WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **1591/20**
Applicant: **Kianosh Vargodi**
Respondent: **Randstad Pty Limited**
Date of Determination: **26 May 2020**
Citation: **[2020] NSWWCC 174**

The Commission determines:

1. The applicant sustained injury to his right knee arising out of or in the course of his employment with the respondent on 19 October 2018.

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

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

4. The proposed right total knee replacement, 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 with the respondent on 19 October 2018.

The Commission orders:

5. The respondent is to pay the applicant's reasonably necessary medical expenses with respect to the proposed right total knee replacement, 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.

A Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Kianosh Vargodi (the applicant) is 62 years old and commenced employment with Randstad Pty Ltd (the respondent) as a pipe fitter on 14 September 2018.

2. There is no dispute that the applicant injured his right knee when walking down a staircase into a railway station on 19 October 2018. Liability was accepted by Allianz Australia Workers Compensation (NSW) Ltd (Allianz) and compensation was paid by it and icare Workers Insurance (the insurer), who took over the management of the claim in late 2019, until 7 March 2020.

3. This initial acceptance letter is not in evidence, but it would seem from other correspondence that Allianz accepted that the applicant had suffered an aggravation of osteoarthritis in his right knee in the incident.

4. On 8 April 2019, the applicant's treating neurosurgeon, Dr Coffey, sought approval from Allianz to perform a right total knee replacement. There is no dispute that the condition in the applicant's right knee is such that the proposed surgery is reasonably necessary.

5. On 13 June 2019, Allianz issued a notice pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act), disputing that it was liable for the cost of the proposed right knee surgery. It cited s 60 of the *Workers Compensation Act 1987* (the 1987 Act).

6. On 24 September 2019, the insurer reviewed Allianz's decision pursuant to s 287A of the 1998 Act. It informed the applicant that the decision that been withdrawn and that it would pay for the procedure.

7. On 15 January 2020, the insurer issued a further notice pursuant to s 78 of the 1998 Act, disputing that that applicant had sustained an injury and that his employment was a substantial or the main contributing factor to the contraction or aggravation of a disease. It disputed that the applicant was entitled to weekly compensation and the payment of medical expenses, including the cost of the proposed right knee surgery. It cited ss 4, 4(b)(i), 4 (b)(ii), 33, 59 and 60 of the 1987 Act.

8. The decision by the insurer to decline liability after having paid the applicant weekly compensation and medical expenses for approximately 72 weeks was surprising. When I made enquiries at the telephone conference, I was advised that the decision to decline liability was made on the advice of the respondent's solicitor, who drafted the last dispute notice. However, I was informed during the conciliation conference on 18 May 2020 that the insurer intended to reinstate payments and pay the applicant's medical expenses. Accordingly, the claim for weekly compensation and medical expenses was withdrawn.

9. By an Application to Resolve a Dispute (the Application) registered in the Workers Compensation Commission (the Commission) on 23 March 2020 and amended at the arbitration hearing, the applicant claims medical expenses for proposed medical treatment pursuant to s 60 of the 1987 Act due to injury sustained on 19 October 2018.

ISSUES FOR DETERMINATION

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

    (a) whether the proposed right total knee replacement is reasonably necessary as a result of the injury sustained on 19 October 2018 – s 60 of the 1987 Act.

PROCEDURE BEFORE THE COMMISSION

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

EVIDENCE

Documentary evidence

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

    (a) The Application and attached documents, and
    (b) Reply and attached documents.

Oral evidence

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

REVIEW OF EVIDENCE

Applicant's claim form and statements

14. The applicant completed a claim form on 24 October 2018, alleging that he twisted his right knee at 7.30 am on 19 October 2018 when he was stepping down to the ground. He reported his injury and he was initially off work until 22 October 2018. He indicated that he had not worked since 24 October 2018.

15. The notice of injury form completed by the respondent on 19 October 2018 recorded that the applicant had twisted his left knee when walking down some stairs, although it referred to the incident occurring at 11 am on 19 October 2018.

16. The applicant provided an undated and unsigned statement to investigators retained by Allianz. In relation to the mechanism of injury on 19 October 2018 he advised,

    > "I was just walking down stairs. Then I felt a little bit of pain in my knee. It wasn't too bad straight away. But then around 1 hour later my knee was swelling up badly, and became really painful."[1]

17. The applicant continued,

    > "I did not slip or trip when my injury happened. I was just walking normally down the stairs and then my knee twisted a little bit, and then I felt some pain in my knee."[2]

[1] Reply, p 122, paragraph 68.
[2] Reply, p 123, paragraph 75.

18. The applicant provided a detailed statement on 9 March 2020. He advised that he could not recall experiencing any pain or restrictions in his right knee before he sustained injury on 19 October 2018. On that day, he was descending the stairs that led to the train station where he was working when he suddenly felt pain shoot through his right knee. He continued to work but his pain worsened, and he developed swelling. He reported his injury and was taken to see Dr Myint, who referred him for an MRI scan. He also consulted Dr Cheung.

19. The applicant stated that he was prescribed physiotherapy treatment and he was referred to Associate Professor Sullivan. He also consulted with Dr Tahmasebi, whose practice was closer to where he lived.

20. The applicant stated that Associate Professor Sullivan told him that he might require surgery to reattach the medial meniscus root, so he was referred to Dr Nagamori, who advised that this procedure was his only option, but he would still be susceptible to further tears.

21. The applicant indicated that he sought a further opinion from Dr Coffey, who confirmed that he had suffered a tear to his right medial and an exacerbation to low-grade arthritis. The doctor told him that if his pain did not subside, he would benefit from joint replacement surgery.

22. The applicant stated that he continued to experience soreness and weakness in his right knee particularly when standing, sitting or walking for prolonged periods. He consulted Dr Coffey on 18 January 2019, and he recommended conservative treatment including walking and exercise.

23. The applicant stated that in late January 2019, he was walking through a park when his right knee gave way and he twisted it. He thought that his knee had been weakened by his work injury and it was more prone to giving way. He experienced increased pain. He saw Dr Coffey on 12 February 2019, and he referred him or a further MRI scan. He was barely able to withstand any weight on his right knee over the next month and he experienced severe pain which often became excruciating when he attempted to walk. In March 2019, he was referred to a psychologist and a psychiatrist for emotional issues.

