WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **6300/20**
Applicant: **Paramjeet Singh**
Respondent: **Christadelphian Homes Ltd**
Date of Determination: **22 January 2021**
Citation No: **[2021] NSWWCC 27**

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 9 July 2017.

2. The applicant's employment was a substantial or the main contributing 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 9 July 2017.

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 chondral debridement, 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 9 July 2017.

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 chondral debridement, 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. Paramjeet Singh (the applicant) is 32 years old and commenced employment with Christadelphian Homes Ltd (the respondent) as a care worker in 2010. His employment was apparently terminated on 14 November 2018.

2. There is no dispute that the applicant injured his left knee on 9 July 2017 when his left leg was struck by a motorised wheelchair. Liability was accepted by Employers Mutual Ltd (the insurer).

3. On 23 October 2019, the insurer issued a Work Capacity Decision (WCD). It confirmed that the applicant's Pre Injury Average Weekly Earnings were $377, and that he was fit to perform some work as a medical receptionist earning $315 per week. Accordingly it determined that he had no entitlement to weekly compensation beyond 11 February 2020. I was informed that payments of weekly compensation were reinstated as from 7 July 2020, when the applicant had further left knee surgery.

4. On 20 December 2019 and 17 January 2020, the insurer issued notices pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act), disputing that it was liable for various medical and travel expenses. These are not relevant in these proceedings.

5. On 22 January 2020, the applicant's treating orthopaedic surgeon, Dr Kinzel, wrote to the insurer and advised that the applicant had problems with his right knee as a result of overcompensating for his injured left knee.

6. On 17 February 2020, the insurer issued a notice pursuant to s 78 of the 1998 Act, disputing that the applicant developed a consequential condition in his right knee as a result of his left knee injury.

7. Dr Kinzel submitted a quote for a meniscectomy, the removal of loose bodies and a chondroplasty on 3 March 2020.

8. On 15 June 2020, the insurer issued a further dispute notice, disputing that the applicant developed a consequential condition in his right knee as a result of his left knee injury.

9. On 3 July 2020, the insurer issued a notice pursuant to s 78 of the 1998 Act, disputing that the applicant was incapacitated and that he was entitled to the payment of medical expenses in respect of the injury to his left knee. It cited ss 33, 59 and 60 of the *Workers Compensation Act 1987* (the 1987 Act).

10. On 30 September 2020, the applicant's solicitor requested the insurer to review its decision dated 15 June 2020.

11. On 14 October 2020, the insurer reviewed its decision pursuant to s 287A of the 1998 Act, and advised the applicant that it intended to maintain its decision.

12. By an Application to Resolve a Dispute (the Application) registered in the Workers Compensation Commission (the Commission) on 29 October 2020, the applicant claims the cost of proposed medical treatment pursuant to s 60 of the 1987 Act due to injury sustained on 9 July 2017.

ISSUES FOR DETERMINATION

13. 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 9 July 2017;

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

    (c) 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

14. 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

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

    (a) The Application and attached documents;
    (b) Reply and attached documents, and
    (c) Application to Admit Late Documents received on 23 December 2020.

Oral evidence

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

REVIEW OF EVIDENCE

Applicant's statements

17. The applicant provided a statement on 29 October 2020. He indicated that he had no symptoms in either of his knees prior to his injury on 9 July 2017. He described the circumstances of his left knee injury on 9 July 2017 and his subsequent symptoms and treatment.

18. The applicant stated that Dr Dagher referred him to Dr Kinzel and she performed left knee arthroscopies in August 2017 and December 2017. He was off work for two to three months, resumed employment on restricted duties and remained in that capacity until his employment ceased on 14 November 2018.

19. The applicant stated that he continued to experience constant left knee pain and swelling. He was referred to Dr Randhawa and a pain specialist, Dr Nazha. He had walked with a limp since his injury and he had developed pain in his right leg, right knee and lower back. Dr Dagher told him that his problems were due to favouring his right leg and his altered gait.

20. The applicant stated that his left knee and leg were weak and his knee was prone to giving way from time to time. In February 2020, his left knee gave way and he twisted his right knee. He had swelling in his right knee and it was becoming more of a problem, so Dr Dagher referred him for an MRI scan. His right knee pain became worse when his left knee gave way and he fell to the ground whilst he was at home on 20 June 2020.

21. The applicant was referred to Dr Kinzel, who recommended a right arthroscopy and chondral debridement. His left knee deteriorated and he had a further debridement and chondroplasty on 7 July 2020. His right knee flared up even more because he was not able to weight bear on his left leg. His left knee again gave way at home on 12 September 2020.

22. The applicant stated that he had difficulty walking and standing for prolonged periods. He was keen to have the surgery to improve is mobility and quality of life.

Clinical notes of Emerald Medical Centre Quakers Hill

23. The clinical notes of Emerald Medical Centre Quakers Hill commence on 6 October 2015 and conclude on 18 February 2020.

24. On 18 July 2017, Dr Dagher noted that the applicant had suffered an injury to his left knee on 9 July 2017. At consultations in August 2017 and September 2017, the doctor recorded that the applicant had constant pain with a restricted range of movement, and he was limping.

