WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **4316/19**
Applicant: **Gemma Sarah Meireles**
Respondent: **Greenhills Child Care Centre Incorporated**
Date of Determination: **4 December 2019**
Citation: **[2019] NSWWCC 388**

The Commission determines:

1. The need for the bilateral knee patellofemoral realignment surgeries proposed by Dr Qurashi results from the injury on 26 October 2018.

2. The respondent to pay the costs of and incidental to the bilateral knee patellofemoral realignment surgeries proposed by Dr Qurashi pursuant to s 60 of the *Workers Compensation Act 1987*.

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

Rachel Homan
Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OF RACHEL HOMAN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Ms Gemma Meireles (the applicant) was employed as a childcare worker by the Greenhills Child Care Centre Incorporated (the respondent). On 26 October 2018, the applicant sustained injury to both knees in a fall in the carpark of her place of employment. Liability for the injury was accepted by the respondent's insurer.

2. On 15 May 2019, the applicant's treating surgeon, Dr Suleman Qurashi sought approval to perform bilateral knee patellofemoral realignment surgeries. The respondent's insurer declined liability for the medical treatment in a dispute notice issued pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act). An internal review of that decision was completed on 20 August 2019, and liability remained declined.

3. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) filed in the Commission on 23 August 2019, seeking compensation pursuant to s 60 of the *Workers Compensation Act 1987* (the 1987 Act) for the costs of and associated with the surgeries proposed by Dr Qurashi.

ISSUES FOR DETERMINATION

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

    (a) whether the need for the bilateral knee patellofemoral realignment surgeries proposed by Dr Qurashi results from the injury on 26 October 2018.

PROCEDURE BEFORE THE COMMISSION

5. The parties appeared for teleconference on 20 September 2019 and conciliation conference and arbitration hearing on 11 November 2019. The applicant was represented by Mr Joshua Beran of counsel, instructed by Mr Claudio Meireles. The respondent was represented by Mr Phillip Perry of counsel.

6. 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

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

    (a) ARD and attached documents;
    (b) Reply and attached documents;
    (c) Application to Admit Late Documents filed by the applicant on 8 October 2019;
    (d) Application to Admit Late Documents filed by the respondent on 15 October 2019, and
    (e) Application to Admit Late Documents filed by the applicant on 11 November 2019.

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

Applicant's evidence

9. The applicant's evidence is set out in a written statement dated 11 July 2019.

10. The applicant, who is now 32 years old, commenced employment with the respondent as a childcare worker on or about October 2008.

11. On 26 October 2018, the applicant started work as usual. The applicant was in the process of opening up the childcare centre as part of her regular duties. The applicant parked in the staff carpark and proceeded to unlock the first gate then returned to her car to retrieve her belongings, uniform, notepad and other items. These items were generally carried in a bag or on rare occasions such as this, in a trolley. The applicant pulled the trolley, walking in a sideward manner. When the applicant reached the path step, she turned to pull the trolley over the step. The applicant took a step whilst in the backward position when suddenly, her ankle slightly twisted and rolled causing her legs to twist on the uneven surface. The applicant lost balance and fell backwards.

12. The applicant reported the fall but finished her shift and went home to rest.

13. On 8 November 2018, the applicant attended her general practitioner as the pain in her knees was persisting. On 16 November 2018, the applicant had an MRI of her left knee. The applicant commenced physiotherapy on 14 December 2018. An MRI of the right knee was performed on 14 January 2019. On 24 April 2019, the applicant consulted Hip and Knee Surgeon, Dr Qurashi. On 8 May 2019, the applicant underwent cortisone injections in both knees. Dr Qurashi recommended realignment surgeries to both knees.

14. The applicant did not take time off work following the injury but was performing light duties at normal hours. The applicant said that she continued to experience moderate pain and discomfort to her knees. The applicant had to sleep with her legs elevated every night to minimise pain. The applicant took pain relief medication on a daily basis. The applicant experienced difficulty carrying out her normal work duties, ascending and descending stairs, walking for long periods, kneeling, bending and squatting, lifting more than light weights and exercising.

15. In her injury claim form, the applicant recorded that she was injured whilst in the process of opening up the centre and getting her belongings and uniform from the car. The applicant indicated that "due to uneven floor, tripped / fell".

16. In a staff accident/incident report, completed on 9 November 2018, the applicant said that she had loaded her belongings onto her wrist in plastic bags and held the trolley in her right hand. The applicant pulled the trolley along making a few steps sideways. When she reached the curb, the applicant took a few backward steps to get ready to pull the trolley up. The applicant stepped into a large ditch in the road. The applicant tried to save herself but hit a lip in the ditch, causing her to put more pressure on her knees as they "twisted or overextended". The applicant landed on her backside and back and was winded from the impact.