24. The applicant stated that he returned to see Dr Coffey due to his worsening pain, and the doctor recommended that he have a total knee replacement. He received physiotherapy treatment and developed symptoms in his left knee and right hip. He had acupuncture that assisted his knee pain, but this was only temporary. He ceased having physiotherapy treatment in September or October 2019, and was unbale to have the knee surgery in January 2020 because the insurer declined liability. He continued to see his general practitioner and was taking Panadeine Forte.

25. The applicant stated that he had constant pain and a restriction of movement in his right knee. His pain was aggravated when sitting, standing and lying down for extended periods. He experienced pain when driving, lifting and squatting. He experienced stiffness and he had lost strength in his knee.

26. The applicant stated that Dr Coffey had explained the risks associated with the operation and he was keen to have the procedure to reduce his debilitating pain, increase the range of movement and mobility, and enhance his ability to participate in his usual activities of daily living.

Clinical notes and medical certificates of Castle Hill Medical Centre

27. The clinical notes of Castle Hill Medical Centre commence on 19 October 2018 and conclude on 21 June 2019. At the first consultation, Dr Myint recorded,

> "**Recorded on: 19/10/2018**
> **History:**
> This morning around 7:30am
> pt was walk down the steps at work when he felt a pop when he was stepping down and accidentally twisted his R knee painful when it happened, but no at 11:30 am the pain is getting much worse as he's been walking around the entire time while he had been at work."[3]

28. Dr Myint observed some swelling and tenderness, and she noted that the applicant complained of significant pain on flexion and extension. She referred the applicant for an MRI scan.

29. The MRI scan dated 22 October 2018 revealed the following findings:

> "Findings: Mucoid degeneration of the anterior cruciate ligament and the posterior cruciate ligament is seen without tear of either. Intact MCL. Fibular collateral ligament, bleeps femoris and popliteus tendons define normally. No abnormality of the iliotibial band.
>
> Radial tear of posterior tibial root attachment of medial meniscus is seen with meniscal gap of up to 3mm transverse. Extrusion of medial meniscus from the joint line is seen. Lateral meniscus is intact and normal in appearance.
>
> Chondral fibrillation and fissuring of the medial condyle and medial plateau is seen. Articular cartilage of the lateral condyle and lateral plateau ls preserved.
>
> Intact extensor mechanism, there is no evidence of quadriceps tendinopathy. There is low-grade proximal patellar tendinopathy.
>
> Full-thickness chondral loss of the patellar apex and the lateral patellar facet and lateral trochlear facet with small degenerative cyst and low-grade reactive marrow oedema pattern with chondral fibrillation elsewhere.
>
> Moderate-sized joint effusion, mild synovitis, no loose body.
>
> CONCLUSION: Mucoid degeneration of the ACL and PCL without tear.
>
> Radial tear of posterior tibial root attachment of medial meniscus with breach of tibia! and femoral articular surfaces.
>
> Grade 3-4 chondral wear of the patellofemoral compartment."[4]

30. On 24 October 2018, Dr Cheung observed swelling and effusion. She discussed the scan results and referred the applicant to Associate Professor Sullivan. She certified that the applicant was fit for his pre-injury duties, but it seems that the applicant did not return to work.

31. The applicant was provided with physiotherapy treatment in October and November 2018 by Peter Ho, who recorded that his condition was improving.

[3] Reply, page 369.
[4] Reply, page 10.

32. On 26 November 2018, Dr Myint recorded that the applicant still had pain over the medial joint line of his right knee, and Dr Nagamori had recommended surgery. The applicant did not attend the surgery again until 21 June 2019.

33. In a report dated 20 June 2019, Dr Cheung stated that it was more likely that the applicant had aggravated the osteoarthritis on the incident. She advised that based on the findings of Associate Professor Miniter, the applicant might be fit for full hours on restricted duties, but she conceded that she had not examined him since October 2018.

34. The applicant was certified as having the capacity to perform some restricted work from 19 October 2018 to 3 December 2018.

Clinical notes and medical certificates of Ponds Medical Centre

35. The clinical notes of the Ponds Medical Centre commence on 24 October 2018 and conclude on 21 July 2019. At the first consultation, Dr Tahmasebi recorded that the applicant had twisted his right knee five days earlier when he was going down stairs. The doctor noted tenderness over the lateral and medial joint lines and there was evidence of slight swelling.

36. On 28 November 2018, Dr Tahmasebi recorded that the applicant had pain in his knee, especially when bending or lifting heavy items. There was no evidence of swelling and only slight tenderness over the joint lines. On this occasion, the doctor referred the applicant to Dr Coffey with a view to meniscal surgery.

37. On 3 December 2018, the doctor noted that the applicant still had increased pain when standing for long periods and when bending. His ability to squat was limited. On 10 December 2018, Dr Maung recorded that Dr Coffey was not keen for the applicant to have an arthroscopy and had recommended conservative treatment.

38. On 12 December 2018, Dr Tahmasebi reported that the applicant's right knee pain had been slowly improving with physiotherapy. There was slight tenderness and minimal effusion in the knee. On 7 January 2019, Dr Jeyendra noted that the applicant had soreness and swelling in the knee.

39. On 26 January 2019, Dr Maung reported as follows:

> **"Recorded on: 26/01/2019**
> **History:**
> yesterday did a long walk
> had to stop due to knee pain
> now right knee quite sore and painful
> was going well prior to this
> **Examination:**
> swollen tender right knee"[5]

40. On 4 February 2019, Dr Tahmasebi recorded the following history:

> "**Recorded on: 04/02/2019**
> two week ago he twisted his right knee while he was walking as usual in a park
> before that he was well improving ·
> since then pain aggravated also swelled. since
> walking would be painful now
> has been on Celebrex and Panadeine
> has medical cert until 11 feb

[5] Reply, page 228.

Examination:
tender medical joint line ++
swelling slightly
ROM full but painful
no redness"[6]

41. The doctor diagnosed an aggravation of the applicant's right knee pain. The applicant had a further MRI scan and the doctor reported that there was no change to the meniscal tear. Thereafter, the applicant complained of persistent right knee pain, limping, difficulties with walking, standing and sleeping, depression and anxiety, and restriction of movement. At the last consultation, the applicant also complained of left knee pain.

42. Dr Tahmasebi certified that the applicant had no current work capacity from 26 November 2018 to 26 May 2019. In the certificate dated 11 February 2019, the doctor noted that the applicant had suffered another twisting injury three weeks earlier and a repeat MRI scan was required.

