WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **4329/19**
Applicant: **Katarina Pejic**
Respondent: **Woolworths Limited**
Date of Determination: **22 October 2019**
Citation: **[2019] NSWWCC 341**

The Commission determines:

1. The need for the left total knee replacement arthroplasty surgery proposed by Dr MacDessi arises as a result of the injury on 12 April 2017.

The Commission orders:

1. The respondent to pay the costs of and incidental to the left total knee replacement arthroplasty surgery proposed by Dr MacDessi pursuant to s 60 of the *Workers Compensation Act 1987*.

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

Rachel Homan
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 RACHEL HOMAN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mrs Katarina Pejic (the applicant) was employed by Woolworths Limited (the respondent) as a "Long Life Team Member".

2. In or about mid-August 2016, the applicant sustained an injury to her left knee whilst on holiday. The applicant was treated by Dr Hugh Jones on her return and, in February 2017, he performed a left knee arthroscopy. On 12 April 2017, the applicant slipped on a wet floor at work, injuring the same knee.

3. The applicant was later referred to orthopaedic surgeon, Dr Samuel MacDessi and initially treated conservatively. Eventually, Dr MacDessi recommended treatment in the form of a left total knee replacement arthroplasty. A quote for the surgery was prepared on 7 December 2017.

4. The respondent's insurer disputed liability to pay compensation for the surgery in a notice issued pursuant to the former s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) on 11 April 2018. Although it was accepted that the applicant sustained injury by way of aggravating degenerative osteoarthritis in her left knee, the respondent considered that the aggravation was temporary and had now resolved such that any ongoing left knee symptoms were solely attributable to the applicant's underlying condition. It was not disputed that the surgery proposed by Dr MacDessi was reasonably necessary medical treatment but the respondent did not accept that the need for the surgery arose as a result of the injury.

5. That decision was maintained in a further dispute notice issued pursuant to s 78 of the 1998 Act on 30 April 2019.

6. Proceedings were commenced in the Commission on 29 May 2019 (2615/19) but discontinued at conciliation conference on 17 July 2019.

7. The present proceedings were commenced on 23 August 2019 by an Application to Resolve a Dispute (ARD) seeking the costs of and incidental to the surgery proposed by Dr MacDessi pursuant to s 60 of the *Workers Compensation Act 1987* (the 1987 Act).

ISSUES FOR DETERMINATION

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

    (a) Whether the need for the left total knee replacement arthroplasty surgery proposed by Dr MacDessi arises as a result of the injury to applicant's left knee on 12 April 2017.

PROCEDURE BEFORE THE COMMISSION

9. The parties appeared for conciliation conference and arbitration hearing on 15 October 2019. The applicant was represented by Mr Bill Carney of counsel instructed by Mr Slobodan Jankovic. The respondent was represented by Mr David Saul of counsel.

10. 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

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

    (a) ARD and attached documents; and

    (b) Reply (admitted as a Late Document on 20 September 2019) and all attachments.

12. Neither party applied to adduce oral evidence or cross-examine any witness.

Applicant's evidence

13. The applicant's evidence is set out in a written statement prepared by her on 14 May 2019.

14. The applicant said she commenced employment for the respondent in or about 1989. In or about mid-August 2016, the applicant was on holiday in Croatia. One morning, she woke up and was unable to stand on her left knee. The applicant was not sure what happened as she went to bed without pain. When the applicant returned to Australia in October 2016, the pain had not resolved. The applicant was treated by Dr Hugh Jones and underwent an arthroscopy performed by Dr Jones in February 2017. The applicant returned to work two weeks after this procedure in mid-March 2017.

15. On 12 April 2017, the applicant was at work pushing a trolley down the biscuit aisle when she slipped on a puddle of water. The applicant's right leg went forward and her left leg went back and the applicant sustained injury to her left knee. The applicant said she felt some discomfort and pain but continued to work for the remainder of her shift. The accident occurred towards the beginning of the shift.

16. The applicant had the next day off as it was Good Friday. On Easter Saturday, the applicant went to work. After about five hours, the applicant was experiencing greater pain and was limping. By the end of the day, the applicant's left leg was swollen.

