WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **4645/19**
Applicant: **Joel Ibrahim**
Respondent: **E Masonry Contracting (NSW) Pty Ltd**
Date of Determination: **4 December 2019**
Citation: **[2019] NSWWCC 386**

The Commission determines:

1. The applicant has sustained a consequential condition to his left knee as a result of the workplace injury to his right knee on 29 March 2010 and the subsequent surgery to his right knee.

2. The proposed left knee arthroscopy surgery is reasonably necessary treatment as a result of the workplace injury on 29 March 2010.

3. Subject to the operation of section 59A of the *Workers Compensation Act 1987,* the respondent is to pay the claim for the left arthroscopic procedure

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

Josephine Bamber
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 JOSEPHINE BAMBER, SENIOR ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr Joel Ibrahim is aged 31. In 2003 when he was aged 15, he injured his right knee and had surgery to that knee and says he completely recovered from that injury.

2. He alleges that he sustained injury to his right knee in the course of his employment E Masonry Contracting (NSW) Pty Ltd (the respondent) on 29 March 2010 when he slipped and fell going down stairs at work. He has undergone multiple surgeries to his right knee and he alleges in these proceedings that this has caused him to favour his right knee and depend on his left knee. As a consequence, he alleges he has developed a condition in his left knee as a result of overcompensation.

3. Dr Waller his orthopaedic surgeon has recommended he undergo arthroscopic surgery to his left knee. In his quote dated 1 May 2019 he says the surgeon's fee is $3,412.50 and the assistant's fee is $682.50. In Part 5.3 of the Application to Resolve a Dispute (ARD) the sum of $4,095 is claimed for the procedure. This is the only claim for compensation made in these proceedings.

4. Mr Ibrahim's counsel confirmed he is relying on an allegation of a consequential condition in the left knee caused by the work-related injury to the right knee. In such circumstances, both parties agree that I do not need to make a finding pursuant to section 4 of the *Workers Compensation Act 1987* (the 1987 Act). However, as the respondent disputes in its Reply that Mr Ibrahim has developed a consequential left knee condition as a result of the right knee injury, the Commission needs to make a finding about causation.

5. In relation to the proposed surgery, the respondent disputes that it is reasonably necessary and as a result of the alleged work injury.

6. There was some discussion at the commencement of the arbitration hearing as to whether section 59A of the 1987 Act would operate, in any event, to preclude an order for compensation being made in favour of Mr Ibrahim for the left knee arthroscopy, if he were otherwise successful. The upshot of this discussion was not conclusive. Mr Ibrahim's counsel did not concede that there would be such a preclusion. The question is complicated because sub-paragraph (2) sets out differing compensation periods which are dependent on the assessment of permanent impairment. If there has been no assessment of permanent impairment, then the compensation period is two years commencing on:

    "(i) the day of which the claim for compensation in respect of the injury was first made (if weekly payments of compensation are not or have not been paid or payable to the worker), or

    (ii) the day on which weekly payments of compensation cease to be payable to the worker (if weekly payments of compensation are or have been paid or payable to the worker)"

7. In Part 2.1 of the ARD Mr Ibrahim's solicitors have answered no to the question as to whether the worker has been examined by an Approved Medical Specialist under Part 7 of Chapter 7 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act). So, it can be inferred from this answer that there has been no assessment of permanent impairment undertaken.

8. There is no evidence before the Commission about the payment of weekly compensation. The insurer did not raise section 59A in its dispute notice dated 19 July 2019, which was issued pursuant to section 78 of the 1998 Act. Nor was it raised in the Reply form where the respondent did assert there had been a failure to determine and sought to dispute the following:

> "1. The worker did not sustain a consequential injury to the left knee resulting from the injury sustained on 29 March 2010,
>
> 2. In the alternative, the worker did not sustain an injury to the left knee arising out of or in the course of his employment for which employment was a substantial contributing factor or the main contributing factor pursuant to s4 and s9A of the 1987 Act (see attached facsimile dated 25 July 2019 from Associate Professor Waller).
>
> 3. The treatment claimed is not reasonably necessary as a result of a work-related injury as required by s60 of the 1987 Act."

