WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**2839/19**
Applicant:	**Eoin Collins**
Respondent:	**Evergreen Turf Australia Pty Ltd trading as Evergreen Turf Australia**
Date of Determination:	**22 October 2019**
Citation:	**[2019] NSWWCC 344**

The Commission determines:

1. The applicant suffered an injury in the course of his employment with the respondent on 28 May 2013 by way of aggravation to a previously asymptomatic cervical-thoracic syrinx.

2. The applicant's employment with the respondent was the main contributing factor to the aggravation referred to in one above.

3. The posterior fossa decompression surgery proposed by Professor Stoodley is reasonably necessary.

4. The respondent is to pay the costs of the posterior fossa decompression proposed by Professor Stoodley and associated treatment expenses.

5. In light of the complexity of this matter, there is to be a 25 per cent uplift in costs for both parties.

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

Cameron Burge
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 CAMERON BURGE, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Eoin Collins (the applicant) is a 32-year-old man born in Ireland who migrated to Australia in 2011. In August of that year he commenced employment with Evergreen Turf Australia Pty Ltd (the respondent) as second in charge of their sport surface construction and renovation department.

2. The applicant continued to work for the respondent up to and beyond 28 May 2013. On that date, at approximately 6.00 pm, the applicant was working at ANZ Stadium when, in the course of his employment, he fell approximately 1 metre from the back of a flatbed truck onto a concrete surface, suffering injuries to his neck, thoracic spine, lumbar spine, shoulders, bladder and bowel together with erectile dysfunction and vertigo.

3. In his statement, the applicant says he landed on his left-hand side, and felt immediate pain in both shoulders and his neck up into his head. Following his fall, the applicant had one day off work then returned to normal duties. He states he continued to work until approximately the end of January 2014, when the ongoing pain in his neck, back and arms became too much for him to cope with and he took 2.5 months away from work.

4. The applicant then had sporadic days away from work until approximately May 2015 when he took roughly eight weeks off work owing to his ongoing and worsening symptoms. He last worked for the respondent (and indeed at all) in September 2015. In his statement, the applicant says at paragraph 47 that following his injury and whilst he continued to work he suffered from the following problems:

   - Reduced motor function skills;
   - Difficulty getting into and out of a vehicle;
   - Interrupted sleep;
   - A lot of trouble writing;
   - Trouble walking for long periods of time;
   - Inability to run;
   - Unable to socialise;
   - Unable to sit for long periods of time and stand for long periods of time;
   - Inability to raise his arms above his shoulders;
   - Migraines;
   - Pins and needles in his back and up his right arm;
   - Numbness in his left fingers, and
   - Constant pain in his back, head, neck and right arm.

5. On 30 May 2013, the applicant attended Royal Prince Alfred Hospital with pain in his neck, back, right arm and pins and needles. He says he kept working through his injuries, notwithstanding the pain continued to increase. On 8 February 2014, he once again presented to Royal Prince Alfred Hospital (RPA). He says he had the same symptoms, but they had greatly increased in intensity, and accordingly he left work between 15 February 2014 and 31 March 2014 before returning to work on light duties. He said he had presented to RPA on many occasions since.

6. The applicant regularly attends his general practitioner, Dr Charteris and also Dr Patterson, pain specialist. He stated he has undergone intermittent nerve block injections and in February 2017 was admitted to Macquarie University Hospital for a Ketamine trial, which resulted in reduced back pain but made the symptoms in his legs worse, including leading to his being unable to properly stand on his own feet. That study was carried out by Dr Patterson in conjunction with Prof Stoodley, treating neurosurgeon. The applicant has also come under the care of Dr Leong, rehabilitation specialist.

7. Since the accident, the applicant has tried the following types of treatment:

- Multiple combinations of medication;
- Physiotherapy;
- Hydrotherapy;
- Other forms of physical therapy;
- Exercise programs;
- Ketamine trial;
- Pain management courses, and
- Psychologist intervention.

The applicant sets out his current symptoms at paragraph 46 of his statement. I do not propose to use them in these reasons, however, they are found from page 461 and following of the Application to Resolve a Dispute (the Application). He says that some of the treatments helped to a small extent, however, his pain and symptoms remain extremely debilitating and each type of treatment only benefits him for a few days a week, and leave him with the need to still consume a great deal of medication.