17. The applicant attended her general practitioner, Dr Theodora Panopoulos, and asked to be referred back to Dr Jones. Dr Jones gave the applicant an injection which helped for about one month. After that, the pain returned. Dr Jones said that the applicant might be a candidate for a total knee replacement in the future.

18. The applicant underwent physiotherapy and hydrotherapy and was advised to lose weight. The applicant underwent gastric sleeve surgery in June 2017 and was able to successfully reduce her weight. Despite a significant amount of conservative treatment and having lost weight, the pain in the applicant's left knee did not subside.

19. The applicant attended upon her general practitioner again and was referred to Dr Samuel MacDessi for a second opinion. Dr MacDessi recommended a left knee replacement surgery on 7 December 2017. The applicant was having a difficult time standing and had started to limp. The applicant was putting extra weight on her good knee and was beginning to experience pain in that knee as well.

20. The applicant said her doctors remained of the opinion that she would benefit from a left total knee replacement. The applicant said she wished to undergo the surgery as she was in a lot of pain and discomfort. The applicant said she had exhausted her conservative treatment options and relied on painkillers.

The applicant's treating doctors

21. There are a series of reports from orthopaedic surgeon, Dr Hugh Jones in evidence, the first of which is dated 26 March 2015. This report related to right medial knee pain and recurrent swelling but noted numbness in both legs below the knees associated with sitting for prolonged periods and lying flat. The applicant was noted to limp intermittently and to have had several steroid injections. Dr Jones considered arthroscopy would be of limited benefit and said the applicant "will most likely come to arthroplasty options in the not-too-distant future."

22. Clinical notes from the applicant's general practitioner, Dr Theodora Panopoulos, reveal a consultation on 10 October 2016 where weight-bearing x-rays of the left knee were requested. The results of the x-ray were discussed with the applicant on 13 October 2016. An MRI of the left knee was requested at a consultation on 22 November 2016. The imaging request noted,

> "ACUTE INJURY TO THE LEFT KNEE - SWELLING, UNABLE TO FULLY EXTEND KNEE ?MENISCAL INJURY"

23. The applicant was referred back to Dr Jones on 29 November 2016.

24. On 2 December 2016, Dr Jones reported to Dr Panopoulos that he had reviewed the applicant after she twisted her knee whilst on holiday around a month earlier. The applicant had a limp and plain x-rays and MRI demonstrated some early medial compartment degenerative disease and a fairly large displaced tear of the posterior horn of the medial meniscus. Dr Jones recommended arthroscopic evaluation but noted in the meantime he had injected the knee with corticosteroid and local anaesthetic.

25. On 3 March 2017, Dr Jones indicated that the applicant had undergone arthroscopic left knee surgery on 24 February 2017. The significant finding was of a complex radial tear of the posterior horn of the medial meniscus which was debrided. Dr Jones said the applicant also had Grade II to III changes involving the medial femoral condyle and Grade II changes involving the tibial plateau.

26. On 21 March 2017, Dr Panopoulos' clinical notes refer to the knee arthroscopy performed in February. A letter of referral for gastric sleeve surgery was written to Dr Michael Talbot.

27. On 30 March 2017, Dr Jones reported that the applicant had made an uncomplicated recovery following her surgery but had some persistent swelling and discomfort in the knee. Dr Jones stated,

> "She has moderate medial compartment arthritis and is aware of her intra-operative findings which I have explained to her today. The long-term prognosis is guarded but we will in the short-term attempt to rehabilitate her knee with the aid of some physiotherapy."

28. On 18 April 2017, Dr Panopoulos recorded the following consultation:

> "Slipped at work on a small puddle of water on the 12th of April (left by the cleaners) - fell on knees, with left knee twisted backwards
> Able to weight bear for 2 days, then left knee became swollen. difficult to WB on Friday - treated
> with RICE, analgesics
> Swelling now reduced, but still unable to weight bear completely
>
> **Reason for visit: ·**
> Osteoarthritis of knee – exacerbation"

29. On 27 April 2017, Dr Jones reported that the applicant had slipped in a puddle at work two weeks earlier and twisted her left knee. The applicant had considerably more pain since her recent injury, localised to the anterior aspect of the left knee. Dr Jones noted the known medial and patellofemoral compartment arthritis revealed during recent arthroscopic debridement. Dr Jones noted the applicant's knee to be quite swollen and clinical examination revealed a moderate sized effusion. Dr Jones recommended further imaging and administered an intra-articular corticosteroid injection.