43. The MRI scan dated 12 February 2019 revealed the following findings:

"Clinical Notes: Injury 4 months ago. Recent twisting knee again.

Findings: Reference is made to the previous images of October 2018. There is full thickness articular cartilage to the medial femoral condyle 10 mm with underlying reactive bony oedema. There is marked attenuation to the tibial plateau in this region.

The posterior root radial tear to the medial meniscus is noted with displacement of the meniscus into the gutter - 4 mm. The coronary ligaments remain intact. The medial collateral ligament is intact.

There is hypointensity to the posterior root of the lateral meniscus. Articular cartilage cover is complete in the lateral compartment. The lateral ligamentous complex is intact.

The ACL and PCL are intact (mucoid degeneration is again present).

There is full thickness articular cartilage loss to the lateral femoral condyle with reactive bony oedema/subchondral cystic change. Further full thickness articular cartilage loss affects the apex and lateral patellar facet, with underlying reactive bony oedema/subchondral cystic change. The PF ligaments and retinacular fibres are intact.

There is a joint effusion with a 25 mm Baker's cyst.

CONCLUSION:

1. Reference made to previous images.

2. Decrease in amount of reactive bony oedema within medial tibial plateau. No significant change to medial meniscal tear and displacement of meniscus into gutter.

3. Reduction in size of effusion and Baker's cyst.

[6] Reply, page 228.

4. Changes to articular cartilage in medial compartment persist, however, with review there is full thickness articular cartilage loss (not simply fibrillation /chondromalacia). No other new features."[7]

44. The applicant was cleared to perform some restricted duties for 15 hours per week from 15 May 2019 to 21 August 2019.

Reports of Associate Professor Sullivan and Dr Nagamori

45. Associate Professor Sullivan reported on 15 November 2018. He recorded that the applicant twisted his right knee at work on 19 October 2018 and he experienced pain and swelling. localised to the medial joint line and anteriorly. He had difficulty walking on stairs and inclines and on some days, he could barely walk at all. The doctor observed marked patellofemoral crepitus, tenderness over the medial joint line and a fairly well preserved range of motion is fairly well preserved.

46. Associate Professor Sullivan considered that the applicant had a tear of the root of the meniscus. He believed that the articular cartilage damage and patellofemoral changes that were shown on the MRI scan predated the injury and he recommended that these be treated with a graded strengthening program.

47. Dr Nagamori reported on 21 November 2018. He noted that the applicant had suffered an injury five weeks earlier when he stepped down and twisted his right knee. The applicant had posterior and medial knee pain with flexion and there was no prior history of knee problems. On examination, the doctor observed a full range of motion, small effusion, medial tenderness and patellofemoral crepitus.

48. Dr Nagamori diagnosed an acute posterior horn medial meniscus root avulsion with a small focal chondral injury. He indicated that he discussed the natural history including the high likelihood of arthritis progression and the role of arthroscopic meniscus repair with the applicant, who was to consider whether he was prepared to have surgery.

Reports of Dr Coffey

49. Dr Coffey reported on 29 November 2018. He recorded that the applicant sustained "a twisting weight-bearing injury stepping down. He heard a noise in the knee and there was immediately posterior pain. He has since then developed moderate medial pain"[8]. On examination, the doctor noted a small effusion of the knee, a range of motion from 0-120°, moderate medial joint line tenderness and patellofemoral crepitus.

50. Dr Coffey noted the MRI scan findings and concluded that the applicant had exacerbated previously low-grade osteoarthritis of his right knee by sustaining an avulsion injury of the posterior root of the medial meniscus. He stated that if the applicant's symptoms did not settle, he might need to consider surgery, but the doctor felt that he was not a candidate for a meniscal root repair due to the nature of changes in the medial compartment. He stated that a meniscal debridement might be a temporary solution, but the applicant might require a total knee replacement in the longer term. He suggested a review in early 2019.

51. Dr Coffey referred the applicant for x-rays on 5 December 2018. These showed early degenerative arthritis in the applicant's right knee.

[7] Reply, page 67.
[8] Reply, page 353.

52. In his report dated 18 January 2019, D Coffey recorded that the applicant had less pain and experienced activity related discomfort. The doctor felt that he was not back to normal, but there had been some good progression in his symptoms. His findings on examination were similar, but there was no effusion and only mild tenderness. He felt that the applicant was making satisfactory progress with non-surgical treatment.

53. In his report dated 15 March 2019, Dr Coffey recorded that the applicant had suffered a relapse in his improvement, and he had moderately disabling right knee pain that was not settling with conservative treatment. He observed marked medial joint line tenderness a small effusion and the range of motion was from 0-130°.

54. Dr Coffey stated that the applicant would gain no benefit from an arthroscopic debridement. He noted that the MRI scan showed a progression of the medial compartment degeneration due to meniscal root failure and there was moderate patellofemoral degeneration. Accordingly, he recommended a right total knee arthroplasty.

55. On 8 April 2019 Dr Coffey sought Allianz's approval for the surgery. This request was initially denied but later approved by the insurer, before the insurer withdrew its consent in January 2020.

56. Dr Coffey provided his final report on 15 July 2019 [sic]. He confirmed that when he first saw the applicant, he considered that the applicant had exacerbated previously low-grade arthritis in the right knee as a result of an avulsion injury of the posterior root of the medial meniscus, which led to a progression of medial knee joint pain caused by the loss of protective hoop stresses from the previously intact medial meniscus. He indicated that if the applicant's condition did not settle adequately, the applicant would be a candidate for joint replacement surgery due to the nature of the medial compartment changes already present.

57. Dr Coffey stated that when he saw the applicant on 18 January 2019, he complained of less pain and imaging confirmed that there had been no progression in the medial compartment osteoarthritis. He recommended conservative treatment but when he saw the applicant on 15 March 2019, he found that the applicant had suffered a relapse and he had moderately disabling right knee pain that was not settling with simple treatment. The MRI scan had also confirmed a progression of medial compartment degeneration due to meniscal root failure, and there was moderate patellofemoral degeneration. In the circumstances, he recommended a right total knee arthroplasty.

58. Dr Coffey stated that the mechanism whereby the applicant twisted his knee as he descended stairs and his symptoms were consistent with meniscal root failure. Therefore, he considered that there was a fairly clear relationship between the onset of his symptoms and his ongoing pain and disability. He believed that the main contributing factor to the applicant's injury was the failure of the medial meniscal root, and he considered that the employment was a significant contributing factor to the progression of degeneration in his knee.

