WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **3634/19**
Applicant: **Marion Hester**
Respondent: **Georges River Council**
Date of Determination: **12 September 2019**
CITATION: **[2019] NSWWCC 300**

The Commission determines:

1. The applicant did not sustain an injury to her lower back on 19 January 2011 when she fell in the course of her employment with the respondent.

2. The applicant has a consequential condition affecting her lower back, as a result of the injury sustained to her left knee on 19 January 2011.

3. A lumbar laminectomy and L3/4 fusion to the applicant's lower back as proposed by Dr Davies is reasonably necessary.

4. The applicant has a consequential condition affecting her left shoulder, as a result of the injury sustained to her left knee on 19 January 2011.

5. A left total shoulder replacement as proposed by Dr Damiani is reasonably necessary.

6. The provisions of section 59A of the *Workers Compensation Act 1987* prevent the respondent from being required to meet the cost of surgery to release tendons in the long and ring fingers of the left hand.

The Commission orders:

1. Pursuant to sections 60 (5) and 61 (4A) of the *Workers Compensation Act 1987*, the respondent is to pay the applicant's costs of the lumbar laminectomy and L3/4 fusion as proposed by Dr Davies.

2. Pursuant to sections 60 (5) and 61 (4A) of the *Workers Compensation Act 1987*, the respondent is to pay the applicant's costs of the total left shoulder replacement surgery as proposed by Dr Damiani.

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

John Isaksen
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 ISAKSEN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

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Senior Dispute Services Officer

As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The respondent, Georges River Council, concedes that the applicant, Marion Hester, sustained an injury to her left knee on 19 January 2011, when she tripped on a ream of paper when working at the Penshurst Long Day Care Centre.

2. The respondent has met liability for four operations performed by Dr Rowden that the applicant has undergone on her left knee as a result of that injury as follows:

    (a) A total left knee replacement on 6 June 2011;
    (b) An arthroscopy on 31 October 2011;
    (c) A further arthroscopy on 3 November 2014;
    (d) A revision of the total left knee replacement on 11 May 2015.

3. In notices dated 16 December 2016 and 31 March 2017, the respondent disputes that the applicant sustained an injury to her lower back in the incident on 19 January 2011 or that the applicant has a consequential condition affecting her lower back as a result of the injury sustained on 19 January 2011.

4. The respondent has denied a claim made by the applicant that the respondent meets the cost of a lumbar laminectomy and L3/4 fusion which is recommended by her treating specialist, Dr Davies, as a result of the injury of 19 January 2011.

5. In notices dated 31 May 2018 and 5 September 2018, the respondent disputes that the applicant has a consequential condition affecting her left shoulder and the long and ring fingers of her left hand as a result of the injury sustained on 19 January 2011.

6. The respondent has denied a claim made by the applicant that the respondent meets the cost of a total left shoulder replacement and surgery to release tendons in the long and ring fingers of her left hand which is recommended by her treating specialist, Dr Damiani, as a result of the injury of 19 January 2011.

ISSUES FOR DETERMINATION

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

    (a) Whether the lumbar laminectomy and L3/4 fusion recommended by the applicant's treating specialist, Dr Davies, is reasonably necessary as a result of the injury received by the applicant on 19 January 2011.

    (b) Whether the total left shoulder replacement and surgery to release tendons in the long and ring fingers of her left hand recommended by the applicant's treating specialist, Dr Damiani, is reasonably necessary as a result of the injury received by the applicant on 19 January 2011.

    (c) Whether the provisions of section 59A of the *Workers Compensation Act 1987* (the 1987 Act) prevent the applicant having the cost of surgery to release tendons in the long and ring fingers of her left hand met by the respondent.

PROCEDURE BEFORE THE COMMISSION

8. The parties attended a conference and hearing on 5 September 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.

9. Mr Steven Hickey appeared for the applicant, instructed by Ms Lawes. Mr David Saul appeared for the respondent, instructed by Ms Maioulo.

EVIDENCE

Documentary Evidence

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

    (a) Application to Resolve a Dispute and attached documents;

    (b) Reply and attached documents;

    (c) Application to Admit Late Documents filed by the applicant on 29 August 2019.

Oral Evidence

11. There was no application to cross examine the applicant or adduce oral evidence.

FINDINGS AND REASONS

Whether the applicant sustained an injury to her lower back in the subject incident on 19 January 2011

12. In her statement dated 27 September 2018 the applicant states:

> "When I tripped over the ream of photocopy paper I fell unexpectedly to the hard floor. I didn't have time to brace myself. The first thing that happened was both knees hit the floor with my left knee taking a more significant load on impact. I then fell forward and I tried to put out my left hand to break the fall. That was somewhat successful as my face didn't smash into the ground but I still had a very severe jarring and I felt pain in my neck and lower back as well as obviously in both knees. I couldn't work on and I had to see medical attention and initially the focus was on the left knee."

13. This statement is made almost eight years after the event in question. The contemporaneous material that is in evidence provides no assistance in a finding that the applicant did sustain an injury to her lower back when she fell at work on 19 January 2011.

14. The Employee Claim Form which the applicant completed on 1 February 2011 states that the injuries suffered were "soft tissue to left knee and neck" and the parts of the body that were affected were "neck, left knee, left leg". There is no mention of the lower back.