8. Prof Stoodley, who has treated the applicant for a number of years at Macquarie University Hospital, has offered him posterior fossa decompression surgery. The applicant brings these proceedings seeking the respondent pay for the cost of that surgery and associated expenses as a reasonably necessary medical expense pursuant to section 60 of the *Workers Compensation Act 1987* (the 1987 Act).

9. A claim was made for the cost of the proposed surgery, and on 8 August 2016, the respondent's insurer issued a section 74 notice disputing liability on the basis that the applicant's symptoms did not relate to a work injury, and also because the surgery was not reasonably necessary. Previous proceedings were instituted in 2017, and on 12 March 2018, Dr Michael Davies, Approved Medical Specialist (AMS) issued a non-binding Medical Assessment Certificate (MAC) providing an opinion to the effect that the applicant would obtain some benefit from the proposed surgery and it is reasonably necessary. Those proceedings were discontinued, and on 11 June 2019, the applicant's solicitors filed this Application.

10. The circumstances of this matter are somewhat unusual, in that Prof Stoodley who proposes to carry out the surgery expressly states that he does not strongly recommend it, but rather believes it is a reasonable course of action given the applicant is desperate to treat his debilitating symptoms.

11. There is no dispute the applicant suffers a syrinx in his cervical spine, which is a fluid collection inside the spinal cord and can be either of constitutional origin or alternatively caused by trauma in less common situations.

ISSUES FOR DETERMINATION

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

    (a) Whether the applicant's symptoms relate to the injurious event in the course of his employment with the respondent, and

    (b) Whether the proposed surgery is reasonably necessary.

PROCEDURE BEFORE THE COMMISSION

13. The parties attended a hearing on 30 August 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.

14. At the hearing, Mr B McManamey of counsel appeared for the applicant and Ms L Goodman of counsel appeared for the respondent.

EVIDENCE

Documentary evidence

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

    (a) The Application and attached documents;

    (b) The Reply and attached documents, and

    (c) The respondent's Application to Admit Late Documents dated 23 August 2019 and attached documents.

Oral evidence

16. No oral evidence was called at the hearing.

SUBMISSIONS

The respondent's submissions

17. Ms Goodman submitted the Commission would not prefer the opinion of Prof Stoodley, seeing as it is three years old, and no update had been provided.

18. Ms Goodman took the Commission to the opinion of Dr Darveniza, the applicant's independent medical examiner (IME) and noted he was alone in saying that the applicant's syrinx was post-traumatic in nature. She submitted the balance of the evidence is the syrinx is congenital, or alternatively it is of unknown aetiology. The other doctors, Ms Goodman submitted, are at variance as to whether the applicant's fall at work may have aggravated a previously asymptomatic syrinx.

19. In relation to Dr Darveniza's second report, Ms Goodman noted his view that surgery would not be helpful unless the syrinx had extended over time or the symptoms worsened, and submitted there was no medical evidence that in fact the syrinx had increased in size.

20. Ms Goodman noted Prof Stoodley's view that the fall was not the cause of the applicant's syrinx, but his ongoing symptoms were precipitated by it. Ms Goodman criticised this opinion of Prof Stoodley and noted that he did not spell out which symptoms in his view relate to the syrinx.

21. In relation to whether the applicant suffers from one or two syrinxes, Ms Goodman referred to the opinion of Dr Allan, treating neurosurgeon who referred to two syrinxes in his report found at page 5 of the Reply and dated 11 August 2014. She relied on the report and the opinion contained therein where Dr Allan stated that it was not appropriate to carry out any surgery on the applicant.

22. Ms Goodman also took the Commission to Prof Stoodley's first report at page 305 of the Application and noted his comment to the effect the applicant's upper limb symptoms were not associated with the syrinx. She asked a rhetorical question that if this is indeed the case, why would Prof Stoodley wish to operate on the applicant at all.

23. In terms of the opinion of Dr Davies, AMS, Ms Goodman impressed upon the Commission that it ought not accept his final view on the surgery, which she submitted stands in contrast to the balance of his report. In summary, Ms Goodman submitted that Dr Davies listed several reasons in his report as to why the surgery would not work and was not reasonably necessary, yet on balance reached a conclusion contrary to those same observations.

24. Ms Goodman submitted the Commission would prefer the views of Dr Cochrane, IME for the respondent and find that the surgery is both not reasonably necessary and any necessity for it has not arisen as a result of the injury at issue.

The applicant’s submissions

25. Mr McManamey noted the applicant was asymptomatic and healthy until he suffered the fall at issue, after which his condition has consistently deteriorated to the point where he suffers debilitating symptoms.

