WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **731/20**
Applicant: **Rhonda Matthews**
Respondent: **Warrigal Care**
Date of Determination: **29 April 2020**
Citation: **[2020] NSWWCC 136**

The Commission determines:

1. Ms Matthews' employment was a substantial contributing factor to her injury. Indeed I am satisfied that it was the main contributing factor.

2. Ms Matthews suffered an injury on 22 July 2009 in the form of a torn left medial meniscus and the aggravation of her pre-existing degenerative osteoarthritis.

3. The proposed surgery by Dr Hartnell is reasonably necessary.

The Commission orders:

1. The respondent will pay the costs of and associated with the total left knee replacement surgery recommended by Dr Nick Hartnell on 29 January 2019.

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

John Wynyard
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 JOHN WYNYARD, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

L Golic

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

STATEMENT OF REASONS

BACKGROUND

1. Rhonda Matthews, the applicant, brings an action against Warrigal Care, the respondent, seeking a declaration pursuant to s 60(5) of the *Workers Compensation Act 1987* (1987 Act) that the proposed left total knee replacement is reasonably necessary.

2. A s 78 notice was issued on 19 March 2019 and the Application to Resolve a Dispute (ARD) was lodged on 12 February 2020, the Reply following on 3 March 2020.

3. On 30 March 2020 ,I issued the following amendment to the pleadings:

> "By consent, I amend the applicant's claim for medical, hospital or related expenses by deleting what there appears and substituting under 'amount sought,' 'reasonable costs of' and in respect of 'details of future treatment' substituting 'left total knee replacement and associated expenses'."

ISSUES FOR DETERMINATION

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

    (a) is the proposed left total knee replacement reasonably necessary?

PROCEDURE BEFORE THE COMMISSION

5. This matter was heard by way of telephone conference on 30 March 2020. Mr Howard Halligan of counsel appeared for the applicant instructed by Mr Phillip Bussoletti. The respondent was represented by Mr Tom Grimes of counsel. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

EVIDENCE

Documentary evidence

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

    (a) ARD and attached documents, and
    (b) Reply and attached documents.

Oral evidence

7. No application for oral evidence was made.

FINDINGS AND REASONS

8. Ms Matthews sustained an injury to her left knee on 22 July 2009 which she described in her statement of 31 January 2020[1]. The statement was drawn with some care, and I infer with the help of her solicitor.

[1] ARD page 1.

9. At paragraph 8 she described the injury in the following terms:

> "On 22 July 2009, I was at work at Warrigal Care in Goulburn at the aged care facility. On a female resident [sic] when the resident appeared to have a stroke and fell heavily against me and my left knee was pinned under the bed. I felt severe pain in my left knee."

10. Ms Matthews described that she attended Goulburn Base Hospital on that day at Accident and Emergency where an x-ray was taken of her knee and she was given a splint and crutches. She saw her general practitioner (GP), Dr Haque on 3 August 2009 who originally treated the injury with physiotherapy and rest for two weeks. A workers compensation claim was made and Ms Matthews received weekly benefits.

11. She saw Dr Haque again on 11 August 2009, when she said her knee had not improved. She was referred to an Orthopaedic Surgeon, Dr Andrew Leicester.

12. She saw Dr Haque again on 18 August 2009 and returned to work on modified duties.

13. On 25 August 2009, she saw Dr Haque again and stated that her knee had remained very painful and she was struggling at work.

14. She attended Dr Haque again on 11 September 2009 stating that she still had pain in her left knee but wanted to try to continue working.

15. She saw Dr Andrew Leicester on 29 September 2009. She said that she had been limping since her knee injury and she had heel pain, but particularly had ongoing pain in the left knee which was disturbing her sleep. Dr Leicester thought that she had a medial meniscal tear from the injury at work and an MRI scan was ordered.

16. She saw Dr Haque on 30 October 2009, again stating that her left knee pain had continued unchanged but that she worked through the pain.

17. An MRI scan was taken on 12 November 2009 and on 19 November 2009 Dr Leicester confirmed to her that the scans showed a medial meniscal tear and medial compartment arthritis.

18. An arthroscopic partial medial meniscectomy was recommended and approved by the insurer. Surgery occurred on 19 January 2010.

19. Ms Matthews attempted a return to work on suitable duties between 24 and 26 February but found her knee very painful and she had episodes of it giving way.

20. On 5 March 2010, Dr Haque recommended 10 days' rest.

21. By 18 March 2010, Ms Matthews' left knee was still very sore and still had swelling, but she wanted to go back to work on light duties.

