machart's opinion that the multi-level degeneration now seen could not have been casued by the injury in 1999, because 19 years had elapsed since the injury and there have were no further investigations after the pubic fusion until 2017.

18. Dr McKee disagrees with Dr Machart's opinion that there is no connection between the current lumbar condition and the 1999 injury,

> "I disagree with that opinion because Orthopaedic Surgeon Dr Jan Davison had remarked that Ms Jarman had made a most unusual and complex presentation soon after the work-related accident, and even Orthopaedic and Spinal Surgeon Dr John Stephen had suspected a lumbar spine injury because her symptoms had been somewhat unusual. Ms Jarman had certainly undergone multiple investigations including the MRI scan on 9 November 1999 which Dr Stephen had criticised because the axial scans had not reached as high as L3."

Dr McEntee

19. Dr McEntee says in his report of 1 March 2018,

> "Ms Jarman Injured herself at work in 1999. She hurt her low back and sustained a left pubic rami fracture I understand. She had surgery for the pubic fracture but has had significant ongolng low backache since and also associated bilateral sciatica more on the left leg than the right. Recent investigations show collapsed discs at L3-4, L4-5 and L5-S1 with neural compression at both the L4-5 and L5-S1 level. EMG testing confirms active left L5 radiculopathy. Given the chronicity and severity of Ms Jarman's symptoms, I have advised surgical intervention in the form oy L3-4 and L4-5 total disc replacements and an L5-S1 anterior lumbar interbody fusion. I consider her work injury in 1999 to have been a significant initiating factor in her current condition which now requires surgical intervention."

Dr Machart

20. In his first report of 29 May 2018 Dr Machart takes the history,

> "Over the years there was gradual increase in the severity of the lumbar pain. The pain radiated to the knees and later below the knees. This had reached the point where she now can hardly walk, visits hospitals from time to time about the severity of the pain."

21. Under "Opinion" Dr Machart considered the diagnosis,

> "Given the description of injury, it is highly unlikely that there was substantial injury to several areas of the body, several discs in the lumbar spine, and pubic symphysis, all concurrently.

The issue now is the lumbar multi-level spondylosis. This pathology that was not caused by the injury. It is not clear whether there was pre-existing spondyloarthrosis. To confirm, I would have to have access to x-rays from that time. The present investigations do not suggest a traumatic cause but rather multi-level degeneration. Multi-level degeneration to such severe degree could not have been caused by the injury. On the balance of probabilities, she is suffering from constitutional spondyloarthrosis, that has nothing to do with the injury 19 years ago.

To establish connection between the injury in 1999 and the spondyloarthrosis now, there would have to be clear cut definition of spinal ailments requiring medical visits, x-rays and visits to doctors, and connection between a specific traumatic lesion to the spine on 22 August 1999 and now. Such specific lesion could not possibly be reflective of multi-level spinal condition. Even if a single lesion could be attributed to a disc, then the current condition of severe multi-level stenosis and arthritis cannot be attributed to the injury. On the balance of probabilities, there is no injury related component still in existence now."

22. Dr Machart also doubts that the proposed surgery would be successful, particularly when he considers Ms Jarman to be "hypersensitive" with psychological factors affecting her presentation.

23. In his report of 5 October 2018, Dr Machart was asked about hydrotherapy and does not change his diagnosis and opinion.

24. In the latest report of 20 September 2019, Dr Machart reiterates his original opinion.

Clinical notes - Sanctuary Point Medical Centre

Hand written clinical notes

25. The handwritten notes are difficult to decipher, and as noted for the respondent, the pages are out of order. There is mention of back pain in the entry following the incident of injury which includes words to the effect of, "bucket slipped at work when trying to grab it and felt a pull" as well as left leg pain and muscle spasm.

26. In September 1999 - mentions ache to left hip. An entry for October 1999 records "pain – left leg/ foot … disc proplapse? MRI".

27. On 9 October 1999 –wording similar to "intense pain in L back and L hip region today" and there is mention of referral to Dr Stephen and an MRI. There is then mention of pain regarding pubic symphysis, and [p 5 Reply annexures] there is mention of pain and inability to vacuum, scrub[?] or walk.

28. In late 1999 - the next sheet [p 8 of the annexures] records, "episodic radicular pain depending on what she does", and mentions MRI Back (N).