26. Mr McManamey submitted that nothing turns on whether one or two syrinxes are present, however, for the record he said the applicant's position was there was one syrinx which manifested itself in two places.

27. The real issue, Mr McManamey submitted, was the cause of the syrinx. He noted several opinions state its origins are idiopathic (unknown), however, there were also opinions to the effect that it was either caused or significantly aggravated by the fall.

28. In relation to Dr Darveniza’s opinion at the top of page 4 of the Application to the effect that a posttraumatic syrinx can arise spontaneously at the point of impact, Mr McManamey noted no medical professional retained in this case or who is treating the applicant contradicts that assertion.

29. Mr McManamey conceded that at the time Dr Darveniza examined the applicant, he thought the surgery would only be minimally helpful. This was, however, a point in time where the applicant suffered largely from pain, and Mr McManamey submitted the doctor's opinion leaves open the option of surgery in the event the applicant's condition worsened. He then submitted the evidence clearly establishes those symptoms have indeed worsened dramatically over time.

30. In relation to the report of Dr Leong, treating rehabilitation physician found at page 425 of the Application, Mr McManamey noted the doctor recorded a slight increase in the diameter of the syrinx upon an MRI examination in or about 2016, which he submitted was an accurate pathological sign of a worsening in the syrinx since initial studies were undertaken into it shortly after the applicant’s fall. Mr McManamey also impressed upon the Commission the opinion of Dr Leong found at page 436 of the Application to the effect that the applicant's symptoms relate to the syrinx.

31. Mr McManamey submitted that when one combines the opinions of Dr Leong, Professor Stoodley and Dr Darveniza, there is a compelling case the applicant's ongoing symptoms and the pathology are work-related.

32. Referring to Dr Cochrane, IME for the respondent, Mr McManamey submitted the Commission would not prefer his view given the way in which he had changed his opinion as to the aetiology of the syrinx. Moreover, Mr McManamey submitted Dr Cochrane does not provide an explanation as to why he believed any aggravation of a pre-existing syrinx had now ceased.

33. In summary, Mr McManamey submitted that the recent opinions of all the treating doctors conclude the applicant's symptoms are linked to the syrinx and those symptoms came about after the fall at issue. Applying a common-sense test of causation, Mr McManamey submitted that the Commission would find that the applicant's symptoms which necessitate the surgery were caused by the forward issue.

The respondent's submissions in reply

34. In reply, Ms Goodman submitted that the applicant must prove his case on the balance of probabilities. That is, she submitted he must satisfy the Commission that the symptoms are causally linked to the fall at work, and that the surgery is reasonably necessary.

35. Ms Goodman submitted that whilst this case was a very sad one, there is great uncertainty as to whether the surgery would benefit the applicant and accordingly he had not satisfied the onus of proof.

DISCUSSION

36. The two issues in dispute are whether the applicant's ongoing symptoms are related to the syrinx, and if so are they linked to the admitted injurious event; and whether the proposed surgery is reasonably necessary as a result of the workplace injury.

37. The first issue requires a determination as to the aetiology of the syrinx, and if pre-existing, whether there is any effect of the fall on it by way of aggravation, acceleration or exacerbation. The second requires an examination of the proposed treatment to determine whether it meets the requirements under section 60 of the 1987 Act.

38. The medical evidence in this matter is extensive, and I have carefully considered all of it. Given the voluminous nature of the documentation, I do not propose to recite a summary of all the reports, both treating and medicolegal. Rather, I propose to deal with the medical evidence only as it relates to the matters at issue, to the extent the opinions of the various doctors relate to those issues. Accordingly, opinions which relate to matters such as the applicant's capacity for employment will not be dealt with in the course of these reasons.

The aetiology of the syrinx and the effect of the fall on it

39. The applicant pleads his case in the alternative, namely as either a frank injury or the aggravation of an underlying and previously asymptomatic condition. On either basis, the contentious issue in this matter is one of causation of his current symptoms, namely whether they are the product of a congenital condition or of a workplace injury.