25. On 27 October 2017, Dr Dagher reported that the applicant had pain and swelling in his left knee after twisting on stairs two days earlier, and he noted increased pain in the knee at the consultations on 7 November 2017 and 15 November 2017.

26. On 11 December 2017, Dr Dagher reported that the applicant had worsening pain and swelling in his left knee, and he was limping. This was about a week after the applicant had an arthroscopy. Similar complaints were noted on 21 January 2018.

27. Dr Dagher reported complaints of left knee pain in February 2018 and March 2018. On 3 April 2018, the applicant complained of increasing left knee pain after twisting his knee when going down stairs two days earlier. The doctor noted that the applicant was limping.

28. On 15 April 2018, Dr Dagher recorded that the applicant had increased pain and swelling in his left knee. He had difficulty walking. On 6 May 2018 and 7 May 2018, the applicant complained of increased pain that had developed over the previous few days. He was still having difficulty walking.

29. On 11 May 2018 and 15 May 2018, Dr Dagher reported that the applicant had twisted his left knee at home and he had experienced increased pain. There was evidence of swelling and a limited range of movement. The applicant reported no improvement in his symptoms at the consultation on 22 May 2018.

30. On 29 May 2018, Dr Dagher noted that the applicant had twisted his left knee again when it gave way as he was turning. His pain was worse and there was evidence of swelling and tenderness. The applicant was also limping. On 5 June 2018, the doctor recorded that the applicant had pain in his knee. It was giving way all of the time and he experienced recurrent twisting.

31. On 20 June 2018,. Dr Dagher reported that the applicant had twisted his left knee twice in the previous three days. His pain was worse, he was limping and he was unable to extend his knee. He reported further twisting episodes at consultations on 4 July 2018 and 13 July 2018.

32. At the consultation on 24 July 2018, Dr Dagher recorded that the applicant had suffered a twisting episode two days earlier. He had increased pain and he was limping. He also reported that the applicant had been troubled by right knee pain for four weeks in the absence of any injury.

33. On 30 July 2018, the doctor recorded a history that the applicant had fallen the day before when walking down stairs and had landed on his knee. He had increased pain and a limited range of motion. On 12 August 2018, there was a report of yet another twisting episode.

34. On 20 August 2018, the doctor recorded that the applicant had increased pain in his left knee and he had right knee pain, whilst on 31 August 2018, the doctor noted that the applicant had twisted his left knee at work and he had increasing pain in his right knee.

35. On 11 September 2018, the applicant complained of severe right knee pain that had been worsening since he twisted his left knee in late August 2018. On 14 September 2018, it was noted that the applicant had increasing right knee pain and he was limping.

36. Dr Dagher recorded complaints of constant pain, swelling, twisting episodes and limping at subsequent consultations in 2018 and in early 2019, but he did not specifically mention the applicant's knees. It seems that the applicant's pain had plateaued, but there was an increase when he slipped and his knee gave way in incidents in late March 2019, April 2019, June 2019 and July 2019.

37. On 27 August 2019, Dr Dagher reported that the applicant had severe pain in his left knee after falling and twisting the knee when going down stairs on 25 August 2019. Further twisting episodes occurred in September 2019 and October 2019.

38. On 2 October 2019, the doctor reported that the applicant's left knee pain was worse following an incident on 29 September 2019, but his right knee was okay, apart from some pain.

39. On 13 November 2019, the applicant complained of left knee pain following a twisting incident in the previous week, which affected this right knee pain. There were further twisting incidents noted in December 2019 that impacted in the applicant's right knee pain. The doctor also reported that the applicant was limping.

40. On 15 January 2020, Dr Dagher recorded that the applicant had twisted his knee three times over the past week and he had right knee and low back pain due to recurrent twisting and an abnormal gait.

41. On 12 February 2020, the doctor noted that the applicant had lost control of his left knee, slipped and landed on his right knee. On 17 February 2020, the doctor indicated that the applicant had constant pain in his knees and lower back. His right knee pain was worsening and he had constant left knee pain "as usual". The doctor referred the applicant for an MRI scan on his right knee.

Reports of Dr Kinzel

42. Dr Kinzel reported on 2 August 2017 and 20 September 2017. She confirmed the circumstances of the applicant's left knee injury, the proposed surgery and the applicant's post-surgical condition.

43. In her report dated 17 January 2018, Dr Kinzel recorded that the applicant still had left knee pain and swelling that restricted his range of motion. On 4 July 2018, the doctor reported that the applicant was still troubled by left knee pain but he was mobilising more easily with only a very mild limp. She advised against a total knee replacement.

44. On 11 September 2019, Dr Kinzel noted that the applicant had suffered flare up when he slightly twisted his left knee. On 30 October 2019, the doctor advised that the applicant was troubled by recurrent giving way and pain. She recommended attendances with an exercise physiologist, but the insurer declined to approve this treatment.