59. Dr Coffey agreed that the applicant had pre-existing osteoarthritis in his right knee as disclosed in the MRI scan dated 22 October 2018, but this was minimally, if at all, symptomatic. He explained that once the meniscus failed, there was unprotected load onto the medial compartment. This allowed for a significant progression of osteoarthritic changes, resulting in increased pain and further articular cartilage loss, which gave rise to the need for surgery.

60. Dr Coffey explained that the need for surgery was based on the fact that the applicant had no significant symptoms prior to the injury. There was a definite failure of the medial meniscus with progression of medial compartment osteoarthritic changes and increased symptoms, and because of the progression, the only surgical option was a total knee arthroplasty, which was an accepted, proven, cost effective and long-term treatment for end stage osteoarthritis of the knee.

61. Dr Coffey stated that conservative measures had failed, and studies had confirmed good or excellent results in the order of 85%. He expected that without the surgery, the applicant's condition would continue to have moderate right knee pain which would most likely preclude a return to work. He also pointed out that Associate Professor Miniter had not seen the actual scans and was reliant on the reports of the radiologists.

Emails

62. According to an email from a rehabilitation consultant, Dee Linehan, dated 31 January 2019, the applicant had to cancel an appointment on 28 January 2019 because he had suffered an exacerbation of his symptoms when "he was walking and went to step down off the curb and landed on his leg awkwardly twisting his knee"[9].

63. On 12 February 2019, Ms Linehan advised that the applicant's general practitioner had confirmed that "due to the exacerbation of IW's symptoms following twisting his knee over 2 weeks ago, his function has decreased, and pain has increased. Increase swelling was observed around the knee joint"[10].

Reports of Dr Bodel

64. Dr Bodel reported on 6 September 2020. He recorded that the applicant twisted his knee as he was going downstairs and he became aware of pain in the front of the knee. His knee became swollen and he reported his injury, He sought treatment, was told to consider having an arthroscopy, and he later consulted Dr Coffey, who advised him that he would require a right total knee arthroplasty. The applicant stated that he had no past or subsequent injuries.

65. Dr Bodel diagnosed a tear of a degenerate posterior horn of the medial meniscus and an aggravation, acceleration, exacerbation and deterioration of the asymptomatic significant medial compartment osteoarthritis and retropatellar articular cartilage damage as a result of the twisting incident at work. An arthroscopy was not an appropriate form of treatment, because it would not address the pathology and a total knee replacement was required to alleviate the applicant's pain and to increase his mobility. He stated that the surgery was cost effective and a well-recognised form of treatment for the underlying pathology and the work injury

66. Dr Bodel agreed with the opinion of Associate Professor Miniter that the applicant had pre-existing osteoarthritis in his knee, but it was likely that the applicant had suffered some additional structural damage and tore his degenerate medial meniscus. Therefore, he disagreed with the Associate Professor's views on causation.

67. In a supplementary report dated 23 February 2020, Dr Bodel noted that the applicant had suffered a further event in January 2019, and he was informed about Dr Coffey's views regarding future surgery and the findings in the later MRI scan.

68. Dr Bodel was satisfied that the applicant suffered a further aggravation of the longstanding pathology in January 2019, and that event was still the substantial contributing factor to the "injury" which occurred at work by way of aggravation, acceleration, exacerbation and deterioration of a disease process and meniscal tear. He felt that whilst the subsequent event further aggravated the situation, it was not as significant as the injury on 19 October 2018.

69. Dr Bodel confirmed that the injury on 19 October 2018 was the main contributing factor to the aggravation, acceleration, exacerbation and deterioration of the arthritic disease process in the applicant's right knee, and he accepted that it was likely that some additional structural damage occurred in the episode in January 2019.

[9] Reply, page 21.
[10] Reply, page 26.

70. Dr Bodel observed that the applicant's condition had appeared to be improving, but he still had problems with his knee prior to the incident in January 2019. The subsequent deterioration was something that would be expected.

Report of Associate Professor Miniter

71. Associate Professor Miniter reported on 31 May 2019. He noted that the applicant had no issues with his right knee until he twisted it when he was coming down stairs at work. The doctor indicated, "He told me that he was simply coming down stairs and that his knee felt uncomfortable. Whether he truly twisted it or otherwise is difficult to determine"[11].

72. Associate Professor Miniter noted that the applicant had an MRI scan on 22 October 2018 that was reported to show a radial tear of the posterior root attachment of the medial meniscus, which was unlikely to be able to be repaired. He also noted the findings of the subsequent MRI scan and the radiologist's comments that the initial scan was underreported

73. Associate Professor Miniter noted that the applicant was simply walking down stairs which could have easily occurred at home, meaning that this would tend to qualify as an unrelated work injury. He thought that it was difficult to determine whether the applicant suffered an acute injury to the meniscal root, but that may have been the case as the applicant denied having any prior issues. As he had not seen the initial MRI scan, he was not in a position to comment.

74. The Associate Professor diagnosed osteoarthritic disease of the right knee, and there appeared to have been a twisting injury, work related or otherwise. He believed that it was unlikely that there was a specific work injury, because the applicant was simply descending stairs and it was not specific to his work duties.

75. The Associate Professor agreed that a right total knee replacement was the definitive solution to the applicant's knee condition, but he doubted that the applicant was a good candidate for the procedure. He considered that the main contributing factor for total knee replacement was the presence of osteoarthritic disease.

Respondent's statements

76. The respondent relies on statements from two employees, Lavendar Pham and Michael Fraser.

77. Ms Pham was advised by the applicant that he had hurt his knee when he was walking down the stairs, and when she asked him how the injury happened, he said "something along the lines of that 'he missed the last step' when walking down the stairs"[12].

78. Mr Fraser stated that he was informed by the site safety officer, Greg Beard, that the applicant had reported that he had twisted his knee. He understood that the applicant twisted his knee when going down stairs.

RESPONDENT'S SUBMISSIONS

79. The respondent's counsel, Mr Flett, submits that the mechanism of injury has been described differently in the applicant's statements and the clinical notes. This is central to the opinions expressed by Drs Coffey and Bodel. The entries in the clinical notes in November 2018 showed that the applicant's condition was improving.

[11] Reply, page 31.
[12] Reply, page 136, paragraph 74.

