WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **5818/20**
Applicant: **Luis Manuel Pombinho**
Respondent: **Coca-Cola Amatil (Aust) Pty Ltd**
Date of Determination: **24 December 2020**
Citation No: **[2020] NSWWCC 425**

The Commission determines:

1. The applicant sustained injury to his left knee arising out of or in the course of his employment with the respondent on 30 April 2018.

2. The applicant's employment was a substantial factor to his injury.

3. The applicant developed a consequential condition in his right knee as a result of the injury sustained to his left knee on 30 April 2018.

4. The applicant requires medical treatment as a consequence of his injury and the respondent is liable to pay reasonably necessary medical expenses.

5. The proposed right knee arthroscopy and removal of loose bodies, and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of the applicant's employment on 30 April 2018.

The Commission orders:

6. The respondent is to pay the applicant's reasonably necessary medical expenses with respect to the proposed right knee arthroscopy and removal of loose bodies, and associated expenses, pursuant to section 60 of the *Workers Compensation Act 1987*.

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

Glenn Capel
Senior 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 GLENN CAPEL, SENIOR ARBITRATOR, WORKERS COMPENSATION COMMISSION.

L Golic

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

STATEMENT OF REASONS

BACKGROUND

1. Luis Manuel Pombinho (the applicant) is 59 years old and commenced employment with Coca-Cola Amatil (Aust) Pty Ltd (the respondent) as a machine operator on 11 December 2017. His current employment status is unknown.

2. There is no dispute that the applicant injured his left knee on 30 April 2018, when his left leg fell into a hole whilst he was standing on a roller. He reported his injury on 2 May 2018, but he did not cease work until 25 July 2018. Liability was accepted by Allianz Australia Workers Compensation (NSW) Ltd (Allianz) and weekly compensation was paid by it. Precise details are unknown, but I was informed that the applicant was paid until a date in early 2020.

3. On 24 July 2019, the applicant's treating orthopaedic surgeon, Dr Rizkallah, sought approval from Allianz to perform a right arthroscopic meniscectomy. A quote for $4,095 was submitted.

4. On 1 August 2019, another orthopaedic surgeon, Dr Thomas, sought approval from Allianz to perform a right knee arthroscopy and removal of loose bodies. A similar quote for $4,095 was submitted.

5. On 18 September 2019, Allianz issued a notice pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act), disputing that the applicant developed a consequential condition in his right knee

6. On 26 November 2019, the applicant's solicitor requested Allianz to review its decision. A claim was also made for weekly compensation and medical expenses, including the cost of the surgery proposed by Dr Thomas. Management of the claim subsequently passed to icare workers insurance (the insurer).

7. On 10 December 2019, the insurer reviewed its decision pursuant to s 287A of the 1998 Act, and advised the applicant that it intended to maintain Allianz's decision, and added that the applicant was not entitled to medical expenses relating to his right knee pursuant to ss 59 and 60 of the *Workers Compensation Act 1987* (the 1987 Act).

8. On 2 September 2020, the applicant's solicitor served a notice of claim on the insurer in respect of medical expenses, including the cost of the surgery proposed by Dr Thomas. It appears that the insurer did not respond to this claim.

9. By an Application to Resolve a Dispute (the Application) registered in the Workers Compensation Commission (the Commission) on 7 October 2020, the applicant claims the cost of proposed medical treatment pursuant to s 60 of the 1987 Act due to injury sustained on 30 April 2018.

ISSUES FOR DETERMINATION

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

    (a) whether the applicant developed a consequential condition in his right knee as a result of the injury sustained to his left knee on 30 April 2018;

    (b) In the alternative, whether the applicant injured his right knee on 30 April 2018 and suffered an aggravation of the condition in his right knee as a result of the injury sustained to his left knee on 30 April 2018 – ss 4 and 9A of the 1987 Act;

(c) whether the respondent is liable to pay for the proposed treatment – s 60 of the 1987 Act, and

(d) whether the proposed right knee arthroscopy is reasonably necessary as a result of the injury sustained on 19 July 2010 – s 60 of the 1987 Act.

PROCEDURE BEFORE THE COMMISSION

11. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

EVIDENCE

Documentary evidence

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

(a) The Application and attached documents, excluding the reports of Dr Poplawski dated 23 October 2019 and 17 June 2020;
(b) Reply and attached documents;
(c) Application to Admit Late Documents received on 9 December 2020;
(d) Application to Admit Late Documents received on 10 December 2020, and
(e) Application to Admit Late Documents received on 21 December 2020.

Oral evidence

13. Neither party sought leave to adduce oral evidence or cross examine any witnesses.

REVIEW OF EVIDENCE

Applicant's statements

14. The applicant provided a statement on 21 January 2020. He indicated that he had no prior symptoms in his knees and he had not sustained any injuries of significance that impacted on his ability to compete his daily activities.

15. The applicant stated that on 30 April 2018, he was directed by his supervisor, Rick, to climb up onto a packer machine to clear a jam. He was only able to step onto one roller, because the second roller was missing. When he reached for a box in the machine, his feet slipped and his left leg fell into a hole. His right leg splayed out to the side. He felt a twisting sensation in his left knee accompanied by excruciating pain.

16. The applicant stated when his right knee splayed and twisted to the side, he felt an odd sensation. He was not sure whether he had injured his right knee, but his focus was on the significant pain in his left knee. He stated that in hindsight, the fall may have initiated his right knee injury that progressed to a severe consequential condition caused by an altered gait and weight bearing.

17. The applicant stated that his supervisor left the scene and later asked the applicant to say that he had injured himself by falling and striking his knees on some stairs. This would explain the history in the x-ray and ultrasound report dated 4 June 2018 that noted that the applicant "Missed a step and hit knee on stairs". The applicant eventually reported the correct circumstances of his injury to the "big boss".

18. The applicant stated that when he consulted Dr Botros on 4 August 2018, he told him that he twisted his left knee and his right knee splayed when he slipped on 30 April 2018. He understood that Dr Boutros did not record this complaint. He was referred to Dr Rizkallah and he had a left arthroscopic meniscectomy and chondroplasty on 30 August 2018.

19. The applicant stated that following his operation, he limped significantly and favoured his right side. His right knee and leg carried his weight and load on a daily basis. He stated that "this was not initially a problem as my right knee was quite healthy without restriction". Over the next six months, his left knee improved, but he occasionally experienced flare-ups of pain and tightness. He also experienced dull soreness in his right knee, and this pain became more constant over the course of six months.