45. On 22 January 2020, Dr Kinzel reported that the applicant's left knee condition had deteriorated since he stopped seeing the exercise physiologist, and he had also developed problems with his right knee because it was overcompensating for his injured left knee. X-rays showed some early degenerative changes but no advanced osteoarthritis. The doctor recommended further conservative treatment because of the significant deterioration in the applicant's left knee.

46. In a report dated 17 February 2020, Dr Kinzel recorded that the applicant had been troubled by left knee pain for a prolonged period and this had placed strain on his right knee that had tended to overcompensate when he was unable to fully weight bear through his left knee. She indicated that there was a direct relationship due to overcompensating.

47. Dr Kinzel advised that there was only mild osteoarthritis in the applicant's right knee, and his symptoms were more in keeping with a soft tissue condition caused by overcompensating. She recommended a review by an exercise physiologist.

48. In a report dated 4 March 2020, Dr Kinzel advised that the applicant had classic compensatory pain in his right knee, especially when sitting or standing for long periods. The knee had deteriorated since exercise treatment had ceased. She commented that an MRI scan showed chondral fraying and defects in his patella, and she recommended an arthroscopy and chondroplasty to remove detached cartilage.

49. On 3 June 2020, Dr Kinzel noted that the applicant was struggling with his right knee symptoms. He experienced night pain and he had difficulty walking for long distances. She recommended debridement because the applicant was too young for a total knee replacement.

50. On 7 July 2020, Dr Kinzel performed a further left knee arthroscopy and chondroplasty, and she reported that there had been a progression in the degenerative changes since her previous operation. She indicated that the applicant's right knee had become more painful because of further "over compensatory insult", and she recommended surgery.

51. In a report dated 23 September 2020, Dr Kinzel described the applicant's left knee treatment and confirmed that over time, the applicant had developed pain in his right knee due to overcompensation and he had changes affecting his patellofemoral joint. She noted that the applicant had chondral changes in his left knee that had progressed to further degenerative changes, and even though he may have had a genetic disposition for the degenerative changes, his symptoms were triggered by the incident in July 2017.

52. Dr Kinzel noted the views of Dr Smith and stated that the applicant had degenerative changes in his knees which would progress to osteoarthritis. She observed that the applicant was asymptomatic and he developed symptoms after the work injury. She stated that the incident was the sole contributing factor to his current condition.

53. Finally, in a report dated 23 December 2020, Dr Kinzel advised that the applicant's right knee had developed an over-compensatory injury and the changes in his patellofemoral joint had become symptomatic due to the applicant taking most of the load through his right knee because of his left knee injury.

54. Dr Kinzel stated that the applicant had developed chondral changes in his patellofemoral joint and fraying, and these were evident in September 2020. She advised that due to the permanent problems in his left knee, the applicant was weightbearing mainly through his right knee, and this subsequently triggered his patellofemoral joint to become symptomatic.

She indicated that debridement of this area would “hopefully” give the applicant some relief and defer the need for a total knee replacement. She advised that the applicant was too young for such a procedure.

55. Dr Kinzel stated that osteoarthritis was a severe degenerative process of the joint where the surface cartilage slowly disintegrated, leading to arthritic complaints. She explained that an arthroscopy, especially in a young patient, had benefits because chondral wear could be debrided and this would hopefully settle the inflammation within the knee. She was confident that the applicant would gain some benefit from the surgery.

56. The applicant relies on reports from Dr Randhawa dated 1 May 2018 and a series of reports from Dr Nazha. They confirmed that the applicant was troubled by persistent left knee pain and required treatment, such as injections, a tens machine, and a total knee replacement.

Diagnostic tests

57. There are a number of diagnostic tests in evidence. The ultrasound of the applicant’s left knee dated 28 May 2018 referred to a history of longstanding left knee pain, and the MRI scan dated 26 April 2019 recorded a history of on-going pain post knee reconstruction.

58. An ultrasound dated 25 July 2018 showed some quadriceps insertional tendinopathy, but was otherwise normal.

59. An MRI scan dated 13 September 2018 reported a history of worsening right knee pain for a few months. This showed moderate chondromalacia patella, mild oedema in the lateral infrapatellar fat pad, minor tendinosis patellar in the patellar tendon and quadriceps insertion. There was also mild scarring in the proximal medial collateral ligament.

60. An x-ray dated 22 January 2020 identified the possibility of osteoarthritis.

61. An MRI scan dated 17 February 2020 showed “chondral fissuring of the patella apex and adjacent medial and lateral patellar facet with low grade reactive marrow oedema pattern” which had progressed since the previous study. Similar findings were reported in the MRI scan dated 29 August 2020.

Report of Michael Ward

62. Michael Ward, a physiotherapist, provided an undated report to the insurer in respect of discussions that he had with the applicant’s physiotherapist, Mr Black, on 9 April 2019. He had access to a number of reports that are not in evidence.

63. Mr Ward reported that Mr Black had “flagged compensatory strategies” that contributed to other joint problems, presumably those in the applicant’s right knee. Mr Ward indicated that that he told Mr Black that “there was no indication that damage was being incurred by alternative movement strategies and that he was effectively performing a graded loading program on two other joints”.

