WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **2447/20**
Applicant: **George Albert Lewis**
Respondent: **Eris McCarthy Electrical Pty Ltd**
Date of Determination: **18 June 2020**
Citation: **[2020] NSWWCC 204**

The Commission finds:

1. The Commission has jurisdiction to decide this case.

2. At the commencement of the hearing the applicant discontinued the application for weekly payments, and the necessity to lodge a notice of discontinuance was dispensed with.

3. The applicant's back condition is a consequence of the subject injury on 23 January 2013 in which both knees were injured, and liability accepted by the insurer.

4. The proposed surgery is reasonably necessary.

5. The need for surgery results from the subject injury.

The Commission orders:

1. The respondent will pay the cost of and associated with the surgery recommended by Associate Professor Papantoniou in his report of 9 July 2019.

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

John Wynyard
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 JOHN WYNYARD, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. George Albert Lewis, the applicant, brings an action for compensation against Eris McCarthy Electrical Pty Ltd, the respondent, in relation to an injury that occurred on 23 January 2013. The matter has a considerable history but the relevant issues were notified in the s 78 notice issued on 2 October 2019. The Application to Resolve a Dispute (ARD) and Reply were duly lodged.

ISSUES FOR DETERMINATION

2. The parties agree that the following issues remain in dispute:

    (a) Does the Commission have jurisdiction to entertain this claim?

    (b) If so, is the applicant's back condition a consequence of the subject injury of 23 January 2013?

    (c) If so, is the proposed surgery reasonably necessary?

    (d) If so, does the necessity result from the subject injury or from other causes?

PROCEDURE BEFORE THE COMMISSION

3. The matter was heard by teleconference on 10 June 2020. Mr Graham Barter of counsel appeared for the applicant instructed by Mr Craig Stewart from Messrs Whitelaw McDonald Solicitors. Mr David Saul of counsel appeared for the respondent instructed by Mr Richard Orr from Messrs Turks Legal. Also present was Ms Dilani Gamlats from GIO. 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

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

    (a) ARD and attached documents,
    (b) Application to Admit Late Documents (ALD) and attached documents, and
    (c) Reply and attached document.

Oral evidence

5. No application was made in respect to oral evidence.

FINDINGS AND REASONS

6. At the commencement of the hearing, the allegation that Mr Lewis had injured his back as part of the subject injury was abandoned. It is common ground that Mr Lewis suffered injury on 23 January 2013 when he fell into a trench whilst in the course of his employment, and injured both knees. He came to an arthroscopy with A/Prof Papantoniou on 25 March 2013 to the left knee and again with A/Prof Papantoniou he came to bilateral knee arthroscopies on 15 June 2015. He subsequently came to a left total knee replacement with A/Prof Papantoniou on 7 May 2018, and on 5 October 2018 came to a further arthroscopy on the right knee.

7. It was also agreed that Mr Lewis has received his entitlement for weekly payments of compensation pursuant to s 39 of the *Workers Compensation Act 1987* (the 1987 Act). In a letter from the insurer dated 10 April 2018 Mr Lewis was advised that his entitlement would reach the 260 week limit on 16 April 2018. Mr Lewis was advised in that letter that the entitlement period had been extended to 10 July 2018 "due to the 13-week notice period"[1].

8. Section 39 of the 1987 Act provides:

> **"39 CESSATION OF WEEKLY PAYMENTS AFTER 5 YEARS**
>
> (1) Despite any other provision of this Division, a worker has no entitlement to weekly payments of compensation under this Division in respect of an injury after an aggregate period of 260 weeks (whether or not consecutive) in respect of which a weekly payment has been paid or is payable to the worker in respect of the injury.
>
> (2) This section does not apply to an injured worker whose injury results in permanent impairment if the degree of permanent impairment resulting from the injury is more than 20%.
>
> **Note:** For workers with more than 20% permanent impairment, entitlement to compensation may continue after 260 weeks but entitlement after 260 weeks is still subject to section 38.
>
> (3) For the purposes of this section, the degree of permanent impairment that results from an injury is to be assessed as provided by section 65 (for an assessment for the purposes of Division 4)."