30. On 2 May 2017, Dr Panopoulos recorded:

> "MRI indicates a large radial tear of the post horn and body of the medial meniscus/
> Bone bruising of the medial compartment with significant OA
> Exacerbation of a previous injury
> Seen by Dr Jones - cortisone injected into the left knee with some relief
> Still has tenderness in the medial joint line
> Unable to stand for prolonged periods, Unable to squat
> Rest for a further week and then trial RTW with restrictions"

31. The applicant returned to Dr Jones with an MRI of her knee on 5 May 2017. On that occasion, Dr Jones stated:

> "This shows a previously demonstrated medial and patella-femoral compartment arthrosis with a degenerate and extruded medial meniscus but superimposed upon this she has a quite significant medial femoral condyle bone bruise. I think it is reasonable to attribute this to her recent fall whilst at work. The bone bruise is likely to recover over a period of 6-8 weeks and she should be managed with low-impact activity during this period. The long-term prognosis for the knee is guarded given her underlying degenerative disease and I will keep you updated regarding her progress."

32. On 9 May 2017, Dr Panopoulos noted that the applicant had been referred for physiotherapy and hydrotherapy. The applicant was noted to need a further two weeks of rest. Examination revealed:

> "Left knee not swollen. Tender over medial joint line. No deformity. Movement restricted."

33. On 18 May 2017, Dr Panopoulos noted that the applicant was still unable to stand for prolonged periods or fully weight bear. The applicant wished to trial a return to work with restrictions. The applicant was noted to want a second opinion regarding the need for total knee replacement in the future.

34. On 11 June 2017, Dr Jones reported that the applicant was "improving slowly". The applicant was noted to have an underlying degenerative problem which had had been exacerbated by a recent fall resulting in bone bruising which appeared "to be resolving with expectant management".

35. On 13 June 2017, Dr Panopoulos noted that the applicant still had left knee pain but was coping well at work and wished to increase her hours.

36. On 12 July 2017, Dr Panopoulos again noted that the applicant still had left knee pain and was unable to weight bear for prolonged periods.

37. On 18 July 2017, Dr Panopoulos recorded that the applicant had lost 10 kg and pain in her left knee was subsiding with weight loss.

38. On 18 July 2017, orthopaedic surgeon, Dr Samuel MacDessi reported that he had seen the applicant. He noted that five weeks after the left knee arthroscopic performed by Dr Jones, the applicant stumbled over and reinjured her knee. Dr MacDessi stated,

> "She has had ongoing pain in her knee since. However, over the last 6 weeks since losing about 10 kg in weight her pain has improved significantly. She still has difficulty walking and some mild medial and anterior lateral knee pain."

39. Examination revealed a mild effusion, tenderness over the medial joint line only and irritable medial compartment. Dr MacDessi said the applicant had medial compartment osteoarthritis causing her symptoms and was responding favourably to weight reduction. Dr MacDessi recommended low-impact strengthening and aerobic conditioning, physiotherapy, hydrotherapy and steroid injection.

40. On 15 August 2017, Dr Panopoulos noted that the applicant's left knee effusion had been drained and a cortisone injection performed on 10 August 2017. Some improvement in knee pain was reported but there was still some tightness/stiffness in the knee. The applicant was to commence hydrotherapy. The examination recorded:

> "Left knee Not swollen. Non-tender. No deformity. No restriction."

41. On 14 September 2017, the applicant again reported to Dr Panapolous that she was experiencing left knee pain, swelling and tenderness but improving. Examination on that date was recorded as follows:

> "Left knee swollen in the suprapatellar region. Tender along the medial joint line. No deformity. No restriction. Crepitus on movement"

42. On 12 October 2017, Dr Panapolous reported that the applicant was still experiencing pain in the left knee under the medial patellofemoral joint/medial joint line. The pain was said to be radiating down the medial left leg.

43. On 17 October 2017, Dr MacDessi reported that the applicant had persistent left medial knee pain radiating down the leg. It was noted that the applicant had lost another 10 kg in weight. Dr MacDessi he said most of the applicant's symptoms were "arthritic in nature". Dr MacDessi said he wished to give the applicant more time, commenting that if the applicant had persistent and significant pain in December he would look at the option of knee replacement.