17. The applicant indicated that no treatment was required or administered at the time of the incident. She was now experiencing, "more pain and an unusual discomfort in the left kneecap especially I'm finding it difficult to squat and will avoid holding children."

18. The applicant indicated that she had seen her general practitioner who had suggested x-rays to see if there was any damage to bones.

Evidence from the applicant's treating doctors

19. Clinical notes from the applicant's general practitioners are in evidence.

20. On 7 June 2015, the applicant reported left posterior knee pain. Examination revealed tenderness over the joint line on the right knee also. A small effusion was noted. An ultrasound of the left knee was requested.

21. On 23 June 2015, a consultation for "left knee? collateral ligament injury" was recorded. An ultrasound report dated the same day revealed,

> "A tiny amount of fluid was seen within the knee but the appearances are otherwise completely normal."

22. On 25 October 2017, the applicant attended a consultation giving a history of left knee pain and crepitus. The applicant was given a referral for an MRI of her left knee. The MRI results were discussed at a consultation on 1 November 2017. The applicant was prescribed Voltaren and advised to undertake physiotherapy with a referral to an orthopaedic surgeon if no improvement.

23. Bilateral knee pain was again discussed on 8 November 2017. The applicant was advised to continue physiotherapy, use knee braces, topical NSAIDs and oral Voltaren. The applicant was to seek review if there was no improvement.

24. On 13 January 2018, the applicant reported a six-month history of knee pain and ongoing physiotherapy. The applicant complained that her pain was ongoing and had impacted on her day-to-day functioning. The applicant was referred to orthopaedic surgeon Dr Darryl Fraser.

25. The next consultation referring to knee pain was on 8 November 2018. The consultation on that date noted:

> "1. Bilateral knee pains since fall
> - Fall at work on Friday 26/10/18
> - Ditch in the car park at work
> - Was pushing a trolley, turned and fell into a ditch that she didn't notice
> - Landed on backside
> - Felt may have twisted knees in the process of the fall but unclear
> - While falling had pain in both knees L>R
> - Work is aware of this - have reported the ditch to the local council who are in charge of the car park
> - Has had ongoing pain in knees since then
> - Has been using heat/cold elevation
> - Panadol, Nurofen PRN
> - ? Bath soak
> - But worsened since Sunday
> - Pain in both knees but L>R
> - Very mild when at rest; pretty much at her baseline levels
> - But with flexion/extension and movement, painful
> - Reports always had a 'bad left knee'
> - October 2017, had MRI of knee which showed mild dysplasia at patellofemoral joint and mild secondary degenerative changes
> - Underwent physiotherapy which improve pain to a tolerable level and also good function
> - Was referred to orthopaedic surgeon but never went
> …

Examination:
Mobilised independently; slight antalgic gait
Nil obvious deformity noted
Mild swelling to left knee lateral area
Both patella tender to palpation
…
Both medial and lateral joint lines tender on palpation bilaterally (with knees flexed)
Pain with movement of knees…"

26. At the same consultation, Dr Sandy Lu issued a WorkCover certificate noting a work-related injury consisting of bilateral knee pain with a date of injury 26 October 2018. The certificate noted that in October 2017, the applicant had an MRI of the left knee which showed mild dysplasia at the patellofemoral joint and mild secondary degenerative changes. This was treated with physiotherapy and the applicant had minimal pain and good function prior to the fall.

27. After this consultation, there were regular consultations with respect to the applicant's knees.

28. An MRI of the applicant's left knee dated 19 November 2018 indicated no significant internal derangement of the left knee. There was a small amount of joint effusion and a small popliteal cyst present. There was also "evidence of patellar maltracking with associated established chondromalacia patella".

29. On 22 November 2018, Dr Lu responded to a series of questions from the insurer indicating that the applicant's injury had been diagnosed as "mild lateral subluxation of both patellofemoral joints". Dr Lu was asked whether employment was "the substantial contributing factor" to the applicant's injury, noting that an MRI performed the previous year confirmed pre-existing arthritis. Dr Lu responded,

> "Her employment is a contributing factor to injury as she was symptom-free until she sustained a fall on 26/10/18 when she stepped into a ditch/depression in her work place's carpark while pushing a trolley.
> …
> The injury sustained 26/10/18 is an aggravation of a pre-existing condition given she was pain-free prior to the fall and now has persistent knee pain."