9. To the extent it is necessary, under section 289A(4) of the 1998 Act leave is granted to the respondent to raise points 1 and 3 above. The matter proceeded in arbitration hearing on this basis.

10. However, if the Commission is ordering compensation be paid it has to do so in accordance with the legislation and thus it has to consider the operation of section 59A, even if it has not been raised in a dispute notice. The Commission does not have a declaratory power to determine questions about injuries where there is no claim for compensation that can be awarded, so it is unsatisfactory that there is no clarity about how section 59A applies in this matter.

11. For the reasons given below, I have found that the left knee condition was as a result of the work place injury to the right knee and the subsequent right knee surgery. However, when making the order in respect to payment of compensation, I have made that subject to the operation of section 59A of the 1987 Act.

PROCEDURE BEFORE THE COMMISSION

12. The matter proceeded in arbitration hearing on 4 November 2019. Mr Bill Nicholson, of counsel, appeared for Mr Ibrahim instructed by Ms Khodr, solicitor, and Mr Ross Hanrahan, of counsel, appeared for the respondent.

13. 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

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

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

Oral evidence

15. There was no oral evidence. Both counsel made oral submissions. The proceedings were sound recorded, and a copy is available to the parties. A written transcript (T) has been made from the recording.

FINDINGS AND REASONS

Joel Ibrahim's statement

16. In his statement dated 6 September 2019, Mr Ibrahim briefly details the treatment given for his right knee in the years following the initial injury on 28 March 2010. In paragraph 17, he states that,

> "Following each of these surgeries to my right knee, I have become extremely cautious about my right knee given that it could easily flare up and be aggravated. I have been more dependent on my left knee and I walk with a limp because I favour my right leg."

17. He adds that his right knee has deteriorated again, and Dr Waller has recommended he undergo a revision surgery to his right knee. He says that his left knee has become painful as a result of overcompensation for his right side.

Dr Dave

18. Dr Dave, orthopaedic surgeon, has treated Mr Ibrahim from the time when he was a child and had an injury to this right knee. There are quite a few reports from Dr Dave in the ARD, but confusingly many bear the date 14 November 2018. This must be the date the reports were printed, because most of them have a consultation date on them from a much earlier period.

19. From consultations on 1 April 2010[1] and on 25 May 2010,[2] Dr Dave, orthopaedic surgeon, reported to Dr Sellathurai that Mr Ibrahim had a work injury on 29 March 2010 when he was going down stairs and he slipped, and his right knee gave way. He felt a popping sensation and his knee was quite painful and swollen after that. It was noted he had been limping. Dr Dave states that he had seen Mr Ibrahim when he was a child when he had an avulsed tibial spine and required internal fixation.

20. Dr Dave also noted that he had seen Mr Ibrahim in 2004 when he was complaining about problems with his knee. He says at that time he had an ache in his knee, but no instability. He was not playing sport but was working as a bricklayer pushing wheelbarrows over uneven ground. Dr Dave says examination at that time revealed an unstable posterolateral corner. He says an MRI scan in 2004 revealed an anterior cruciate ligament injury, but he did not want to proceed with surgery at that time.

21. Dr Dave says the most recent MRI scan shows a torn anterior cruciate ligament along with a tear of the lateral meniscus and some intrameniscal degenerative changes. There was some bone bruising in the lateral femoral condyle suggestive of a fresh injury. Dr Dave recommended surgery.[3]

22. On 12 June 2010, Dr Dave reported to Allianz in response to their letter dated 28 May 2010, setting out similar information.

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[1] ARD page 21
[2] ARD page 22
[3] ARD page 22

23. On 8 July 2010, Dr Dave consulted with Mr Ibrahim noting his right knee tends to give way on him and the knee was loose. Dr Dave diagnosed that the ACL was deficient, and he proposed doing an ACL reconstruction using hamstring tendon graft.[4]

24. On 13 July 2010, Dr Dave performed an arthroscopy and ACL reconstruction hamstring tendon[5]. Dr Dave had another consultation on 27 July 2010 and in the report, also dated 14 November 2018, he records his examination findings[6].

25. On 1 September 2010, Dr Dave reviewed Mr Ibrahim and found the right knee stable, but he said it was disappointing that there was increased anterior drawer test of grade 2[7].