15. There are no clinical notes in evidence from the general practitioner whom the applicant attended upon following the injury. A clinical history recorded for an x-ray of the cervical spine and left knee on 24 January 2011 records: "slipped and fell onto knee and jarred neck."

16. The history recorded on 4 March 2011 by Dr Rowden, whom the applicant was referred to for treatment for her left knee, includes: "tripped over a ream of paper that had been put on the floor at work landing on left knee and jerking the neck." There is reference to back pain but does not record that as occurring at the time of the fall.

17. The applicant was examined by Dr Powell some three months after the incident at work on 8 April 2011, at the request of the respondent, and in a report of that same date it is recorded

that the applicant "was aware of pain in the left knee and neck" immediately after she fell. Dr Powell also records the applicant being "aware of some pain affecting the lower back and left buttock" but, like Dr Rowden, does not record that as occurring at the time of the fall.

18. Mr Hickey for the applicant did not refer me to any evidence within the first few months of 19 January 2011 that would support a finding that the applicant did sustain an injury to her lower back.

19. Although the applicant states that following the incident on 19 January 2011 "the focus was on the left knee", that did not preclude her from providing a history to a number of doctors within the first few months of that incident that she had also sustained an injury to her neck. Yet no record was made by those doctors of any injury to the lower back.

20. The available evidence does not allow me to be satisfied, on the balance of probabilities, that the applicant did sustain an injury to her lower back when she fell on 19 January 2011.

Whether the applicant's lower back condition is as a consequence of the injury she sustained to her left knee on 19 January 2011

21. The applicant underwent a L4 and 5 laminectomy and L4/5 posterior lumbar interbody fusion, performed by Dr Davies, in January 1997.

22. Dr Davies continued to review the applicant for over two years following that surgery. In February 1999 he records that the applicant continued to have back and bilateral shooting leg pain. In May 1999 he records the applicant was still taking six Panadeine Forte per day and referred to an MRI scan which records "some mild lateral recess stenosis at the L3/4 level."

23. The applicant states that she made a good recovery from this lower back surgery and was able to live an active life, including snow skiing with her grandchild. The applicant was able to return to her work and undertake her usual duties in a part time capacity as an administration assistant in a child-care centre until she sustained the injury to her left knee on 19 January 2011.

24. The applicant states that she started using a walking stick within a few weeks or months of the injury to her left knee. She states that following the second knee replacement surgery in May 2015 her mobility "went backwards" and she also started to use Canadian crutches and a rollator to assist with her walking and mobility. She states: "I virtually always used one of these aids" after that surgery in May 2015.

25. The applicant does not provide her own evidence as to how her gait or walking patterns have changed since the injury of 19 January 2011.

26. The applicant does not provide her own evidence as to the progression of her lower back pain after the injury on 19 January 2011. However, the medical evidence indicates that by the beginning of 2016 the condition of the applicant's lower back had become serious enough to warrant investigations and treatment for this condition.

27. An MRI scan requested by Dr Rowden and dated 16 January 2016 records severe central canal stenosis at the L3/4 level.

28. Dr Rowden writes to the insurer for the respondent on 2 February 2016 that:

> "It is possible altered gait, following knee replacement has aggravated the stenosis noted on MRI scan, resulting in significant limitation of mobility which is impacting negatively on her post operative progress."

29. The applicant is referred to A/Prof Boesel for pain management and he records in a report dated 11 March 2016 that:

> "I would expect that her lumbar spine adjacent segment failure has probably been significantly accelerated by a combination of weight gain caused by immobility and abnormal gait caused by ongoing knee pain."

30. The applicant ultimately returned to see Dr Davies on 22 August 2016, after the passage of some 17 years. Dr Davies records the applicant having a worsening of back and bilateral leg pain over the previous four years and that she had been using a walking frame or sticks for the past 12 months. On examination he found that the applicant walked in a flexed posture with a rollator frame. He records that the applicant "is completely reliant on a rollator frame or crutches."

31. Dr Davies writes:

> "Part of Marion's walking problem is secondary to her knee pain and swelling. I believe her dominant problem at present is probably her neuropathic leg symptoms secondary to lumbar spinal canal stenosis at the L3/4 level."

32. Dr Davies recommended a lumbar laminectomy and an extension of lumbar internal fixation and fusion to the L3/4 level.

33. Dr Davies also provided a response on 15 October 2016 to questions asked by the insurer for the respondent. Dr Davies writes that the radicular leg pain that is secondary to canal stenosis at the L3/4 level is of "mixed causation." He writes that it is due to a progression of degeneration at the site of the previous surgery in 1996, which is due to inevitable age related degenerative changes and the fusion increasing the risk of adjacent segment disease. He writes that there was a degree of largely asymptomatic canal stenosis before the injury sustained by the applicant in 2011.

34. Dr Davies also writes that the secondary gait impairment following the fall in 2011 has accelerated degenerative changes at the L3/4 level and led to the development now "of symptomatic L3/4 canal stenosis." He concludes that "the work injury 2011 has probably accelerated onset of symptom at L3/4."

35. The applicant attended Dr New, orthopaedic surgeon, at the request of her solicitors on 20 February 2017 and has provided a report dated 23 February 2017. Dr New records that the applicant had "a minor injury to her lumbar spine" on 19 January 2011 and that there was a gradual progression of back pathology following the second knee replacement in May 2015 with a gain of approximately 35kg in weight and walking on Canadian crutches. Dr New opines:

> "There is certainly no doubt that she had a well described workers compensation condition in 1996 which has been well treated. The natural history of that is such that she was coping well with her permanent part-time work until 2011. There has been a significant acceleration of her back and leg pain since that time, complicated by the profound gait abnormality as a result of her workers compensation approved left knee pathology, as well as significant weight gain."