30. An MRI of the right knee dated 14 January 2019 found features of:

> "…advanced patellofemoral dysfunction with advanced grade 4 chondromalacia patella. There was also minimal popliteal fossa cyst formation with mild leakage and septation."

31. A report from Hip and Knee Surgeon, Dr Qurashi, dated 24 April 2019, stated that the applicant attended on account of problems with her knees:

> "Most of this started after an injury involving a fall at work in November 2018 after which she has been experiencing ongoing symptoms by way of anterior knee pain. It is there most of the time particularly with activity, particularly going up and downstairs or sitting down or standing up from a seated position. The discomfort is associated with some clicks and clunks; no locking or giving way apart from some pain related pseudo instability. This I think is pain related quad inhibition."

32. Dr Qurashi confirmed that the MRI scan of the applicant's

> "…left knee shows an increased Q-angle (underestimated here) and patella alta. MRI of the right knee is suggestive of patellofemoral chondromalacia."

33. Dr Qurashi indicated that the pathology would progressively worsen with time. Dr Qurashi suggested the avoidance of deep squats and lunges and felt that the applicant would benefit from a good course of physiotherapy. Dr Qurashi indicated that he also wished to investigate the distal alignment by CT scan.

34. On 8 May 2019, Dr Qurashi indicated that the CT scan showed significantly elevated distal malalignment. Dr Qurashi injected the applicant's knees with Kenacort anaesthetic and said,

> "We will see how things go with this but based on the imaging at hand, the distal malalignment is likely to cause her ongoing symptoms. She should continue with physiotherapy. We did discuss general principles of treatment by way of realignment surgery to reduce the severity of her symptoms and hopefully slow down the degenerative process."

35. A quote for surgery was prepared on 15 May 2019.

Dr Bodel

36. The applicant relies on medicolegal reports by orthopaedic surgeon Dr James G Bodel, dated 18 July 2019, 5 August 2019 and 25 September 2019.

37. Dr Bodel took the same history of injury as a set out in the applicant's statement. Dr Bodel noted that there were some complaints about her knees in 2017 but they were asymptomatic after physiotherapy treatment and the use of anti-inflammatories for several months. On examination, Dr Bodel found quite marked painful retropatellar crepitus in both knees and pain on resisted knee extension.

38. Dr Bodel indicated that surgeries proposed by Dr Qurashi were appropriate and that employment had made a material contribution to the need for surgery. Dr Bodel said that the applicant had no clinical indication of pre-existing abnormality before the work injury. Dr Bodel said there had been an aggravation of an underlying disease process and the aggravation was continuing.

39. In the report dated 5 August 2019, Dr Bodel indicated that he had been given a report of an MRI scan of the left knee performed on 28 October 2017. Dr Bodel indicated he had access to the films of the left knee from that date at the time of his previous examination. The MRI report showed,

> "mild dysplasia at the patellofemoral joint and mild secondary degenerative change. Previous low-grade partial tear of the medial collateral ligament".

40. Dr Bodel said the additional information as well as records from the local doctor did not add to his understanding of the applicant's circumstances but supported the surgery proposed by Dr Qurashi.

41. In a supplementary report dated 25 September 2019, Dr Bodel was asked to give an opinion on whether the injury had made a material contribution to the need for the surgeries recommended by Dr Qurashi. Dr Bodel responded,

> "The mechanism of injury would indicate to me that she has suffered an additional soft tissue injury to both knees, aggravating the pre-pathology in the bilateral patellofemoral joint arthritic change which is seen in her MRI scans.
>
> She had intermittent symptoms since approximately the year 2017, prior to the fall that occurred on the 26 October 2018. Therefore, the rapid deterioration that occurred following the event on the 26 October 2018 has caused additional structural pathology to the arthritic retropatellar regions leading to the need for surgery as proposed by Dr Qurashi.

> It is possible that she may well have required this surgery at some later stage, but the events of 26 October 2018 have brought forward the timing of that surgery as recommended by Dr Qurashi."

Dr Wallace

42. The respondent relies on medicolegal reports prepared by orthopaedic surgeon, Dr Raymond Wallace, dated 13 May 2019 and 14 October 2019.

43. Dr Wallace took a history of the injury on 26 October 2018 as follows,

> "…she had arrived at work in darkness and whilst walking from her car to her workplace, she tripped in a shallow ditch in the car park and fell backwards onto her buttocks. She noted the onset of pain at her buttocks, coccyx and bilateral knees. She picked herself up and continued work that day. She subsequently noted persisting pain and swelling at her bilateral knees and took some Panadol analgesic medication."