22. On 24 September, Dr Leicester reviewed her after x-rays of her left knee and left hip had been taken.

23. Another MRI scan was organised for 11 October 2010 and on 2 November 2010 Dr Leicester advised that the scan showed osteoarthritis with a further tear of the medial meniscus.

24. At this stage Ms Matthews was experiencing difficulties at work, and another arthroscopy was recommended but she said that Dr Leicester told her that her degenerative arthritis would slowly progress. She said at [31] of her statement that she was told her prognosis was poor but that her symptoms were not severe enough at that stage for a knee replacement. By 2 November 2010, she was unable to work.

25. On 27 January 2011, she reported to Dr Haque that she continued to have pain and swelling in her left knee which would give way after walking for a while. She said she had experienced a few falls for that reason. She was still off work at this time.

26. By 10 February 2011, Ms Matthews had also seen Dr Caldwell for the insurer who, at that stage, recommended a partial knee replacement. Around this time she returned to work on light duties.

27. Ms Matthews continued to consult Dr Haque.

28. In March 201,1 she had a further x-ray of her left knee and consulted Dr Leicester again on 28 March 2011.

29. A further MRI scan was taken.

30. Throughout April 2011, Ms Matthews was managing at work on suitable duties but her knee remained painful and swollen. The MRI scan occurred on 21 April 2011 and on 21 June 2011 at a further consultation with Dr Leicester, Ms Matthews was told that she had medial compartment osteoarthritis on the MRI scan and a small meniscal tear.

31. Ms Matthews was told that a further arthroscopy would not give further pain relief and non-surgical approach was encouraged.

32. Ms Matthews was told that the prognosis for her knee was poor and that she would likely need a total knee replacement in the longer term.

33. She continued her light duties work and continued to see Dr Haque. Ms Matthews stated that she noticed that her pain was being aggravated by her work duties.

34. On 20 February 2012, Ms Matthews' knee locked on her that morning and she had fallen and grazed her thigh. She went to see Dr Haque. She said that the only suitable duties she was doing were in the laundry and the prolonged standing was making her left knee more painful.

35. She was told when she saw Dr Leicester again on 22 February 2012 that she had degenerative arthritis. She was again told that an arthroscopy would not be of any great benefit and that she would eventually need the knee replacement surgery. Nonetheless Dr Leicester said that he would seek approval for a further arthroscopy to at least attempt to try and relieve the current symptoms of her knee locking.

36. Ms Matthews continued to work with pain and said that her knee seemed to be getting worse throughout the first half of 2012.

37. The approval was given for the further arthroscopy which occurred on 18 December 2012.

38. When she spoke to Dr Leicester again on 25 January 2013, Ms Matthews did so by phone as she was having an extreme amount of pain since the last surgery.

39. She had swelling and pain in the left knee. By this time Ms Matthews was being looked after by Dr Ahmad at the **Clinton** Medical Centre. He continued to issue certificates and she was continuing to work part time.

40. By July she was managing to work two days per week on separate days and she saw Dr Leicester on 16 July 2013. He told her that a further arthroscopy would not help and that she was heading towards a knee replacement.

41. On 14 August 2013, she was advised by the respondent that it could no longer provide her with suitable duties. She said that since she ceased work she continued to have ongoing pain and disability which is gradually getting worse. She continued to consult the doctors at the Goulburn Medical Clinic and did not see Dr Leicester again until 13 May 2015.

Onset of right knee symptoms

42. Ms Matthews said that she changed general practitioners to the Goulburn Medical Clinic and that she consulted in relation to the left knee but "also indeed in relation to problems I was developing with my right knee due to what I considered to be pain associated with overuse of the right knee due to me favouring the left knee".

43. She saw Dr Leicester again on 13 May 2015 and discussed the right knee problem. Dr Leicester's suggested treatment was a knee replacement surgery for the right knee.

44. Ms Matthews persevered until 3 February 2016 when she returned to Dr Leicester because of the increased pain in her right knee. She went to the public hospital system, as the insurer would not accept liability for that procedure.

45. In November 2016, she came to a total right knee replacement at Goulburn Base Hospital with Orthopaedic Surgeon, Dr Nick Hartnell.

46. She continued to see the doctors at the Goulburn Medical Clinic for management of her knees but she had ongoing deteriorating pain in her left knee.

47. She was on medication throughout 2017-2018.

48. On 13 December 2018, she saw Dr Hartnell again. She said that her right knee had progressed reasonably although she was still having some swelling and pain. However her main problem was still the left knee. He said that the time had now come that her only option was to proceed with the total left knee replacement.

49. On 29 January 2019, Dr Hartnell wrote to the insurer seeking approval, but the insurer declined liability.

50. Ms Matthews was sent by her solicitors to Dr Roger Pillemer for a medico-legal opinion.

51. Ms Matthews said:[2]

> "My left knee pain and symptoms have become progressively worse over time since my injury in July 2009."