Jurisdiction

9. A preliminary issue was raised by Mr Saul as to whether I had jurisdiction to make any orders at all. Section 59A of the 1987 Act provides relevantly:

> **"59A LIMIT ON PAYMENT OF COMPENSATION**
>
> (1) Compensation is not payable to an injured worker under this Division in respect of any treatment, service or assistance given or provided after the expiry of the compensation period in respect of the injured worker.

[1] ARD page 376.

(2) The compensation period in respect of an injured worker is—

(a) if the injury has resulted in a degree of permanent impairment assessed as provided by section 65 to be 10% or less, or the degree of permanent impairment has not been assessed as provided by that section, the period of 2 years commencing on--

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

(b) …"

10. It can be seen by s 59A(2)(a)(ii) that Mr Lewis had a period of two years to seek compensation under Division 3 of Part 2 of the 1987 Act. The insurer notified Mr Lewis that the relevant date was 10 July 2020.

11. An application was immediately made to the Commission for expedition. I was advised that the applicant would have preferred to mount an action regarding his lump sum options, but the immediacy of the cut-off date left him no choice. Hence, as I understood him, he sought to have the proposed surgery declared reasonably necessary, so that surgery could be performed by10 July 2020. A claim for weekly payments was originally part of the application, but was discontinued at the commencement of proceedings.

12. Mr Saul, however sought to establish that the relevant cut-off date was that notified in the s 39 letter, if I can call it that, which was sent to Mr Lewis on 10 April 2018.[2] It provided:

"IMPORTANT INFORMATION REGARDING YOUR CLAIM

As discussed on the phone on 10/04/2018, injured workers with a permanent impairment of 20% or less are entitled to weekly payments for up to a maximum of 260 weeks. You were assessed by Dr Harrington on 03/05/2016 as having a whole person impairment of 1%.

As your whole person impairment is under 21% you will not be entitled to weekly payments beyond 260 weeks.

As at today's date you have been paid 259 weeks of payments. If you continue to receive weekly payments, you are likely to reach the 260-week limit on 16/04/2018. This has been extended to 10/07/2018 due to the 13-week notice period.

You will be entitled to reasonably necessary medical expenses for up to 2 years after your weekly payments cease."

13. Accordingly, liability for the proposed surgical treatment either has expired at the expiry of the 260 weeks as provided by s 39 or, will not expire until 10 July 2020, the date the payments actually ceased in 2018. Mr Saul argued that there was no jurisdiction to hear the claim, as the 260 week entitlement period had expired on 16 April 2020.

14. Relevant to that issue is a further letter from the insurer to Mr Lewis dated 14 January 2020, the purpose of which was to remind Mr Lewis that his entitlement to medical and related treated expenses would come to an end on 10 July 2020. It was this letter that prompted Mr Lewis to seek an expedited hearing before the Commission. It stated, relevantly:[3]

[2] ARD page 376.
[33] ARD page 393.

> "Your entitlement to treatment expenses will end on 10/7/2020.
>
> Before your entitlement ends, please speak to your treatment providers about the treatment options that may be available to you.
>
> …..
>
> If you have not already, we strongly encourage you to speak to your treating doctor and treatment providers before your entitlement ends.
>
> They can help identify the treatment options available to you…"

15. Mr Saul submitted that the proper interpretation of s 59A(2)(a)(ii) was 16 April 2018, the date on which the entitlement given by s 39 of the 1987 Act expired.

16. Mr Barter relied on the actual wording of s 59A(2)(b)(ii) that spoke of the weekly payments having been paid up to a date, which was in this case 10 July 2018. That meant that the time limit set by s 59A would run until 10 July 2020. That, Mr Barter submitted, was the date that the insurer had notified Mr Lewis, and the respondent could not now allege that a different date was actually the cut-off date. As I understood Mr Barter to submit, the respondent could not approbate and reprobate, and it was bound by its conduct.

Discussion

17. I accept Mr Barter's submissions. It would be unconscionable for the respondent, having given notice to the applicant that 10 July 2020 was the cut-off date, to allege at the hearing that a different date applied. The respondent is bound by its conduct.

18. Further, both notices to the applicant – that of 10 April 2018 and that of 14 January 2020 – advised that the actual cut-off date for the 260 week period had been 16 April 2020, but that it had been extended.