44. On 7 December 2017, Dr MacDessi sought approval from the insurer for the applicant to undergo total knee replacement at St George Private Hospital. In a report of the same day to the applicant's general practitioner, Dr MacDessi stated,

> "Despite significant weight reduction following her bariatric surgery, Katarina's arthritic left medial knee pain persists. She has difficulty with prolonged walking and standing. She has come to the realisation that she is not going to get away without having a total knee replacement. We have obviously given her at least another two months to see if her pain settled down with the significant weight reduction she has experienced, and it really has not. I have now recommended to Katarina a total knee replacement for her arthritic knee pain."

45. On 11 January 2018, Dr Panopoulos reported:

> "Seen by one of the insurer's orthopaedic surgeons - X-rays of knees performed which indicated bilateral medial compartment DJD, left knee effusion
> -Also seen by Dr MacDessi in December who felt that left TKR an inevitability
> Pain in the left knee improved, since weight loss, but still has pain on prolonged walking and standing.
> Await review with Dr MacDessi
> Continue physiotherapy and hydrotherapy"

46. On 1 March 2018, Dr MacDessi reported that the applicant's left knee symptoms were persistent with mainly pain, which was activity related. It was noted that the applicant was awaiting workers compensation approval for the replacement surgery.

47. In a letter to UHG dated 26 November 2018, Dr MacDessi responded to a series of questions put to him as follows,

> **"Diagnosis of the patient's condition**.
>
> Osteoarthritis left knee
>
> **Whether you consider our clients employment with Woolworths was a substantial contributing factor to the injury reported to the left knee.**
>
> The patient injured her left knee whilst at work, 5 weeks after undergoing a left knee arthroscopy. As such it is likely that degenerative changes were present in the knee prior to the injury however a report from that surgery is required.
>
> **Opinion as to whether the client's employment was the main contributing factor to aggravation, acceleration, exacerbation and deterioration of the pre-existing condition.**
>
> It is likely that the injury sustained at work on 12th April aggravated the pre-existing osteoarthritis in the knee and that aggravation normally settles within a period of 3 to 6 months. Any further deterioration in the condition is due to degenerative osteoarthritis.
>
> **Please advise on whether a left total knee replacement is necessary.**
>
> Yes."

Dr Stephenson

48. The applicant relies on medicolegal reports prepared by Dr J Brian Stephenson, orthopaedic surgeon, dated 30 November 2018 and 18 March 2019.

49. In his first report, Dr Stephenson reported that the applicant complained of weakness of the left knee and constant pain. The applicant could not kneel on the left knee and needed assistance to kneel or walk up and down stairs. Dr Stephenson expressed the view that the slip or fall at work may have caused some aggravation of pre-existing osteoarthritis of the left knee and may have aggravated the pre-existing pain and discomfort of the left knee. Asked to comment on the proposed treatment, Dr Stephenson stated:

> "Proposed treatment is the advice from Dr MacDessi regarding the left total knee replacement. It was scheduled for February of this year but has not been undertaken due to lack of approval, I understand. In my opinion, the injury may have, to some degree, aggravated the discomfort in the left knee and this may have brought forward a need for total knee replacement somewhat earlier than it might otherwise have been required; Ms Pejic currently is aged 58 years."

50. Dr Stephenson noted that he had not seen the operative report of Dr Jones. With regard to prognosis, Dr Stephenson stated:

> "There are indications for a left total knee replacement. On the basis of the previous advanced osteoarthritis, there has been some degree aggravated by the slip and fall injury."

51. Dr Stephenson also indicated that the aggravation of the applicant's pre-existing condition was permanent.

52. In his supplementary report, Dr Stephenson was provided with Dr Jones' operative report and concluded,

> "The proposed left total knee replacement is both reasonable and necessary as a result of her work-related injury history."

Dr Rimmer

53. The respondent relies on medicolegal reports prepared by Dr Stephen Rimmer, orthopaedic surgeon, dated 20 December 2017 and 14 March 2018.