20. The applicant claimed that he mentioned his right knee pain to Dr Rizkallah on 2 April 2019, but the doctor did not record this. At the consultation on 23 May 2019, the doctor recorded his complaints of right knee pain and noted that this was the second time that the applicant had reported right knee symptoms. The applicant had an MRI scan, and subsequently Dr Rizkallah recommended surgery. Dr Thomas had also recommended the procedure.

21. The applicant stated that he had constant pain, a clicking sensation, a restricted range of motion, numbness and swelling in his left knee, and he walked with an antalgic gait. He had constant pain and a restricted range of motion in his right knee. He had difficulty carrying moderate to heavy objects, negotiating stairs and walking on uneven surfaces, standing and driving for prolonged periods, walking, bending, twisting, kneeling, squatting, stooping and lunging, as well as other non-physical issues. He was certified partially fit for work. He wished to undergo the proposed right knee surgery as he had tried every form of conservative treatment.

22. The applicant provided a further statement on 22 May 2020. He gave details of prior injuries and advised that on 21 November 2017, he saw Dr Botros regarding some slight pain in his right knee. He had an x-ray and was advised that he had mild arthritis. He claimed that his pain resolved over a period of two to four weeks, and he had no further issues. He maintained that in the period immediately prior to his work injury, he had no physical conditions or injuries that impacted on his ability to complete daily or work activities.

23. The applicant stated that on 17 January 2019, he consulted Dr Botros about ongoing pain in his right foot that developed following his work injury. Dr Botros diagnosed plantar fasciitis. The condition did not affect his knees. He had two cortisone injections into his right foot. He suffered an aggravation of his left knee injury when he bumped his knee on a pallet on 5 February 2019, but the aggravation settled over the following days. He also developed pain in his right ankle during the time that he was limping and he was treated with a cortisone injection. His disabilities had largely remained the same.

Clinical notes and report of HGMC Pty Ltd (Dr Botros)

24. The handwritten clinical notes of Dr Botros commence on 23 August 1993 and conclude on 21 February 2013.

25. On 7 June 2004, Dr Botros reported that the applicant had jumped out of a forklift onto his right leg which collapsed due to a previous injury to his right thigh. The prior injury was recorded on 31 May 2004, when the applicant's right thigh was struck by a trolley. There was no reference to any right knee injury or symptoms.

26. On 21 February 2008 and 5 May 2008, Dr Botros recorded that the applicant had right plantar fasciitis. On 8 May 2009, the applicant was diagnosed with left plantar fasciitis, so the applicant's recent diagnosis of right plantar fasciitis mirrors past issues.

27. On 21 November 2012, Dr Botros referred the applicant for an ultrasound of his knee. There was some effusion and degenerative changes. It is unclear which knee was involved.

28. The typed clinical notes of Dr Botros commence on 15 August 2011 and conclude on 1 April 2020. Unlike the handwritten notes, the typed entries rarely refer to the reasons for the consultation or record a history.

29. The first reference to any right knee complaints was at the consultation with Dr Ibrahim on 15 September 2016. The entry merely referred to “right knee pain”. The applicant was prescribed Mobic and Nexium.

30. The next entry regarding the applicant’s right knee was on 21 November 2017, when the applicant complained of moderate right knee pain and depression. Dr Botros recorded that there was no swelling, tenderness, deformity or restriction. He referred the applicant for x-rays and prescribed Lexapro for his depression. It seems that the x-rays showed mild patellofemoral osteoarthritis.

31. On 4 May 2018, Dr Botros recorded that the applicant had slipped and landed on his flexed knee, suffering a moderate left knee injury. The circumstances of the injury were not noted. The doctor reported that there was tenderness, but there was no swelling, deformity or restriction, whilst an ultrasound showed no abnormality.

32. Dr Botros issued an initial WorkCover certificate on 25 July 2018. He certified that the applicant had no current incapacity from 25 July 2018 to 26 July 2018, and fit for some duties from 27 July 2018 to 3 August 2018 due to pain in his right knee. The reference to the right knee would seem to be a typographical error.

33. The entries in the latter part of 2018 largely concerned psychological issues. On 17 January 2019, Dr Botros suspected that the applicant had developed right plantar fasciitis. The doctor referred him for an ultrasound and gave him a WorkCover certificate. The certificate is not in evidence, and it is unclear whether the insurer accepted liability for a separate work injury.

34. On 6 February 2019, Dr Rizk reported that the applicant had left knee pain after striking it on a pallet the previous night. The applicant also complained of right ankle pain. On 7 February 2019, Dr Botros referred the applicant for an ultrasound guided ankle injection, and on 17 May 2019, the doctor referred the applicant for an ultrasound to determine whether the applicant had plantar fasciitis.

35. At the consultation on 22 July 2019, the applicant complained of acute left knee pain. This may be an incorrect entry, because on 29 July 2019, Dr Botros recorded that the applicant had seen a specialist and he had been advised to have a right knee operation.

36. On 6 August 2019, Dr Botros referred the applicant to Dr Thomas. The balance of the notes concern other health issues that are not relevant to this dispute.

37. Dr Botros reported on 21 August 2020. He advised that the applicant first sought treatment for his right knee on 29 November 2017. The doctor confirmed that there was no swelling, tenderness or restriction of movement. An x-ray showed early osteoarthritis.

38. The doctor reported that on 30 April 2018, the applicant was trying to release jammed boxes from a machine when his left leg slipped into a gap formed by a missing roller and his right leg splayed. When seen on 4 May 2018, the applicant complained of pain in his left knee. On 27 July 2019, the doctor arranged an MRI scan and referred him to Dr Rizkallah.

39. Dr Botros indicated that when the mild osteoarthritis identified in November 2017 was different in character and symptomatology to the right meniscal tear that was disclosed in the MRI scan dated 13 June 2019. The doctor agreed that the right knee injury and pain were masked by the more painful left knee injury. The applicant also suffered an aggravation of the right knee condition due to overcompensation..

40. Dr Botros stated that plantar fasciitis could occur on its own or could be aggravated by prolonged standing or pressure on the foot. It was difficult to say whether the condition occurred on its own or was related to the right knee condition.