19. Mr Saul advanced an argument that s 39 was clear in its terms as to there being a limit of 260 weeks for payment of weekly compensation, and that therefore the extension was contrary to the terms of the statute. However, that submission overlooked the limitation in s 39 that its provisions applied "despite any other provision of this Division". Section 59A is in a different Division, and accordingly is not affected by the limitation.

20. It therefore follows that I have jurisdiction to deal with this matter and that Mr Lewis has until 10 July 2020 to avail himself of the surgical treatment that is the subject of this claim.

Is the back condition consequential upon the subject injury?

Mr Saul

21. The theme of Mr Saul's submissions was that a consideration of the clinical notes that were contained in the ALD revealed that Mr Lewis had been suffering symptoms in his back since he was assaulted in 2003. The clinical notes had been obtained after the expert opinion had been given on both sides of the record. They also showed that there were complaints about the back made to Mr Lewis's GP in 2015. I was referred by Mr Saul to an entry from "North Lakes Wellness Practice"[4]. This showed that on 27 May 2015 there had been an x-ray of the cervical and lumbar areas of the spine the result of which showed in relation to the lumbar spine, pathology at L5/S1. A reference was also made to an assault which had caused a fracture of the L2 and L3 transverse vertebrae. The date of the assault was said to be 2005 but it was common ground that that assault was in 2003.

[4] ALD page 21.

22. Further in that entry, there was a reference to “chronic L upper L pain from assault”. Mr Saul referred to an entry in the ALD dated 6 May 2005[5] that referred to an assault in 2003 in which Mr Lewis had fractured the transverse process of L2 and L3 and suffered continuous pain since then. Mr Saul also referred to a CT scan taken on 9 May 2005[6] which showed that the L3/4 in vertebral disc appeared normal and that there was no significant bulge at the L4/5 demonstrated. The report noted a broad-based central disc bulge at L5/S1 level.

23. Mr Saul referred to a report of A/Prof Michael Ryan dated 29 August 2005[7] in the ALD, which reported the assault in 2003 and the fractures of the L2 and L3 transverse process. A complaint of left leg pain that year was also made and a CT scan that it showed a broad-based disc protrusion.

24. Mr Saul used these entries to base a submission that this background was not available to either Professor Papantoniou or Dr Bodel (or, for that matter I interpolate to observe, to Dr Harrington). Their reports were accordingly sufficiently tainted that I could not accept their opinions. Mr Saul submitted that this background was a relevant fact in the assessment of the development of the back condition, which may have caused both doctors to change their mind. Accordingly each opinion became no more than an ipse dixit. Mr Saul submitted that other evidence could not overcome this deficiency to create a fair climate.

25. I was referred to a report of A/Prof Papantoniou dated 6 June 2019, which Mr Saul submitted was the first report of any back problem.

26. A/Prof Papantoniou said:

> “[Mr Lewis] also continues to complain about pain around the L3/4 level of his lower back and has a bilateral sciatica”

27. Mr Saul referred to A/Prof Papantoniou’s next report of 9 July 2019[8]. A/Prof Papantoniou in that report noted that the complaint of central and left sided lower back pain, radiation to the left buttock posterior thigh. He noted the results of an MRI scan which he said demonstrates severe disc degeneration at the L5/S1. A/Prof Papantoniou’s opinion was:

> “**Opinion:**
> Mr Lewis has ongoing pain associated with L5/SI disc pathology. I believe this is an aggravation due to his knee injuries and the chronic limp that will have been present since the original injury. Given the more than six years since the original Injury there ls no question that the abnormal gait will have led to the L5/S l disc pathology.”

28. Mr Saul submitted that there was “no question” that the abnormal gait had not hitherto been noted by A/Prof Papantoniou, who had been treating Mr Lewis for his knee conditions for several years.

29. I was then referred to Dr Bodel’s reports. Dr Bodel, it was submitted, had made no note of any complaint of back pain in his earlier reports of 9 November 2016 and 6 January 2017, but first noted back complaints on 24 July 2019[9]. Dr Bodel noted that Mr Lewis had developed increasing back pain over a period of about four to five years:

[5] ALD page 3.
[6] ALD page 9.
[7] ALD page 10.
[8] ARD page 76.
[9] ARD page 11.