44. Dr Wallace said there was no previous history of injury at the knees although there was an episode of left knee pain in late 2017. The applicant had been referred for MRI investigation of the left knee which showed evidence of chondromalacia patellae. The applicant was referred for physiotherapy, completing two sessions, after which, her left knee symptoms resolved.

45. Dr Wallace noted that the applicant now complained of constant aching pain at her knees in the peripatellar region, worse on the right side. Pain was worse when sitting on a floor, walking, stair climbing or squatting. There was no swelling but intermittent catching and giving way.

46. Dr Wallace indicated that he had reviewed investigations dated 28 October 2017 and 16 November 2018 of the left knee. Dr Wallace diagnosed,

> "Minor aggravation of pre-existing degenerative osteoarthritis patella-femoral joints, bilateral knees - now resolved."

47. In giving an opinion on "causation", Dr Wallace stated,

> "Ms Meireles' work-related injury of 26 October 2018, some 6 months ago, has resolved. At that time, she suffered a minor aggravation of pre-existing patellofemoral joint osteoarthritis at her bilateral knees which would have settled within 6 weeks of this incident. The mechanism of injury she describes of falling backwards impacting her buttocks with no direct impact to her knees is not consistent with being the cause of any significant patella-femoral joint pathology. At worst, she suffered a minor aggravation of pre-existing degenerative patella-femoral osteoarthritis at her bilateral knees which would have settled within 6 weeks of this incident."

48. Dr Wallace considered the applicant's residual bilateral knee symptoms were due to the pre-existing degenerative osteoarthritis at the patellofemoral joint, complicated by current obesity. Dr Wallace did not consider that the applicant required any treatment or medical review, including surgical intervention, for any work-related condition.

49. In his report of 14 October 2019, Dr Wallace indicated that he had previously prepared a report on 26 August 2019. That report is not in evidence. Dr Wallace was asked whether treatment was reasonably necessary in accordance with s 60 of the 1987 Act noting that all that was necessary was to establish that the work injury "materially contributed to the need for treatment". Dr Wallace indicated that he remained of the firm opinion that the work-related injury did not materially contribute to the need for operative intervention. Dr Wallace stated,

> "Ms Meireles suffered a minor aggravation of pre-existing degenerative osteoarthritis at the patello-femoral joints of her bilateral knees as a result of her work incident on 26 October 2018 which would be resolved with a conservative regime of treatment including a weight reduction program, exercise-based therapy and simple analgesic medication.
>
> I note in Dr Qurashi's letter of 8 May 2019, he is proposing surgical intervention in the form of distal realignment for correction of her patello-femoral joint malalignment which is a congenital problem.
>
> Ms Meireles' work injury of 26 October 2018 has not materially contributed to the need for surgical realignment at her bilateral knees."

Applicant's submissions

50. Mr Beran submitted that liability for the surgeries had been declined by the insurer in reliance on the opinion of Dr Wallace that the aggravation to the applicant's knee pathology was temporary and had ceased. Mr Beran submitted that the applicant claimed that the aggravation continued. The applicant relied on Dr Bodel who accepted that there was pre-existing pathology but an aggravation of that pathology by the injury brought forward the need for surgery and therefore "materially contributed" to the need for surgery.

51. Mr Beran referred to *Murphy v Allity Management Services Pty Ltd*[1] and said there could be multiple causes for the need for surgery. All that was required was to establish that the injury materially contributed to the need for surgery.

52. Mr Beran referred to the applicant's statement and said there was no doubt from the applicant's description of her ongoing symptoms that the aggravation was persisting.

53. Mr Beran noted that the clinical records in evidence commenced in 2004. No reference to the knees appeared in the notes until 7 June 2015. Mr Beran noted that the report of the ultrasound in 2015 revealed normal pathology apart from a small amount of fluid. The next record of note was in October 2017. Knee pain was further identified in January 2018 but between that date and 8 November 2018, a period of 10 months, there were no attendances in respect of the knees whatsoever.

54. After 8 November 2018, the applicant attended the general practitioner on a regular basis with respect to her knees. Mr Beran submitted that the clinical records identified pre-existing problems but showed that the incident in October 2018 caused significantly increased symptoms and need for treatment.