Reports of Dr Khong and IPAR

64. Dr Khong, physician, provided a report on 12 May 2020. He identified the applicant’s left knee injury as retropatellar damage. It seems that he was only provided with the report of Dr Smith, a surgery request and quote dated 4 March 2020 [sic], and a pain management report dated 4 March 2020 [sic] from Dr Deshpande.

65. A functional capacity evaluation report was provided by Mr Pinto-Hayes, occupational therapist of IPAR, on 23 October 2020. He was provided with a number of reports, most of which are not in evidence, including a report of Dr Kinzel dated 2 September 2020. Yet again, the insurer did not provide a complete copy of the reports and clinical notes of the applicant's treating doctors.

66. Mr Pinto-Hayes indicated that the applicant was highly pain focused and fear avoidant during the assessment. He repeatedly ceased functional tasks due to increased pain and he had severe pain scores in the absence of significant signs.

67. Mr Pinto-Hayes stated that there were significant psychosocial barriers and the applicant would be a poor candidate for job-seeking until he had participated in a comprehensive multi-disciplinary pain management program.

Reports of Dr Smith

68. Dr Smith reported on 8 April 2020. He obtained a consistent history of the incident and subsequent treatment. He noted that the applicant had only gained temporary relief from his left knee operations and his right knee became symptomatic in 2019 without any further injury. The doctor did not record any history of the nature and extent of the applicant's symptoms in his knees since 2019.

69. Dr Smith diagnosed bilateral knee osteoarthritis which was part of the aging process and occurred most commonly at around 40 years of age. It was inherited and familial, and occurred bilaterally, and this was unrelated to the applicant's employment.

70. Dr Smith stated that the applicant may have dislocated his previously asymptomatic left knee on 9 July 2017 on the background of a small high patella in the shallow trochlear, which were structural anatomical variants. He believed that the applicant would have recovered from the incident after less than one week at the most, and once his knee was rendered symptomatic, he would continue to aggravate it by various activities. He indicated that these aggravations would become increasingly frequent and severe with the passage of the years. The same pathology was present in the applicant's right knee.

71. Dr Smith stated that the osteoarthritis was unrelated to the applicant's employment, and he would have experienced symptoms whether he worked or not. He stated that there was no real place for arthroscopy in the treatment of knee osteoarthritis and he cited an article by Mosley et al in support of his opinion. He recommended physiotherapy, splints and further tests before any surgery was undertaken. An osteotomy, which would delay a knee replacement operation, might be an option, depending on the radiological findings.

72. In his report dated 11 June 2020, Dr Smith advised that the proposed surgery was an inappropriate form of treatment for knee osteoarthritis. It was highly unlikely to produce any benefit, and there was the possibility that the surgery could make the condition worse. He stated that there was one chance in three that there would be some temporary improvement, one chance in three that there would be no change, and one chance in three that the condition would be worse.

73. Dr Smith confirmed that the applicant's left knee injury in July 2017 would have resolved as a pathological entity with or without treatment, after three months at the most, and any on-going symptoms in the left knee after late October 2017 were due to his underlying knee osteoarthritis.

APPLICANT'S SUBMISSIONS

74. The applicant's counsel, Mr Jobson, submits that there were regular reports of the applicant experiencing twisting and his left knee giving way in the clinical notes of Dr Dagher from May 2018 onwards. There were references to on-going pain, limping and swelling.

75. Mr Jobson submits that on 15 January 2020, Dr Dagher recorded that the applicant had twisted his left knee three times over a week and he had developed right knee and low back pain due to recurrent twisting and an abnormal gait. On 12 February 2020, it was noted that the applicant had slipped when he lost control of his left knee and landed on his right knee.

76. Mr Jobson submits that on 17 February 2020, Dr Dagher reported that the applicant had constant knee and back pain, and his right knee condition was worsening. He identified the reason for the consultation was "Workers compensation". He submits that it is significant that Dr Smith was not provided with a copy of these notes.

77. Mr Jobson submits that in his statement, the applicant confirmed that he had been walking with a limp since his injury in 2017 and over time, he had developed pain in his right knee and lower back. Dr Dagher told him that his problems were due to favouring his right leg and his altered gait.

78. Mr Jobson submits that Dr Kinzel reported that the applicant was walking with a mild limp in July 2018. In October 2019, she reported that the applicant suffered recurrent pain and giving way of his left knee. On 22 January 2020, the doctor advised that the applicant was having problems with his right knee because it was overcompensating for his left knee.

79. Mr Jobson submits that on 4 March 2020, Dr Kinzel reported that the applicant had pain in his right knee which was classic compensatory pain. On 3 June 2020, the doctor reported that the applicant was struggling with both knees and was overcompensating. He submits that the reason why the applicant was overcompensating was because of his left knee injury.

80. Mr Jobson submits that on 23 September 2020, Dr Kinzel reported that the applicant had a compensatory injury to his right knee and had changes affecting his patellofemoral joint. She indicated that the applicant was a classic example where there was an asymptomatic knee and symptoms developed after an injury. He submits that the evidence is all one way.