Radiological tests of right knee

41. The applicant had an x-ray of his right knee on 21 November 2017. There were early degenerative changes in the patellofemoral joint and some intercondylar spurring, but no effusion, bony destruction or loose bodies.

42. The applicant had an MRI scan on his right knee on 13 June 2019. This showed tears of the medial meniscus and posterior horn, two loose bodies, chondral fissuring on the medial and lateral facets of the patella, a Baker's cyst and mild bursitis.

Reports of Dr Rizkallah

43. In his initial report dated 15 August 2018, Dr Rizkallah noted that the applicant injured his left knee at work on 30 April 2018. The mechanism of injury was not mentioned. The doctor noted that the applicant had pain, clicking and swelling in his left knee, together with numbness in the upper leg. A left knee meniscectomy and chondroplasty was performed on 30 August 2018.

44. In a report dated 2 April 2019, the doctor confirmed that on 27 March 2019, the applicant complained of on-going problems in his left knee. The doctor arranged for a further MRI scan.

45. In a report dated 23 May 2019, Dr Rizkallah advised that an MRI scan revealed the chondral injury in the left knee without any meniscal pathology. The applicant admitted that there had been improvement in his left knee, so the doctor felt that no further treatment was required. The doctor also reported that at the previous consultation (i.e. 27 March 2019) and again at this consultation, the applicant complained of pain and clicking in his right knee. Accordingly, the doctor referred the applicant for an MRI scan.

46. In a report dated 24 July 2019, Dr Rizkallah advised that the MRI scan had revealed a meniscal tear. He believed that the applicant had injured his right knee as a result of overcompensating following his left knee injury. The doctor sought approval for a right knee arthroscopic meniscectomy and debridement.

47. Dr Rizkallah provided a report to Allianz on 6 August 2019. He indicated that the applicant was having right knee problems as a result of overcompensation secondary to his left knee injury and surgery. He stated that the applicant had achieved an excellent outcome following his left knee surgery.

48. Dr Rizkallah advised that meniscal tears could occur as a result of overloading of the knee secondary to overcompensating. He stated that it was impossible to ascertain whether there had been any pre-existing changes in the applicant's meniscus, but he observed that the applicant had no problems with his right knee prior to the accepted left knee injury. He knew of no activities outside of the applicant's employment that might have caused the current pathology.

49. Finally, in a report dated 26 November 2020, Dr Rizkallah advised that the applicant had very mild arthritis in his right patella, and the articular cartilage in the medial and lateral compartments was pristine. He also noted that there was no mention any degree of damage to the medial or lateral compartments in the MRI scan.

50. Dr Rizkallah confirmed that the applicant had medial knee pain with clicking and swelling, so it was most certain that the medial meniscus tear was the source of the applicant's pain and disability. He considered that the applicant sustained the meniscal tear at the time of the incident on 30 April 2018 and it was significantly aggravated by overloading and overcompensating on the right side. He felt that favouring the right lower limb and excessive loading and pressure following his left knee injury, long disability and subsequent surgery, in addition to the possibility of sustaining a small tear at the time of his work related injury, were the cause of his knee problems and this predisposed him to plantar fasciitis and other foot and ankle problems.

51. Dr Rizkallah indicated that it was extremely unlikely that any foot and ankle conditions such as plantar fasciitis could cause a significant medial meniscal tear and cyst formation, whereas the opposite was extremely common and likely. These factors and the injury gave rise to the need for the right arthroscopic medial meniscectomy.

Report of Dr Thomas

52. Dr Thomas reported on 14 August 2019. He recorded no details of the mechanism of injury, and merely reported that the applicant had injured his left knee in April 2018 [sic]. The applicant had been troubled by bilateral knee pain for some time. The doctor noted that after the applicant had left knee surgery, his symptoms improved for a short time, but they had returned and were centred over the medial aspect and patellofemoral joint.

53. Dr Thomas reported that the applicant had pain in his right knee which had been taking the load following his left knee injury. The applicant claimed that he injured his right knee when he twisted it when trying to remove his left leg from the roller out on 30 April 2018 [sic]. The applicant told the doctor that because his left leg symptoms were worse, he did not concentrate too much on his right knee.

54. Dr Thomas stated that the applicant had a torn right medial meniscus that was causing painful clicking and there were loose interarticular bodies. The cause of the tear was not disclosed. He believed that the applicant would benefit from an arthroscopy, but the surgery would not address the degenerative changes in the applicant's right knee.

Reports of Dr Lai

55. Dr Lai reported on 26 March 2019. He reported that the applicant's left leg was caught between two rollers causing him to twist his left knee. He eventually saw his local doctor and was given pain killers. He had an MRI scan and in August 2018, Dr Rizkallah carried out a partial medial meniscectomy and chondroplasty of the left knee.

56. Dr Lai noted that as a result of compensating for his left knee pain, the applicant started to rely more on his right leg to bear the weight of his work. This resulted in increasing right knee pain. The applicant told the doctor that his left knee pain had increased since his operation and he was troubled by numbness. He had also noticed increased pain in his right knee as a result of compensating for his left knee pain.

57. Dr Lai confirmed that the applicant had suffered a left meniscal tear and had on-going pain and numbness. He had also developed consequential pain in his right knee due to overcompensation. He stated that the applicant's employment was a substantial contributing factor to his condition and incapacity. The doctor did not comment on the proposed right knee surgery.

58. Dr Lai provided a further report on 9 December 2020. He agreed that the mild right patellofemoral arthritis that was diagnosed in November of 2017 was completely different in character and symptomatology when compared to the tear of the right medial meniscus and the two loose bodies. The arthritis was still present in the MRI scan.

59. Dr Lai stated that the applicant's right knee symptoms completely resolved with inflammatory medication after he saw Dr Botros on 21 November 2017. The applicant did not complain of right knee pain at the next consultation on 14 December 2017, but had gastric pain which was most likely due to his anti-inflammatory medication.

60. Dr Lai stated that the applicant's current right knee symptoms occurred after he injured his left knee due to compensating and placing an increased load on his right knee. This resulted in a meniscal tear. The favouring and limping probably also caused the plantar fasciitis and right ankle symptoms. This condition was treated with steroid injections and seemed to have resolved, because there was no further mention of his foot symptoms in the clinical notes.