> "…but only significant back pain in the last six to 10 months. He woke up one day with significant pain in the back and he has been back to Professor Papantoniou who has done an MRI scan of the lumbar spine which shows definite disc pathology at L4/5 and L5/S1 and Professor Papantoniou has apparently recommended spinal fusion in the L4/5 and L5/S1. …… The back has never been mentioned as part of the injury until now."

30. Mr Saul also drew my attention to comments by Dr Bodel that Mr Lewis had developed a gradual onset of lower back pain, and that he had had no problems with the back so far as any past medical history was concerned.

31. Mr Saul also referred me to the investigations that Dr Bodel acknowledged having seen, submitting that Dr Bodel did not have access to the CT scan of 2005.

32. Mr Saul then took me to the later report of Dr Bodel dated 16 April 2020[10]. This report, Mr Saul submitted "muddies everything up". Dr Bodel then had access to Mr Lewis's statement in which he recalled having a previous episode of back pain, which had been treated conservatively and had completely resolved.

33. Dr Bodel referred to scans as being "just plain x-rays".

34. Mr Saul submitted that Dr Bodel's failure to consider the CT scan of 2005 was a compelling omission, as the CT scan showed 'significant' pathology. Dr Bodel said that he continued to hold his view that the subject injury, that is to say, the injury to the knees on 23 January 2013, had caused an aggravation, acceleration, exacerbation and deterioration of the disease process seen on the various investigations in the lower back which had prompted him for the fusion. Mr Saul submitted that the comment constituted an opinion that the back had been injured at the time of the subject injury and was therefore a s 4 injury, which allegation had been abandoned by the consent amendment of the proceedings.

35. He then referred to answers Dr Bodel made to specific questions. Dr Bodel said that he was satisfied that the injury to the back was causally related to the subject injury. Dr Bodel thought that whilst there was some soft tissue damage at that time, as time passed with the increasing problems in Mr Lewis's knee and his continuing limping that the aggravation (etc) had led to the need for the proposed surgery.

36. He gave a fuller explanation in answer to question 3. He said: [11]

> "This gentleman has had substantive physical injuries to the knees in the fall into the trench that occurred in 2013. This has left him with pain, swelling, weakness, giving way and a limp for which he has had extensive treatment including a total knee replacement which has not gone all that [well].
>
> All of these factors contributed to an abnormal gait pattern and therefore aggravation, acceleration, exacerbation and deterioration of the disease process of the lumbar spine."

[10] ARD page 16.
[11] ARD page 17.

37. Mr Saul submitted that if there had been evidence that Mr Lewis had been suffering problems with his gait for a longer period of time, and had complained of the same, then it would be difficult to resist a conclusion that the abnormal gait had caused the development of the back condition. Mr Saul said however, on the basis of the principle of *Kooragang Cement Pty Ltd V Bates*[12] in examining the causal chain, that the absence of such complaints together with the failure by A/Prof Papantoniou and Dr Bodel to be aware of the prior back problems, created a situation where Mr Lewis must fail to satisfy his onus on the balance of probabilities.

38. Mr Saul conceded that the level of proof to establish a consequential condition was "a low bar" to show that the injury had made a material contribution to the onset of the back pain, but he submitted that nonetheless that bar had not been reached in the circumstances.

39. Mr Saul noted that in the first report from Dr Harrington of 3 May 2016[13] there was no mention of any complaints regarding Mr Lewis's back. In Dr Harrington's second report of 30 September 2019 Dr Harrington recorded that Mr Lewis advised that he had always had niggling pain in his back, however, "his symptoms had worsened in the last two years."

40. Dr Harrington accepted that the investigations showed an old degenerative disc prolapse with end-plate changes and longstanding features[14].

41. Mr Saul acknowledged the comments made by Dr Harrington[15]:

> "Whilst Mr Lewis may have some restricted movement of the lumbar spine, I do not believe there is an assessable impairment causally related to his workplace injury."

42. Mr Saul then conceded that a comment by Dr Harrington "might be a small problem for me". Dr Harrington said[16]:

> "There may be a very slight aggravation to the lumbar spine caused by his limp and fixed flexion of the left knee however the significant underlying changes are likely to have become symptomatic irrespective of the knee injury."