Rosemeadow Medical Centre and Appin Family Practice

26. On 20 February 2017, Dr Wang, general practitioner, issued a referral letter for Mr Ibrahim to see Dr Craig Waller for management of his ACL, noting he had a reconstruction by Dr Dave a year earlier.[8]

27. On 21 February 2017, an MRI scan was undertaken of Mr Ibrahim's right knee noting amongst other findings a complete graft tear[9].

28. On 18 August 2017, Dr Jun Wang records in his clinical notes the following:

> "limping because right knee ACL tear and reconstruction
> Left knee pain and locking sometime for one year
> …
> **Examinations:**
> Limping
> …
> Left knee ROM 0-130 degree, no joint line tenderness
>
> **Reason for visit:**
> **…**
> Left knee pain and locking
>
> **Actions:**
> …
> Imaging request printed to I-Med radiology: MRI of left knee (pain and locking of left knee injured left knee from limping
> ? meniscal tear)"

29. On 22 August 2017, an MRI scan was performed on the left knee. The clinical history in the report is "Pain and locking left knee. ? Meniscal tear."[10] The radiologist found:

> "There is myxoid degeneration of the posterior horn of the medial meniscus, with a longitudinal tear across the peripheral capsular portion at the posterior corner. The adjacent meniscotibial and meniscofemoral ligaments are indistinct, probably partially torn. The superficial component of the medial collateral ligament is intact. No flipped meniscal fragment is identified. Mild proximal patellar and distal quadriceps tendinosis Is also present.

[4] ARD page 27
[5] ARD page 26
[6] ARD page 28
[7] ARD page 29
[8] ARD page 51
[9] ARD pages 48/49
[10] AD page 46

> There is also incidental note of an osteochondroma arising from the posterior aspect of the proximal tibia, however this has only been partially imaged. Plain radiography can be obtained for further evaluation."[11]

30. On 1 September 2017, Dr Wang refers to oesteochondroma of left proximal tibial small tear of medical meniscus, posterior horn, no flap. Meniscotibial and meniscofemoral ligaments partial tear, osteomalacia. He states his plan was to request an x-ray and then make a referral to an ortho.

31. On 3 October 2017, a left knee x-ray was reported to Dr Wang finding there is a well-defined sessile osteochondroma arising from the posterior cortex of the proximal tibia. No aggressive features were detected. The radiologist commented that "There is no significantly increased density in the suprapatellar region to suggest a joint effusion."[12]

32. On 24 January 2018, Dr Wang records that Mr Ibrahim had an ACL reconstruction and he was limping and there was moderate swelling of the right knee.

33. On 19 February 2018, Dr Wang records that Mr Ibrahim's right knee had fully recovered, and he was happy to go back to normal duties.

34. On 28 February 2018 , it was noted in the practice notes that Mr Ibrahim had now been cleared for pre-injury duties from 26 February 2018 and as such in line with section 59A(3) of the 1987 Act entitlement to medical benefits have now ceased from 26 February 2018. This was said to be in an email received from the Senior Case Manager from Allianz[13].

35. On 10 November 2018 ,Dr Wang records right knee pain, superior patella, click sound at lateral of right knee, pain at B/L joint line sometimes.

Dr Waller

36. On 2 March 2017, Dr Waller, an Associate Professor of Orthopaedic Surgery, Macquarie University, reported to Dr Wang noting that he found Mr Ibrahim had a grossly unstable right knee from a failed ACL reconstruction and he was developing some wear in the joint and has meniscal tears[14].

37. On 25 October 2017, Dr Waller reported to Dr Wang about the problems with the right knee. He noted Mr Ibrahim has "generalised hypermobility with 15 degrees of hyperextension of both knees." He adds:

> "I also note that Joel has developed pain on the medial aspect of the left knee. He has some medial joint line tenderness. The ligaments are stable considering his hypermobility. X- rays of the left knee have shown a benign exostosis on the posterior aspect of the proximal tibia. It doesn't need any treatment. MRI scans have shown a torn medial meniscus."[15]

38. On 12 January 2018, is Dr Waller's operation report for the revision ACL reconstruction of the right knee[16].

[11] ARD page 47
[12] ARD page 44
[13] ARD page 61
[14] ARD page 50
[15] ARD page 45
[16] ARD page 42

39. On 7 February 2018, the physiotherapist, Andrew Hreszcuk, wrote to Dr Waller noting that Mr Ibrahim's knee was feeling good and that he had some pain in the anterior knee. He said he was keen to return to work and gym. He noted Mr Ibrahim had a good gait pattern[17].