80. Mr Flett submits that in his report dated 29 November 2018, Dr Coffey recorded that the applicant sustained a twisting weight-bearing injury when stepping down. Other doctors later recorded different version that the applicant experienced pain followed by a twist.

81. Mr Flett submits that Dr Coffey stated that the applicant's condition might settle, or he might only need a meniscal debridement. The doctor stated that the applicant might need a total knee replacement in the future, but he did not suggest that the need for this surgery was due to the effects of the work injury.

82. Mr Flett submits that the applicant began seeing doctors at the Ponds Medical Centre in October 2018 and they recorded that the applicant had less pain and his condition was improving. On 10 December 2012, Dr Maung noted that the applicant might need an arthroscopy, but Dr Coffey was not keen to repair the meniscus, and on 7 January 2019, it was reported that the applicant only had minor swelling.

83. Mr Flett submits that on 26 January 2019, Dr Maung recorded that the applicant had gone on a long walk and he had needed to stop because his right knee had become sore and painful. His knee had been going well prior to this episode.

84. Mr Flett submits that on 4 February 2019, Dr Tahmasebi recorded that the applicant had twisted his knee, his pain was aggravated, and he developed swelling. Prior to this incident, his condition had been improving.

85. Mr Flett submits that the physiotherapist's email dated 31 January 2019 indicated that the applicant had stepped off a kerb, landed on his leg awkwardly and twisted his knee. This suggests that the mechanism of injury in this later incident was significantly more destructive than the injury in 2018. This is consistent with the history of a twisting incident and the findings in the second MRI scan.

86. Mr Flett submits that according to the MRI scan dated 12 February 2019, on review, there were changes in the articular cartilage with full thickness articular cartilage loss, not simply fibrillation or chondromalacia. This is an important finding and is consistent with the finding on page 2 of the initial MRI scan, and perhaps Dr Coffey did not have that page. That might explain why Dr Coffey was critical of the opinion of Associate Professor Miniter's opinion and the fact that he relied on reports of the scans.

87. Mr Flett submits that Dr Coffey did not discuss the significance of the finding of grade 3-4 chondral wear of the patellofemoral compartment. This was discussed by Associate Professor Miniter in his report and he observed that there was a reduction in the amount of reactive bone oedema within the tibial plateau which not reported in the initial scan and there were osteoarthritic changes present in the first scan.

88. Mr Flett submits that when Dr Coffey reviewed the applicant on 18 January 2019, the applicant complained of less pain and given the improvement, he recommended a non-operative approach, but when he reviewed the applicant on 15 March 2019, he noted that the applicant had suffered a relapse, but he was not aware that the applicant had suffered a significant injury in the park in late January 2019.

89. Mr Flett submits that Dr Coffey noted that there was marked medial joint line tenderness, rather than mild or moderate tenderness, and a small effusion, and that there had been a progression of the medial compartment degeneration. Therefore, there was a significant difference in the scans between October 2018 and the second injury in January 2019, and this gives credence to Associate Professor Miniter's view that the main contributing factor to the need for the surgery was the osteoarthritis. There was no need for the surgery before January 2019, so the change in the circumstances could only be due to the injury in January 2019.

90. Mr Flett submits that Dr Bodel recorded that the applicant twisted his knee when walking down the stairs. That history might not be entirely correct, but there are no credit issues regarding the applicant's evidence. He agreed that the applicant needed surgery and he treated the subsequent incident with some disdain, but did not develop his view beyond that comment. The doctor did not have the earlier MRI scan for comparison, so he only had half of the story and his views carry no weight.

91. In reply, Mr Flett submits that there seemed to be no reason why Dr De Leon altered his certification of the applicant's capacity on 28 November 2019, which was the day before the applicant saw Dr Coffey.

92. Mr Flett submits that when one compares the two MRI scans, the finding by the radiologist of progression of the meniscus into the gutter from 3 mm to 4 mm, and a full thickness tear of 10 mm, suggested a progression in the pathology, consistent with the applicant's complaints recorded in the clinical notes after the January 2019 incident. Drs Bodel and Coffey did not have an accurate history of the January 2019 incident, and that is why they said that the need for surgery was the result of the work injury.

APPLICANT'S SUBMISSIONS

93. The applicant's counsel, Mr McManamey, submits that the issue to be determined is whether the applicant's work injury materially contributed to the need for the knee replacement surgery. A large part of the respondent's case is that the incident in January 2019 was a novus actus that broke the chain of causation.

94. Mr McManamey submits that the authorities confirm that the crucial principle is that where there is a subsequent incident, it can be considered in three ways, either as merely an aggravation of the original condition, the consequences are worse because of the existence of the original condition, in which case both are compensable, or as a novus actus which is totally unrelated. The respondent bears the onus of establishing that the need for surgery was caused by the January 2019 incident and there is no medical evidence to that effect, meaning that the respondent must fail.

95. Mr McManamey submits that when the applicant saw Dr Myint on 19 October 2018, he said that he was walking down stairs, felt a pop and twisted his right knee. Whether the knee popped first is immaterial, as there was a twisting of the knee. This history is consistent with the contemporaneous claim form. Drs Coffey, Bodel, Nagamori and Sullivan all had the correct history. The treating doctors accepted that the applicant had suffered a tear of the root of the medial meniscus and this was new pathology and was consistent with a twisting motion.

96. Mr McManamey submits that Dr Coffey explained that the applicant had suffered an exacerbation of previously low-grade osteoarthritis of his right knee due to an avulsion injury of the posterior root of the medial meniscus. The initial MRI scan showed a radial tear of the posterior tibial root attachment of the medial meniscus with a meniscal gap of up to 3 mm, with a breach of the tibial and femoral articular surfaces.

97. Mr McManamey submits that it appears that the radiologist did a comparison between the two MRI scans, and despite the recent exacerbation in January 2019, it appears that there had actually been some improvement in the applicant's condition, because there was a decrease in the bony oedema and there was no change in the meniscus, and a reduction in the size of the Baker's cyst.

98. Mr McManamey submits that the radiologist indicated that the changes to articular cartilage in medial compartment persisted, however, with review, there was full thickness articular cartilage loss, and not simply fibrillation or chondromalacia. So, it seems that the radiologist looked at both films for comparison, but he was not saying that this occurred on the later occasion. Rather, he was reviewing the two MRI scans and there was no significant change. There was no change in the damage to the medial meniscus, and the tear is crucial to the process.