36. Dr New also states that he concurs with Dr Davies on the need for the applicant to have revision spinal surgery.

37. The applicant attended Dr Powell, orthopaedic surgeon, at the request of the respondent on five separate occasions between April 2011 and May 2018. I have already referred to the record made by Dr Powell in April 2011 of "some pain affecting the lower back and left buttock."

38. At the third attendance by the applicant in February 2014 Dr Powell records the applicant having a steady deterioration of her lower back over the past few years. At the fourth attendance by the applicant in March 2015 (which is just prior to her second knee replacement surgery), Dr Powell records that the applicant's lumbar spine "has been aggravated by the increasingly antalgic gait resulting from the chronic left knee pain."

39. When Dr Powell examines the applicant on the fifth and final occasion in May 2018, his diagnoses of injury includes advanced degenerative change in the lumbar spine with adjacent segment disease at L3/4 with associated spondylolisthesis on a background of a previous posterior instrumented fusion at L4/5 undertaken in the 1990s. In a supplementary report dated 4 January 2019, Dr Powell opines:

> "I have considered all the available information and maintain my opinion that the lumbar spine condition is not secondary or consequential to the initial left knee injury. If one objectively considers the extent of the significant pre-existing and long-standing pathology in the lumbar spine and the concept of adjacent segment disease versus any possible alteration in biomechanics related to altered gait secondary to a knee injury, it is quite clear that it is the former point that predominates in relation to the subsequent progression of pathology and need for surgery."

40. The applicant also attended Dr Cochrane, neurosurgeon, at the request of the respondent in December 2016. Dr Cochrane records a history of the applicant having a flare up of low back pain around May 2015. He opines that the applicant has age-related degenerative changes in her lumbar spine and has developed adjacent segment disease which is to be expected with her high body mass index and previous surgery to her lumbar spine. However, he also opines: "there may have been a degree of acceleration of her pre-existing degenerative spinal condition because of her knee injury, gait alteration, use of crutches and the like."

41. Dr Cochrane did not consider that the applicant's weight gain had been caused by immobility but rather a relative excess of caloric intake relative to expenditure. Dr Cochrane does state:

> "I fully concede that the work-related knee injury would alter gait and this would conceivably accelerate her lumbar spinal degenerative condition… However, noting the workers compensation definitions of "substantial contributing factor", I do not believe that the gait alteration could reasonably considered as the *substantial* contributing factor when other more substantial contributing factors (previous surgery and adjacent segment degeneration, general lumbar spine degenerative problems, body mass index in the morbidly obese range) are far more pertinent."

42. The determination of whether a pathological condition suffered by a worker is as a consequence of a work injury was considered by DP Roche in *Moon v Conmah Pty Limited* [2009] NSWWCCPD 134 (*Moon*). In that matter the worker claimed whole person impairment from symptoms experienced in the left shoulder as a consequence of an accepted injury to the right shoulder. DP Roche said at [45-46]:

> "It is therefore not necessary for Mr Moon to establish that he suffered an 'injury' to his left shoulder within the meaning of that term in section 4 of the 1987 Act. All he has to establish is that the symptoms and restrictions in his left shoulder have resulted from his right shoulder injury. Therefore, to the extent that the Arbitrator and Dr Huntsdale approached the matter on the basis that Mr Moon had to establish that he sustained an 'injury' to his left shoulder in the course of his employment with *Conmah* they asked the wrong question.
>
> The test of causation in a claim for lump sum compensation is the same as it is in a claim for weekly compensation, namely, has the loss 'resulted from' the relevant work injury (see *Sidiropoulos v Able Placements Pty Limited* [1998] NSWCC 7; (1998) 16

NSWCCR 123; *Rail Services Australia v Dimovski & Anor* [2004] NSWCA 267; (2004) 1 DDCR 648)."

43. Deputy President Roche then proceeded to state that the expression "results from" should be applied using the principles set out by Kirby P in *Kooragang Cement Pty Limited v Bates* (1994) 35 NSWLR 452 (*Kooragang*) which includes at 463-4: "a common sense evaluation of the causal chain."

44. I consider that the best evidence and opinion in regard to the causal chain between the injury the applicant sustained to her left knee and the consequential condition affecting her lower back is provided by the specialist who has treated the applicant throughout the time that she has had problems with her lower back, namely Dr Davies. Dr Davies is in the unique position of having performed surgery on the applicant's lower back in 1997, monitored her progress for the ensuing two years, and then has had to review her condition and the appropriate treatment when there was a worsening of symptoms in her lower back which occurred after the injury the applicant sustained in January 2011.

45. I consider that Dr Davies gives due and proper consideration to the reasons for the increase in the applicant's lower back symptoms and bilateral leg pain which then forms his opinion that her gait impairment, which is due her work injury, has accelerated the degenerative changes at the L3/4 level, even though he concedes that those symptoms have also been caused by age related degeneration and the increased risk of segment disease adjacent to the fusion site from the 1997 surgery.