40. On 13 March 2019, Dr Waller noted that he had performed a revision of the ACL reconstruction and lateral loop augmentation of the right knee for a failed previous ACL reconstruction in January 2018. He said when he saw Mr Ibrahim in March 2018 his knee demonstrated excellent stability, strength and range of motion. However, he says when he examined him on 13 March 2019 his ACL had stretched out probably due to his natural hyperextension. He sought a new MRI scan.[18]

41. On 1 May 2019, Dr Waller wrote to GIO recommending treatment for injury including revision ACL reconstruction, right knee and arthroscopic surgery, left knee. He gives a quote for the same for $3,412.50 surgeon's fee and assistant's fee $682.50.[19] In a report of the same date to Dr Wang, Dr Waller noted that an MRI scan of the right knee confirmed a disrupted ACL graft and that Mr Ibrahim had symptomatic instability of the right knee. Dr Waller also notes that Mr Ibrahim has a torn medial meniscus in his left knee that will require an arthroscopy.[20]

42. On 20 June 2019, Dr Waller answered a questionnaire sent to him by the insurer in relation to the right knee[21]. At point 8 the insurer informed Dr Waller they had not approved the proposed arthroscopy to the left knee. Dr Waller wrote underneath this "Understood". In a separate facsimile sent to Dr Waller by the insurer on 3 July 2019 the insurer wrote:

> "I note that you acknowledged that the left knee issues and related arthroscopy are non-compensable on 28/6/19. In your professional opinion, is there any causal relationship between the meniscus tear to Joel's Jeff knee and his original workplace Injury of 29/3/10? If yes, please provide clinical reasoning for this opinion."

43. On 25 July 2019, Dr Waller wrote beneath this question "No. No Causal relationship"[22].

Dr Habib

44. Dr Habib is a consultant he says in orthopaedics and trauma. His qualifications are that of general surgeon. He has been qualified by Mr Ibrahim's solicitors to provide a medico-legal report, which he has done on 23 August 2018[23] and 28 February 2019[24].

45. He notes the history of the work injury with the respondent on 29 March 2010 and that when employed by High Light Aluminium on 20 June 2013, he severely twisted his right knee when walking over some timber on the floor and feeling a sharp pain in his knee with the feeling of something pop and he fell. The respondent has not disputed liability for any such further injury to the right knee.

46. Dr Habib notes the treatment given to Mr Ibrahim by Dr Waller, including the ACL reconstruction surgery on 12 January 2018.

47. Dr Habib records that Mr Ibrahim has pain in the right knee medially and some pain along the lateral aspect of the distal thigh. He has weakness of the right knee with occasional feeling of giving way. He says both knees exhibited hyperextension, part of hypermobility of the joints.

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[17] ARD page 40
[18] ARD page 52
[19] ARD page 54
[20] ARD page 53
[21] Reply page 4
[22] Reply page 6
[23] ARD page 8
[24] ARD page 15

48. The investigation reports are summarised by Dr Habib, including that on 22 August 2017 an MRI of the left knee reported to show myxoid degeneration of the posterior horn of the medical meniscus with longitudinal tear and intact cruciates and collateral ligaments. Dr Habib also referred to the x-ray of the left knee dated 31 October 2017 that showed well defined sessile osteochondroma arising from the posterior cortex of the proximal tibia.

49. Dr Habib described the right knee having a complicated history. In his first report apart from mentioning the radiology of the left knee Dr Habib does not otherwise deal with the same.