Reports of Dr Panjratan

61. Dr Panjratan reported on 5 September 2019. He noted that on 30 April 2018 [sic], the applicant's left leg went through an area where there was a missing roller and right leg went sideways. He finished the shift, notified his supervisor that he could not go to work the next day and he consulted his doctor. He was referred to Dr Rizkallah, who recommended left knee surgery.

62. The applicant told the doctor that his right knee was not injured in the incident, although he felt that he had probably twisted the knee when he was removing his left leg from the rollers. The applicant indicated that Dr Rizkallah had advised him that his right knee problem had developed because of his weight and because he had been limping. The applicant stated that as far as he could recall, he had no previous right knee problems and x-rays had not been done. The applicant questioned the accuracy of the clinical records.

63. The applicant told the doctor that he first noticed problems with his right knee about six months after his left knee surgery. He had sought a second opinion regarding right knee surgery from Dr Thomas.

64. The applicant complained of pain in his right knee, but he did not experience any swelling. He was still working and his workmates were allowing him to do more sedentary work on the forklift. After five to six hours at work, his right knee started to hurt.

65. Dr Panjratan stated that the applicant did not injure his right knee in the work incident as it went to the side. He could not explain how the pathology could have been caused by overcompensating following the injury to the applicant's left knee. He stated that the majority of meniscal tears and patellofemoral chondral injuries were caused by rotational forces directed to a flexed knee, such as pivoting or twisting, and there was no medical evidence that tears could result from compensatory mechanics.

66. Dr Panjratan stated that there would have been pre-existing degenerative changes in the applicant's right knee prior to the work injury. He agreed that these changes could have been aggravated, and any aggravation was not related to the work place incident. He stated that the need for a right knee arthroscopy and the removal of loose bodies was not directly related to the incident on 30 April 2018.

67. Dr Panjratan provided a supplementary report on 11 March 2020. He confirmed that it was unlikely that the applicant could have developed a torn meniscus, and a consequential right knee injury, due to increased weight-bearing. The applicant had pre-existing patellofemoral chondromalacia that could have caused pain at the time, and that pain could have been aggravated.

68. Dr Panjratan stated that if the applicant had torn his right meniscus in the incident, he would have had symptoms of catching and giving way at the time, and this would have come to the attention of the surgeons. He rejected the suggestion by Dr Thomas that the loose bodies were related to the injury.

69. In his report dated 30 May 2020, Dr Panjratan stated that the applicant's right foot and ankle complaints from January 2019 to May 2019 could have caused his right knee symptoms and aggravated the pathology in his right knee. He believed that the applicant suffered an increased load on the left knee to compensate for the right foot and ankle issues, and this resulted in an aggravation or further aggravation of the right knee symptoms.

70. Dr Panjratan stated that he did not consider that the proposed surgery was reasonably necessary as a result of the applicant's work injury, because it was due to the right foot and ankle condition which was not work related.

71. Finally, in a report dated 18 November 2020, Dr Panjratan indicated that he did not consider that the applicant's left knee injury caused symptoms in the applicant's right foot and ankle. He stated that plantar fasciitis was an idiopathic condition and it was unusual for such a condition to develop following a knee injury.

APPLICANT'S SUBMISSIONS

72. The applicant's counsel, Mr Stanton, submits in his initial statement, the applicant described the circumstances of his injury, his symptoms and his treatment. Dr Rizkallah performed an arthroscopy on the applicant's left knee on 30 August 2018 and found a complex tear of the posterior horn of the medial meniscus and a chondral injury in the lateral facet of the patella. This was significant damage, and on 2 April 2019, Dr Rizkallah reported that the applicant was still having trouble with his left knee.

73. Mr Stanton submits that Dr Rizkallah reported on 23 May 2019 that the applicant had complained about pain and clicking in his right knee at this consultation and at the previous consultation. The doctor attributed the applicant's symptoms to overcompensating for his left knee injury. The MRI scan showed a meniscal tear, two loose bodies, full thickness chondral fissuring and bursitis.

74. Mr Stanton submits that in his report dated 24 July 2019, Dr Rizkallah indicated that the applicant had injured his right knee as a result of overcompensating following his left knee injury. He submits that whilst these are concise reports, the doctor was the treating surgeon who saw the applicant over a period of time and would be in a good position to express an opinion regarding the pathology and causation. He had treated the applicant's left knee injury and was aware of the applicant's symptoms and the fact that he was overcompensating. This is compelling evidence.

75. Mr Stanton submits that in his statement dated 21 January 2020, the applicant indicated that after his operation, he was troubled by post-operative pain. He was limping significantly and was favouring his right side. There is no evidence to challenge the applicant's statement and it is logically persuasive.. This history fits in with the history recorded by Dr Rizkallah, so one can accept that the applicant is being truthful.

76. Mr Stanton submits that in his report dated 6 August 2019, Dr Rizkallah stated that the applicant had right knee problems as a result of overcompensation secondary to his left knee injury and surgery. He confirmed that meniscal tears could occur due overloading secondary to overcompensating.

77. Mr Stanton submits that Dr Panjratan considered that the right knee symptoms were unrelated to the left knee injury and his analysis referred to the presence of osteoarthritis that was in existence prior to the fall. However, the surgery is intended to treat the meniscal tear.

78. Mr Stanton submits that in his report dated 26 November 2020, Dr Rizkallah noted that the applicant's right knee osteoarthritis was very mild and the cartilage was pristine. His opinion is more persuasive as the operation will be addressing the meniscal tear, not the mild osteoarthritis. Dr Rizkallah suspected that the applicant tore the right medial meniscus at the time of the incident and this was significantly aggravated by overloading and overcompensating on the right side. This explains why it took some months for the knee symptoms to increase before the applicant brought it to the attention of Dr Rizkallah.

79. Mr Stanton submits that according to Dr Rizkallah, it is extremely unlikely that the plantar fasciitis could lead to a significant meniscal tear, but the opposite was likely. Therefore, one could not be satisfied that the plantar fasciitis caused the meniscal tear.

80. Mr Stanton submits that in his report dated 30 May 2020, Dr Panjratan indicated that the need for the right knee surgery was due to the plantar fasciitis, meaning that the knee pathology was consequential to the plantar fasciitis. This view is fundamentally illogical, because the doctor dismissed the possibility of overcompensation on the right knee could cause symptoms, but at the same time he said that awkward walking due plantar fasciitis could cause knee symptoms.