52. A s 78 notice issued from the insurer on 19 March 2019, denying liability on the basis that employment was not a substantial contributing factor to the injury, and that the proposed surgery was not reasonably necessary. In giving the reasons for the refusal the authors of the notice acknowledged Dr Hartnell's opinion that Ms Matthews' symptoms were related to secondary arthritis as a result of the two arthroscopies. However, reference was made to a report of Dr Anthony Smith, Orthopaedic Surgeon, who reported on 12 March 2019. The insurer relied on Dr Smith's opinion that the subject incident did not cause the osteoarthritis, and "if one takes a view" that the medial meniscal tear was caused by the subject injury then "she was cured" by the first arthroscopy. There was "no relationship" between Ms Matthews' arthritis in the hip and knee and her employment.

53. The authors of the notice also relied on Dr Smith's opinion that Ms Matthews would have had her current problem whether she had worked or not.

[2] ARD page 9.

54. Ms Matthews did have some trouble with her left knee prior to the subject injury, which she discovered when the clinical notes from Clinton Medical Centre were produced. She said[3]:

> "…… I note there is an entry I note there is an entry in the clinical notes recorded by Dr D Haque on 18 July 2008 when I attended on him and he recorded that I had *'injured left knee at home'.* I did not have any independent recollection of that incident before as it was so long ago, however now that I have had the opportunity of reviewing my GP's clinical notes, I do recall that there had been a minor injury to my left knee at home and that I had a bit of pain with no swelling or lack of any range of movement in my knee. I note that Dr Haque refers to a *'splint'.* In fact, this was merely an elastic knee guard which I had purchased from the pharmacy myself. I recall I wore the splint for one day only as it was too tight for me and it annoyed me. I recall that the symptoms in my left knee following this incident completely resolved within a few days, after which I had no further problems with the knee until the incident at work on 22 July 2009…."

55. Ms Matthews also noted an entry on 22 July 2008, that she had gone back to work and that her knee was fine with there being no aggravation and no swelling or bruising and almost full movement without any pain. She said:

> "……I recall I had no further problems in the knee and I carried on with my normal daily activities including bicycle riding and carrying on with my normal work duties with no further symptoms until …. 22 July 2009."

56. The Clinton Medical Centre clinical notes were lodged by the applicant. Those entries were referred to by Dr Haque at pages 68 and 69 of the ARD. Similarly, the x-rays referred to were also lodged.

57. The x-ray dated 22 July 2009 taken at Goulburn Base Hospital on the day of the left knee injury showed "no fracture detected. Further evaluation with MRI as suggested for assessment of ligamentus injury"[4].

58. The report of the MRI scan is dated 12 November 2009[5], the conclusion of the radiologist Dr Zita Gacs was:

> "Chronic radial tear of the posterior, horn and body of the medial meniscus. Associated osteoarthritis. Osteochondral lesion in the medial femoral condyle anteriorly and subchondral cystic lesion posteriorly".

59. With regard to the osteochondral lesions Dr Gacs noted:

> "Early osteoarthritis is seen in the patello-femoral joint."

60. Dr Gacs reported again on 11 October 2010 following the surgery on 19 January 2010. Dr Gacs found that there was "moderately advanced osteoarthritic change" present and her conclusion was that there was an extensive complex tear of the posterial of the medial meniscus and a chronic partial tear of the ACL. She said[6]:

> "Osteoarthritic changes and osteochondral defect in the medial femoral condyle and complex subchondral cyst ? osteoarthritis in the medial femoral condyle."

61. Reports were lodged by Dr Leicester, which confirmed the history of his management as described by Ms Matthews.

---

[3] ARD page 1[6].
[4] ARD page 34.
[5] ARD page 36.
[6] ARD page 43.

62. On 19 November 2009, having received the MRI scan, he said that it showed a medial meniscal tear and early medial compartment arthritis.

63. On 11 February 2010, Dr Leicester reported that on operation he found an area of chondral damage of the medial femoral condyle which he debrided. He also found a horizontal cleavage tear of the medial meniscus which he resected.

64. On reporting to the insurer on 6 December 2011, Dr Leicester noted that he had not seen Ms Matthews since 21 June 2011, at which stage an MRI scan of the left knee showed medial compartment osteoarthritis. He said:[7]

> "Ms Matthews' pathology is consistent with her history and onset of the injury. She has had a significant deterioration in the knee over the past 18 months, There was minimal arthritis in the knee when I performed an arthroscopy in January 2010 .."