99. Mr McManamey submits that in his report dated 15 July 2019 [sic], Dr Coffey explained the tear of the meniscus in the incident and that this caused an exacerbation of the osteoarthritis and a progression of medial knee joint pain due to loss of protective hoop stresses from the previously intact medial meniscus. So, the continuing problems can be attributed to the tear.

100. Mr McManamey submits that Dr Coffey noted that the second MRI scan confirmed the progression of medial compartment degeneration due to meniscal root failure. Therefore, if there was a deterioration in the osteoarthritis, then this was due to the progression of the degeneration, and there was no new pathology.

101. Mr McManamey submits that Associate Professor Miniter did not have the scan films, and whilst he noted that the findings of the radiologist, he did not say if there was any evidence of progression of the osteoarthritis, and he did not identify any new pathology. Therefore, there was no basis to suggest that the incident in January 2019 was anything other than a routine exacerbation of the earlier problem.

102. Mr McManamey submits that the respondent submits that the applicant's right knee condition was improving, and up until December 2018, he was certified as being fit to perform suitable duties for 15 hours per week, but when he saw Dr de Leon on 19 December 2019, he was certified as having no current work capacity. This was one month before the January 2019 incident, so he was not improving. Throughout the clinical notes there were continuing complaints of pain and swelling, which is consistent with the continuing effects of the initial injury. This continuation was accepted by Drs Coffey and Bodel.

103. Mr McManamey submits that Associate Professor Miniter stated that there was no injury in November 2018, and he was not asked the correct question, namely whether the need for surgery resulted from the work incident. He was asked whether the applicant's injury was the main contributing factor for the surgery, but that is not the test. At no stage does Associate Professor Miniter engage with Dr Coffey's opinion, namely if there is a progression in the degenerative changes, then this is the consequence of the meniscal tear.

REASONS

Nature of the Injury

104. The first matter that requires some comment is a determination of the nature of the injury that the applicant sustained in 19 October 2018.

105. There is no dispute that the applicant suffered an injury to his right knee in the incident on 19 October 2018.The insurer's correspondence refers to the nature of the applicant's injury as an aggravation of osteoarthritis in his right knee. Liability was appropriately accepted by Allianz and weekly compensation was paid until 7 March 2020. In my view, the decision to cease payments based on the advice of its solicitor was misconceived, and this seems to have been acknowledged by the insurer when it agreed to reinstate payments.

106. It is true that the mechanism of injury has been described differently in the evidence, but there is a consistency in the histories regarding a twisting movement.

107. The notice of injury form completed by the respondent on 19 October 2018, being the earliest evidence regarding the event, recorded that the applicant had twisted his knee when walking down some stairs, although it referred to the left knee.

108. At the consultation on 19 October 2018, Dr Myint recorded that the applicant had felt a pop when he was stepping down and twisted his knee. On 24 October 2018, Dr Tahmasebi recorded that the applicant had twisted his right knee five days earlier. In his claim form dated 24 October 2018, the applicant indicated that he twisted his right knee on 19 October 2018 when he was stepping down to the ground.

109. In his statement given to the investigator on 14 August 2019, the applicant downplayed the incident and said that he felt some pain when walking down stairs and he twisted his knee a little bit.

110. In his statement dated 9 March 2020, there was no mention of any twisting movement. This seems to have been merely an oversight by the person who drafted the statement on behalf of the applicant, when one considers the earlier contemporaneous evidence.

111. Associate Professor Sullivan saw the applicant one month after the incident and he recorded that the applicant twisted his right knee at work on 19 October 2018. Dr Nagamori saw the applicant a few days later and he reported a similar history.

112. On 29 November 2018, Dr Coffey reported that the applicant sustained a twisting weight bearing injury. Associate Professor Miniter reported on 31 May 2019 that the applicant twisted his right knee, and this was also the history recorded by Dr Bodel on 6 September 2020.

113. Therefore, despite what might be described as minor inconsistencies in the evidence, I am satisfied that the applicant twisted his knee when walking down stairs on 19 October 2019, and there is no evidence to suggest otherwise.

114. Allianz accepted that the applicant suffered an aggravation of osteoarthritis in his right knee. However, it seems that the injury was far more sinister. The MRI scan taken on 22 October 2018, a matter of days after the incident, showed a radial tear of posterior tibial root attachment of medial meniscus with a breach of the tibial and femoral articular surfaces, grade 3-4 chondral wear of the patellofemoral compartment and degeneration of the anterior and posterior cruciate ligaments.

115. Dr Cheung diagnosed an aggravation of the osteoarthritis in the incident, but she did not comment on the significance of the MRI findings.

116. Associate Professor Sullivan and Dr Nagamori agreed that the applicant had suffered a tear of the root of the medial meniscus. Both identified the presence of osteoarthritis, but did not comment on any aggravation of the condition.

117. Dr Coffey diagnosed an avulsion injury of the posterior root of the medial meniscus that caused an exacerbation of low grade osteoarthritis in the applicant's knee. Dr Bodel expressed a similar view.

118. Associate Professor Miniter acknowledged the presence of the radial tear of the posterior root attachment of the medial meniscus, but he thought that it was difficult to determine whether the applicant suffered an acute injury. However, he seemed to concede that this was a possibility because the applicant had no prior symptoms. Confusingly, and without a detailed explanation, he then expressed the view that it was unlikely that there was a specific work injury. Given, the preponderance of medical opinion to the contrary and the acceptance of an injury by Allianz, I am satisfied that the Associate Professor's opinion can be safely disregarded.

119. In the circumstances, I accept the diagnosis provided by Dr Coffey and the other doctors, namely that the applicant suffered an avulsion injury of the posterior root of the medial meniscus that caused an exacerbation of the asymptomatic osteoarthritis in the applicant's right knee. This seems to invoke s 4 and s 4(b)(ii) of the 1987 Act, so given the weight of medical opinion, I accept that the applicant's employment was both a substantial and the main contributing factor to his injury.

120. The next question to consider is whether the need for surgery resulted from the applicant's work injury.

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

121. Section 60 of the 1987 Act provides:

> "60 (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)".