81. Mr Stanton submits that in his report dated 5 September 2019, Dr Panjratan noted a history that the applicant did not injure his right knee in the incident, but he later reported that the applicant said that he had probably twisted his right knee when he took it out. The doctor reported a history of an injury, so his opinion is inconsistent with the history and is less persuasive.

82. Mr Stanton submits that Dr Thomas recorded a history that the applicant had right knee pain because it had been taking the load following the left knee injury. He noted clinical evidence of right knee pathology and he agreed that the applicant required surgery to address the meniscal pathology and loose bodies. There is a consensus amongst Drs Rizkallah and Thomas, and their opinions satisfy the relevant criteria discussed in the authorities.

83. Mr Stanton submits that Dr Botros explained the significance of the radiological findings that predated the work injury, and he noted that the applicant's symptoms at that stage were different in character to his meniscal symptoms.

84. Mr Stanton submits that Dr Lai reported a similar history and he accepted that there was a causal connection between the applicant's knee symptoms and the incident. He also believed that favouring and limping caused by the left knee injury paled o role in the development of the plantar fasciitis. The doctor supported the need for surgery.

85. Mr Stanton submits that one could be satisfied from the applicant's medical evidence that there was a causal connection between the meniscal tear and the work incident and that the proposed surgery was reasonably necessary as a result of the injury on 30 April 2018.

RESPONDENT'S SUBMISSIONS

86. The respondent's counsel, Ms Goodman, submits that in the Report of Injury Form, the injury to the applicant's left knee was identified, but there was no mention of his right knee. When the applicant saw Dr Botros on 4 May 2018, the doctor recorded that the applicant had suffered a moderate left knee injury when he slipped and landed on his left knee. This history differs from the later history of the right leg splaying and twisting. The doctor recorded that there was no swelling, deformity or restriction. It was not until the applicant saw Dr Rizkallah that there was mention of right knee symptoms.

87. Ms Goodman submits that on 21 November 2017, Dr Botros recorded that the applicant complained of moderate right knee pain and depression, but there was no swelling, deformity or restriction. He referred the applicant for an x-ray that showed mild right patellofemoral osteoarthritis. Therefore, there was pain in the applicant's right knee five months before the work incident. There was also a report of right knee pain on 13 May 2016.

88. Ms Goodman submits that the history in Dr Botros' report dated 21 August 2020, namely the applicant's right knee splaying in the incident, was not recorded in his clinical notes. Dr Rizkallah reported no right knee symptoms at the time of the operation in August 2018. The first complaint was not recorded until 23 May 2019.

89. Ms Goodman submits that Dr Lai did not record a history of the applicant injuring his right knee in the incident, and there was no swelling, clicking or popping in the right knee.

90. Ms Goodman submits that Dr Thomas reported that the applicant had pain in both his knees for some time, but the earliest report of right knee pain was in March 2019, which was only four to five months before the doctor saw the applicant.

91. Ms Goodman submits that in his report dated 6 August 2019, Dr Rizkallah stated that the right knee problems were the result of overcompensating secondary to the left knee injury, but the doctor was not aware of the right knee problems in November 2017. Therefore, no weight can be given to this report.

92. Ms Goodman submits that in his last report, Dr Rizkallah stated that the right meniscal tear was caused by the work injury and not overcompensation. This was based on a history of splaying of the right leg. This opinion is inconsistent with the history recorded in Dr Botros' clinical notes and the Report of Injury Form. Therefore one could not accept that there was a direct injury to his right knee when his symptoms were reported in 2019.

93. Ms Goodman submits that Dr Panjratan recorded an incorrect history from the applicant in his report dated 5 September 2019, and this is not recorded in the clinical notes of Dr Botros or in the Report of Injury Form.

94. Ms Goodman submits that in his report dated 11 March 2020, Dr Panjratan said that there was no history of any right knee injury and he thought that it was unlikely that the tear was due to weight bearing secondary to the left knee injury.

95. Ms Goodman submits that in his report dated 30 May 2020, Dr Panjratan indicated that the applicant's right foot and ankle conditions may have caused the right knee symptoms due to overcompensation. He considered that the right knee surgery was reasonably necessary as a result of the right foot and ankle conditions.

96. Ms Goodman submits that one could not be satisfied that the applicant suffered a right meniscal tear in the incident on 30 April 2018. There was a difference of opinion regarding the cause of the tear, and the later development of symptoms has not been addressed by the applicant's doctors.

APPLICANT'S SUBMISSIONS IN REPLY

97. Mr Stanton submits that the Report of Injury Form was completed by the respondent and is not the applicant's claim form. It is not a comprehensive document and is not persuasive.

98. Mr Stanton submits that Dr Botros was concise in his reporting of the applicant's symptoms and he concentrated on the applicant's left knee. This was the concern of the applicant. He focussed on the pressing issue, namely his left knee injury, and it was understandable why the right knee was not mentioned. The clinical notes and the Report of Injury Form need to be viewed in that context.

99. Mr Stanton submits that according to Dr Rizkallah, the first report of right knee symptoms was in March 2019. This did not mean that the applicant did not have symptoms before then. Whilst the doctor indicated that the meniscal tear was caused in the incident, he also stated that limping and overcompensating could aggravate a tear. So the damage was done initially and was not aggravated until the applicant was overcompensating.

100. Mr Stanton submits that whilst there was no mention of the right leg moving sideways in the clinical notes or the Report of Injury Form, the applicant's left leg fell into a hole, and it would have been impossible for the right leg to maintain a normal posture. The right leg must have splayed, and there is no lay evidence to challenge this. Therefore, one can be satisfied that the applicant's right leg would have moved as the applicant indicated.

101. Mr Stanton submits that the doctors commented on the prior knee pathology, namely mild osteoarthritis, which was different to the meniscal tear. In this matter, there is opinion evidence as to the pathology in the applicant's right knee, and this pathology that needs to be addressed by the surgery.

REASONS

Did the applicant develop a consequential condition in his right knee?

102. There is no dispute that the applicant injured his left knee on 30 April 2018. What I need to determine is whether the applicant developed a consequential condition in his right knee.

103. I do not need to find that the applicant sustained a further injury or developed pathology. This is a question of causation and the common-sense evaluation of the causal chain discussed in *Kooragang Cement Pty Ltd v Bates*[1].