81. Mr Jobson submits that Dr Smith made no mention of an altered gait, low back pain or compensatory pain. He had the reports of Dr Kinzel, but he did not engage with her opinion. He only referred to osteoarthritis in the applicant's knees. There is osteoarthritis, but the applicant's left knee injury caused an altered gait, limping, right knee pain and low back pain. Dr Dagher gave reasons for the altered gait. There is no difficulty in finding that the applicant developed a consequential condition in his right knee.

82. Mr Jobson submits that Dr Kinzel cannot guarantee a positive outcome, but the purpose of the surgery was to settle the inflammation in the applicant's right knee. The doctor had recommended the procedure on a number of occasions. The use of the word "hopefully" was of no consequence. The surgery is reasonably necessary.

83. In reply, Mr Jobson submits that Dr Kinzel indicated in her report that she was hopeful that the proposed surgery would settle the inflammation in the applicant's right knee. The applicant has an altered gait and limp. These were the relevant biomechanical elements.

84. Mr Jobson submits that Dr Kinzel explained in her last report that the applicant had developed chondral changes in his patellofemoral joint and fraying, and these were evident in September 2020. She stated that the applicant was weightbearing mainly through his right knee due to his left knee injury, this being the causative link, and this subsequently triggered his patellofemoral joint symptoms.

85. Mr Jobson submits that Dr Kinzel indicated that debridement of this area would “hopefully” give the applicant some relief and defer the need for a total knee replacement. The doctor fully and appropriately explained her reasoning regarding the right knee condition and the surgery.

RESPONDENT’S SUBMISSIONS

86. The respondent’s counsel, Mr Hanrahan, submits that Dr Kinzel has not provided an adequate explanation for her conclusion. He submits that the clinical notes provide a context but they are lacking an explanation for the expressed conclusions. They do not explain the biomechanics of the incident or the occasions when the applicant placed weight on his right side, apart from the reference to a twisting of the left knee and landing on the right knee. There was no other description of the pathology that resulted from these events.

87. Mr Hanrahan submits that Dr Kinzel referred to the applicant being a “classic” presentation and was shifting his weight onto his right side, but she did not explain what was happening in the applicant’s right knee to justify the operation. It is an “ipse dixit” situation without an explanation.

88. Mr Hanrahan submits that the applicant said that he had been walking with a limp since his injury in 2017, and in time, he had pain in his right leg, knee and back. He said that Dr Dagher told him that the pain was caused by favouring his right leg and an altered gait. It was unclear if these were two different things and if so, what was the difference between them.

89. Mr Hanrahan submits that one must have reservations about the evidence of Dr Kinzel. In her report dated 23 September 2020, the doctor referred to an “insult” to the right knee, but it is unclear what she meant, because an insult would normally relate to a frank injury. This terminology clouds the situation. There were no accurate details of the biomechanics.

90. Mr Hanrahan submits that it was clear from the functional report that there have been five operations on the applicant’s left knee, but there is only one report in evidence. There is no information regarding the nature of the arthroscopic procedures that were undertaken and the seriousness of the left knee condition as a basis for relating it to the problems in the right knee.

91. Mr Hanrahan submits that Dr Kinzel merely adopted the convenient conclusion that there was a “classic” presentation and used the term “overcompensating”. She did not explain the nature of the degenerative changes and whether there was any distinction between the injury to the applicant’s left knee and the subsequent development of the degenerative changes. These were two separate entities, and that was the way that Dr Smith approached it. The applicant has degenerative changes and it might have nothing to do with his injury. The pleadings do not refer to the nature of the pathology and there was no description of the injury as an aggravation of degenerative changes. The doctor must explain how those symptoms arose and describe the mechanism to show a sufficient causal connection.

92. Mr Hanrahan submits that the applicant needs to show that there had been a material contribution to the need for right knee surgery from the left knee injury. Dr Kinzel did not say in what sense that there had a been a material contribution from the shift of weight, walking with a limp or with an altered gait. One could not be satisfied that the applicant had a consequential condition in his right knee. It has not been spelt out by any of the doctors in this case , and the applicant does not rely on the opinion of an independent medical expert. in her last report, Dr Kinzel did not give any further insight as to how the applicant’s right knee condition had developed over time and why it had become symptomatic.

93. Mr Hanrahan submits that Dr Kinzel first referred to the applicant's right knee in her report dated 22 January 2020, some six months or so after her initial examination. There was no explanation apart from the knee giving way. She did not explain what she meant by overcompensating and a "classic" presentation. She noted that the applicant had pain whether he was sitting or standing, so it seems that there was no difference.

94. Mr Hanrahan submits that Dr Kinzel needed to explain in sufficient detail why the problems in the applicant's right knee were compensatory. The doctor referred to the development of right knee problems arising when the applicant stopped having physiotherapy on his left knee, rather than any overcompensation or transferral of weight.

95. Mr Hanrahan submits that Mr Ward reported that there was no indication that damage was being caused to the applicant's right knee by any alternative movement strategies. He submits that there needs to be a material contribution and there was no evidence or expert evidence that established such a connection.

96. Mr Hanrahan submits that Dr Smith noted that the applicant developed right knee pain without any injury. He commented that the applicant had an unusual condition in his right knee, namely a patella alta, which was an anatomical variant. This of itself might be responsible for the degenerative changes, but this was unknown.