54. Dr Rimmer took a history of the immediate onset of pain and difficulty weight-bearing following the incident at work on 12 April 2017. The applicant complained of intermittent pain pointing to the medial aspect. There was associated clicking and swelling but no locking or instability.

55. Dr Rimmer considered that a series of x-rays of the left knee in the erect position was required. Dr Rimmer also indicated that he required a copy of Dr Jones' operation report. Dr Rimmer noted that there was severe pre-existing degenerative osteoarthritis of the left knee.

56. Dr Rimmer said he did not consider the respondent liable for the cost of the left knee replacement but said he required further investigations in the operation report.

57. In his supplementary report, Dr Rimmer indicated that he had been provided with an x-ray report of the left knee dated 5 January 2018 and the operation report by Dr Jones dated 24 February 2017.

58. Dr Rimmer was asked whether employment was "the main substantial contributing factor to the worker's compensable condition." Dr Rimmer responded in the negative stating:

> "The overwhelming facts are that she has severe pre-existing degenerative osteoarthritis of her left knee and the probability that this or a similar injury would have happened around the same time in the worker's life without being in employment I would rate as high."

59. Asked whether the worker's condition was "an aggravation/exacerbation of a pre-existing degenerative condition", Dr Rimmer responded in the affirmative, stating:

> "Given the mechanism of injury it would be consistent with an aggravation of this pre-existing condition however given the period of time that has elapsed since the date of injury in conjunction with the extensive conservative management she has had any ongoing symptoms on the balance of probabilities are due to pre-existing degenerative change."

60. Asked whether the respondent was liable for the cost of the "right" [sic] total knee replacement surgery, Dr Rimmer responded:

> "No, I do not believe Ms Pejic's employer Woolworths is liable for the cost of a left total knee replacement the reasons being that it is more than likely she would require this procedure given her pre-existing pathology in her left knee at around this time of her life regardless of her employment with Woolworths. This is in combination with her significant pre-existing condition having required a left knee arthroscopy only 2 months prior to the alleged work injury which essentially confirms she has a pre-existing condition of her left knee which is not work related at all."

Applicant's submissions

61. Mr Carney took me through the applicant's evidence and noted that the applicant had returned to work two weeks after the surgery performed by Dr Jones. In his report of 30 March 2017, four weeks after the surgery, the applicant was complaining of minimal symptoms. Mr Carney submitted that the evidence indicated an increase in symptoms consistent with an aggravation following the work incident, which had persisted.

62. Mr Carney submitted that Dr Rimmer had applied the wrong test, apparently confusing the relevant test with those in ss 4(b) and 9A of the 1987 Act. Mr Carney submitted that Dr Rimmer had not asked whether the injury had materially contributed to the need further surgery. Mr Carney submitted that Dr Rimmer appeared to have already made up his mind in his first report despite not having seen the additional imaging and Dr Jones' operation report.

63. Mr Carney said the reports of Dr Stephenson should be read together. Dr Stephenson had received the further investigations and the operative report of Dr Jones. Mr Carney submitted that Dr Stephenson had applied to the correct test, as evident in his first report and maintained the opinion that the arthroplasty was reasonably necessary as a result of the work injury in his second report.

64. Mr Carney submitted that the clinical notes of Dr Panopoulos were consistent with the applicant's case but did not add a lot to the evidence on causation.

65. Mr Carney noted Dr MacDessi's opinion on causation but said that he only indicated that the aggravation would "normally" settle within 3-6 months. Mr Carney said this had not occurred in the applicant's case. While there was some evidence of an improvement in the applicant's symptoms after bariatric surgery there was no resolution of the aggravation in the applicant's case.

Respondent's submissions

66. Mr Saul submitted that the case required a commonsense appraisal of the causal chain, referring me to the test set out in *Kooragang Cement Pty Ltd v Bates*[1]. Mr Saul said the relevant question was whether the accepted injury materially contributed to the need for surgery. Mr Saul submitted that an opinion on causation favourable to the applicant had not been provided by any treating specialist and the applicant relied on the opinion of Dr Stephenson.

67. Mr Saul took me through the reports of Dr Jones noting, in particular, that in his report of 30 March 2017, some two weeks prior to the work injury, the applicant complained of persisting swelling and discomfort. Dr Jones was pessimistic about the prognosis.

[1] (1994) 35 NSWLR 452; 10 NSWCCR 796.