65. He said further:

> "Ms Matthews symptoms have not resolved. She has ongoing pain secondary to medial compartment arthritis which is likely to have been precipitated by her knee injury."

66. He said that prognosis was poor and as he had previously stated, she was likely to come to a knee replacement in the longer term.

67. Dr Leicester reported on 24 February 2012 that Ms Matthews had a combination of meniscal and arthritic symptoms in the left knee. He confirmed to Ms Matthews that she did have degenerative arthritis and could expect only a limited response to the second arthroscopy.

68. On 23 July 2012, in writing to the insurer, Dr Leicester said that the expected result would be an improvement in her mechanical symptoms of locking. Dr Leicester noted that Ms Matthews did have some osteoarthritis in the left knee and may have some ongoing discomfort from it[8].

69. Dr Leicester confirmed Ms Matthews' statement that she called him on 25 January 2013 complaining of an extreme amount of pain several months following the arthroscopy.

70. Dr Leicester requested her local doctor to order a septic screen to rule out infection[9]. On 30 January 2013 Dr Leicester confirmed the secondary arthroscopy about six weeks prior and noted that there was another tear in the posterior horn of the medial meniscus. He noted "early osteoarthritis of the medial compartment" and that about two weeks post operatively she developed an effusion. He said:

> "Clinically there is no evidence of infection with an excellent range of movement".

71. He said:

> "Clinically I can find no evidence of anything untoward."

[7] ARD page 52.
[8] ARD page 54.
[9] ARD page 56.

72. On 16 July 2013,[10] Dr Leicester wrote to Ms Matthews' GP following the left knee MRI scan in May 2013. He said that the MRI showed "advanced medial and patella femoral osteoarthritis". Dr Leicester said that another arthroscopy would be of no help whatsoever. He said that Ms Matthews was heading for a knee replacement, and Dr Leicester "reinforced" that such procedure should be a last resort. Ms Matthews was then working two days week reasonably well. Dr Leicester said:

> "When Rhonda feels that she is ready for knee replacement I would be happy to review her again to get things organised."

73. On 13 May 2015,[11] Dr Leicester wrote to the GP saying that Ms Matthews was experiencing pain in the right knee. An MRI showed early tricompartmental osteoarthritis, and Dr Leicester said that she will require knee replacement surgery at some stage. Clinically and radiologically her degeneration was not then quite severe enough to warrant a replacement. Dr Leicester encouraged conservative treatment, repeating[12]:

> "When Rhonda feels that she is ready for bilateral knee replacements, I would be happy to review her then".

74. On 3 February 2016, Dr Leicester again, in reporting to the GP, noted the symptomatic right knee condition. He noted that the x-rays of the right knee showed medial compartment osteoarthritis with minimal remaining medial joint space. He said this was confirmed on the MRI of the year before, 2015.

75. Dr Leicester recommended a right total knee replacement.

76. Dr Nick Hartnell reported on 13 December 2018.[13] He referred to the right knee replacement of 2016 and said that overall she had done "OK". He said:

> "I think more of a problem is her left knee".

77. He noted the two arthroscopies of the left knee and said that the only treatment left for her was a total left knee replacement. He said "It is consistent that because of the meniscectomy the knee has got worse and therefore is still likely part of [the] claim."

78. Dr Roger Pillemer, Orthopaedic Surgeon, supplied four reports. On 18 October 2017[14] he took a consistent history of the injury, that Ms Matthews came to two surgical procedures where she had partial medial meniscectomies and chondroplasties carried out, and that there had been progressive deterioration of the osteoarthritis in the left knee. He said:

> "In my opinion the injury would have aggravated this underlying osteoarthritic condition …"

79. Ms Matthews was asymptomatic prior to her injury in July 2009 and may well have remained asymptomatic for a considerable period of time if not for this incident, Dr Pillemer said. He simply noted the right total knee replacement in November 2016 without investigating its cause.

[10] ARD page 60.
[11] ARD page 61.
[12] ARD page 61.
[13] ARD page 65.
[14] ARD page 19.

80. In considering the investigations, he noted the evidence of medial compartment osteoarthritis in the MRI of 12 November 2009, and that by 10 May 2013 a further MRI "now shows severe medial compartment osteoarthritis as well as advanced patellofemoral arthritis."

81. In his opinion Dr Pillemer noted that Ms Matthews was asymptomatic prior to the subject injury and was "very active riding her push bike to and from work". He thought that if not for the subject injury "Ms Matthews might well have continued in an asymptomatic fashion for a very long reasonable period of time".

82. In his report of 29 May 2019 Dr Pillemer concluded[15]:

> "In my opinion her injury in July 2009 aggravated an underlying osteoarthritic condition which was asymptomatic prior to the injury, and it may well have remained asymptomatic for a considerable period of time if not for this incident. As noted Ms Matthews has had two surgical procedures carried out on her left knee, and her treating specialist has recommended a total knee replacement."