97. Mr Hanrahan submits that Dr Smith indicated that the applicant would have recovered from his left knee injury in less than a week, but once symptomatic, he would continue to experience aggravations. This was reflective of the pre-existing degenerative changes and the anatomical variant. In order to challenge this opinion, the applicant needed to show that the degenerative changes in his knees related to the work incident. There was no explanation how that occurred.

98. Mr Hanrahan submits that the applicant's claim form described the nature of his left knee injury and a recurrence form was submitted with reference to the knee giving way in the past. It was unclear what nature of injury was accepted by the insurer in 2017.

99. Mr Hanrahan submits that Dr Kinzel has not explained how the arthroscopy would assist the applicant's right knee symptoms. The applicant gained no benefit from the left knee operations. There was no evidence that suggested that the operation was proposed to deal with inflammation in the applicant's knee, and it could not be inferred from the evidence. The applicant has not discharged the onus and his claim should fail.

REASONS

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

100. There is no dispute that the applicant injured his left knee on 9 July 2017. He has undergone a number of surgical procedures in his left knee and despite Dr Smith's opinion that the applicant would have recovered from the effects of his left knee injury within a week or up to three months, the insurer has quite correctly continued to pay weekly compensation to the applicant.

101. One wonders how Dr Smith could speculate that the applicant would have recovered from his injury within a short time frame in 2017, when he did not examine the applicant until April 2020. His opinion is also inconsistent with the extensive clinical notes of Dr Dagher and the multiple reports of Dr Kinzel.

102. Of course, this is not a matter that concerns me in these proceedings. 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]

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 applicant has undergone two MRI scans and the most recent scan described "chondral fissuring of the patella apex and adjacent medial and lateral patellar facet with low grade reactive marrow oedema pattern".

107. According to the applicant, he has continued to experience swelling and constant pain in his left knee since his injury in 2017. He also walked with a limp. He had gained little benefit from the surgical procedures. He gradually developed some symptoms in his right knee and he was told that this was because he was favouring his right leg and because he had an altered gait.

108. The applicant claimed that his left knee gave way and twisted from time to time. He also indicated that he twisted his right knee in February 2020 and fell onto his right knee in June 2020 when his left knee gave way. His right knee pain increased and he suffered a flare up

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[1] (1994) 35 NSWLR 452; 10 NSWCCR 796 (*Kooragang*), [463].
[2] [2012] NSWWCCPD 8 (*Kumar*).
[3] *Kumar*, [35].
[4] *Kumar*, [55].
[5] [2016] NSWWCCPD 23 (*Brennan*).
[6] [2013] NSWWCCPD 4 (*Bouchmouni*).
[7] *Brennan*, [169].

after he had left knee surgery in July 2020 because he could not place any weight on that limb. The a[applicant's evidence is corroborated by numerous entries in the clinical notes of Dr Dagher.

109. The clinical notes of Dr Dagher record multiple attendances when the applicant complained about the pain in his left knee, together with regular episodes of giving way and twisting. There were many reports of left knee pain, swelling, restriction of movement and limping. The applicant complained of having difficulty with walking. There was certainly no suggestion of any resolution of symptoms as suggested by Dr Smith.

110. The applicant first told Dr Dagher about his right knee pain on 24 July 2018. It was noted that this had been troubling him for four weeks. In September 2018, the applicant complained that his right knee pain was severe and the doctor recorded that he was limping. Thereafter, the applicant regularly consulted the doctor about his bilateral knee pain.

111. Therefore, whilst Dr Dagher did not express an opinion regarding any consequential condition in the applicant's right knee, his notes provide a valuable record of the nature and severity of the applicant's symptoms from July 2017 to February 2020.

112. We do not have the benefit of the clinical notes of Dr Kinzel, but she provided a number of reports to Dr Dagher and to the insurer. It is apparent from her reports that the applicant continued to experience pain and swelling in his left knee, which was prone to giving way and twisting.

113. Whilst Mr Hanrahan submits that there is only one left knee operation report in evidence, the absence of operative reports is not of any major consequence. It is clear from the applicant's evidence and the reports of Dr Kinzel that the applicant gained minimal benefit from the operations on his left knee. He had on-going left knee symptoms and he took the weight on his right leg.

114. The fact that the applicant had multiple procedures would suggest that he was suffering major issues and Dr Kinzel felt that surgery would assist to alleviate those symptoms, otherwise she would not have performed the surgery. The lack of any long-lasting relief of symptoms in the applicant's left knee does not necessarily mean that he will have a similar outcome following right knee surgery.

115. It is true that the first mention of any right knee symptoms was recorded in the doctor's report dated 22 January 2020, almost 18 months after the applicant complained about his right knee to Dr Dagher. Of course, there are only three reports in evidence that date from the period July 2018 and October 2019, and two of those reports are very brief. We do not know how often she saw the applicant, but this would have been clearer if the doctor's clinical notes were in evidence.