68. Mr Saul referred me to the reports of Dr Rimmer and, whilst conceding that he had been asked to apply the wrong test, submitted that he had provided a qualified opinion that the ongoing symptoms experienced by the applicant were related to pre-existing pathology. Dr Rimmer had noted that the applicant had been able to return to work. Dr Rimmer had expressed the view that the need for surgery arose from the pre-existing pathology and the need for surgery would have arisen around the same time absent the work injury.

69. Mr Saul noted that Dr Stephenson had expressed the view that the work injury had brought forward the need for surgery but submitted that his opinions were hypothetically expressed noting the use of the word "may".

70. Mr Saul submitted that the opinion expressed in Dr Stephenson's subsequent report offended the principles set out in *Makita (Aust) Pty Ltd v Sprowles*[2] and *Hancock v East Coast Timber Products Pty Ltd*[3]. Dr Stephenson provided no explanation for how the injury had materially contributed to the need for surgery. Applying the test in *Kooragang*, Mr Saul submitted that I would find an award for the respondent.

FINDINGS AND REASONS

71. Section 9 of the 1987 Act provides that a worker who has received an 'injury' shall receive compensation from the worker's employer in accordance with the Act.

72. Section 60 of the 1987 Act relevantly provides:

> "(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
> (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)."

73. There is no dispute in this case that the applicant sustained an "injury" on 12 April 2017 in the nature of an aggravation of pre-existing osteoarthritis in her left knee. There is also no dispute that the surgery proposed by Dr MacDessi is reasonably necessary. The question I am required to determine is whether the surgery proposed by Dr MacDessi is reasonably necessary as a result of the accepted injury to the applicant's left knee on 12 April 2017.

74. In considering this question of causation, the authorities require me to conduct a commonsense evaluation of the causal chain. In *Kooragang Cement Pty Ltd v Bates*[4], Kirby P said:

> "… it has been well recognised in this jurisdiction that an injury can set in train a series of events. If the chain is unbroken and provides the relevant causative explanation of the incapacity or death from which the claim comes, it will be open to the Compensation Court to award compensation under the Act.

[2] (2001) 52 NSWLR 705; (2001) 25 NSWCCR 218; [2001] NSWCA 305; BC200105538.
[3] (2011) 80 NSWLR 43; (2011) 8 DDCR 399; [2011] NSWCA 11; BC201100628.
[4] (1994) 35 NSWLR 452; 10 NSWCCR 796

.

> …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 commonsense 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."[5]

75. It is apparent from the material before me that a major cause for the applicant's need for surgery is her pre-existing osteoarthritis. The need for surgery can, however, arise from multiple causes for the purposes of s 60 of the 1987 Act. In *Murphy v Allity Management Services Pty Ltd*[6] Roche DP stated[7]:

> "…That is because a condition can have multiple causes (*Migge v Wormald Bros Industries Ltd* (1973) 47 ALJR 236; *Pyrmont Publishing Co Pty Ltd v Peters* (1972) 46 WCR 27; *Cluff v Dorahy Bros (Wholesale) Pty Ltd* (1979) 53 WCR 167; *ACQ Pty Ltd v Cook* [2009] HCA 28 at [25] and [27]; [2009] HCA 28; 237 CLR 656). The work injury does not have to be the only, or even a substantial, cause of the need for the relevant treatment before the cost of that treatment is recoverable under s 60 of the 1987 Act.
>
> Ms Murphy only has to establish, applying the commonsense test of causation (*Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796), that the treatment is reasonably necessary 'as a result of' the injury (see *Taxis Combined Services (Victoria) Pty Ltd v Schokman* [2014] NSWWCCPD 18 at [40]–[55]). That is, she has to establish that the injury materially contributed to the need for the surgery (see the discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716)."

76. Similarly, in *Taxis Combined Services (Victoria) Pty Ltd v Schokman*[8] Roche DP held that the injury need not be the only, or even a substantial, cause of the need for treatment:

> "It is trite law that a condition can have multiple causes (*ACQ Pty Ltd v Cook* [2009] HCA 28 at [25] and [27]; [2009] HCA 28; 237 CLR 656). More importantly, the injury does not have to be the only, or even a substantial, cause of the need for the proposed treatment before the cost of that treatment is recoverable under s 60 of the 1987 Act. As the section states, and the Arbitrator acknowledged (at [55] and other places), Mr Schokman only has to establish that the proposed treatment is reasonably necessary "as a result of" the injury."