40. The applicant bears the onus of proving that his ongoing problems giving rise to the need for surgery are work-related. In determining the cause of an injury, the Commission must apply a common-sense test of causation. In the workers compensation context, the appropriate test for causation was set out by Kirby P (as he then was) in *Kooragang Cement Pty Ltd v Bates* (1994) 10 NSWCCR 796 (*Kooragang*) where his Honour said:

> "The result of the cases is that each case where causation is in issue in a worker's compensation claim, must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from', is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent death or injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. **What is required is a common-sense evaluation of the causal chain**. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation." (at 810; emphasis added)

41. "Injury" is defined in s 4 of the 1987 Act as follows:

> "In this Act: injury means
>
> (a) personal injury arising out of or in the course of employment,
> (b) includes a "disease injury", which means:
>
> (i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and
>
> (ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, and
>
> (c) does not include (except in the case of a worker employed in or about a mine) a dust disease, as defined by the Workers' Compensation (Dust Diseases) Act 1942, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined."

42. There is a useful review of the authorities concerning the issue of injury in *Castro v State Transit Authority* (NSW) [2000] NSWCC 12; (2000) 19 NSWCCR 496 ("Castro"). That case makes clear that what is required to constitute "injury" is a "sudden or identifiable pathological change". In Castro a temporary physiological change in the body's functioning (atrial fibrillation: irregular rhythm of the heart), without pathological change, did not constitute injury.

43. A worker is able to rely on injury simpliciter despite the existence of a disease. This is highlighted in *Zickar v MGH Plastic Industries Pty Ltd* (Zickar) [1996] HCA 31; 187 CLR 310. In that case, the worker suffered brain damage due to the rupture, at work, of a congenital aneurism. The congenital condition could be characterised as a disease, however that would not have satisfied the requirements of clause (b) of the definition in s 4. The worker succeeded in the High Court on the basis that the rupture itself could be described as an injury simpliciter. The Court held that the presence of a disease did not preclude reliance upon that event as a personal injury. Toohey, McHugh & Gummow JJ agreed with a passage in *Accident Compensation Commission v McIntosh* [1991] 2 VR 253 that, "it is nonetheless a rupture – something quite distinct from the defect, disorder or morbid condition, which enables it to occur" (at [262]). The terms "personal injury" and "disease" are not mutually exclusive categories. A sudden identifiable physiological (pathological) change to the body brought about by an internal or external event can be a personal injury and the fact that the change is connected to an underlying disease process does not prevent the injury being a personal injury."

44. Following the decision in Zickar, section 9A of the 1987 Act was introduced. The section relevantly provides:

> "No compensation is payable under this Act in respect of an injury (other than a disease injury) unless the employment concerned was a substantial contributing factor to the injury.
>
> Note: In the case of a disease injury, the worker's employment must be the main contributing factor. See section 4."

45. Subsection (2) of section 9A provides examples of matters to be taken into account in determining whether employment was a substantial contributing factor. The list, which is not exhaustive, has six examples:

    (a) the time and place of the injury,

    (b) the nature of the work performed and the particular tasks of that work,

    (c) the duration of the employment,

    (d) the probability that the injury or a similar injury would have happened anyway, at about the same time or at the same stage of the worker's life, if he or she had not been at work or had not worked in that employment,

    (e) the worker's state of health before the injury and the existence of any hereditary risks,

    (f) the worker's lifestyle and his or her activities outside the workplace.

46. Whether employment is a substantial contributing factor to an injury is a question of fact and is a matter of impression and degree (*Dayton v Coles Supermarkets Pty Ltd* [2001] NSWCA 153 at [29] (Dayton); *McMahon v Lagana* [2004] NSWCA 164 (McMahon) at [32]) to be decided after a consideration of all the evidence. See also *Workcover Authority of NSW v Walsh* [2004] NSWCA 186.

47. It is important to recognise in s 9A that the employment must be a substantial contributing factor to the injury, not to the incapacity, need for treatment or loss. In *Rootsey v Tiger Nominees Pty Ltd* [2002] NSWCC 48; (2002) 23 NSWCCR 725 Neilson CCJ stated "employment must be a substantial contributing factor to the event causing the injury; that is, to the receipt of the injury, rather than to be a substantial contributing factor to the ongoing incapacity" (at [19]).