46. I reject a submission made by Mr Saul that Dr Davies' opinion is compromised by emphasising the effect of altered gait and not acknowledging the effect of abnormal pressure being placed on the L3/4 level by the surgery that was performed in 1997. Dr Davies does consider that in his response to StateCover Mutual dated 15 October 2016 and opines that the lower back symptoms and bilateral leg pain is of "mixed causation." He ultimately opines that the applicant's gait impairment has been a cause for the accelerated degenerative changes at the L3/4 level.

47. I prefer and accept that opinion of Dr Davies. It is an opinion supported by another treating specialist, A/Prof Boesel, who opines that the applicant's lumbar spine adjacent failure has been accelerated by her abnormal gait, and by an experienced orthopaedic surgeon, Dr New, who opines that the applicant's back and leg pain have been "complicated" by her profound gait abnormality.

48. That causal connection is also given qualified support by Dr Cochrane who concedes that "there may have been a degree of acceleration of her pre-existing degenerative spinal condition because of her knee injury, gait alteration, use of crutches and the like." Even Dr Powell does not rule out the effect of abnormal gait upon the applicant's lower back symptoms. He identifies the significant pre-existing and long-standing pathology in the lumbar spine as the predominant cause for the progression in lower back symptoms and the need for surgery but does write that the condition of the lumbar spine "has been aggravated by the increasingly antalgic gait resulting from the chronic left knee pain."

49. There can be multiple reasons for a pathological condition. As DP Roche in *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49 (*Murphy*) said at [57]:

> "…a condition can have multiple causes (*Migge v Wormald Bros Industries Ltd* (1973) 47 ALJR 236; *Pyrmont Publishing Co Pty Ltd v Peters* (1972) 46 WCR 27; *Cluff v Dorahy Bros (Wholesale) Pty Ltd* (1979) 53 WCR 167; *ACQ Pty Ltd v Cook* [2009] HCA 28 at [25] and [27]; [2009] HCA 28; 237 CLR 656)."

50. In my view, the evidence as a whole supports a finding that the applicant's lower back condition is a consequence of the injury she sustained to her left knee on 19 January 2011, due to the significant alteration of her gait because of that knee injury and subsequent operations.

51. Dr Davies does not refer to the applicant's weight gain as a cause for increase in lower back symptoms, although it is referred to as a cause by A/Prof Boesel and Dr New. Mr Saul submits that the applicant's weight gain is a cause for her increase in lower back symptoms but that does not result from her knee injury because a review of the medical evidence reveals that unfortunately the applicant has battled with weight issues before the 2011 injury. In a report dated 8 September 1998, Dr Davies writes that the applicant "needs to seriously loose weight" and recommends her seeing a dietitian.

52. I cannot be satisfied that the applicant's weight gain since her injury in January 2011 has been due to that injury, which has in turn been a cause of deterioration at the L3/4 level. The opinions of both A/Prof Boesel and Dr New are based upon them both recording that the applicant having gained 35 kilograms in weight since the subject injury. A review of the medical records reveal that when the applicant first attended Dr Rowden on 4 March 2011, the applicant's weight is recorded at 79 kilograms. At a consultation with her general practitioner, Dr Koumoulas, on 8 December 2015, some three months before she sees A/Prof Boesel, the applicant is recorded as having her weight at 98 kilograms. I accept that is a significant increase in weight over four and a half years but not nearly the weight increase which is accepted by A/Prof Boesel and Dr New and which forms the basis of their opinions that the applicant's increase in weight has been a cause of deterioration at the L3/4 level.

Whether the applicant's need for surgery to her lower back results from the injury of 19 January 2011

53. Mr Saul for the respondent submits that even if I were to accept that the applicant's lower back condition is as a consequence of her left knee injury, the effects of the left knee injury do not materially contribute to the need for surgery that has been recommended by Dr Davies. That is the test which is set out in the decision already referred to of *Murphy*. DP Roche said at [57-58]:

> "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 28 at [25] and [27]; [2009] HCA 28; 237 CLR 656). The work injury does not have to be the only, or even a substantial, cause of the need for the relevant treatment before the cost of that treatment is recoverable under s 60 of the 1987 Act.
>
> Ms Murphy only has to establish, applying the commonsense test of causation (*Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796), that the treatment is reasonably necessary "as a result of" the injury (see *Taxis Combined Services (Victoria) Pty Ltd v Schokman* [2014] NSWWCCPD 18 at [40]–[55]). That is, she has to establish that the injury materially contributed to the need for the surgery (see the discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716)."

54. Mr Saul refers to the opinions of both Dr Powell and Dr Cochrane who opine that the applicant's gait alteration does not materially contribute to the reason for the applicant to undergo surgery. Dr Powell opines that the significant pre-existing and long-standing pathology in the lumbar spine "predominates in relation to the subsequent progression of pathology and the need for surgery." Dr Cochrane opines that gait alteration is not a substantial contributing factor when compared with factors that are – previous surgery,

general degeneration of the lumbar spine, and morbid obesity (the latter being unrelated to the effects of injury).

55. Mr Saul submits that the need for surgery to the lower back (and also the left shoulder, which I have yet to address) is due to osteoarthritis which effects many parts of the applicant's body. This is identified not only in examinations undertaken by Dr Powell over several years but also in material from a general practitioner, Dr Ibrahim. In a referral letter for treatment of the applicant's left knee from Dr Ibrahim to Dr Kirsh dated 18 February 2011, a past history is noted of osteoarthritis in March 2010 and spinal stenosis in August 2010.