50. In his second report, Dr Habib has a history that "the limping and gait change resulted in increased stress and strain on the uninjured left knee". Dr Habib stated:

> "Mr Ibrahim stated that his left knee had steadily become more painful for which he had seen his NTD and also Dr C Waller, orthopaedic surgeon. He had investigations including MRI scan. Dr Waller in his letter to his family doctor dated 25/10/17 stated the left knee joint to be tender at the medial joint line and that the MRI scan dated 22/08/17 ad [sic] shown:
>
> - Degenerative changes of the posterior horn of the medial meniscus with a longitudinal tear across the peripheral capsular portion at the posterior corner. The adjacent menisco-tibial and menisco-femoral ligaments to be indistinct, probably partially torn
>
> - Loss of normal cartilage stratification over the medial patellar facet and medium patellar eminence suggestive of chondromalacia patellae
>
> - Osteochondroma (benign findings) of the posterior aspect of the proximal tibia."

51. Dr Habib records that Mr Ibrahim complains of left knee pain frequently locking while seated with the knee bent at 90°. He reported to having to wriggle or move the knee to unlock it before getting up.

52. After recording his examination findings and the radiology, Dr Habib diagnosed:

> "During the period of instability of the right knee, which remains symptomatic despite the surgery. Mr Ibrahim severely strained the left knee because of:
>
> a. Overloading the left side to protect the damaged right knee
> b. Altered gait resulting in moderate left patella femoral arthropathy (patellar chondromalacia) also the medial meniscal and menisco-ligamentous injury."

Dr Machart

53. Dr Machart was qualified by the insurer and in his report dated 8 December 2018 he does not take a history about the left knee, nor does he refer to it under current symptoms, and he does not examine the left knee. The only reference to the left knee is when he refers to an assessment by Dr Waller of 15 December 2017, which refers to symptomatic tear of the medial meniscus in the left knee, for which he sought approval for an operation on the left knee at the same time as the right knee.

Discussion

54. The only medical evidence dealing with the left knee is contained in the reports from Dr Habib, Dr Waller's request to perform a left knee arthroscopy and then his response to the insurer that there was no causal relationship between the left knee meniscal tear to the right knee injury on 29 March 2010.

55. Mr Ibrahim has the onus of proof. It is of concern that there is not a report from the doctor who has proposed the treatment explaining why it is reasonably necessary and dealing with the case now put forward by Mr Ibrahim, that is he has a consequential condition in the left knee caused by the work-related injury to the right knee from overuse and altered gait.

56. Dr Waller's answer to the insurer is so brief that I cannot be sure that he has considered this allegation.

57. Mr Ibrahim's counsel submitted that the findings in Dr Habib's report are consistent with the general practitioner's clinical notes.

58. In *Nguyen v Cosmopolitan Homes (NSW) Pty Limited* [25] McDougall J stated at [44]:

> "A number of cases, of high authority, insist that for a tribunal of fact to be satisfied, on the balance of probabilities, of the existence of a fact, it must feel an actual persuasion of the existence of that fact. See Dixon J in *Briginshaw v Briginshaw* [1938] HCA 34; (1938) 60 CLR 336. His Honour's statement was approved by the majority (Dixon, Evatt and McTiernan JJ) in *Helton v Allen* [1940] HCA 20; (1940) 63 CLR 691 at 712."

59. I find such an actual persuasion of the existence of the fact that Mr Ibrahim did, as he states, become more dependent on his left knee and when he walks with a limp because he favours the right knee. Of course, Mr Ibrahim cannot provide a medical opinion regarding causation, but I do accept the fact that he limps due to his right knee. This is supported by an examination of the clinical notes.

60. On 18 August 2017 Dr Wang refers to Mr Ibrahim "limping because of right knee ACL tear and reconstruction. Left knee pain and locking sometime for one year." The doctor queried whether there was a meniscal tear and obtained an MRI scan. Dr Wang again records limping on 24 January 2018 because of the right knee, which he noted was swollen.

61. Dr Waller in his report of 25 October 2017 noted that Mr Ibrahim had developed pain in the left knee and that an MRI scan has shown a torn medial meniscus. He referred also to an x-ray of the left knee showing a benign exostosis on the posterior aspect of the proximal tibia and then the doctor says, "it doesn't need any treatment." I infer this means the exostosis does not need treatment. Because the next sentence refers to the MRI scan and the torn meniscus so if the doctor was intending to say the tear did not need treatment he would have written after this reference, not before.