55. Mr Beran noted that the first WorkCover certificate issued by Dr Lu recorded that the applicant had minimal pain and good function prior to the fall on 26 October 2018. Mr Beran noted that Dr Lu had also reported to the insurer on 22 November 2016 that the applicant had been symptom-free prior to the fall and had a work-related aggravation of pre-existing pathology. Dr Qurashi had recorded the same mechanism of injury and noted that there were ongoing symptoms of pain.

56. Mr Beran submitted that there was a medical dispute between Dr Bodel and Dr Wallace as to whether the aggravation had ceased.

[1] [2015] NSWWCCPD 49.

57. Mr Beran submitted that Dr Bodel had taken a history of the applicant being asymptomatic for a period of time after her knee issues in 2017 consistently with the clinical notes. Dr Bodel confirmed in July 2019 that the applicant's aggravation was continuing. In his report of September 2019, he explained the material contribution made by the injury to the need for surgery. The rapid deterioration following the injury in October 2018 led to the need for the surgery proposed by Dr Qurashi by bringing forward the timing of the surgery. Mr Beran submitted that the applicant would not have required surgery at this stage of her life but for the fall on 26 October 2018. Mr Beran submitted that Dr Wallace did not provide an opinion on this matter.

58. Mr Beran submitted that Dr Wallace did not take a history of a 10-month period of no symptoms prior to the fall. Dr Wallace did not explain how or why the aggravation would have settled and his opinion was not consistent with the clinical notes. Dr Wallace did not explain why the applicant continued to experience significantly increased pain symptoms when prior to the fall she was receiving no treatment at all. Dr Wallace did not answer the question, whether the applicant would need the surgery if it had not been for the fall.

Respondent's submissions

59. Mr Perry submitted that the applicant bore the onus of demonstrating a causal link between the injury and the need for surgery.

60. Mr Perry submitted that no evidence had been provided from the applicant with respect to her previous knee symptoms and treatment and described this as a "fatal flaw" in the applicant's case. The mere fact that there were no consultations in the 10-month period prior to injury did not mean she was asymptomatic.

61. Mr Perry noted that at the consultation with her general practitioner on 13 January 2018, the applicant reported a 6-month history of knee pain and "ongoing" physiotherapy. The applicant's pain was said to be "ongoing" and impacting her day to day functioning.

62. Mr Perry referred me also to the June 2015 clinical notes and observed that there were bilateral knee symptoms at that stage.

63. Mr Perry noted that on 31 October 2018, the applicant had consulted her general practitioner with regard to quitting smoking but made no mention of the injury which had occurred on 26 October 2018.

64. Mr Perry said Dr Wallace had opined that the mechanism of injury, being falling backwards onto her buttocks, would not be consistent with causing the patellofemoral pathology. Mr Perry noted that the record of the first doctor consultation on 8 November 2018 indicated that the applicant "may" have twisted her knees but it was "unclear". Although the applicant's written statement indicated that her knees did twist, this may have been put together after the event.

65. Mr Perry submitted that the failure to report knee symptoms at the first consultation with her general practitioner after the fall and the uncertainty around whether the fall involved twisting of the knees suggested that the fall was a very minor event as indicated by Dr Wallace. Mr Perry submitted that I would not come to the conclusion that the applicant did twist her knees. The applicant's knees were already osteoarthritic and the applicant had experienced symptoms of pain. It was too great a leap to find that realignment of the knees was made necessary by an event which did not even warrant mentioning to the general practitioner on 31 October 2018.

66. Mr Perry noted that on examination on 8 November 2018, Dr Lu noted only mild swelling to the left knee but no swelling at the right knee.

67. Mr Perry submitted that Dr Bodel's reports did not assist the applicant. In his first report, Dr Bodel took a history that the applicant had no clinical indication of pre-existing abnormality contrary to the clinical notes in evidence. It was unclear whether Dr Bodel considered the injury had caused a disease process which was not present previously. In his August 2019 report, Dr Bodel indicated that the report of the MRI in 2017, which predated the injury, was consistent with his findings on examination after the injury.

68. Mr Perry noted that the surgeries being proposed by Dr Qurashi were realignment surgeries. None of the doctors had explained how the need for such surgeries was related to the injury. Dr Qurashi's reports indicated that it was elevated distal malalignment which was causing the applicant's pain and other symptoms.

69. Mr Perry submitted that the malalignment had caused symptoms in the past and now and what happened on 26 October 2018, which was insufficient for the applicant to even mention to her general practitioner initially, did not cause the need for the surgery. The applicant had not provided any evidence herself as to her pre-existing symptoms and the expert reports on which she relied were unreliable. Dr Qurashi did not indicate whether the injury brought forward the need for surgery or whether the injury was of a type capable of doing so. Dr Qurashi had articulated a reason for the surgery that had nothing to do with the injury on 26 October 2018.