56. Dr Davies does not specifically address the question as to whether the effects of the work injury materially contribute to the need for surgery which he recommends. However, it is not uncommon for treating specialists to provide opinions that are not expressly in the terms of the workers compensation legislation. DP Roche in *State Transit Authority v El-Achi* [2015] NSWWCCPD 71 *(El-Achi)* at [72] said:

> "That a doctor does not address the ultimate legal question to be decided is not fatal. In the Commission, an Arbitrator must determine, having regard to the whole of the evidence, the issue of injury, and whether employment is the main contributing factor to the injury. That involves an evaluative process."

57. I have preferred the opinions expressed by Dr Davies because of his long history of treatment and observation of the applicant. Dr Davies specifically identifies the applicant's altered gait as having accelerated the onset of symptoms at the L3/4 level. That, in my view, amounts to a material contribution to the need for surgery which seeks to ameliorate those symptoms in the lower back by way of a laminectomy and extension of the previous fusion to the L3/4 level.

58. There is other evidence which supports this conclusion. Although there is reference in the referral letter from Dr Ibrahim in February 2011 of a past history of osteoarthritis and spinal stenosis in 2010, the applicant was able to undertake her work duties for well over 10 years after her spinal surgery in 1997. There is no evidence from the respondent which casts any doubt on the applicant's ability to perform her work duties due to any problems with her lower back for many years following the spinal surgery in 1997, until the left knee injury in January 2011.

59. The applicant states that she lived an active life following the lower back surgery in 1997. The applicant did not have the need to return to Dr Davies for some 17 years. That provides a reasonable inference that the applicant was coping well with her lower back following her spinal surgery. It is only after the injury in January 2011 that there is a progression of lower back pain which warrants an MRI scan (which reports severe canal stenosis at the L3/4 level), referral to a pain management specialist, and referral back to Dr Davies.

60. In my view, Dr Cochrane fails to properly consider the history of problems the applicant has had with her lower back. Firstly, Dr Cochrane fails to consider the significance of the applicant having no significant problems with her lower back between the spinal surgery in 1997 and the January 2011 injury. Secondly, he fails to fully consider the increase in symptoms in the applicant's lower back which occur after the injury to the left knee and two total knee replacement operations, particularly after the second operation in May 2015. Dr Cochrane states that the applicant "inconsistently commented on back pain" over those years but then only chooses to refer to Dr Powell's reports, and not any material from treating doctors. He then provides the opinion that: "it is reasonable to conclude that at some stage in her life she would have required the surgery which Dr Mark Davies is recommending with or without the subject work-related injury."

61. A similar criticism is made in regard to the opinion provided by Dr Powell as it relates to the applicant's lower back, although his reports are generally more focussed on the condition of

the applicant's left knee, shoulders and neck. When Dr Powell sees the applicant in March 2015 he notes ongoing complaints of pain in the lower back but with no further investigation, treatment or specialist review. When the applicant next sees Dr Powell some three years later, after a second total knee replacement and an increase of symptoms that warrant referral back to Dr Davies, there is no consideration in that report of what has occurred to the applicant over those three years other than to report "the return of chronic lower back pain."

62. I am satisfied that the left knee injury in January 2011 materially contributes to the need for lower back surgery because of the opinion of Dr Davies that, notwithstanding his concession that there has been degeneration at the L3/4 level due to the effects of age and the adjacent segment disease, the applicant's altered gait from that injury has accelerated that degeneration, and that the evidence reveals that the applicant's altered gait has coincided with a deterioration of her lower back following the injury to her left knee.

Whether the surgery to the lower back proposed by Dr Davies is reasonably necessary

63. The respondent concedes that the surgery proposed by Dr Davies is appropriate. Dr Cochrane opines that the surgery is "reasonable and necessary."

64. The respondent also concedes that as the surgery involves internal fixation, which is the provision of treatment by an artificial aid, that treatment meets the exception provided by sub-section (6)(a) of section 59A of the 1987 Act, which would otherwise bar the applicant from having this surgery met by the respondent.

65. There will therefore be an order that pursuant to section 60 (5) of the 1987 Act, the respondent is to pay for the cost of a lumbar laminectomy and L3/4 fusion proposed by Dr Davies.

Whether the applicant's left shoulder condition is as a consequence of the injury she sustained to her left knee on 19 January 2011

66. The applicant states that following the second knee replacement surgery in May 2015 her mobility "went backwards" and she also started to use Canadian crutches and a rollator to assist with her walking and mobility. She states: "I virtually always used one of these aids" after that surgery in May 2015. She states: "Both the crutches and rollator, when used, always put significant pressure and strain on my hands, wrists, arms and shoulders." The applicant states that both shoulders take the pressure when using the crutches and rollator, but the left shoulder is significantly worse than the right shoulder.

67. The applicant underwent an ultrasound of the left shoulder in July 2012, some 18 months after the work injury. That ultrasound reports tendinosis and bursitis in the left shoulder.

68. The applicant underwent another ultrasound of both shoulders in July 2013, which reports a full thickness tear in the left shoulder.

69. There is a report from Dr Rowden dated 5 August 2015 which reports the applicant having "sore joints, especially in the shoulders."