29. On 30 December 1999 - there is mention of "back" but the other words around it are indecipherable.

30. In January 2000 - mentions "constant ache in bursa", "paraethesia in left foot and pain left buttock – pain pubic region." Another legible fragment is "tried mowing lawn 10 mins - next day bed". On the next page in sequence [p 9 of the annexures] the legible parts are "pain gradually improving [now?] putting up with it", "pain still persists in left groin – seems to be nerve irritation" … "neuralgic pain" "Pubic area still tender".

31. In July 2000 [p 6 annexures] - largely illegible but there seems to be mention of a twisted right ankle at home.

32. 15 November 2000 [p 4 annexure] - seems to refer to a referral to Dr Staley.

33. On 15 March 2001 [p 11 annexures] - is legible and reads, “see letter Dr Staley”. The date of the following entry is illegible but it is sometime before 14 June 2001. It reads,

> “Almost 2 yrs ago – accident at work had a fall / chronic back pain – radicular pain this morning bent over – coughed felt a sudden pain in L lower back passsed urine since then able to move legs / no weakness … injection morphine sulphate 15mg … script for panadeine forte … Diazepam.

34. The latter entries on that sheet are illegible.

35. On possibly 3 September 2001 [p10 annexures] notes “letter requesting MRI”.

36. In July and August 2002 - refer to the pubic bone graft and the failure to take. There is an entry some time between December 20004 and May 2005 which notes pain, but it is not possible to discern to what this refers.

37. On 21 May 2014 [p 16 annexures] - refers to back pain as well as bilateral hip pain.

Computer generated clinical notes

38. Dr Jackson’s note for 26 November 1999 records “Pain – back – radiating to leg”, and a prescription for Panadeine Forte was printed.

39. There follow 10 consultation records with further prescriptions for Panadeine Forte between 7 December 1999 and 1 May 2000.

40. The entry for 22 May 2000 records “PAIN – BACK – RADIATING TO LEG phone discussuion increase endep” with Endep 50 mg replacing 10 mg.

41. Between 14 June 2000 and 14 October 2002 there are many consultation notes with further prescriptions for Panadeine Forte, Endep, and Tramal.

42. The entry on 28 November 2002 notes “Pain – back – radiating to leg” with a change in the Tramal prescribed from 150 mg to 200 mg and also Oxycontin 20 mg.

43. Numerous notes for consultations follow with further pain management prescriptions being issued, with occasional reference to back pain up to 3 March 2008 when imaging of the lumbosacral spine and pubic symphysis was requested. Further prescriptions continued to the end of 2008.

44. The Helensvale notes cover the intervening period.

45. The next entry by Dr Jackson is for a consultation on 21 May 2014,

> “assessment for total and permanent incapacity ongoing mechanical back pain with severe left-sided paravertebral muscle spasm radicular pain down both legs significant pain rehef usage but has been stable highly unlikely this lady will ever work again as her symptoms have progressively deteriorated”

Clinical notes – Medicross Helensvale surgery

46. Under the heading “Active past history” there is an entry “08/1999 Back pain - followed accident 1999 - ruptured discs, fractured pelvis - bone graft to pelvis”.

47. The entry for 22 November 2005 records a prescription for Oxycontin and the entry “Has Ph of ruptured discs L3 and L4”.
48. The entry for 2 September 2006 notes, “exacerbation of lower left lumbar pain to left leg (knee) from yesterday - followed bending”, with Tramadol, Panadeine Forte and Oxycontin being prescribed.

49. The note for 1 October 2007 says the visit was for “Back pain” and further painkillers and an antidepressant (Endep) were prescribed.

50. On 4 and 8 September 2008 a fall and pain in the right hip is noted.

51. On 18 September 2008 notes the history of injury in 1999 including “L4 and L5 disc bulging”, and records, “has lots of symptoms due to injury.”.

52. On 23 April 2010 there is reference to the 1999 injury and the pubic bone injury and “lumbar disc bulge” and a current reference to “chronic pain”.

53. On 26 July 2010 the notes record under “Subjective”, “tearful/low back pain pain”.

54. On 8 September 2011 “severe pain” is recorded; the Tramal dosage was increased to 200 mg.

55. The 25 September 2014 the consultation note records, “disc trauma from workplace fall in 1995 [sic - 1999] rates pain as : 7/10 bilateral sciatica++”

56. On 21 January 2015 the note states, “Flare up of back pain”.

57. The note for 4 June 2015 records, “chronic hip / back pain / work / accident / injury, operation, under work cover”.

DISCUSSION

Does the need for the surgery proposed by Dr McEntee result from the injury on 22 August 1999?