48. It is also important to note that the employment must be "a" substantial contributing factor to the injury, not "the" substantial contributing factor. The Court held in *Mercer v ANZ Banking Corporation* [2000] NSWCA 138 that there may be more than one substantial contributing factor to a single injury, of which employment only need be one (at [16]). The Court also excluded the relevance of a predisposition or susceptibility to injury, Mason P saying:

> "Section 9A does not require that the employment must be 'the' substantial contributing cause, nor does it attempt to exclude predisposition or susceptibility to a particular condition (cf *University of Tasmania v Cane* (1994) 4 Tas R 156)." (at [27])

49. The question of “main contributing factor” in claims surrounding injuries involving a disease process was considered by Arbitrator Harris in *Ariton Mitic v Rail Corporation of NSW* (Matter number 8497 of 2013, 8 April 2014). In considering the terms of section 4(b)(ii), the Arbitrator said:

> “The opening words of the amended s. 4(b)(ii) relate to the aggravation, acceleration, exacerbation or deterioration ‘in the course of employment of any disease’. In my view, those opening words therefore direct attention to the work related component of the ‘aggravation, acceleration, exacerbation or deterioration’. The following words of clause (ii) then state ‘but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease’. The concluding words of clause (ii) requires an examination of whether the employment was the main contributing factor ‘to the aggravation, acceleration, exacerbation or deterioration of that disease’ and not to the overall pathology or the overall disease process…
>
> In my view, the amendment to s 4(b)(ii) does not require the applicant to establish that the employment must be the main contributing factor to the overall disease process or pathology within his left knee but simply that the employment must be the main contributing factor to the injury, that is, the aggravation, acceleration, exacerbation or deterioration of such disease.”

50. Arbitrator Rimmer adopted this approach in *Mylonas v The Star Pty Ltd* [2014] NSWWCC 174 at [151]-[166], as did Arbitrator Edwards in Egan v Woolworths Limited [2014] NSWWCC 281 at [60]-[82]. Arbitrator Harris further considered this approach in *Harrison v Central Coast Local Health District* [2015] NSWWCC 86. In *Meaney v Office of Environment and Heritage – National Parks and Wildlife Service* [2014] NSWWCC 339 (at [138]-[147]) and *Wayne Robinson v Pybar Mining Services Pty Ltd* [2014] NSWWCC 248, Arbitrator Capel (as he then was) considered the meaning of “main contributing factor” and interpreted the word “main” to mean “chief” or “principal” (at [78]-[88]).

51. It is important to note that employment must be the main contributing factor to any aggravation or exacerbation of symptoms, not to the underlying pathology itself (see *Kelly v Western Institute NSW TAFE Commission* [2010] NSWWCCPD 71 per Roche DP at [66]).

52. As the parties noted in their submissions, there is a divergence of opinion as to the cause of the applicant’s syrinx. Whilst the consensus of opinion is that a syrinx can be caused by trauma, only Dr Darveniza and Dr Leong say the fall at issue caused the syrinx. The balance of the medical opinion is the syrinx is either congenital or its origins are uncertain.

53. On balance, I accept the view expressed by the majority of the medical specialists, including the applicant’s treating surgeon Professor Stoodley that the syrinx was pre-existing, though I find for the reasons set out below it was asymptomatic before the fall. That opinion broadly accords with those of Dr Magee-Collett, treating neurosurgeon and also AMS Dr Davies, who said:

> “It is difficult to know whether the injury has contributed to the syrinx, but it is possible it has aggravated it and caused the onset of symptoms.”

54. I also find, taking a common-sense approach to the applicant’s condition, that the fall at issue has been the cause of the applicant’s ongoing symptoms in that it has aggravated or exacerbated a previously asymptomatic condition, namely the syrinx itself. It is no mere coincidence, in my opinion, that the applicant began suffering symptoms after the injurious event, and those symptoms have worsened in a manner consistent with the onset and worsening of syringomyelia after such an event, as set out by treating physician Dr Leong in her report at page 436 of the Application.

55. In making this finding, I reject the views of Dr Cochrane, who lastly indicated the fall had caused only a temporary aggravation of the syrnx. I do not consider Dr Cochrane's views on this aspect particularly reliable, given that he changed his mind as to the aetiology of the syrinx on several occasions, and also altered his opinion as to the reasonable necessity of the proposed surgery. I prefer instead the opinion of Prof Stoodley and that Dr Davies, AMS who accept the premise the fall has precipitated the applicant's ongoing symptoms.