Applicant's submissions in reply

70. Mr Beran noted that it had not been disputed that the applicant suffered an "injury" to her knees.

71. Mr Beran submitted that the most contemporaneous and reliable record of the mechanism of injury was the handwritten incident report prepared by the applicant herself.

72. Mr Beran conceded that the applicant's statement was silent as to the previous history but submitted that the applicant had not tried to conceal that history. The history was provided to Dr Bodel.

73. Mr Beran submitted that it was reasonable to infer from the absence of any reference to treatment in the clinical notes during the 10-months prior to the fall, that there were no symptoms. Dr Lu had confirmed that the applicant was asymptomatic in her report for the insurer.

74. Mr Beran noted that all the doctors accepted that the applicant's pre-existing pathology was not caused by the fall. There was ample evidence that there was an aggravation after the fall. This had been accepted by the insurer. The aggravation brought forward the need for surgery and that was all the applicant needed to demonstrate. The only evidence relied on by the respondent was Dr Wallace's report which said the aggravation should have resolved, but in fact it did not.

FINDINGS AND REASONS

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

76. Section 60 of the 1987 Act relevantly provides:

> "(1) If, as a result of an injury received by a worker, it is reasonably necessary that:

(a) any medical or related treatment (other than domestic assistance) be given, or
(b) any hospital treatment be given, or
(c) any ambulance service be provided, or
(d) any workplace rehabilitation service be provided,

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

77. There is no dispute in this case that the applicant sustained an "injury" on 26 October 2018. There is also no dispute that the surgery proposed by Dr Qurashi is reasonably necessary. The question I am required to determine is whether the surgeries proposed by Dr Qurashi are reasonably necessary as a result of the accepted injury to the applicant's knees on 26 October 2018.

78. In considering this question, the authorities require me to conduct a commonsense evaluation of the causal chain. In *Kooragang Cement Pty Ltd v Bates*[2], Kirby P said:

> "… it has been well recognised in this jurisdiction that an injury can set in train a series of events. If the chain is unbroken and provides the relevant causative explanation of the incapacity or death from which the claim comes, it will be open to the Compensation Court to award compensation under the Act.
> …
> The result of the cases is that each case where causation is in issue in a worker's compensation claim, must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from', is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent death or injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a commonsense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation."[3]

79. It is apparent from the material before me that a major cause for the applicant's need for surgery is the pre-existing condition. The need for surgery can, however, arise from multiple causes for the purposes of s 60 of the 1987 Act. In *Murphy v Allity Management Services Pty Ltd* Roche DP stated[4]:

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

[2] (1994) 35 NSWLR 452; 10 NSWCCR 796.
[3] At 462-463.
[4] At [57].

80. Similarly, in *Taxis Combined Services (Victoria) Pty Ltd v Schokman*[5] Roche DP held that the injury need not be the only, or even a substantial, cause of the need for treatment:

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

81. Much of the respondent's submissions focused on the nature of the injury on 26 October 2018. Although the respondent has not notified the applicant of a dispute as to whether she sustained an injury affecting both of her knees on that date, the nature of that injury and its ongoing effects remain in dispute. The respondent's case is that the injury on 26 October 2018 involved a minor and temporary aggravation of pre-existing pathology that has ceased and which has no causal connection to the need for surgery proposed by Dr Qurashi.

82. One difficulty for the applicant arises from the delay in reporting symptoms in her knees after the fall. The first record of any symptoms appears in the clinical notes on 8 November 2018. That is, 11 days after the event. In the meantime, the applicant had consulted her general practitioner on 31 October 2018. The applicant has not claimed that she reported any knee symptoms to the doctor on that occasion and the clinical notes do not reveal that any knee symptoms were discussed at the consultation. Mr Perry submitted that this suggested that the fall and the aggravation of pre-existing pathology were relatively minor.

83. The applicant's own evidence is that she was able to continue with and complete her shift on the day of the fall. This does not suggest a sudden onset of debilitating symptoms. The clinical notes on 8 November 2018 indicated that the applicant did experience pain in the knees while falling and this had been ongoing since the fall but the pain had "worsened since Sunday". This is broadly consistent with the incident report the applicant completed the next day on 9 November 2018. The applicant indicated that she initially tried to treat the pain herself with rest, elevation and ice but she was now experiencing more pain. Although the applicant has not explained the delay in reporting symptoms directly, I am prepared to accept that her description of the progression of symptoms reasonably accounts for the delay.