83. Dr Pillemer confirmed the need for a total knee replacement and said that that need was a result of her work injury "on the basis of aggravation of an underlying condition".

84. Dr Pillemer supplied a further report dated 30 January 2018[16], in which he discussed his opinion that the right knee condition was unrelated to the subject injury. This opinion is not relevant to the present enquiry.

85. On 8 January 2020[17] Dr Pillemer reviewed the evidence contained in Ms Matthews' statement as to the earlier incident of 18 July 2008. He reviewed his notes and confirmed his diagnosis, as it was clear that the 2008 incident did not interrupt with Ms Matthew's normal daily activities including bicycle riding and carrying on with her work doing normal duties. He confirmed that the mechanics of the subject injury were significant, and sufficient to render symptomatic a previously asymptomatic condition.

Respondent medical evidence

86. The respondent filed reports of Dr Anthony LG Smith but also reports from Dr Kalev Wilding and Dr Bruce Caldwell.

Dr Caldwell, Orthopaedic Surgeon

87. Dr Caldwell's report was dated 29 October 2010[18]. He took a consistent history of the subject injury and subsequent treatment. Dr Caldwell in his opinion[19] said of the left knee injury:

> "1. This lady essentially has medial compartment osteoarthritis with wear of the bare bone and has had a medial meniscectomy. Not surprisingly this has had little benefit as removal of the medial meniscus in the presence of wear to bare bone will not address the problems associated with the osteoarthritis.
>
> Some patients indeed do get some benefits from removal of the meniscus but studies looking at patients with a degree of wear would note that arthroscopy is little better than placebo.

[15] ARD page 28.
[16] ARD page 24.
[17] ARD page 26.
[18] Reply page 17.
[19] Reply page 19.

> This lady essentially had a mildly osteoarthritic knee which was markedly aggravated by an accident at work. This has led to a decompensation of her osteoarthritic changes.
>
> I do note that from her doctor's letters that she had previously attended for problems with her left knee but there appears to be a period of one year when she didn't complain of any symptoms up until her accident. On this basis, I think that the accident has been considered a significant contributing factor to her current situation."

88. Dr Caldwell felt that her treatment should either be a unicompartmental replacement or a total joint replacement.

Dr Wilding, Orthopaedic Surgeon[20]

89. Dr Kalev Wilding reported on 9 November 2011 to the insurer. He took a consistent history of the injury and treatment, including Ms Matthews' determined conduct in remaining at work.

90. Dr Wilding said that as a consequence of the injury, Ms Matthews sustained a tear of the medial meniscus which led to the arthroscopy of January 2010. He thought that the findings on examination suggested that there was still a persisting tear of the medial meniscus, and that the MRI scans of 11 October 2010 and 24 April 2011 confirmed that there was a persisting tear of the medial meniscus, as well as early degenerative change in the left knee. Dr Wilding said:[21]

> "It would therefore appear that either the initial tear was not completely resected, which occasionally can happen, or there has been a further extension of the tear with the medial meniscus after resection of the tear."

91. Dr Wilding said:

> "In my opinion her continuing symptoms in the left knee are due to a persisting left medial meniscal tear superimposed on early degenerative change in the medial compartment.
>
> The aggravation is continuing because her symptoms have not settled.
>
> It is well recognised that a medial meniscal tear and partial medial meniscectomy will accelerate the progression of degenerative change in the knee."

92. He thought that in the long term Ms Matthews may require a knee replacement.

Dr Smith

93. As indicated, the respondent relied on the opinion of Dr AGL Smith who reported on 12 March 2019[22]. Dr Smith took a consistent history of the subject injury and noted much of the contemporaneous medical evidence. He noted the finding on arthroscopy by Dr Leicester in January 2010 of "minimal arthritis in her knee". He noted Dr Hartnell's opinion of 13 December 2018 that the menisectomy was reasonably necessary for Ms Matthews' current predicament. Dr Smith also noted the contents of the MRI scan of 12 November 2009 showing chronic radial tear of the posterial horn and body of the medial meniscus and osteochondral lesion in the medial femoral condyle.

[20] Reply page 15.
[21] Reply page 16.
[22] Reply page 6.

94. He noted Dr Caldwell's opinion that Ms Matthews had been symptomatic prior to the subject injury, but that for a period of almost 12 months prior to the said injury she had been asymptomatic.