122. 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)*[13], 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."[14]

123. Further, His Honour added:

> "1. *Prima facie*, if the treatment falls within the definition of medical treatment in section 10(2), it is relevant medical treatment for the purposes of this Act. Broadly then, treatment that is given by, or at the direction of, a medical practitioner or consists of the supply of medicines or medical supplies is such treatment.
>
> 2. However, although falling within that ambit and thereby presumed reasonable, that presumption is rebuttable (and there would be an evidentiary onus on the parties seeking to do so). If it be shown that the particular treatment afforded is not appropriate, is not competent to alleviate the effects of injury, then it is not relevant treatment for the purposes of the Act.

[13] (1986) 2 NSWCCR 32 (*Rose*).
[14] *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."[15]

124. 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*[16] 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."[17]

125. In *Diab v NRMA Ltd*[18], Deputy President Roche questioned this approach and cited *Rose* with approval. He provided a summary of the principles as follows:

> "In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in *Rose* (see [76] above), namely:
>
> (a) the appropriateness of the particular treatment;
> (b) the availability of alternative treatment, and its potential effectiveness;
> (c) the cost of the treatment;
> (d) the actual or potential effectiveness of the treatment, and
> (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.
>
> With respect to point (d), it should be noted that while the effectiveness of the treatment is relevant to whether the treatment was reasonably necessary, it is certainly not determinative. The evidence may show that the same outcome could be achieved by a different treatment, but at a much lower cost. Similarly, bearing in mind that all treatment, especially surgery, carries a risk of a less than ideal result, a poor outcome does not necessarily mean that the treatment was not reasonably necessary. As always, each case will depend on its facts.
>
> While the above matters are 'useful heads for consideration', the 'essential question remains whether the treatment was reasonably necessary' (*Margaroff v Cordon Bleu Cookware Pty Ltd* [1997] NSWCC 13; (1997) 15 NSWCCR 204 at 208C). Thus, it is not simply a matter of asking, as was suggested in *Bartolo*, is it better that the worker have the treatment or not. As noted by French CJ and Gummow J at [58] in *Spencer v Commonwealth of Australia* [2010] HCA 28, when dealing with how the expression 'no reasonable prospect' should be understood, '[n]o paraphrase of the expression can be adopted as a sufficient explanation of its operation, let alone definition of its content'".[19]

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[15] *Rose*, [47].
[16](1997) 14 NSWCCR 233 (*Bartolo*).
[17] *Bartolo*, [238].
[18] [2014] NSWWCCPD 72 (*Diab*).
[19] *Diab*, [88] to [90].

126. 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. The accepted view regarding causation was set out in *Kooragang Cement Pty Ltd v Bates*[20], where Kirby J stated:

> "The result of the cases is that each case where causation is in issue in a workers compensation claim must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from' is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a common sense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation."[21]

127. There is no dispute that the condition of the applicant's right knee is such that the proposed right knee replacement is reasonably necessary. The present issue is whether the need for the procedure results from the work injury on 19 October 2018, or is due to the incident when the applicant injured his knee when he was walking in a park in January 2019.

128. The applicant did not mention the park incident when he was interviewed by the investigator. He advised that he still had a lot of pain in his right knee and he was waiting for the insurer to approve the knee replacement surgery. In his later statement, he acknowledged that his right knee gave way and he twisted it when he was walking in a park in late January 2019.

129. The applicant stated that prior to the park event, he had soreness and weakness in his right knee, which suggests that he was still suffering from the effects of the work injury, given that his knee had been asymptomatic before then.

130. However, after the incident in the park, he was barely able to withstand any weight on his right knee for a month and he experienced severe and at times excruciating pain. This history suggests that the park incident was more than just a minor twisting episode. The applicant indicated that he continued to have constant pain and a restriction of movement, and that his symptoms impacted on his daily activities. Therefore, it would seem from his evidence that he has not recovered from the effects of both incidents.

131. The applicant's evidence regarding the persistence of his symptoms is corroborated by the evidence of his treating doctors. In late 2018, the applicant was provided with certificates that certified that he had the capacity to do some restricted work. Whilst it seems that there had been improvement in his condition, there was no suggestion that he had reached the stage where he could return to his full pre-injury duties. Dr Tahmasebi reported that the applicant's right knee pain had been slowly improving with physiotherapy on 12 December 2018. At that stage he only had slight tenderness and minimal effusion in the knee.

132. The day after the park incident, which seems to have happened on 25 January 2019, the applicant saw Dr Maung, who noted that the applicant had to stop when he was on a long walk because his right knee had become quite sore and painful. There was no mention of any twisting incident. The applicant had swelling in his knee, suggestive of some form of trauma.

[20] (1994) 35 NSWLR 452; 10 NSWCCR 796 (*Kooragang*).
[21] *Kooragang* [463].

133. According to the emails from the rehabilitation consultant, who is not a doctor and would presumably be a physiotherapist, the applicant awkwardly twisted his knee and he suffered an increase in his pain and decrease in his function. This supports the contention that the park incident was not minor, but I do not feel that one could conclude that this incident was more destructive that the work incident as submitted by Mr Flett, particularly when the MRI scan findings are considered. I will comment on these tests later.

134. When the applicant saw Dr Tahmasebi on 4 February 2019, the doctor recorded that he had twisted his knee in the park and had suffered an aggravation of his pain and swelling. The doctor diagnosed an aggravation of the applicant's right knee pain, so the park incident had impacted on the applicant's knee condition. The clinical notes show that the applicant continued to complain of persistent right knee pain and difficulties that this presented when he performed his daily activities.

135. Unlike Dr Myint, Dr Tahmasebi certified that the applicant had no current work capacity from 26 November 2018. Whilst there is no explanation from the doctor why he downgraded the applicant's capacity, this certificate was issued after the applicant had seen Dr Nagamori, who had recommended an arthroscopy, so this may have influenced Dr Tahmasebi. For whatever reason, the applicant was certified as unfit for all work prior to the park incident. Such certification would not be consistent with improvement in the applicant's condition.

136. Associate Professor Sullivan and Dr Nagamori only examined the applicant on one occasion shortly after the work injury. Associate Professor Sullivan recommended conservative treatment, whereas Dr Nagamori suggested an arthroscopy. Neither addressed any treatment of the osteoarthritic changes. As they did not see the applicant after the park incident, their evidence is of minimal assistance regarding the knee replacement surgery.

137. Dr Coffey recommended conservative measures when he saw the applicant in late November 2018, but he foreshadowed an arthroscopic debridement in the short term if the applicant's pain persisted, rather than a meniscal root repair, and eventually he would need a total knee replacement due to the nature of the medial compartment changes already present . The doctor reported some improvement prior to the park incident, comprising less pain and discomfort, and he noted that there had been no progression in the medial compartment osteoarthritis, but he acknowledged that the applicant had not returned to normal.