84. Submissions were also made by the respondent suggesting that the mechanism of injury was in dispute. Mr Perry noted Dr Wallace's opinion that the mechanism of injury of falling backwards onto her buttocks would not be consistent with having caused patellofemoral pathology. I do not, however, take it to be the applicant's case that the fall necessarily caused the pathology which Dr Qurashi proposes to treat with surgery. Rather, it is the applicant's case that the fall aggravated that pathology.

85. Mr Perry also noted that there was some uncertainty with regard to whether the applicant's knees twisted in the fall. I accept that the clinical notes on 8 November 2018 suggest that the applicant was uncertain whether she had twisted her knees in the process of the fall although she felt that she may have. The applicant's evidence in the incident report and in her later written statement suggests a greater degree of confidence that she had twisted or overextended her knees. As noted in *Onassis v Vergottis*[6]:

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[5] 2014] NSWWCCPD 18 at [54].
[6] (1968) 2 Lloyds Report 403.

> "Witnesses, especially those who are emotional, who think that they are morally in the right, tend very easily and unconsciously to conjure up a legal right that did not exist. It is a truism, often used in accident cases, that with every day that passes the memory becomes fainter and the imagination becomes more active. For that reason, a witness, however honest, rarely persuades a Judge that his present recollection is preferable to that which was taken down in writing immediately after the accident occurred. Therefore, contemporary documents are always of the utmost importance."

86. I am not satisfied, however, that whether or not the applicant twisted her knees in the fall is determinative of this case. The clinical notes of 8 November 2018 do indicate clearly that the applicant experienced pain in both knees, left worse than right whilst falling and had experienced ongoing pain in the knees since the fall. All of the doctors involved in this case appear to agree that the mechanism of injury was capable of causing an aggravation of the pre-existing pathology in the applicant's knees. It is for this reason that injury pursuant to s 4 of the 1987 Act is not in dispute. It is the nature of that aggravation and its ongoing effects that constitute the real dispute in this case.

87. To determine this dispute, it is necessary to consider the evidence with regard to the pre-existing pathology. There is no doubt that the applicant had experienced symptoms at her knees since at least June 2015. Some of the symptoms reported after the fall appear to have been the same as those experienced previously, including pain and crepitus at the left knee. The symptoms were severe enough for the applicant to consult a doctor in June 2015 and again in October 2017, at which time radiological investigations were considered appropriate.

88. The ultrasound report taken in June 2015 revealed little abnormality apart from a tiny amount of fluid. The clinical notes taken in October 2017 suggest pain and crepitus. Although the report of the MRI of the left knee taken at that time is not in evidence, it is quoted by Dr Bodel as showing mild dysplasia at the patellofemoral joint mild secondary degenerative change as well as the previous low-grade partial tear of the medial collateral ligament. Rather unhelpfully, it appears Dr Bodel may have mistakenly understood this scan to post-date the injury. Dr Bodel said it did not add to his understanding of the applicant's circumstances. Mr Perry submitted that this suggested that the pathology shown in the MRI taken in October 2017 was no different to the applicant's condition after the fall. I note that there is no imaging of the applicant's right knee prior to injury for the purposes of comparison.

89. The applicant submits and I accept that what is most significant is the increase in the severity of her symptoms and her increased need for treatment after the fall. This is a matter in respect of which Mr Perry submitted that I should have some doubt. Although it was conceded that there were no clinical records referring to knee symptoms for a period of some 10-months prior to the fall, Mr Perry submitted that this did not lead to a conclusion that the applicant's knees were asymptomatic during this period. Mr Perry was also critical of the absence of any evidence from the applicant herself as to the nature of any symptoms prior to the fall.

90. I accept that it would have been helpful had the applicant provided direct evidence on this matter. I also accept in theory that an absence of clinical records referring to symptoms or treatment does not necessarily mean the applicant was asymptomatic. I do, however, have before me evidence other than the absence of clinical records to suggest that the applicant was asymptomatic. This is indicated by Dr Lu in her initial WorkCover certificates and in her response to the insurer's questions on 22 November 2018. It was quite clearly Dr Lu's understanding that the applicant had been pain-free prior to the fall. Similarly, Dr Qurashi took a history indicating that most of the applicant's problems with her knees started after the fall at work. The applicant told Dr Bodel that she did have complaints about her knees in 2017 but they were asymptomatic after physiotherapy treatment and the use of anti-inflammatories for several months. This history is consistent with what appears in the clinical notes and the evidence from Dr Lu and Dr Qurashi. In all the circumstances, I accept it was correct.