95. Dr Smith also noted the opinion of Dr Wilding, that Ms Matthews had osteoarthritis in the left knee as a consequence of the persisting left knee meniscal tear superimposed on early arthritic change. Having given those summaries, Dr Smith then gave the following diagnosis[23]:

> "With regard to the incident at work on 22 July 2009, it is more likely than not that she simply aggravated her left knee osteoarthritis on that occasion. It is possible she had aggravated this condition from time to time prior to 22 July 2009, according to the letter of Dr Caldwell. It is more likely than not that the meniscal tear operated on originally by Dr Leicester pre-dates 22 July 2009. See excerpts from Bhattacharrya et al at the end of this report."

96. Dr Smith considered that the subject injury did not cause the knee osteoarthritis which he said was the primary cause of her symptoms. He said:

> "If one takes a view that the incident of 22 July 2009 is reasonable for her left knee medial meniscal tear, then she was cured of that by the original arthroscopy which was undertaken in January 2010 by Dr Leicester.
>
> The operation actually undertaken on that occasion in January 2010 was a clean-out procedure. These operations have the effect that one third of the time the patient does well, one third of the time the patient has no benefit and one-third of the time the patient can get worse. No surgeon can predict into which group the patient will fall. These operations have been demonstrated to be basically unhelpful with knee arthritis. See excerpts from Moseley at the end of this report."

97. Dr Smith was then asked whether the injury aggravated a pre-existing condition. He said:[24]

> "It is more likely than not the incident of 22 July 2009 represented an aggravation to her previously asymptomatic osteoarthritic left knee and that would result with or without treatment and has left no disability in itself."

98. When asked whether the incident would cause a temporary aggravation he said:[25]

> "By 2009 she would have been aggravating her left knee osteoarthritis by walking any distance, kneeling, squatting and an enormous variety of different activities of daily living. The aggravations could come and go."

99. When asked whether the symptoms complained of were "a mere manifestation of a pre-existing deteriorating condition," Dr Smith said that Ms Matthews' symptoms consequent to the subject injury "were due to an aggravation of an underlying constitutional abnormality, namely left knee osteoarthritis".

100. Dr Smith agreed that a total knee replacement was the only treatment option that one would contemplate for Ms Matthews' left knee problem.

101. Dr Smith essayed an opinion that the meniscal tear probably pre-dated the subject injury but was asymptomatic. There is no evidence that would substantiate that conclusion as was conceded by Mr Grimes in his submissions.

---

[23] Reply page 9.
[24] Reply page 9.
[25] Reply page 10.

SUBMISSIONS

102. Mr Grimes referred to the relevant authorities as to the onus lying on a worker who seeks a declaration that a particular form of treatment is reasonably necessary.

103. Mr Grimes referred to the earlier incident of 18 July 2008. Mr Grimes submitted that this evidence supported Dr Smith's view that her condition was constitutional, and would have occurred in any event regardless of the subject injury. He referred to two entries in the clinical notes, noting that they showed no more than a non-violent accidental fall at home.

104. Mr Grimes said that the investigations carried out from time to time demonstrated the presence of osteoarthritis and he referred to the opinion of Dr Wilding that the radiology indicated that Ms Matthews had a vulnerable knee and pre-existing problems.

105. Each surgical intervention, Mr Grimes argued, had produced a good result.

106. The clinical notes indicated that the right knee condition was in a similar state to the left knee, which again confirmed Dr Smith's view that Ms Matthews suffered no more than a constitutional condition which degenerated regardless of injury. Mr Grimes referred to the results of a body scan at ARD page 149 taken on 18 November 2016. The conclusion by the radiologist was that Ms Matthews had osteoarthritis "everywhere." I observe in passing that the conclusion found "mildly active synovitis/osteoarthritis involving bilateral knees, wrists and ankles."

107. Mr Grimes relied on the opinion of Dr Smith, submitting that I would accept Dr Smith's view that the ligamentous injury had been successfully treated by the 2010 arthroscopy, and that Ms Matthews' remaining symptoms had been caused by the constitutional condition. Mr Grimes conceded that Ms Matthews had been asymptomatic prior to the subject injury and that there was no evidence of any pre-existing meniscal tear. Mr Grimes contended that the evidence supported Dr Smith's opinion that Ms Matthews had occasionally suffered aggravations of her constitutional condition, but that such aggravations were temporary.

Mr Halligan

108. Mr Halligan submitted that Mr Grimes' submissions that the osteoarthritic condition of the right knee was indicative that Ms Matthews was suffering a chronic condition that had no relation to the subject injury, overlooked the evidence of her statement.