77. There is a dispute arising from the medical evidence in this case as to whether the work-related aggravation of the applicant's pre-existing osteoarthritis had resolved and whether it had materially contributed to the need for surgery.

78. One difficulty in determining this issue arises because of the close proximity between the arthroscopic surgery to the applicant's left knee of 24 February 2017 which was not work-related and the work-related injury on 12 April 2017.

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[5] At 462-463.
[6] [2015] NSWWCCPD 49.
[7] At [57].
[8] 2014] NSWWCCPD 18 at [54].

79. The evidence of Dr Jones indicates that the applicant's recovery from the arthroscopy was uncomplicated although there was some persistent swelling and discomfort. Dr Jones did indicate in his report of 30 March 2017 that the long-term prognosis was guarded in view of the applicant's moderate medial compartment arthritis and intra-operative findings. In the short-term, however, Dr Jones considered the applicant should attempt to rehabilitate her knee through physiotherapy. The applicant's undisputed evidence is that she was able to return to work two weeks after the surgery.

80. There was a clear deterioration in the applicant's symptoms and some new pathology in the nature of bone bruising after the fall on 12 April 2017. Dr Panopolous' notes indicate that the applicant was having trouble weight-bearing and her knee was swollen. On 27 April 2017 Dr Jones said the applicant had "considerably more" pain, swelling and a moderate sized effusion. This led to a need for further imaging, treatment by injection and aspiration of the effusion.

81. Both Dr Jones and Dr MacDessi to whom the applicant was later referred have given an opinion broadly consistent with Dr Rimmer that the work injury was expected to resolve. Dr Jones said the bone bruise could be expected to recover over a period of 6-8 weeks although the long-term prognosis for the knee was guarded in view of the degenerative condition. Dr MacDessi said the aggravation of the applicant's pre-existing osteoarthritis would "normally" settle within 3-6 months.

82. The treating evidence does not, however, indicate a material abatement of the applicant's worsened symptoms in the period that followed, despite thorough conservative treatment and a significant reduction in weight after the bariatric surgery.

83. That is not to say there was no improvement in symptoms. Dr Jones reported that the applicant was improving slowly on 11 June 2017. The applicant was able to return to work and, at one point, appears to have increased her hours. The pain seems to have subsided to a degree particularly in association with the applicant's weight loss. Nonetheless, the applicant continued to report persisting pain, stiffness, intermittent swelling and difficulty with prolonged walking and standing. By December 2017, Dr MacDessi had reached the view that a total knee replacement was necessary. Dr Macdessi said the pain had not "settled down" and the applicant was having difficulty with prolonged walking and standing.

84. Mr Saul has correctly submitted that there was no opinion on whether the need for surgery arose a result of the work injury from the applicant's treating doctors. Dr Panopoulos and Dr Jones have not expressed an opinion on the issue. Dr MacDessi was asked a series of questions related to this issue but was not asked the particular question I am required to determine. Rather, Dr MacDessi was asked separately whether employment was the main contributing factor to an aggravation of the applicant's pre-existing condition. He was also asked whether the surgery was necessary. Although Dr MacDessi said the work injury would normally settle within 6 months, he did not expressly state whether this had occurred. He also did not state whether the work injury had materially contributed to the present need for surgery. Dr Macdessi considered that any further deterioration in the applicant's condition would be due to the underlying pathology. The evidence does not, however, suggest a further deterioration but rather a failure of the increased symptoms following the work injury to settle.

85. The only direct opinion on the relevant issue favourable to the applicant is that contained in Dr Stephenson's reports. I accept Mr Carney's submission that Dr Stephenson's reports should be read together. The second report supplements the first. In his first report, Dr Stephenson expressed the view that the injury may have brought forward the need for total knee replacement somewhat earlier that it might otherwise have been required. Dr Stephenson also indicated that the aggravation of the applicant's pre-existing condition was permanent. In expressing his opinions, Dr Stephenson did, however, note that he would like to see Dr Jones' operative report. When provided with that report, his opinion remained unchanged.