56. I note the report of Dr Leong, who refers to a later MRI scan from 2016 which demonstrated slight widening of the syrinx since the first scan in 2014. Dr Leong is a physician who is experienced in the treatment of syringomyelia and who clearly states at page 436 of the Application:

> "As previously stated, I am not an expert in the pathophysiology of syringomyelia associated with CM1, being more experienced in post-traumatic syringomyelia. However, based on the above theories, I do not think it inconceivable that his fall on his head may have resulted in a rapid onset of syringomyelia formation. As he has CM1, he might be predisposed to developing syringomyelia, but there is no evidence that he had syringomyelia prior to the fall, and there is no established way to ascertain if he would develop syringomyelia at any point in his life. The quick onset of his symptoms adds strength to the hypothesis that the fall may have precipitated syringomyelia symptoms, as the natural history of syringomyelia associated with CM1 is usually slow…
>
> If Mr Collins had not had a fall on his head at work as reported, the natural history of [the syrinx and cervical pathology] might have been benign, and he may not have become symptomatic. As such, my opinion is that surgery is reasonable and necessary and due to the work-related injury."

I also accept Prof Stoodley's explanation of the applicant's symptoms in his report of 20 September 2018, in which he says:

> "9. Syringomyelia can cause symptoms and signs that do not cause any abnormality on neurological examination. This is because a syrinx can cause disturbance of pain sensation with a person experiencing pain but without any definite sensory deficit or motor deficit."

Those summaries and explanations by Dr Leong and Prof Stoodley in my view accord with the both the onset and the worsening of the applicant's symptoms being linked to the syrinx, and support the finding that the asymptomatic syrinx has been aggravated by the fall at issue.

57. I refer to Ms Goodman's submission that Prof Stoodley's opinion is unreliable owing to its age, and to the submission that the syrinx has not worsened over time. It seems to me the respondent cannot have it both ways. If it is indeed the case the syrinx has not progressed over the years since the applicant's injury and the initial studies thereafter, it would follow that Prof Stoodley's opinion would still be viable as it relates to pathology which has not changed. On the other hand, the applicant's symptoms seem to have worsened with the slight widening of the syrinx between the two MRIs, which in my view is consistent on a common-sense basis with those symptoms being linked to an ongoing aggravation of the previously asymptomatic syrinx. In any event, I note Prof Stoodley has provided an updated report in 2018, in which he addresses various matters put to him by the applicant's solicitors and raised in the other medical reports, before confirming his view that the syrinx may well have become symptomatic following the fall.

58. On the balance of probabilities, I find this to be the case. I accept Mr McManamey's submission that the applicant was a healthy young man before the fall, and has slowly been debilitated by its effects, to the point where he has been unable to continue with a career about which he was very passionate. Adopting the approach in Kooragang, it seems to me a matter of common sense that the fall rendered the pre-existing syrinx symptomatic, and that the effect of that aggravation is ongoing and gradually worsening. There is no evidence which suggests the applicant would have been in a similar position had the fall not taken place. The syrinx had not troubled him at all before the fall, and if it had, I find it unlikely on balance that he would have been able to carry out the at times strenuous work which he undertook in the greenkeeping trade, and with the respondent.

Reasonable necessity of the proposed surgery

59. It is trite to say the applicant has the onus of proving the proposed surgery is reasonably necessary. The standard test adopted in determining if medical treatment is reasonably necessary as a result of a work injury is that stated by Burke CCJ in *Rose v Health Commission (NSW)* [1986] 2 NSWCCR 2 (*Rose*), where his Honour said:

> "3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.
>
> 4. It is reasonably necessary that such treatment be afforded a worker if this Court concludes, exercising prudence, sound judgment and good sense, that it is so. That involves the Court in deciding, on the facts as it finds them, that the particular treatment is essential to, should be afforded to, and should not be forborne by, the worker.
>
> 5. In so deciding, the Court will have regard to medical opinion as to the relevance and appropriateness of the particular treatment, any available alternative treatment, the cost factor, the actual or potential effectiveness of the treatment and its place in the usual medical armoury of treatments for the particular condition."

60. It is settled law that the presence of a pre-existing condition such as osteoarthritis does not prevent the need for treatment being "as a result of an injury" pursuant to section 60 – see *Taxis Combined Services (Victoria) Pty Limited v Schokman* [2014] NSWWCCPD 18. The fact that pre-existing conditions may have been factors in the need for treatment does not mean that the proposed treatment is not a result of the injury – see *Murphy v Allity Management Services Pty Limited* [2015] NSWWCCPD 49 per Roche DP. At [58] in Murphy, the DP said:

> "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)."