70. The report of A/Prof Boesel dated 11 March 2016, which has already been referred to, identifies "bilateral shoulder pathologies and some ulnar nerve pathology related to chronic crutch and rollator frame use."

71. An MRI scan of the left shoulder dated 24 November 2017 reports severe osteoarthritis of the glenohumeral joint.

72. The applicant was referred to Dr Damiani, a hand and upper limb surgeon, in January 2018. Dr Damiani records the applicant using a walking stick since the work injury and using

Canadian crutches and a wheelie frame since her second total knee replacement surgery in May 2015. He records that the applicant mentioned she had no problems with her left shoulder before the work injury. He refers to the MRI scan showing evidence of glenohumeral arthritis.

73. Dr Damiani recommends a left total shoulder replacement. He then writes:

> "In terms of how this fits in with her story, I believe that she has had a predisposition towards the arthritis from having a mildly retroverted glenoid. Also I believe however that her use of walking aids over the past 7 years has accelerated the wear on the posterior aspect of the shoulder. Without the knee injury I do not think she would have needed a shoulder replacement for at least another 15 years."

74. In a subsequent letter to the insurer for the respondent dated 7 February 2018, Dr Damiani opines that: "Without repetitive loading of her shoulder with walking aids, she may never have developed clinically significant arthritis in her shoulder."

75. In his first report dated 23 February 2017, Dr New takes a history of the applicant sustaining an injury to her left shoulder when she fell at work on 19 January 2011. There is, however, no other medical evidence which supports this, nor is it referred to by the applicant in her own statement dated 27 February 2018. The ARD claims an injury to the left arm, but not specifically to the left shoulder. For the sake of completeness, I find that the available evidence does not allow me to be satisfied that the applicant did sustained injury to her left shoulder when she fell on 19 January 2011.

76. In his second report dated 23 August 2018, Dr New takes a history of the applicant developing pain in her left shoulder in approximately 2015. In between the two consultations with Dr New, the applicant had attended Dr Damiani.

77. Dr New opines that:

> "It is my opinion that the medical treatment proposed by Dr Damiani is reasonable and necessary and causally related, on the balance of probabilities, to the injury dated 1 January 2011 and the consequential restrictions and difficulties this patient has faced since then.
>
> There is a particular emphasis on the use of crutches with her gross mobility restrictions due to leg conditions, additional weight gain and strain on her shoulders, arms and hands."

78. There is no reference to the applicant's shoulders in the first report of Dr Powell dated 8 April 2011.

79. Dr Powell does record symptoms in both shoulders in his next report dated 23 September 2013, those symptoms being "similar in character and location, though currently more severe on the left side."

80. In his next report dated 17 February 2014, Dr Powell reports no significant change to the applicant's bilateral shoulder symptoms, although they remain more severe on the left side.

81. In his next report dated 16 March 2015, Dr Powell reports that the applicant continues to complain of symptoms affecting both shoulders.

82. In his next report dated 8 May 2018, Dr Powell records that the applicant "complains of the insidious onset of bilateral shoulder symptoms." He then opines:

> "Though I acknowledge the prolonged use of mobility aids whilst rehabilitating from her series of left knee operations could result in aggravation of some underlying degenerative pathology in the shoulder, it is not sufficient to be considered the main contributing factor in either the development or aggravation of the advanced glenohumeral joint osteoarthritis which was evident on the recent MRI scan."

83. Dr Powell also notes in that report that on the occasions that he has examined the applicant, she has used a walking stick in her right hand and yet the right shoulder condition has not progressed in the intervening period.

84. In a final report dated 4 January 2019, Dr Powell opines:

> "I do not believe that the advanced degenerative pathology identified in the left shoulder has resulted from the initial left knee injury on 19 January 2011. This condition would have become symptomatic at or about the same time without the aggravation provided by the use of walking aids. Any such aggravation would have been minor."

85. Applying the principles that I have already referred to in *Moon*, I am satisfied that the restrictions and symptoms in the applicant's left shoulder have resulted from her left knee injury, in that the use of Canadian crutches and walking frame due to that injury and subsequent operations, have placed repetitive loading upon the left shoulder, which has then accelerated the arthritis found in that shoulder. That is the opinion of Dr Damiani, which I prefer and accept, given that he is the applicant's treating specialist and has the role of providing the best possible diagnosis and treatment for the applicant.

86. Dr Damiani has only seen the applicant since January 2018, and does not have the long association with the applicant that Dr Davies has for the treatment of her back, but from the very first time he sees the applicant, when he writes to the applicant's general practitioner, he draws the causal connection between the use of walking aids and the condition of her left shoulder.

87. That the use of Canadian crutches and walking frame places repetitive loading upon the applicant's left shoulder, thereby accelerating the effects of arthritis found in that shoulder, fits "a common sense evaluation of the causal chain" referred to in *Kooragang*.

88. Dr Powell does not initially rule out the same causal connection identified by Dr Damiani when Dr Powell concedes that the prolonged use of mobility aids could result in aggravating underlying pathology in the left shoulder, only that in his opinion "it is not sufficient to be considered the main contributing factor in either the development or aggravation of the advanced glenohumeral joint osteoarthritis." He then qualifies that opinion in a later report when he opines that the left shoulder would have become symptomatic at or about the same time without the aggravation provided by the use of walking aids.