104. The principles to be applied in cases involving consequential conditions were discussed in *Kumar v Royal Comfort Bedding Ltd*[2], where Deputy President Roche stated:

> "By asking if Mr Kumar has suffered a s 4 injury to his right shoulder, the Arbitrator erred in his approach and asked the wrong question. This error affected his approach to the medical evidence and his conclusion. Mr Kumar's claim was always, as the respondent has conceded on appeal, that the right shoulder condition, and the need for surgery, resulted from the accepted back injury. It was not necessary for him to prove that he suffered a s 4 injury to his right shoulder."[3], and
>
> "…Of more significance is that Dr Wallace's opinion that Mr Kumar's activities after the back surgery would not be consistent with the cause of 'significant right shoulder pathology' failed to address the correct issue. It is not necessary for Mr Kumar to establish that he has significant pathology in his shoulder, only that the proposed surgery is reasonably necessary as a result of the injury on 19 March 2009. Dr Wallace's opinion may well be relevant to the ultimate question of whether the shoulder surgery is reasonably necessary, but it does not determine the question of whether the right shoulder condition has resulted from the back injury."[4]

[1] (1994) 35 NSWLR 452; 10 NSWCCR 796 (*Kooragang*), [463].
[2] [2012] NSWWCCPD 8 (*Kumar*).
[3] *Kumar*, [35].
[4] *Kumar*, [55].

105. This was also confirmed by Deputy President Snell in *Trustees of the Roman Catholic Church for the Diocese of Parramatta v Brennan*[5], where he considered the principles discussed in *Kumar* and *Bouchmouni v Bakhos Matta t/as Western Red Services*[6]*.* He stated:

> "The above do not suggest any need that a finding of a consequential condition necessarily involves the identification of pathology. It is sufficient to find (if the evidence supports it) a condition that results from an employment injury. I accept the respondent's submission that it is sufficient to find a consequential condition, pathology need not necessarily be identified. In *Kumar,* the relevant finding was based on the existence of symptoms."[7]

106. In this matter, there is no dispute regarding the pathology in the applicant's right knee. The MRI scan dated 13 June 2019 confirmed that the applicant had tears of the medial meniscus and posterior horn as well as two loose bodies. This is the pathology that is top be addressed by the proposed surgery. There is also mild patellofemoral osteoarthritis..

107. There is evidence that supports the contention that the meniscal tear was sustained at the time of the work incident on 30 April 2018. There is also evidence that supports a consequential condition arising from the accepted left knee injury.

108. The handwritten notes of Dr Botros refer to the applicant's right leg giving way on 7 June 2004, Curiously, the applicant had right plantar fasciitis in February 2008 and May 2008, and left sided plantar fasciitis in May 2009. This seems to be a recurring condition in the applicant's right foot. The applicant had an ultrasound in November 2012, but the result of the test and the knee that was involved is unknown. There was also an isolated complaint on right knee pain in September 2016.

109. The x-ray that was taken on 21 November 2017 showed some early degenerative changes in the patellofemoral joint and some intercondylar spurring. Dr Botros did not deem it necessary to refer the applicant for an MRI scan in November 2017, which is not surprising, given his clinical findings, so one can infer that the doctor did not consider that the applicant had meniscal damage at that stage.

110. It is true that the applicant did not complain to Dr Botros about his right knee when he saw the doctor on 4 May 2018. The Report of Injury Form completed by the respondent only referred to the left knee, and given that the information in this document would have been provided by the applicant, it would seem that he had no knowledge of any right knee injury.

111. In his statement dated 21 January 2020, the applicant indicated that his right knee splayed and twisted to the side, and he felt an odd sensation. He did not know whether he had sustained an injury. He claimed that he told Dr Botros about the splaying of his right leg at the consultation on 6 August 2018, but this is not apparent from the doctor's inadequate entry on that date.

112. I agree with Mr Stanton that the applicant's right leg would not have remained in a stable position when his left leg fell into a hole, so I have no reason to doubt the applicant's unchallenged evidence regarding the mechanism of the incident. The incident was witnessed by the applicant's supervisor before he left the scene, and no statement was obtained from him to cast doubt on the applicant's evidence. What is clear from the evidence is that the applicant suffered a serious injury to his left knee and this was the focus of his attention and his doctors.

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[5] [2016] NSWWCCPD 23 (*Brennan*).
[6] [2013] NSWWCCPD 4 (*Bouchmouni*).
[7] *Brennan*, [169].

113. The applicant claimed that following his left knee surgery, he limped significantly and favoured his right leg. The initial soreness gradually progressed to pain over a period of six months. He mentioned this to Dr Rizkallah, who referred him for an MRI scan and then recommended surgery. Therefore, whilst the applicant's evidence seems to support the possibility of injury in the incident, it is more in keeping with a consequential condition.

114. The typed clinical notes of Dr Botros are of no assistance regarding the matters that I need to determine. The entries are brief and rarely refer to reason for the attendance. Therefore, any submission that the applicant did not complain about his right knee to Dr Botros will carry minimal weight, given the inadequacy of the typed clinical notes. Even his report dated 21 August 2020 is of limited assistance regarding any injury to the right knee in the incident or the development of a consequential condition. The doctor merely explained that the applicant's left knee injury and pain masked the applicant's right knee symptoms.

115. Dr Rizkallah first obtained a history of right knee pain at the consultation on 27 March 2019, even though this is not reflected in his report dated 2 April 2019. In his reports dated 24 July 2019 and 6 August 2019, the doctor indicated that the applicant had injured his right knee as a result of overcompensating following his left knee injury and surgery. He stated that it was possible for a meniscal tear to be caused by overloading of the knee secondary to overcompensating, so he supported the possibility of the tear being caused by overcompensation secondary to the left knee injury.

116. In his report dated 26 November 2020, the doctor confirmed that the applicant's right knee pain and clicking was due to the damaged meniscus rather that the mild osteoarthritis. Despite his earlier opinion regarding a secondary condition, the doctor indicated that the applicant suffered the tear of the right meniscus in the incident on 30 April 2018. Therefore, he has identified the nature of the pathology and its cause, although he did not explain why the applicant did not report any right knee symptoms before March 2019.

117. Dr Rizkallah also accepted that the tear was significantly aggravated by overloading and overcompensating on the right side following the left knee injury and surgery, consistent with a secondary or consequential condition, and this may have also caused right plantar fasciitis.