61. In *Diab v NRMA Limited* [2014] NSWWCCPD 72 (*Diab*), Deputy President Roche noted that the Court of Appeal considered the meaning of "reasonably necessary" in *Clampett v WorkCover Authority (NSW)* [2003] NSWA 52 (*Clampett*), albeit in the context of home renovations rather than medical treatment. The Court noted that the trial judge had sought guidance from the decision in *Rose*. Grove J referred to the dictionary definition of "necessary" as being "indispensable, requisite, needful, that cannot be done without" (Oxford Dictionary) and "that cannot be dispensed with" (Macquarie Dictionary). At paragraphs 23 and 24, his Honour stated:

"23. The essential issue is what effect flows from conditioning such qualities as 'reasonably'. The consequence is to moderate any sense of the absolute which might otherwise be conveyed by the word 'necessary' if it stood alone. In order to contemplate such moderation, it is apt to consider surrounding circumstances, but the question to be addressed is whether modification of a worker's home, having regard to the nature of the worker's incapacity, is reasonably necessary. In contemplation of what might be 'reasonably necessary' there is this statutory obligation specifically to have regard to the nature of the worker's incapacity. It provides emphasis towards moderating the meaning of 'necessary' in this context.

24. The statute does not inhibit inquiry as to what may be thought reasonable in all, or in any particular, circumstances but its terms clearly point to predominant attention being paid to the nature of the worker's incapacity. In my opinion, to reject the appellant's proposal on the basis that expenditure is to be made on premises of which he is a weekly tenant is an elevation rather than a moderation of the meaning of 'necessary'."

62. In *Diab*, Roche DP noted the effect of the decision in *Clampett* and commented as follows:

"85. The approach in Clampett is consistent with the modern approach to statutory interpretation, which is to construe the language of the statute, not individual words (*Sea Shepherd Australia Limited v Commissioner of Taxation* [2013] FCAFC 68 per Gordon J (Besanko J agreeing)). Thus, "reasonably necessary" is a composite phrase in which necessity is qualified so that it must be a reasonable necessity (Giles JA (Campbell JA agreeing) in *ING Bank (Australia) Ltd v O'Shea* [2010] NSWCA 71 at [48] (O'Shea)). The Court, Bathurst CJ, Beazley and Meagher JJA, followed this approach in *Moorebank Recyclers Pty Ltd v Tanlane Pty Ltd* [2012] NSWCA 445 at [113] (Moorebank).

86. Reasonably necessary does not mean "absolutely necessary" (Moorebank at [154]). If something is "necessary", in the sense of indispensable, it will be "reasonably necessary". That is because reasonably necessary is a lesser requirement than "necessary". Depending on the circumstances, a range of different treatments may qualify as "reasonably necessary" and a worker only has to establish that the treatment claimed is one of those treatments. A worker certainly does not have to establish that the treatment is "reasonable and necessary", which is a significantly more demanding test that many insurers and doctors apply. Dr Bodel and Dr Meakin were both wrong to apply that test.

87. Giles JA added (at [49] in O'Shea) that the qualification whereby the necessity must be reasonable calls for an assessment of the necessity having regard to all relevant matters, according to the criteria of reasonableness. His Honour was talking in the context of whether an easement should be granted under s 88K of the Conveyancing Act 1919, which provides that "the Court may make an order imposing an easement over land if the easement is reasonably necessary for the effective use or development of other land that will have the benefit of the easement". However, his Honour's observations are applicable in the present matter and are clearly consistent with Clampett.

88. In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in Rose (see [76] above), namely:

(a) the appropriateness of the particular treatment;
(b) the availability of alternative treatment, and its potential effectiveness;
(c) the cost of the treatment;

> (d) the actual or potential effectiveness of the treatment, and
>
> (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.
>
> 89. With respect to point (d), it should be noted that while the effectiveness of the treatment is relevant to whether the treatment was reasonably necessary, it is certainly not determinative. The evidence may show that the same outcome could be achieved by a different treatment, but at a much lower cost. Similarly, bearing in mind that all treatment, especially surgery, carries a risk of a less than ideal result, a poor outcome does not necessarily mean that the treatment was not reasonably necessary. As always, each case will depend on its facts.
>
> 90. While the above matters are "useful heads for consideration", the "essential question remains whether the treatment was reasonably necessary" (*Margaroff v Cordon Bleu Cookware Pty Ltd* [1997] NSWCC 13; (1997) 15 NSWCCR 204 at 208C). Thus, it is not simply a matter of asking, as was suggested in Bartolo, is it better that the worker have the treatment or not. As noted by French CJ and Gummow J at [58] in *Spencer v Commonwealth of Australia* [2010] HCA 28, when dealing with how the expression "no reasonable prospect" should be understood, "[n]o paraphrase of the expression can be adopted as a sufficient explanation of its operation, let alone definition of its content"."