86. Mr Saul criticised the lack of reasoning or explanation in Dr Stephenson's second report. Reading the two reports together, however, I accept that Dr Stephenson has given proper and cogent reasons for the opinions he has formed. Mr Saul also noted also the tentative language in which Dr Stephenson's relevant opinions were expressed. In this regard, I note the principles stated by Herron CJ, with whom Asprey and Holmes JJA agreed (at 245), in *EMI (Aust) Ltd v Bes*[9]:

> "... it is not incumbent upon the applicant, upon whom the onus rests, to produce evidence from medical witnesses which proves to demonstration that the applicant's contention is correct. Medical science may say in individual cases that there is no possible connexion between the events and the death, in which case, of course, if the facts stand outside an area in which common experience can be the touchstone, then the judge cannot act as if there were a connexion. But if medical science is prepared to say that it is a possible view, then, in my opinion, the judge after examining the lay evidence may decide that it is probable."

87. In *Woolworths Limited v Christopher-Coates*[10], Keating P, referring to the decision in *Tubemakers of Australia Ltd v Fernandez*[11] stated at [176] that:

> "*Fernandez* was cited with approval in *Commonwealth v McLean* (1996) 41 NSWLR 389 (McLean), where Handley and Beazley JJA said this at 410: 'A tribunal of fact is entitled to find causation as a matter of commonsense from the sequence of events, although medical science does not support an affirmative answer, provided it does not exclude such a finding: see *Adelaide Stevedoring Co Ltd v Forst* [1940] HCA 45; (1940) 64 CLR 538 at 563-564, 569 and *Tubemakers of Australia Ltd v Fernandez* (1976) 50 ALJR 720.'"

88. Notwithstanding the tentative language used by Dr Stephenson, I am satisfied that his opinion, taken together with the applicant's lay evidence and the evidence of the treating doctors provides a sufficient basis on which to find, on the balance of probabilities, that the need for surgery has resulted from the work injury.

89. Weighing against Dr Stephenson's opinions are the reports of Dr Rimmer. I accept Mr Carney's submission that Dr Rimmer was not asked to consider the correct test. That is not to say, however, that his answers do not bear on the question I am to determine. In his second report, Dr Rimmer has expressed the view that there was a high probability that "this or similar injury would have happened around the same time in the worker's life" without being in employment. Dr Rimmer also expressed the view that the applicant's ongoing symptoms were, on the balance of probabilities, due to the pre-existing degenerative change, having regard to the passage of time and the extensive conservative management. The difficulty I have in accepting Dr Rimmer's opinions is that he does not sufficiently engage with the applicant's actual circumstances and the evidence from her the treating doctors with regard to the work injury and its effects.

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[9] [1970] 2 NSWR 238.
[10] [2014] NSWWCCPD 14.
[11] [1975] 2 NSWLR 190.

90. My analysis of that evidence indicates that following the arthroscopy surgery in February 2017, Dr Jones considered that in the long-term a total knee replacement surgery may be required although in the short-term the knee could be rehabilitated through physiotherapy. There was a clear increase in troubling symptoms following the work injury. While there was some improvement with conservative treatment, the troubling symptoms persisted. Although the doctors expected the aggravation would subside after a period of time, the evidence does not indicate that it did. Within the year, Dr MacDessi had expressed the view that a total knee replacement was now necessary. This is an opinion on which all the doctors agree. As a matter of commonsense, having regard to this sequence of events, I prefer the opinion of Dr Stephenson over that of Dr Rimmer and consider that the injury has brought forward the need for surgery. I am satisfied on the balance of probabilities that the injury on 12 April 2017 has materially contributed to the present need for treatment even if it is not the only or even a substantial cause for the need for treatment.

91. I am satisfied that the applicant has discharged her onus of proof in relation to the claim and that the need for the left total knee replacement arthroplasty surgery proposed by Dr MacDessi arises as a result of the injury on 12 April 2017. There will be an award for the applicant.

SUMMARY

92. The need for the left total knee replacement arthroplasty surgery proposed by Dr MacDessi arises as a result of the injury on 12 April 2017.

93. The respondent to pay the costs of and incidental to the left total knee replacement arthroplasty surgery proposed by Dr MacDessi.