118. Dr Thomas noted a history that the applicant injured his right knee when he twisted it as he was attempting to remove his left knee from the hole, but his focus was on his left knee injury. The doctor also recorded a history of increased pain in the applicant's right knee due to taking the load following his left knee injury. The doctor did not comment on causation and merely confirmed that the applicant had a torn meniscus and surgery was indicated. It is remarkable that the applicant's solicitor did not ask the doctor to comment on causation.

119. The history recorded by Dr Lai was not suggestive of a frank injury to the applicant's right knee. The doctor acknowledged that the applicant had right knee pain which he attributed to overcompensation following his left knee injury. When he was provided with a copy of the MRI scan, the doctor advised that as a result of overcompensation following his left knee injury, the applicant had suffered a right medial meniscus tear.

120. Dr Lai stressed that the nature and symptoms caused by the mild osteoarthritis differed to those associated with the meniscal tear and the loose bodies. The consequential condition was probably also responsible for the onset of plantar fasciitis.

121. In summary, the applicant has the support of Dr Rizkallah, an experienced knee surgeon, Dr Thomas, a specialist hip and knee surgeon, and Dr Lai, a plastic and reconstructive surgeon. Dr Rizkallah believes that the meniscal tear was caused by the incident and was aggravated by overcompensation secondary to the left knee injury.

122. Dr Thomas did not express an opinion, but he recorded a consistent history of twisting in the incident followed by overcompensation. Dr Lai attributed the tear to overcompensation, an outcome that Dr Rizkallah agreed was a possibility.

123. Even though the doctors have differing views as to the aetiology of the meniscal tear, they all accept that there is a causal connection, either by way of a primary injury, or alternatively, as a secondary condition arising from the incident on 30 April 2018.

124. The only doctor to dispute a causal connection is Dr Panjratan. He obtained a history of the applicant's right leg going sideways, which is not dissimilar to the splaying movement recorded by other doctors. Ms Goodman submitted that this history was incorrect, so I am not sure what weight is to be given to the doctor's views.

125. The applicant told Dr Panjratan that he did not injure his right knee, which would seem consistent with the contemporaneous evidence, but the applicant also said that he had probably twisted the knee when he was removing his left leg from the rollers. So there was a history of a twisting movement.

126. Dr Panjratan also advised that the applicant would have experienced symptoms at the time if he had suffered a tear. Such a comment seems logical, but he did explain whether a meniscal tear could also be asymptomatic.

127. The history of the onset of right knee symptoms about six months after the left knee operation is consistent with the complaints made to Dr Rizkallah in March 2019. Dr Panjratan stated that the degenerative changes in the right knee may have been aggravated, but any aggravation was not work related. The doctor provided no reasons for this view.

128. Dr Panjratan's conclusion that the applicant did not injury his right knee in the incident, or that he developed a consequential condition in his right knee is at odds with that of Dr Rizkallah. He was unable to explain how the meniscal tear occurred because there was no history of a twisting or rotational movement, but the applicant did inform the doctor that he might have twisted the knee. This seems somewhat inconsistent.

129. In his report dated 11 March 2020, it seems that the doctor softened his approach regarding a secondary cause of the meniscal tear, when he indicated that:

> "There was no twisting injury to the knee, and it is unlikely that he could have developed a torn meniscus just due to increased weight-bearing, and a consequential right knee injury. He had pre-existing patellofemoral chondromalacia which could have caused pain at the time, and that pain could have been aggravated".

130. The use of the word "unlikely" would seem to be an acknowledgement of a possibility, and this is the view held by Dr Lai.

131. Dr Panjratan indicated that as a result of his plantar fasciitis, the applicant had an increased load on his left knee to compensate for his right foot and ankle symptoms, and this in turn aggravated or further aggravated the applicant's right knee symptoms. Therefore, he seems to be saying that the applicant developed a consequential condition in his left knee due to overcompensating for his right foot symptoms, and this in turn caused a consequential condition in the applicant's right knee. His views are at odds with those of Drs Rizkallah and Lai, who both acknowledged the possibility of the plantar fasciitis being secondary to the right knee condition.

132. I must confess that I find Dr Panjratan's reasoning particularly confusing and illogical, because he dismissed the proposition of a consequential condition arising in the applicant's right knee due to overcompensation for the accepted left knee injury.

133. One would have thought that if the applicant was limping due to his left knee injury, as opposed to a secondary condition caused by the right plantar fasciitis, and as a consequence placed an increased load on his right leg, then any symptoms in his right knee would have been causally related, irrespective of the cause of the limping . In the circumstances, one must question what weight can be given to the doctor's opinion regarding the current dispute.

134. There is medical evidence to support a causal connection between the meniscal tear, either by way of a direct injury on 30 April 2018, or a consequential condition arising from the accepted left knee injury, or a combination of both.

135. The authorities confirm that it is not necessary for me to find that the applicant suffered an injury to his right knee. Rather, I need to determine whether as a result of the accepted left knee injury, the applicant developed symptoms in his right knee.

136. The fact that the applicant had prior right knee symptoms and treatment is irrelevant, as there is no requirement to identify any pathology, only symptoms. In any event, the prior symptoms seemed to be related to mild osteoarthritis and they were relatively short lived or of minimal on-going effect. Further, the applicant's doctors indicated that the nature of the condition and the symptoms differed from the symptoms arising from the meniscal tears. All that needs to be established is that a condition, irrespective of the pathology, results from a work injury. This was confirmed in *Kumar* and *Brennan.*

137. The applicant bears the onus of proof to show that his right knee symptoms have resulted from the accepted left knee injury. He relies on the views of Drs Rizkallah, Thomas, Lai and Botros. I am mindful that Dr Rizkallah has treated the applicant for an extended period, and he would be in the best position to comment on the applicant's symptoms, treatment and operative needs, so his views should carry the greatest weight. The respondent has no persuasive medical opinion to challenge the applicant's medical case.

138. When one reviews the evidence as a whole, the applicant has support for a consequential condition in his right knee that either caused or aggravated a meniscal tears. His symptoms arise from the tear of the right medial meniscus. I am satisfied that the left knee injury materially contributed to the applicant's right knee symptoms, consistent with the principles discussed in *Murphy* and *Secretary, Department of Family and Community Services v Colleen Jones by Executor of her Estate Carol Hewston*[8]*.*

139. Therefore, applying the common sense causal chain in accordance with *Kooragang*, and the principles discussed in *Kumar* and *Brennan,* I am satisfied on the balance of probabilities that the applicant has discharged the onus of establishing that he developed a consequential condition in his right knee as a result of the accepted injury to his left knee.