109. The right knee symptoms did not occur spontaneously, but rather because the condition of the left knee was such that Ms Matthews favoured it and consequently aggravated the osteoarthritic condition of her right knee. Mr Halligan acknowledged that the applicant had not claimed that the right knee was also a consequential condition, noting that the total knee replacement surgery had already occurred in the Public Hospital system. There had been no challenge to Ms Matthews' statement in that regard and it was accordingly incorrect to submit that the condition of the right knee was unrelated.

110. Mr Halligan submitted that Mr Grimes' interpretation of the body scan of 18 November 2016 was not sustainable. It did not show that Ms Matthews was "riddled" with osteoarthritis, and missed the point that the right knee only became symptomatic because it had been necessary for her to favour the left knee

111. Mr Halligan submitted that the governing definition regarding an aggravation injury was that it be "a substantial contributing factor ", because the contemporary test of "main contributing factor" had not been introduced until 19 June 2012, and this injury preceded that date.

112. Mr Halligan submitted that I would accept the opinion of Dr Leicester, Ms Matthews' treating surgeon, who found that there were two separate tears to the medial meniscus, which were surgically treated with some reluctance, bearing in mind the advanced state of Ms Matthews' osteoarthritic condition, and his prediction that a total knee replacement would be likely was made as early as July 2011.

113. Mr Halligan referred to the opinion of Dr Caldwell, that Ms Matthews "essentially" had a mildly osteoarthritic knee which had been markedly aggravated by the subject accident.

114. Dr Wilding too supported the applicant's case, Mr Halligan submitted. Dr Wilding confirmed Dr Leicester's view that the second arthroscopy had been caused because of the meniscal tear either was not completely resected in the 2010 procedure or had been further torn since. The evidence would support either alternative, although it is not without relevance that Ms Matthews was a diligent and motivated employee who kept working as much as she could.

115. Mr Halligan referred to *Mahony v Kruschich (Demolitions) Pty Ltd*[26] in support of the proposition that negligent treatment by an operating surgeon which worsened the condition being treated did not constitute a *novus actus interveniens.* Whilst I did not understand Mr Halligan to submit that there had been any negligence in this case, the evidence did sustain an inference that the surgery for the torn meniscus aggravated the "minimal" osteoarthritis that Ms Matthews was found to have.

Discussion

116. As noted in the direction I issued on 30 March 2020, by consent the claim was amended to seek the costs of a total knee replacement rather than an arthroscopy, without objection.

117. Mr Grimes submitted that the claim should fail upon the basis that although it was conceded by the respondent expert witnesses that a left total knee replacement was reasonably necessary, he submitted that the necessity had been caused by the underlying arthritic condition which, he argued, was a constitutional condition. It followed that the applicant had not established that employment was a substantial contributing factor to the injury.

118. He submitted that the applicant's evidence showed no more than two earlier surgical procedures related to a meniscal tear, both of which were successful. The arthroscopies occurred on 19 January 2010 and 18 December 2012, and after the second procedure, the treating surgeon, Dr Leicester, on examination stated that he found nothing "untoward."

119. However the statement by Dr Leicester was that he did not find "anything untoward" "clinically" in his report of 30 January 2013. It has to be read in context of the earlier report of 25 January 2013 that was concerned with investigating whether any infection had entered the wound. Dr Leicester's reference to "anything untoward" was as to the question of infection. Ms Matthews was clearly still suffering from pain, as Dr Leicester said he would review her in eight weeks or so if her pain was not better.

120. The reference to Battacharrya et al was followed up at page 11 of Dr Smith's report. The paper was published in the *Journal of Bone Joint Surgery 2003* from the USA. It was a survey of 154 patients with a control group of 49 asymptomatic controls. It was found that medial and lateral meniscal tears were found in 76% of the asymptomatic subjects but 91% of those with symptomatic osteoarthritis. The conclusion was that there was no real difference with regard to pain between those osteoarthritic tears and the osteoarthritic knees without tears.

[26] [1985] HCA 37.

121. I did not find the paper in the *Journal of Bone Surgery* to be of assistance. In this case, Ms Matthews clearly had meniscal tears and pain. Dr Smith made reference to other literature published regarding various trials and statistics about knee injuries. Whilst such papers are of theoretical interest, I prefer to deal with the practical issues thrown up by Ms Matthews' case.

122. Accordingly, I do not accept Dr Smith's opinion that the arthroscopy of January 2010 had "cured" the left knee medial meniscal tear. It was contradicted by both Dr Wilding and Dr Caldwell.

123. Dr Caldwell on 29 October 2010 expressed the reservations that were indeed later expressed by Dr Leicester himself that a medial meniscectomy in the presence of medial compartment osteoarthritis would not be of much benefit in the presence of bone on bone osteoarthritis. Dr Caldwell's view at that stage was of "mildly osteoarthritic knee which was markedly aggravated by an accident at work."