89. I prefer the opinion of Dr Damiani, who from the outset identifies the causal connection between the use of walking aids and the condition of her left shoulder, over that of Dr Powell who initially provides a concession on this issue but then chooses, without any explanation, to disregard any effect the prolonged use of walking aids have had upon the applicant's left shoulder.

90. I am therefore satisfied that the applicant's left shoulder condition is a consequence of the injury she sustained to her left knee on 19 January 2011.

Whether the applicant's need for surgery to her left shoulder results from the injury of 19 January 2011

91. Mr Saul submits that the effects of the left knee injury do not materially contribute to the need for surgery that has been recommended by Dr Damiani. It is the same submission that he

makes in regard to the applicant's need for lower back surgery, namely that the predominant reason for undergoing the left shoulder surgery is due to the arthritic condition of her left shoulder which would have developed irrespective of the use of walking aids by the applicant.

92. That submission is supported by the opinion of Dr Powell, who writes:

> "I would consider it likely that Ms Hester is likely to have required a total shoulder replacement at this stage of her life, regardless of any contribution from factors associated with the workplace injury involving the left knee."

93. I have already expressed my preference for the opinion provided by Dr Damiani in his capacity as the applicant's treating specialist. A reading of the report he provides following his initial consultation with the applicant, and in a further letter to the insurer of the respondent, makes it clear that the use of walking aids, which involves repetitive loading upon the left shoulder, does materially contribute to the symptoms she has experienced in the left shoulder and which he now recommends can be improved by shoulder replacement surgery. He opines that but for the knee injury the applicant would not have needed shoulder replacement surgery for at least another 15 years.

94. There is other evidence to support this conclusion. The applicant states that she had no problems with her shoulders prior to the work injury in January 2011. There is no evidence to suggest otherwise. There is reference to general osteoarthritis in a referral letter from Dr Ibrahim in February 2011, but not a specific reference to the shoulders. The applicant does complain to Dr Powell in September 2013 of symptoms in her shoulders. At that time, she is using a walking stick, which Dr Powell later states was used with her right arm only.

95. When Dr Powell sees the applicant at examinations in September 2013, February 2014, and March 2015, he records bilateral shoulder symptoms, although more severe in the left shoulder. There is however an increase of symptoms in the left shoulder following the second total knee replacement surgery, which the applicant underwent in May 2015, and the prolonged use of either Canadian crutches or a walking frame thereafter. This is accurately identified in the history taken by Dr Damiani when he first sees the applicant in January 2018. The symptoms in the left shoulder had increased to such an extent from using those mobility aids for three years since the second total knee replacement surgery, that shoulder replacement surgery is now recommended for the applicant.

96. I therefore do not accept the opinion of Dr Powell that the applicant would have had symptoms in her left shoulder at this time in her life, irrespective of the use of mobility aids, because the evidence clearly reveals an increase of symptoms in the left shoulder due to the prolonged use of those aids, which is confirmed in the history taken and opinion expressed by Dr Damiani.

97. I am also not convinced that Dr Powell has a proper understanding of the way the walking aids are being used by the applicant to assist her with her mobility. In his report dated 8 May 2018, Dr Powell records that the applicant claimed aggravation of her shoulder conditions "on the basis of altered gait and having to use a walking stick." There is no record made in that report of the applicant's use of Canadian crutches and rollator, although Dr Powell does refer to "the prolonged use of mobility aids whilst rehabilitating."

98. In a supplementary report dated 30 May 2018, Dr Powell writes:

> "You have indicated that Ms Hester uses the right hand to hold the Canadian crutch and stick and this would be consistent with her presentation at several of my assessments, though I did not record on my most recent assessment what hand she was holding the stick in."

99. Dr Powell's opinion proceeds on an assumption that the applicant is using a walking stick or Canadian crutch only with her right hand, whereas the evidence which I accept from the applicant and the history taken by Dr Damiani, is that the applicant has been using both Canadian crutches and a walking frame since May 2015, which has involved repetitive loading upon both shoulders. It is that repetitive loading on the shoulders, which has been a cause of symptoms in the applicant's left shoulder.

100. I am therefore satisfied upon a review of all the evidence, and having particular regard to the opinion of the applicant's treating specialist, that the left knee injury in January 2011 materially contributes to the need for left shoulder surgery because of the repetitive loading upon the left shoulder from prolonged use of mobility aids, which has aggravated the arthritic condition of her left shoulder.

Whether the surgery to the left shoulder proposed by Dr Damiani is reasonably necessary

101. The respondent concedes that the surgery proposed by Dr Damaini is appropriate. Dr Powell opines that the surgery is "appropriate for the management of the pathology identified in the left shoulder."

102. The respondent also concedes that as the shoulder replacement surgery involves internal fixation, which is the provision of treatment by an artificial aid, that treatment meets the exception provided by sub-section (6)(a) of section 59A of the 1987 Act, which would otherwise bar the applicant from having this surgery met by the respondent.

103. There will therefore be an order that pursuant to section 60 (5) of the 1987 Act, the respondent is to pay for the cost of the total left shoulder replacement surgery proposed by Dr Damiani.

The claim for the cost of surgery to release tendons of the long and ring fingers proposed by Dr Damiani

104. When the applicant first attended Dr Damiani in January 2018, he found tenderness in the left ring finger consistent with a trigger finger.