116. Nevertheless, when one examines Mr Ward's report, it is apparent that he had access to two reports from Dr Kinzel dated 8 August 2018 and 5 September 2018. Neither of these reports are in evidence, although they would have been in the possession of the insurer.

117. Mr Ward summarised the contents of these reports and commented that in the report dated 5 September 2018, Dr Kinzel noted that the applicant's overall condition was improving, but he reported an irritable hip and he also had pain in his right knee, so it seems likely that Dr Kinzel was aware of the right knee symptoms not long after the applicant told Dr Dagher.

118. According to Dr Kinzel, the applicant had been unable to fully weight bear on his left knee, and his right knee symptoms had been caused by overcompensating for his injured left knee. His symptoms impacted on his ability to walk and sleep. The reference to pain when the applicant was sitting or standing is consistent with the history of constant pain.

119. Dr Kinzel described the applicant as having “classic” compensatory pain, and although Mr Hanrahan submits that the doctor did not explain what she meant by the term “classic”, it is not difficult to understand what the doctor meant, particularly in this jurisdiction where Arbitrators regularly deal with claims for consequential conditions that arise from overuse or overcompensating of the contralateral limb.

120. The online version of the Macquarie Dictionary defines “classic” as including “someone or something considered to be a perfect example of its type,” so it means that the applicant’s presentation was a typical example of overcompensation in his non-affected limb. In my view, the use of the term “classic” by the doctor to describe the applicant’s presentation requires no explanation.

121. Although Dr Kinzel used the term “over compensatory insult” in her report dated 7 July 2020, it is clear that, when viewed with her other reports, she was not suggesting that the applicant suffered any direct trauma or injury, although on at least two occasions, the applicant suffered twisting or trauma to his right knee as a result of his left knee giving way. Such episodes would clearly be consequential.

122. Despite Mr Hanrahan’s submissions to the contrary, in her last report, Dr Kinzel provided a detailed explanation regarding the mechanics of the applicant’s right knee condition.

123. Dr Kinzel explained that the changes in the applicant’s patellofemoral joint became symptomatic due to overcompensation on that limb because he was taking most of the load through his right knee due to his left knee injury. Such an explanation is concise, logical, and unambiguous. The applicant could not put weight on his injured left knee, so he put more load on his right knee. This action caused the patellofemoral changes to become symptomatic and caused pain, which gradually became severe. Dr Kinzel’s opinion is unchallenged.

124. Common sense suggests if a worker had pain and restrictions in one leg, had an altered gait and was limping, he would try to protect his injured limb and use the other limb more in order to reduce the impact on the injured limb. This is not rocket science.

125. Mr Hanrahan focussed his submissions on the applicant’s medical case and made few submissions regarding the respondent’s medical evidence. One can understand why he took that course, given the nature of the respondent’s evidence.

126. The respondent relies on the report of Mr Ward. He did not examine the worker, so it is unclear what history was provided to him. His dealings were only with the applicant’s physiotherapist, Mr Black. Mr Ward had a limited medical file and only had two reports from Dr Kinzel. He was provided with the MRI scans of both knees, but he did not comment in any detail on causation.

127. Mr Ward considered that there was no evidence of any damage being caused by “alternative movement strategies and that he was effectively performing a graded loading program on two other joints”.

128. What Mr Ward meant is not entirely clear, given the absence of any reference to the applicant’s knees, but it seems that he was of the view that overcompensation was not causing any damage to the applicant’s right knee, as opposed to symptoms. Unfortunately, he did not provide a detailed explanation for his opinion, so little, if any, weight can be given to his report.

129. Dr Khong supported the opinion of Dr Smith, but he failed to give any reasons for doing so. Remarkably, it appears that he was not provided with any of the medical reports or clinical notes of the applicant’s treating doctors. Accordingly, his report carries no weight.

130. Similarly, the functional assessment report is of no assistance, because the focus was on the applicant's functional capacity for work.

131. In the notice dated 17 February 2020, the insurer disputed that the applicant had developed a consequential condition in his right knee as a result of the accepted injury to his left knee because it did not have enough evidence. It issued further notices after medical evidence because available. That evidence was identified as the clinical note of Dr Bandaranayaka dated 12 February 2020, reports of Dr Kinzel, the MRI scan, a referral of Dr Dagher and the initial report of Dr Smith. Given that Dr Dagher and Dr Kinzel support the applicant, it would seem that the insurer relied predominantly on the report of Dr Smith.

132. According to Dr Smith, the applicant would have recovered from the effects of his left knee injury in less than one week, although in his second report, he suggested a recovery within three months. He did not explain why he extended the period in his second report. Significantly, his opinion is inconsistent with the applicant's evidence, the contemporaneous medical evidence and the insurer's decision to reinstate payments after the applicant had surgery in July 2020.

133. Dr Smith stated that the applicant developed right knee symptoms without any injury. That is consistent with the applicant's evidence and the concept of a consequential condition.

134. Dr Smith diagnosed bilateral knee osteoarthritis, which was inherited, familial and unrelated to the applicant's employment. This is not controversial, because the applicant's claim concerns a consequential condition, not an injury or aggravation of an underlying pathology.