43. Later in his report Dr Harrington, in answering a question from his retaining solicitors, said that he did not believe that Mr Lewis suffered from a consequential lumbar spine condition. He referred to Dr Bodel's opinion and said:

> "…..Dr Bodel has not adequately justified how the lumbar spine is causally related to the bilateral knee injury over 6 ½ years ago."

44. Finally Mr Saul submitted that I would accept Dr Harrington's opinion that the proposed surgery was not reasonably necessary, as he did not believe that the lumbar spine condition was causally related to the workplace injury. The longstanding changes seen on MRI and the lack of clinical radiculopathy that Dr Harrington said were shown on examination made it more probable that the cause was constitutional.

45. The report of Dr Harrington accordingly posed a barrier to the applicant's assertions. Applying the test I would not accept, even on a common sense basis, that the applicant's back condition was materially contributed to by the subject injury.

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[12] (1994) 35 NSWLR 452.
[13] ARD page 349.
[14] ARD page 388.
[15] ARD page 390.
[16] ARD page 390.

46. The opinion of Dr Harrington that the cause was the longstanding degenerative condition was strengthened by the evidence in the ALD and the revelation in the clinical notes of a prior back injury in 2003 and subsequent complaints, Mr Saul submitted. This material had been unavailable to Dr Bodel, A/Prof Papantoniou or Dr Harrington, and was evidence that cast such doubt on the expert evidence that the applicant had failed to satisfy his onus. It could not be said that the subject injury materially contributed to the onset of Mr Lewis's back condition. It was clearly as a result of the degenerative condition and the assault in 2003.

47. The next issue Mr Saul addressed was as to whether, assuming that the back was found to be a consequential condition, it could be said that the need for surgery resulted from the back condition, or from other causes. In this regard Mr Saul relied on Dr Harrington who found that there was a "very slight" aggravation caused by the altered gait.

48. Dr Harrington's view was that the pathology suffered by Mr Lewis had not been caused by the altered gait, in fact it was degenerative. Dr Harrington conceded that there had been a slight aggravation to Mr Lewis's underlying back condition caused by the altered gait[17], but Mr Saul submitted that notwithstanding, the applicant had failed to establish that the altered gait caused by the condition of the knees had created any lasting back problem. If Mr Lewis had been genuine, Mr Saul contended, one would have expected to have seen complaints about the back before 2019, in conjunction with his complaints regarding the knee problem.

Mr Barter

49. Mr Barter referred to the often cited case of *Diab v NRMA Ltd*[18]. in which DP Roche distilled the relevant principles from the existing authorities and reduced them to a set of principles at paragraph 88, a passage which is well-known to the Commission.

50. Mr Barter referred to the learned DP's earlier comments at [76]:

> "76. The standard test adopted in determining if medical treatment is reasonably necessary as a result of a work injury is that stated by Burke CCJ in *Rose v Health Commission (NSW)* [1986] NSWCC 2; (1986) 2 NSWCCR 32 (*Rose*) where his Honour said, at 48A-C:
>
> '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.'"

51. Mr Barter submitted that the test of relating to reasonable necessity was whether its purpose and potential effect was to alleviate the consequences of injury. It was accordingly not concerned with whether the treatment resulting from the injury was directed at pathology or whether indeed it had caused any pathology.

[17] ARD page 388.
[18] [2014] NSWWCCPD 72 (*Diab*).

52. Indeed Mr Barter referred to the submissions made by Mr Saul as to existence of pathology in the back going back to the injury in 2003. He noted the North Lakes Wellness Practice showing an x-ray on 27 May 2015 of the lumbar spine and a reference to the "05" assault which caused a fracture of the L2 and L3 transverse section, established that such pathology did exist.

53. The first recorded entry about the complaint of back pain to A/Prof Papantoniou was on 6 June 2019 where A/Prof Papantoniou said[19]:

> "[Mr Lewis] also continues to complain of pain around the L3/4 level in his lower back and has a bilateral sciatica. …"

54. Mr Barter submitted that whilst there was pain, it was symptomatically not sufficient to require operative treatment until 2019. Mr Barter submitted that it was important to note that A/Prof Papantoniou's first report of back pain on 6 June 2019 was clearly not the first complaint as when he first mentioned it on 9 July 2019 he said that Mr Lewis "continues to have" back pain. This would indicate that there had been prior complaints to him but that they were very much a minor concern compared to the "horrendous" time Mr Lewis had had with his knees, which involved multiple attendances on doctors and multiple procedures culminating in the left total knee replacement in May 2018.