105. When Dr Damiani again examined the applicant on 28 February 2018 he found that the triggering had spread to the left long finger. He writes in a report of same date:

> "In terms of the fingers, these are problems which are unlikely to settle down without surgery. The issue is that the fingers have not been approved as part of the shoulder injury. There is a risk however that after the shoulder surgery, there will be some increased swelling in the tendons which will increase the triggering and locking of the those fingers and may affect the rehab and return to work after surgery. It may be worthwhile considering releasing the triggering fingers at the same time which is something I can do rather than sending her to a separate specialist under a different anaesthetic. Clinically this would be a better option for her."

106. In a letter to the insurer for the respondent dated 7 March 2018, Dr Damiani opines that this triggering of the fingers of the left hand has been accelerated from the applicant's increased use of her hands to grip mobility devices.

107. In a report dated 8 May 2018, Dr Powell opines that that: "In the case of the trigger fingers, it is reasonable to accept this as a consequential injury related to the prolonged use of a walking stick."

108. However, in a supplementary report dated 30 May 2018, Dr Powell opines that although the prolonged use of mobility aids could potentially contribute to the subsequent development of a trigger finger, it is only relevant to the hand which holds the mobility aid. He opines that on

the assumption that that the applicant used her right hand to hold the Canadian crutch and walking stick, then the triggering of her left hand is not the result of holding a mobility aid. He concludes:

> "Where one hand is favoured, as is the case with the use of a single Canadian crutch or a stick, obviously that hand would be the one expected to develop the pathology.
>
> On balance, taking into account the information provided, I would adjust my opinion to conclude that there is insufficient evidence to link the current left hand triggering symptoms to her employment."

109. Dr Powell does, however, consider the surgery proposed by Dr Damiani on the fingers of the left hand to be reasonable.

110. Again, I prefer the opinion of the applicant's treating specialist, Dr Damiani, over that of Dr Powell because the opinion of Dr Damiani is based upon the applicant gripping the mobility aids that she uses for prolonged periods of time with both hands and not simply the right-hand that is assumed by Dr Powell. The opinion of Dr Damiani supports a finding that the triggering of the applicant's long and ring fingers of the left hand is as a consequence of the injury sustained on 19 January 2011 and materially contributes to the need for the surgery that is proposed by Dr Damiani.

111. The difficulty for the applicant, however, is that she is met with the provisions of section 59A of the 1987 Act. I have not been provided with a list of payments from the respondent but the submissions from both parties at the arbitration proceeded on the basis that the applicant, being now almost 70 years of age, needs to meet an exception provided in section 59A to have the respondent meet the cost of the three separate surgical procedures which the applicant seeks to undergo. In the case of the surgery to the lower back and left shoulder, this is met by those operations involving the provision of artificial aids. There is, however, no firm evidence that an artificial aid is required in the surgery that is recommended for the long and ring fingers of the left hand.

112. Dr Damiani does not provide any information in his report as to whether the proposed surgery requires an artificial aid. Dr New states that surgery for the triggering of fingers usually does not require artificial aids although the tendons are sometimes coated with anti-adhesion gel. That is mere speculation on the part of Dr New and, in any event, he is not the doctor who is going to undertake the proposed surgery.

113. Mr Hickey referred me to the Presidential decision of *Pacific National v Baldacchino* [2018] NSWWCCPD 12 (*Baldacchino*) in regard to the discussion of the term 'artificial aids' as it is applied in section 59A, but I found nothing in that decision that could extend the application of the term 'artificial aids' to the surgery that is proposed to the applicant's left hand. The proposed surgery does not fit the meaning of 'artificial aids' that was set out by Hutley JA in *Thomas v Ferguson Transformers Pty Ltd* [1979] 1 NSWLR 216, and confirmed in both the decisions of this Commission and Court of Appeal in *Baldacchino* that [at 220F-G]:

> "An artificial aid, in my opinion, is anything which has been specifically constructed to enable the effects of the disability (the result of injury) to be overcome."

114. Mr Hickey submits that the proposed surgery can fit the definition of 'secondary surgery', which is also an exception to the restrictions imposed by section 59A. 'Secondary surgery' is defined in section 59A (7) as:

> "(7) Surgery is **secondary surgery** if:
>
> (a) the surgery is directly consequential on earlier surgery and affects a part of the body affected by the earlier surgery, and

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

115. I do not accept that submission. The proposed surgery to the left hand is not directly consequential on any earlier surgery to the left knee. It may become consequential on the surgery to be undertaken on the left shoulder, and the fingers of the left hand are affected by that surgery. Indeed, Dr Damiani opines that following the left shoulder surgery there may be some increase in swelling of the tendons of those fingers which will increase their triggering and locking, which may well mean that the proposed surgery to those fingers meets the definition of 'secondary surgery'. However, that can only be ascertained after the applicant undergoes surgery to her left shoulder.

116. It might also be that following upon the applicant undergoing surgery to her lower back and left shoulder that she will be assessed as having permanent impairment which is more than 20% and can have the cost of the surgery to the left hand met by the respondent.

117. For those reasons, I do not propose to enter an award for the respondent for the claim made for the cost of surgery to the fingers of the left hand as it may be that there will be future circumstances which will allow the applicant to have the cost of that surgery met by the respondent. Despite the good intentions and logic of Dr Damiani to undertake the surgery to the fingers of the left hand at the same time he performed surgery on the left shoulder, the provisions of 59A of the 1987 Act do not allow me to make an order for that surgery to be met by the respondent at this point in time.