135. Unfortunately, Dr Smith was not asked to comment in the relevant question, namely, "Did the applicant develop symptoms in his right knee as a consequence of his accepted left knee injury?". The doctor did not address this at any stage in his reports.

136. Remarkably the insurer, and more importantly, the respondent's solicitor, failed to identify this deficiency in the doctor's evidence. They failed to obtain a report from the doctor that addressed the precise issue that the insurer raised in its dispute notices, and that I have been called upon to determine. Accordingly, his opinion can be dismissed as it does not address the current matter in dispute.

137. There is medical evidence to support a causal connection between the applicant's right knee symptoms and the applicant's accepted left knee injury. 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, which was previously asymptomatic.

138. There is no requirement to identify any pathology, only symptoms. 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.*

139. 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 Dr Kinzel and Dr Dagher. I am mindful that Dr Kinzel has treated the applicant for an extended period, and she would be in the best position to comment on the applicant's symptoms, treatment and operative needs. Therefore, her views should carry the greatest weight. The respondent has no persuasive medical opinion to challenge the applicant's medical case.

140. When one reviews the evidence as a whole, the applicant has support for a consequential condition in his right knee. 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]*.* There is no evidence to the contrary.

141. 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?

142. 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
> (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)".

143. 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]

144. 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.

[8] [2016] NSWWCCPD 63.
[9] (1986) 2 NSWCCR 32 (*Rose*).
[10] *Rose*, [42].

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]

145. 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]

146. 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

[11] *Rose*, [47].
[12](1997) 14 NSWCCR 233 (*Bartolo*).
[13] *Bartolo*, [238].
[14] [2014] NSWWCCPD 72 (*Diab*).

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]

147. 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*.

148. According to the applicant, he has experienced worsening pain in his right knee. He has difficulty walking and standing for prolonged periods, and he wants to undergo surgery in the hope that this will improve his mobility and quality of life.

149. Dr Dagher's clinical notes corroborate the applicant's evidence regarding his right knee symptoms, but he has not expressed an opinion regarding the proposed surgery. The notes show that the applicant has been prescribed various forms of painkillers and anti-inflammatory medication since 2017. He has had physiotherapy and has received treatment from an exercise physiologist.

150. In her last report, Dr Kinzel gave detailed reasons why surgery was appropriate. She advised that the MRI scan showed chondral fraying and defects in his patella and she felt that debridement would help to settle the inflammation and "hopefully" give the applicant some relief. So she felt that the operation would be of benefit and alleviate the applicant's right knee symptoms.

151. In contrast, Dr Smith recommended conservative treatment, or a high tibial osteotomy, rather than an arthroscopy. He stated that an arthroscopy was not an appropriate form of treatment for osteoarthritis, citing the study undertaken by Moseley et al in 2002. This study indicated that patients who had arthroscopic debridements reported no more pain relief than those who were part of a placebo group. That might well be the case in that study, but the symptom of pain is subjective, and it would vary from case to case, depending on the extent of pathology and the factual matrix. Therefore, one needs to focus on the applicant's situation rather than a dated case study.

152. Dr Smith stated that there was a one third chance of no improvement and a one third chance that the condition would be made worse. Nevertheless, he said that there was a one third chance of some temporary improvement.

153. In *Diab*, the Deputy President stated that the actual or potential effectiveness of the treatment was one of the relevant criteria to be considered, but it was not determinative, and a poor outcome did not necessarily mean that the treatment was not reasonably necessary.

154. Although Dr Smith has suggested conservative forms of treatment, Dr Kinzel believes that an invasive approach is preferable. The evidence shows that the applicant has had various forms of conservative treatment, and he is keen to have surgery on his right knee. It seems that the best treatment option is a total knee replacement, but the applicant is too young to have such a procedure.

155. Dr Kinzel is a specialist knee surgeon, and I expect that she would not recommend surgery if she did not feel that it would benefit the applicant's condition and alleviate some of his symptoms. All forms of surgery have risks, and outcomes cannot be guaranteed. She has been treating the applicant for a long time, she has an intimate knowledge of his condition, and in my view, she would only perform surgery if it was in the applicant's best interests.

[15] *Diab*, [88] to [90].

156. 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 Dr Kinzel is hopeful that it can be effective. Alternative forms of treatment have not been recommended by her.

157. The cost is not unreasonable, particularly when one considers the cost of the alternative, a total knee replacement. An arthroscopy would also be more cost effective than a high tibial osteotomy that was recommended by Dr Smith. This satisfies the relevant factors discussed in *Rose* and *Diab*.

158. Accordingly, I am satisfied that the treatment proposed by Dr Kinzel, namely a right knee arthroscopy and chondral debridement, 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 9 July 2017.

FINDINGS

159. The applicant sustained injury to his left knee arising out of or in the course of his employment with the respondent on 9 July 2017.

160. The applicant's employment was a substantial or the main contributing factor to his injury.

161. The applicant developed a consequential condition in his right knee as a result of the injury sustained to his left knee on 9 July 2017.

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

163. The proposed right knee arthroscopy and chondral debridement, 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 9 July 2017.

ORDERS

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