58. The respondent submits that while there may have been some involvement of the L5/S1 level in the 1999 injury, the proposed surgery involves two other levels above, and the surgery for these levels is not the result of the work injury in August 1999, but of degenerative change. There is little in the clinical records of back problems and it was 18 years between the incident of injury and the further MRI in 2017.

59. Roche DP in *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49, noted the established authority[1] that there may be multiple causes of an injury, and also emphasised that the test with medical expenses is whether the injury was a material contribution to the need for the claimed treatment.

60. In the familiar case of *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452 the Court 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. … What is required is a common-sense evaluation of the causal chain.”

[1] See *Comcare v Martin* [2016] HCA 43.

61. It has since been suggested by the High Court that the “common sense” concept does not operate at large. All the evidence must be considered, with the onus of proof on the applicant throughout.[2]

62. The evidence is extensive of back symptoms from the time of the incident in August 1999 as reflected in the clinical records extracted above. There was no further investigation of the lumbar spine from soon after the incident up to 2017 at the time of referral to Dr McEntee but there was extensive treatment via medication. There was some uncertainty initially as to the various elements of injury between the hip, pelvis and lower back at least until the diagnosis of the displaced pubic bone, and the imaging showing a damaged disc at L5/S1. Mr Jarman’s account of the history with a painful lumbar spine is supported by the clinical records including the prescription of medication for back pain over the many years from the time of injury. Given the severity of the pubic bone element most attention was given to that in the early years, but the lumbar symptoms were prominent and continuous from the time of injury.

63. The proposed surgery involves three levels. The contemporaneous imaging did not reveal any disc damage above L5/S1; that is, the L3/4 and L4/5 discs, as the respondent submits. However these three levels are the most affected by degenerative change currently.

64. Dr McKee’s opinions are described as “worthless” by the respondent because it is submitted that there is no basis for his opinion which comprises “motherhood statements”, whereas D Machart applies a proper “scientific approach”.

65. Similarly the respondent dismisses Dr McEntee’s opinion because he does not explain why the surgery is necessary as a result of the 1999 injury.

66. Dr Machart bases his opinion on the imaging after the incident. He says that for the 1999 incident to be the cause of the current condition,

> “there would have to be clear cut definition of spinal ailments requiring medical visits, x-rays and visits to doctors, and connection between a specific traumatic lesion to the spine on 22 August 1999 and now.”

67. There wasn’t any further imaging, or a “clear cut definition” of spinal ailments other than at L5/S1 but there were many visits to doctors, continuous complaints of lumbar and referred leg pain and multiple prescriptions for pain medication. In my view, Dr Machart’s opinion is not consistent with the ongoing symptoms and treatment from the time of the injury; a history which he takes himself.

68. Dr Machart is of the opinion that the mechanism of injury could not have caused injury to all three levels and the other body parts at the same time. This is not convincing to me given the clear and severe injury to the pubic bone of the pelvis; the immediate and ongoing symptoms from the back; plus trochantic pain. It was clearly a violent incident to cause the damage to the pubis, as Dr McKee says.

69. The only issue is whether the need for proposed surgery at the subject levels results from the 1999 incident. It is true that Dr McEntee’s report lacks the detail of Dr McKee in explanation of the opinion as to causation.

70. Dr McKee’s opinion is no less “scientific” than Dr Machart’s as to the injury to all the levels and it takes full account of the history including the uncertainties expressed soon after the accident as to the origins of some of the symptoms.

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[2] *March v Stramare (E & M H) Pty Limited* [1991] HCA 12; (1991) 171 CLR 506; *Flounders v Millar* [2007] NSWCA 238.

71. I do not consider it “unscientific” for medical specialists to apply their clinical expertise and experience to a detailed history of injury, investigations, and treatment.[3] Dr McKee clearly allows that imaging does not always reveal the origin of symptoms, whereas Dr Machart finds the imaging soon after the incident conclusive in establishing there were no symptoms generated by injury to the levels above L5/S1. He does not appear to fully consider the history of symptoms and treatment throughout the interim period to date and what this might mean for the connection to the 1999 incident. In my view there does not necessarlily need to be an early “clear cut definition of spinal ailments” along with the other pre-requisites Dr Machart sets out before there can be a connection between “a specific traumatic lesion and now”. This does not properly allow for the innate difficulty found with medical diagnoses, which appears to me to be an element in this matter. To rule out a connection because of the imaging soon after or because there was no further imaging for a long period before 2017 is too narrow a view compared with that of Dr McKee.