138. Mr Flett submits that Dr Coffey may not have had page 2 of the MRI scan report dated 22 October 2018. However, page 2 was only a one line summary of the findings reported on page 1 of the scan report, and Dr Coffey's summary identified advanced patellofemoral degeneration with associated bone oedema, which seems consistent with page 2 of the MRI scan report. Further, it would extremely surprising if a specialist knee surgeon only relied on a radiologist's report without examining the actual scan films, particularly if he was contemplating surgical treatment.

139. It is true that Dr Coffey was not provided with a history of the park incident, and he only referred to it as a relapse, but he noted that this had resulted in moderately disabling right knee pain, marked medial joint line tenderness, a small effusion and a restricted range of movement. Further, there had been a progression of the medial compartment degeneration, but he attributed this to meniscal root failure rather than any new pathology caused by the "relapse", and whilst there was moderate patellofemoral degeneration, he did not comment on its relationship to the work injury or the relapse. He thought that an arthroscopy would be of no benefit, and he recommended a total knee replacement.

140. Although Mr Flett submits that the second MRI scan showed a progression of the meniscus into the gutter from 3 mm to 4 mm, this appears a minor progression of only 1 mm. The radiologist commented that there was a full thickness tear of 10 mm, however his comment that “changes to articular cartilage in medial compartment persist, however, with review there is full thickness articular cartilage loss (not simply fibrillation/chondromalacia)” would seem to suggest that this pathology was present in the first MRI scan but was unreported. Nevertheless, there is no medical evidence that confirms that this was caused by the park incident rather than merely the progression of the effects of the work injury.

141. Dr Coffey’s explanation of the aetiology of the pathology in the applicant’s right knee is particularly persuasive. The root of the medical meniscus had been ruptured as a result of the twisting movement, and this could not be surgically repaired. This rupture caused unprotected load onto the medial compartment and resulted in further articular cartilage loss. This had contributed to the aggravation and progression of the osteoarthritic changes in the knee and gave rise to the need for surgery. In other words, the need for surgery resulted from the rupture and its consequences.

142. The second MRI scan showed a reduction in the bony oedema within medial tibial plateau and in the Baker’s cyst, and no significant change to medial meniscal tear and displacement of meniscus into gutter. If anything, this would suggest improvement or maintenance of the status quo with no structural damage caused by the park incident. Further, the radiologist reported that the changes to articular cartilage in medial compartment persisted, and there was full thickness articular cartilage loss, which seemed to have been present, but unreported, in the first scan.

143. Similarly, Dr Bodel was not informed about the park incident, but when he was informed of the event, he indicated that the applicant had suffered a further, but less significant, aggravation of the longstanding pathology on the background of the original injury. He felt that there was probably some further structural damage. Such an opinion is logical and seems consistent with the facts and the contemporaneous evidence. However, the doctor did not indicate that the need for surgery resulted from the work injury, the park incident, or both. He merely stated that the applicant needed the operation.

144. Associate Professor Miniter had some doubts that the applicant had actually suffered an injury and he seemed to be referring to the test for main contributing factor, but of course injury is not in dispute. Therefore, this raises some concerns in my mind regarding the doctors’ views about the work injury and the need for surgery.

145. Associate Professor Miniter stated that the applicant required a total knee replacement to address the osteoarthritis. In that regard, he agreed with Drs Coffey and Bodel.

146. However, the Associate Professor did not comment on any causal nexus between the work injury and the need for surgery. He did not address Dr Coffey’s opinion regarding the progression of the degenerative changes as a consequence of the meniscal tear. He stated that the main contributing factor for total knee replacement was the presence of osteoarthritic disease, and in doing so, he seems to have confused the requirements of ss 4 (b)(i) or 4(b)(ii) of the 1987 Act, rather than saying that the surgery resulted from the accepted work injury. His opinion is also compromised because he did not see the actual MRI scans, and he was reliant on the interpretation given to them by the radiologists. Therefore, I consider that the Associate Professor’s evidence carries minimal, if any, weight.

147. I am satisfied that there is a difference in the findings between the first and second MRI scans. In some aspects, there seems to have been some improvement, and in other aspects, there has been a progression of the osteoarthritic changes. I would not describe these changes as significant.

148. It is accepted that a condition can have multiple causes, but the applicant must establish that the injury materially contributed to the need for surgery. The principles were discussed by Deputy President Roche in *Murphy v Allity Management Services Pty Ltd*[22]. The facts in that case were similar to the present matter.

149. Ms Murphy suffered an injury at work, and later injured herself when she fell in a supermarket. She required surgery following the later incident. The Deputy President made the following observations:

> "Moreover, even if the fall at Coles contributed to the need for surgery, that would not necessarily defeat Ms Murphy's claim. 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)."[23]

150. Therefore, the work injury must make a material contribution to the need for surgery, even if there are other factors that contribute to the procedure.

151. I accept that the park incident impacted on the pathology in the applicant's right knee, but I am not satisfied that its effects did not break the chain of causation. It is true that there was no immediate need for surgery prior to the park incident, and it may well have brought forward the timing for the operation, but this was on the background of a knee that was already damaged and would eventually require surgery.

152. Accordingly, I am satisfied that the applicant's work injury on 19 October 2018 materially contributed to the need for the right total knee replacement.

153. I accept that the surgery has the potential to alleviate the applicant's symptoms, is an appropriate treatment and is likely to be effective. There seems to be no alternative forms of treatment and the cost is not unreasonable. This satisfies the relevant factors discussed in *Rose* and *Diab*.

154. Accordingly, I am satisfied on the balance of probabilities that the treatment proposed by Dr Coffey, namely a right total knee replacement, 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 with the respondent on 19 October 2018.

FINDINGS

155. The applicant sustained injury to his right knee arising out of or in the course of his employment with the respondent on 19 October 2018.

[22] [2015] NSWWCCPD 49 (*Murphy*).
[23] *Murphy*, [57] to [58].

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

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

158. The proposed right total knee replacement, 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 with the respondent on 19 October 2018.

ORDERS

159. The respondent is to pay the applicant's reasonably necessary medical expenses with respect to the proposed right total knee replacement, and associated expenses, pursuant to s 60 of the 1987 Act.