124. The nature of the accident was described by Ms Matthews in her statement and I accept Dr Pillemer's view that the mechanics of the subject injury were significant. Ms Matthews had been forced to take the full weight of a female resident who had collapsed on her after suffering a stroke, and Ms Matthews' left knee had been pinned under the bed.

125. Dr Wilding was also supportive of Ms ~~Matthews'~~ case in November 2011. He was satisfied that Ms Matthews' symptoms had not settled, neither was he surprised in view of the degree of osteoarthritis found and the "well-recognised" proposition that a medial meniscal tear and partial medial meniscectomy will "accelerate the progression of degenerative change in the knee." Dr Wilding also contradicted Dr Smith's opinion that the meniscal tear had been "cured".

126. I accept the evidence contained in the statement of Ms Matthews. She said that on 16 July 2013 Dr Leicester advised her that another arthroscopy would not help her and that she was headed towards knee replacement when the pain became severe and intolerable. In his report of 16 July 2013 Dr Leicester noted that Ms Matthews thought she could manage a little longer on her two days a week on light duties. When those duties were withdrawn in August 2013, Ms Matthews said that she continued to have ongoing pain and disability in her left knee which gradually worsened as time went by.

127. It follows that the opinion of Dr Smith is unsupported by any of the other medical opinions before me. I am unable to accept Dr Smith's opinion, with respect, that the first meniscectomy of 19 January 2010 "cured" her condition. It may be that Dr Smith was influenced by the fact that Ms Matthews continued to work with the respondent (albeit on light duties) and thought that she had accordingly recovered completely following the meniscectomy. As I have indicated, the evidence does not sustain that inference, and indeed it is not supported by any other medical practitioner.

128. Dr Smith allowed that there had been an aggravation of Ms Matthews' degenerative condition, but he qualified that submission by saying that there were many aggravations. He said that it was even "possible" that she had aggravated that condition from time to time prior to 22 July 2009, the date of the subject incident. As I indicated in considering Mr Grimes' submissions, there was no evidence upon which that opinion was based, and Mr Grimes did not press it. As to any aggravation following the subject incident, Dr Smith approached the subject by accepting that walking any distance, kneeling, squatting and an enormous variety of different activities of daily living would constitute aggravation. However, he said they would come and go.

129. There is no evidence that Ms Matthews' left knee ever became symptom free and I am not able to accept Dr Smith's thesis that in fact there were many aggravations, which ceased and were renewed by the activities of daily living. I accept the opinion of Dr Pillemer who found unequivocally that the subject injury aggravated Ms Matthews' underlying osteoarthritic condition. Ms Matthews stated that her left knee pain and symptoms had become progressively worse over time since her injury in July 2009. No reason has been advanced that would dissuade me from accepting Ms Matthews as a witness of truth.

130. No submissions have been put that the proposed surgery is inappropriate, or that there are alternative treatments which could also be effective. It has not been suggested that the cost of the recommended surgery is unreasonable, nor that the treatment has no potential or actual effectiveness. Indeed the total knee replacement has been recommended since 2011. There was no dissent amongst the medical practitioners in the case – not even Dr Smith – that the treatment was appropriate and likely to be effective.[27]

131. I am satisfied that Ms Matthews suffered an injury on 22 July 2009 to her left lower extremity, namely her knee. I am satisfied that the incident itself caused the tear of her medial meniscus and that it aggravated Ms Matthews' underlying constitutional osteoarthritic condition, which had been largely asymptomatic. The severity of the accident itself caused the immediate onset of Ms Matthews' symptoms and her duties were the main contributing factor to her injury, and certainly a substantial contributing factor, which Mr Halligan submitted was the appropriate test..

132. I accept Mr Matthews' statement that she did not remember complaining to Dr Haque about a minor injury she had to her knee on 18 July 2008 which she said did not cause swelling or restrict the motion of her knee. I accept also that the partial meniscectomies of 19 January 2010 and 18 December 2012 may well have accelerated the progress of her osteoarthritic condition.

SUMMARY

133. I find that Ms Matthews' employment was a substantial contributing factor to her injury. Indeed I am satisfied that it was the main contributing factor.

134. I find therefore that Ms Matthews suffered an injury on 22 July 2009 in the form of a torn left medial meniscus and the aggravation of her pre-existing degenerative osteoarthritis.

135. I find that the proposed surgery by Dr Hartnell is reasonably necessary.

136. Accordingly, the respondent will pay the costs of and associated with the total left knee replacement surgery recommended by Dr Nick Hartnell on 29 January 2019.

[27] See *Diab v NRMA Ltd* [2014] NSWWCCPD 72 per DP Roche at [88].