72. Dr McKee thoroughly examines the full history of the medical events immediately after the fall and subsequent history of treatment and the deterioration of symptoms. He also considers that the left groin pain could have been referred from the lumbar spine.

73. Dr McKee, in answer to a question for his report about Dr Machart’s opinion that the traumatic injury could not be the cause of the current multilevel degeneration. (I infer the word “not” in the second paragraph below was omitted in error, as submitted for the applicant),

> “I disagree that the present investigations do not suggest a traumatic cause but rather multilevel degeneration to such a severe degree that could not have been caused by the injury because 19 years have now elapsed since the work injury in 1999, and there had been no further investigations following the pubic symphysis arthrodesis.
>
> I do not believe that the present investigation results can [not] in any way determine whether or not there had been a traumatic cause and simple multilevel degenerative changes without having a traumatic cause.”

74. Dr Machart is also on his own in finding “hypersensitivity” and psychological issues going to presentation, none of which was found by Dr McKee or Dr McEntee.

75. In answer to a question as to whether the event on 22 August 1999 caused or materially contributed to the development of degenrative change Dr McKee answered,

> “Yes, the traumatic event on 22 August 1999 did cause or materially contribute to the development of degenerative change in your client's lumbar spine.
>
> Yes, in my opinion your client's employment was a substantial contributing factor in causing or materially contributing to the development of that degenerative change.”

76. Taking Dr McKee’s report as a whole it is consistent with the other evidence and includes a detailed analysis of the medical history. Contrary to the submissions for the respondent there is a “fair climate” for accepting the opinions he expresses.[4] For these reasons I prefer the opinions of Dr McKee over those of Dr Machart.

77. The course of the injury over the some 20 years since the incident of injury can be followed throughout. The passage of time is replete with records of lumbar symptoms and treatment with painkillers, including opiates, and anti-depressants. As Dr McKee points out there is nothing to suggest pre-existing lumbar pathology before the incident in 1999. There has been no intervening event to break the causative chain since the 1999 incident.

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[3] See *Australian Security and Investments Commission v Rich* [2005] NSWCA 152 at [170].

[4] *Paric v John Holland (Constructions) Pty Ltd* [1984] 2 NSWLR 505 at 509-510; *Paric v John Holland (Constructions) Pty Ltd* [1985] HCA 58; (1985) 62 ALR 85).

78. Taking account of all the evidence I find that the injury on 22 August 1999 was a material contribution to the need for surgery proposed by Dr McEntee; the need for the surgery results from the injury.

Is the proposed surgery reasonably necessary?

79. In terms of *Rose v Health Commission (NSW)* [1986] NSWCC 2 and *Diab v NRMA Ltd* [2014] NSWWCCPD 72 relied on by the respondent, and *Pelama Pty Ltd v Blake* [1988] NSWCC 6 the proposed treatment is appropriate, as it is directed at the source of back pain and sciatic pain present over many years since the injury and which has gradually worsened, particularly in more recent times. There has been prolonged alternative treatment over the years in the form of medication including strong analgesics and opiates. Dr McEntee as treating surgeon is of the view that the procedure will alleviate the "the chronicity and severity" of the symptoms. Dr Machart doubts this, but I prefer the view of the treating surgeon as to the appropriate treatment together with Dr McKee's opinion which is set out in his report addressing questions in terms of the principles in *Rose*.

80. The procedure is one well known and accepted by the medical profession. As to effectiveness, Dr McKee notes that the surgery is unlikely to allow a return to work given Ms Jarman's deconditioning over the years, but the objective is to reduce pain, increase mobility and prevent deterioration. The cost is not excessive given the history of severe symptoms and the current restrictions; much of the cost will be for a week in hospital following the surgery. In all the circumstances it is surgery that should not be forborne by Ms Jarman.

81. It follows from the above findings that Ms Jarman is entitled to s 60 of the 1987 Act expenses, including expenses for the proposed lumbar disc replacement and interbody fusion surgery.

SUMMARY

82. The need for the surgery proposed by Dr McEntee comprising total disc replacement at L3/4 and L4/L5, and anterior lumbar interbody fusion at L5/S1 results from the injury in the course of Ms Jarman's employment with the respondent on 22 August 1999.

83. The surgery proposed is reasonably necessary as a result of Ms Jarman's work injury on 22 August 1999.