55. Mr Barter submitted that it was hardly surprising in view of the concentration of treatment on the knees that no complaints had earlier been recorded. However, he continued, it was clear from the language used by A/Prof Papantoniou that complaints had been made prior to 6 June 2019. It was clear, Mr Barter submitted, that the reason why the back complaint became significant was because it was caused by his altered gait. Even Dr Harrington conceded that the altered gait had caused restricted movement in the lumbar spine and caused "a very slight aggravation" as a result of the limp and fixed flexion of the left knee.

56. Mr Barter referred to Mr Saul's submission that the applicant must fail because the medical specialists did not have a full history of the back condition. He referred again to *Diab* at [71]-[72] in which DP Roche said:

> "71. What is required by way of an explanation for the basis of the expert's opinion will depend on the circumstances in each case (Adler v Australian Securities and Investments Commission [2003] NSWCA 131; 79 FLR 1 at [631]). However, an expert does not have to 'offer chapter and verse in support of every opinion' (Sydneywide Distributors Pty Ltd v Red Bull Australia Pty Ltd [2002] FCAFC 157; 117 FCR 189 at [89]).
>
> 72. As Spigelman CJ (Giles and Ipp JJA agreeing) explained in Australian Security and Investments Commission v Rich [2005] NSWCA 152 at [170] '[a]n expert frequently draws on an entire body of experience which is not articulated and, is indeed so fundamental to his or her professionalism, that it is not able to be articulated'. In other words, experts are allowed to use their general experience and knowledge, as experts, even though it is not stated in their reports."

57. Applying that dicta, Mr Barter submitted that the history was sufficient to be able to find that the past back history was not as relevant as Mr Saul had indicated. The evidence showed that there had been some complaint of pain in the back both before and after the subject injury, as had been illustrated by the clinical notes. However, the evidence also was that Mr Lewis had recovered from the 2003 back condition, and that by the time he started working in 2012 for the respondent, he was asymptomatic.

[19] ARD page 74.

58. The work Mr Lewis was doing for the respondent since 2012 had been shown to be of a heavy nature, Mr Barter said, and Mr Lewis had remained asymptomatic. However, the "dawning consciousness" of the seriousness of his back problems then led Mr Lewis to seek treatment in 2019. Mr Barter said that the entry by North Lakes Wellness Practice in 2015, which described the knee pain as well as the back pain, was an illustration of how the knee pain was generally masking the back pain. It was an indication that Mr Lewis was aware of the problem at that stage, but his failure to seek specific treatment for the back was consistent with his evidence that the onset of the back really began to become serious as he struggled with mobilising in 2018, which appeared to coincide with the 2018 procedures.

59. The need for surgery as indicated by both A/Prof Papantoniou and Dr Bodel was to alleviate the symptoms that arose from the pathology in Mr Lewis's back, Mr Barter submitted. This was the appropriate test, as DP Roche had said in *Diab* following *Rose*, Mr Barter said, alluding to his submission above.

60. Mr Saul responded that it was not correct that just the symptoms were relevant. The applicant's medical experts said that the need for surgery was brought on by the injury to the knees, but their opinions were not based on all the relevant facts. He submitted that there was no proof that the knee injuries materially contributed to the need for surgery.

Mr Lewis's statements

61. Neither counsel referred to Mr Lewis's statements. There was nothing advanced before me to suggest that Mr Lewis's credit was in issue. It was not suggested by Mr Saul that Mr Lewis had deliberately withheld the past history regarding the back.

62. Mr Lewis did, however, give some explanation as to both of the onset the back pain, and as to his prior back history in his statements of 3 February 2020 and 9 April 2020.

63. In his statement of 3 February 2020 he said of the knee injuries:[20]

> "2. Basically I fell into a trench. The trench was about 3 feet or a bit deeper. I landed on both my knees.
>
> 3. I also jarred my back in the fall into the trench but I didn't think any more of it because it was relatively minor and I was in a lot of pain for me knees.
>
> 4. From then on there was minor niggles in my back but very little. I may have reported it to doctors, and I may have had an occasional x-ray.
>
> 5. About two years ago the pain in my back became somewhat more severe. It started going down from my back across my left buttock and into the top of my left leg.
>
> 6. At that stage the pain wasn't there all the time but was intermittent."