62. In any event, Dr Waller has proposed the arthroscopy of the left knee and Dr Habib says the arthroscopy surgery could be used to accurately assess the left knee and do a partial meniscectomy and debridement, if required.

63. Mr Ibrahim's counsel submitted that notwithstanding that Dr Waller stated to the insurer that there was no causal relationship, it is overcome by other material.

[25] [2008] NSWCA 246

64. The respondent's counsel submitted that there is not a fair climate for Dr Habib's opinion. He stated there is no history of the serious injury that took place in 2003 to the right knee. But this is not correct in the report dated 24 August 2018 Dr Habib states "in 2003, aged 15 years, he injured his right knee for which he had open reduction and internal fixation."[26] The fact that Dr Habib does not repeat this in his second report, in my view, is not material given the findings made in earlier proceedings about there being a work related injury to the right knee from the incident on 29 March 2010. Furthermore, the subsequent surgery that has taken place has been found to be reasonably necessary as a result of the work place injury. In addition, there is no evidence to suggest Mr Ibrahim had problems with his left knee before about August 2017.

65. The respondent's counsel suggests that Dr Habib has also not expressed his opinion about causation in a precise manner. However, I do not accept this submission. Dr Habib expresses the opinion that the limping and gait change has resulted in increased stress and strain on the uninjured left knee. He also expresses the view that there has been overloading of the left side to protect the right damaged knee. Dr Habib's view has not been challenged or considered by Dr Machart. Given the clinical notes confirm Mr Ibrahim's account that he was limping due to his right knee, I find that Dr Habib's opinion has sufficient foundation and should be accepted.

66. The legal test of causation is that discussed by the Court of Appeal in *Kooragang Cement Pty Ltd v Bates*[27] wherein Kirby P (as his Honour then was) said (at 461G) (Sheller and Powell JJA agreeing) that "[f]rom the earliest days of compensation legislation, it has been recognised that causation is not always direct and immediate". After referring to earlier English authorities, his Honour added (at 462E):

> "Since that time, 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."

67. His Honour said at 463–464:

> "The result of the cases is that each case where causation is in issue in a workers' 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 injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a common sense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation. In each case, the question whether the incapacity or death 'results from' the impugned work injury (or in the event of a disease, the relevant aggravation of the disease), is a question of fact to be determined on the basis of the evidence, including, where applicable, expert opinions. Applying the second principle which Hart and Honoré identify, a point will sometimes be reached where the link in the chain of causation becomes so attenuated that, for legal purposes, it will be held that the causative connection has been snapped. This may be explained in terms of the happening of a *novus actus*. Or it may be explained in terms of want of sufficient connection. But in each case, the judge deciding the matter, will do well to return, as McHugh JA advised, to the statutory formula and to ask the question whether the disputed incapacity or death 'resulted from' the work injury which is impugned."

[26] ARD page 8
[27] (1994) 35 NSWLR; (1994) NSWCCR 796, *Kooragang*

68. Deputy President Roche in *Kumar v Royal Comfort Bedding Pty Ltd* [28]is authority for the proposition that *Kooragang* is the test to determine if a consequential condition arises from a work injury. Applying such principles, I am satisfied that the work-related injury to the right knee and the subsequent surgery has set in train a series of events, one being the left knee becoming symptomatic due to Mr Ibrahim's altered gait and overcompensation.

69. Therefore, I am satisfied that Mr Ibrahim has discharged his onus of proof. I find that he has developed a left knee condition as a result of the workplace injury to his right knee on 29 March 2010, and the subsequent surgical procedures. I have found that Mr Ibrahim has limped and so had altered gait because of the right knee injury and its sequelae. Thus, I am satisfied he has overcompensated because of the right knee problems.

SUMMARY

70. The determination and orders are as follows:

    (a) The applicant has sustained a consequential condition to his left knee as a result of the workplace injury to his right knee on 29 March 2010 and the subsequent surgery to his right knee.

    (b) The proposed left knee arthroscopy surgery is reasonably necessary treatment as a result of the workplace injury on 29 March 2010.

    (c) Subject to the operation of section 59A of the 1987 Act, the respondent is to pay the claim for the left arthroscopic procedure.

[28] [2012]NSWWCCPD 8