91. The medical evidence and lay evidence clearly show an increase in knee symptoms and the need treatment after the fall. There are, after 8 November 2018, regular consultations with Dr Lu with regard to the knees. The symptoms described to Dr Lu were sufficient to warrant a referral for MRI of both the left and right knees, noting that no investigation of the right knee had previously been considered necessary. Dr Lu also considered the applicant's condition to be sufficiently serious as to warrant a referral to an orthopaedic surgeon. Although the applicant had been referred to an orthopaedic surgeon, Dr Darryl Fraser, in January 2018, the applicant said she did not attend. There is no evidence to the contrary and the applicant's non-attendance would be consistent with her symptoms having resolved with physiotherapy and oral anti-inflammatories.

92. After the fall, the applicant did consult Dr Qurashi consistently with the referral from Dr Lu. The applicant underwent physiotherapy for a period of time and also received corticosteroid injections, which had not been administered previously. By mid May 2019, Dr Qurashi had formed the view that surgery was necessary to "reduce the severity of her symptoms and hopefully slow down the degenerative process".

93. Whilst I accept Mr Perry's submission that Dr Qurashi has not provided a clearly expressed opinion on the causal connection between injury and the need for surgery, he has prepared a quote for the surgeries for the insurer which suggests he did consider that some connection existed.

94. Dr Bodel has provided a clear opinion on the material contribution made by the fall to the need for surgery, explaining that there was aggravation which had brought forward the need for surgery. I do, however, accept Mr Perry's submissions that aspects of Dr Bodel's reports are problematic.

95. It is unclear, for example, what Dr Bodel meant when he said the applicant had "no clinical indication of pre-existing abnormality before the work injury", in light of the history of knee symptoms and treatment referred to earlier in his first report. It may be that Dr Bodel was referring to the period immediately prior to the fall but this is unclear.

96. Similarly, it is not apparent from the 5 August 2019 report that Dr Bodel understood that the imaging he was asked to consider pre-dated the injury. Dr Bodel said the imaging was "consistent with the clinical findings that I observed at the time of my examination on 18 July 2019". The contribution made by the work injury is, in these circumstances, unexplained.

97. Some the opinions given by Dr Bodel are opaque. For example, his statement, "This lady does now have a disease process of gradual onset" suggests the injury may have caused the onset of the disease. This is somewhat difficult to reconcile with his later statement, "There is aggravation of an underlying disease process." The opinion, "the aggravation is continuing, as is the aggravation, acceleration, exacerbation and deterioration of the disease process" is poorly expressed.

98. Notwithstanding these deficiencies, I am satisfied, overall, that at the time of his final report of 25 September 2019 Dr Bodel had accurately comprehended the history and treating evidence. I accept that there is a sound basis for the acceptance of the opinions expressed in that report.

99. Dr Wallace has taken an accurate medical history and history of the fall. Dr Wallace accepts that there was a minor aggravation of pre-existing pathology but does not accept that any patellofemoral pathology was caused by the fall given the mechanism of injury. There is in this regard some difference between the reports of Dr Bodel and Dr Wallace in that Dr Bodel appears to suggest that in addition to an aggravation of pre-existing pathology some pathology may have been caused by the fall. The primary difference between the two experts, however, relates to whether the aggravation has ceased.

100. Dr Wallace gives the view that the aggravation “would have settled within six weeks” and “would be resolved”. The difficulty I have accepting this opinion is that it does not sufficiently engage with the applicant’s actual circumstances and the evidence from her treating doctors with regard to her symptoms prior to the injury and ongoing symptoms and need for treatment after the work injury.

101. For this reason, I prefer the opinion of Dr Bodel as expressed in his final report over that of Dr Wallace, notwithstanding the deficiencies in Dr Bodel’s earlier reports identified above.

102. I am satisfied on the balance of probabilities that the injury on 26 October 2018 has materially contributed to the present need for surgical treatment even if it is not the only or even a substantial cause for the need for the treatment.

103. I am satisfied that the applicant has discharged her onus of proof in relation to the claim and that the present need for bilateral knee patellofemoral realignment surgeries proposed by Dr Qurashi results from the injury on 26 October 2018

104. There will be an award for the applicant.

SUMMARY

105. The need for the bilateral knee patellofemoral realignment surgeries proposed by Dr Qurashi results from the injury on 26 October 2018.

106. The respondent to pay the costs of and incidental to the bilateral knee patellofemoral realignment surgeries proposed by Dr Qurashi.