Is the proposed treatment reasonably necessary as a result of the injury sustained during the course of the applicant's employment?

140. Section 60 of the 1987 Act provides:

> "**60 Compensation for cost of medical or hospital treatment and rehabilitation etc**
>
> (1) If, as a result of an injury received by a worker, it is reasonably necessary that:
>
> (a) any medical or related treatment (other than domestic assistance) be given, or

[8] [2016] NSWWCCPD 63.

(b) any hospital treatment be given, or
(c) any ambulance service be provided, or
(d) any workplace rehabilitation service be provided,

the worker's employer is liable to pay, in addition to any other compensation under this Act, the cost of that treatment or service and the related travel expenses specified in subsection (2)".

141. What constitutes reasonably necessary treatment was considered in the context of s 10 of the *Workers Compensation Act 1926* in *Rose v Health Commission (NSW)*[9], Burke CCJ stated:

> "Treatment, in the medical or therapeutic context, relates to the management of disease, illness or injury by the provision of medication, surgery or other medical service designed to arrest or abate the progress of the condition or to alleviate, cure or remedy the condition. It is the provision of such services for the purpose of limiting the deleterious effects of a condition and restoring health. If the particular 'treatment' cannot, in reason, be found to have that purpose or be competent to achieve that purpose, then it is certainly not reasonable treatment of the condition and is really not treatment at all. In that sense, an employer can only be liable for the cost of reasonable treatment."[10]

142. Further, His Honour added:

> "1. *Prima facie*, if the treatment falls within the definition of medical treatment in section 10(2), it is relevant medical treatment for the purposes of this Act. Broadly then, treatment that is given by, or at the direction of, a medical practitioner or consists of the supply of medicines or medical supplies is such treatment.
>
> 2. However, although falling within that ambit and thereby presumed reasonable, that presumption is rebuttable (and there would be an evidentiary onus on the parties seeking to do so). If it be shown that the particular treatment afforded is not appropriate, is not competent to alleviate the effects of injury, then it is not relevant treatment for the purposes of the Act.
>
> 3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.
>
> 4. It is reasonably necessary that such treatment be afforded a worker if this Court concludes, exercising prudence, sound judgment and good sense, that it is so. That involves the Court in deciding, on the facts as it finds them, that the particular treatment is essential to, should be afforded to, and should not be forborne by, the worker.
>
> 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."[11]

[9] (1986) 2 NSWCCR 32 (*Rose*).
[10] *Rose*, [42].
[11] *Rose*, [47].

143. His Honour considered the relevant factors relating to reasonably necessary treatment under s 60 of the 1987 Act in *Bartolo v Western Sydney Area Health Service*[12] and stated:

> "The question is should the patient have this treatment or not. If it is better that he have it, then it is necessary and should not be forborne. If in reason it should be said that the patient should not do without this treatment, then it satisfies the test of being reasonably necessary."[13]

144. In *Diab v NRMA Ltd*[14], Deputy President Roche questioned this approach and cited *Rose* with approval. He provided a summary of the principles as follows:

> "In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in *Rose* (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.
>
> 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.
>
> 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'".[15]

145. Whether the need for reasonably necessary treatment arises from an injury is a question of causation and must be determined based on the facts in each case. This also involves the common-sense evaluation of the causal chain discussed in *Kooragang*.

146. According to the applicant's evidence, he has constant pain and restricted movement in his right knee. There is also mention in the evidence of clicking and swelling. His symptoms impact on his ability to undertake his usual daily activities. The applicant said that he has exhausted conservative measures and is keen to have surgery.

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[12](1997) 14 NSWCCR 233 (*Bartolo*).
[13] *Bartolo*, [238].
[14] [2014] NSWWCCPD 72 (*Diab*).
[15] *Diab*, [88] to [90].

147. The MRI scan that was taken in June 2019 confirmed that the applicant had tears of the medial meniscus and posterior horn, together with two loose bodies. This is the pathology that Drs Rizkallah and Thomas wish to address, rather than the mild osteoarthritis in the patellofemoral compartment.

148. Dr Panjratan disputes that the applicant requires surgery as a result of a work related condition because he considered that the need for the operation arose from the right plantar fasciitis. It seems that this condition may have arisen at work, given that the applicant obtained a WorkCover certificate from Dr Botros, so there is the possibility that the plantar fasciitis was work related, although this has not been the subject of any medical evidence or determination. In any event, is not a matter that that concerns me in these proceedings.

149. In my opinion, the evidence of Drs Rizkallah, Thomas and Lai supports the need for the operation to address the effects of the applicant's right knee pain. I have already expressed my concerns about Dr Panjratan's views, and this effects the weight to be given to his opinion regarding the surgery.

150. The applicant has tried conservative treatment, but this has not assisted his symptoms. Surgery appears to be the only option. I am satisfied that the surgery has the potential to alleviate the applicant's symptoms, it is an appropriate treatment and it is likely to be effective. There seems to be no alternative forms of treatment and the cost is not unreasonable. This satisfies the relevant factors discussed in *Rose* and *Diab*.

151. Accordingly, I am satisfied that the treatment proposed by Drs Rizkallah and Thomas, namely a right knee arthroscopy and removal of loose bodies, and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of the applicant's employment on 30 April 2018. It is presently unclear who will perform the surgery, but this is immaterial, as both doctors have provided quotes for the same procedure.

FINDINGS

152. The applicant sustained injury to his left knee arising out of or in the course of his employment with the respondent on 30 April 2018.

153. The applicant's employment was a substantial factor to his injury.

154. The applicant developed a consequential condition in his right knee as a result of the injury sustained to his left knee on 30 April 2018.

155. The applicant requires medical treatment as a consequence of his injury and the respondent is liable to pay reasonably necessary medical expenses.

156. The proposed right knee arthroscopy and removal of loose bodies, and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of the applicant's employment on 30 April 2018.

ORDERS

157. The respondent is to pay the applicant's reasonably necessary medical expenses with respect to the proposed right knee arthroscopy and removal of loose bodies, and associated expenses, pursuant to s 60 of the 1987 Act.