63. I note the stated aim of the surgery as set out in Prof Stoodley's report dated 20 September 2018 is reduction in the size of the syrinx to minimise the risk of further spinal cord damage and prevent further worsening of the applicant's condition, rather than to rectify his current symptoms. In my view, such an aim is of benefit to the applicant. It is not necessary for proposed treatment to guarantee a cure, or even a vast improvement.

64. For the respondent, Dr Cochrane provided three reports in which he changes his mind as to the reasonable necessity of the proposed surgery. In his first report, Dr Cochrane indicates that the surgery proposed by Prof Stoodley is neither indicated nor reasonably necessary. By July 2016, Dr Cochrane stated that the applicant would have some benefit from the surgery, only to change his mind again in his August 2019 report to indicate that there would be no benefit. With respect to Dr Cochrane, who I have no doubt approached this difficult matter extremely carefully, I cannot accept his opinion, which has changed back and forth without, in my opinion, sufficient explanation for doing so, over the course of three years and three reports.

65. I prefer the opinion of Prof Stoodley that the surgery will provide the applicant with some benefit in ameliorating his deteriorating symptoms. He has been consistent in that opinion, and coming as it does from a treating professor, I ascribe substantial weight to it. I also accept the opinion of Dr Davies, AMS, who indicates in his non-binding MAC that the surgery is reasonably necessary. Those doctors are a treating professor and an AMS, and I give substantial weight to their opinions, noting they do not approach the matter as experts retained by either party.

66. In my view, Dr Darveniza's opinion that surgery would not be helpful is heavily qualified by his stating it would be of benefit if the applicant's symptoms worsened or the syrinx extended in size. There is no doubt, based on the evidence before me, that those symptoms have indeed worsened. As such, notwithstanding Ms Goodman's considered submission to the contrary, I believe Dr Darveniza's opinion is, on balance, supportive of the requirement for surgery given what has transpired since his initial report dated 14 November 2016 at page one of the Application. In that report at page four, Dr Darveniza says:

> "In his current state with mainly pain only, in my view, there is only a small chance (about 10%) that surgical intervention (?decompression of the foramen magnum) would be helpful. I would not recommend surgical intervention, on the basis of his current imaging, unless a progressive neurological syndrome evolved.
>
> Hence, a further detailed MRI of the neuraxis (whole spine including the posterior fossa) to show the detailed full extent of the syrinx, including CSF flows, is strongly recommended to see if there is any obstruction at the cervicomedullary junction."

67. In his subsequent report of 20 March 2017, Dr Darveniza maintains his position with regards to the utility of the proposed surgery, however, he again notes that this may change if there is evidence of extension of the syrinx over time.

68. I also note Dr Leong's findings on the later MRIs that the cervical syrinx has increased in width, and the applicant's progressively broadening and worsening symptoms. In my view, given the increase in size of the syrinx and the decline in the applicant's symptoms over time, I am of the view the situation has now progressed to the point where the surgery is reasonably indicated.

69. In making this finding, I accept the opinion of treating physician Dr Leong, who opines in her report at page 436 of the Application:

> "My expertise is not in surgery so I cannot comment if the surgical technique proposed (posterior decompression with duraplasty) is the most appropriate surgical management method for Mr Collins. My clinical experience though suggests that in patients with symptomatic syringomyelia, the above surgery is one of the most common methods, and that surgery can be helpful in relieving pain and preventing progression. This is supported by the following articles. This list is by no means exhaustive."

In other words, Dr Leong says the proposed surgery is a widely regarded method of dealing with pathology and symptoms of the kind from which the applicant suffers.

70. Having regard to the totality of the medical evidence, I am of the view that the proposed surgery falls within the requirements set out in the line of authority starting with *Rose* and including *Diab*. That is, the surgery is appropriate (accepting Professor Stoodley and Dr Leong as I do); is readily available and is potentially effective in ameliorating the applicant's decline; is not overly expensive (no issue having been raised as to the cost by the respondent) and is accepted by the medical experts as likely to be effective in the applicant's circumstances. The applicant has also tried a wide range of conservative treatments to little or no effect.

71. Taking into account all of the medical evidence, I am satisfied for the above reasons on the balance of probabilities that the proposed surgery is reasonably necessary as a result of the workplace injury at issue, and accordingly will order the respondent pay the costs of an associated with that surgery.