64. Mr Lewis then referred to his total knee replacement in May 2018 and said that he was having, at that stage, occasional back pain. He said however:

> "9. A few weeks after that I started noticing the pain in my back become more severe and it was becoming more constant and running across my back into the top of my left buttock and down into the leg. It didn't seem to be going away.
>
> 10. Basically ever since the accident in 2013 I had been limping in various ways. I had a number of surgeries over the years."

[20] ARD page 285.

65. He said that after the total knee replacement he was on crutches for a week and limping quite badly for some time after that. He said:

> "11. In fact I still limp and [walk] rather strangely."

66. He said that the knee replacement was not as successful as he had hoped, and he continued to hobble and walk "in a very strange fashion". He said that the pain in his back just kept getting worse, and he reported it to A/Prof Papantoniou.

67. On 9 April 2020, he made a statement regarding his prior back condition[21]. He said that he "recently recalled" that previous injury. He said when he was 38 or 39 years old he was assaulted and kicked or punched in the back. He sought assistance from the local GP and attended on a chiropractor on about five occasions for manipulations. He thought that he had fractured his back but "thankfully I hadn't". At that time he was running a small business as a handyman based in Mosman. He had only a few days off work and then kept working because he had to earn an income in his business. He said:

> "Over the next few months the condition in my back and neck improved and eventually came good over that period so I stopped seeing the chiropractor".

68. He did not believe he had been referred to a specialist at that time. (In fact he had been referred to Dr Ryan, who reported on 29 May 2005.) He said he continued working his handyman business until 2009 and that by that stage "my back was in good shape and remained in good shape for many several years afterwards". He said he then had a business working with his next door neighbour installing and dealing with water tanks, which he said was also a heavy job that he was able to handle. He had no back problem at that stage and he continued to work doing that job for about three years until about 2012. He said that he only worked for the respondent for nine months before he fell in the trench.

DISCUSSION

69. As indicated, Mr Lewis's credit has not been impugned. I accept his explanation regarding his prior back history, and I agree with Mr Barter that it made no difference to the opinions expressed by Dr Bodel and A/Prof Papantoniou that the back condition was a consequence of the subject injury, and that the proposed surgery was reasonably necessary. At the time of the subject injury, Mr Lewis was experiencing no symptoms in his back. I accept that he developed occasional intermittent symptoms in his back following the event of 23 January 2013, but that they did not become significant until after the knee replacement surgery in May 2018. Mr Lewis's limp and the fixed flexion of the knee then further aggravated the degenerative pathology within his lumbar spine, and made the grumbling aggravations of the previous years permanent and significant.

70. This history was the basis upon which the applicant's medical experts found a causal connection between the injuries to the knees and the onset of the back complaint.

71. I reject Mr Saul's submission that I could draw an adverse inference against Mr Lewis by virtue of the fact that he did not complain to A/Prof Papantoniou about his back until June 2016. I accept that Mr Lewis was experiencing occasional back symptoms at that time, and I accept that the use of the word "continues" by A/Prof Papantoniou was an indication that complaints had been made about the back before that report, but that neither Mr Lewis nor A/Prof Papantoniou had then regarded the back symptoms as being significant. I accept Mr Lewis's evidence that he had been limping since the subject injuries occurred, and I accept that he continues to walk with an antalgic gait.

[21] ARD page 283.

72. In this regard, Dr Harrington lent support to the opinions **of** Dr Bodel and A/Prof Papantoniou when he found that the antalgic gait had caused an aggravation to the lumbar spine pathology. His opinion was also supportive in that on examination he conceded that Mr Lewis "may have" some restricted movement in the lumbar spine. Although Dr Harrington thought that no assessable impairment had been thereby caused which was related to the subject injury, once he had conceded that there was a causal relationship, the question of assessment became one for an AMS.

73. Dr Harrington was concerned to emphasise that the antalgic gait had not been a substantial contributing factor to the back condition, and that the underlying degenerative changes would have become symptomatic in any event. As conceded by Mr Saul, issues such as substantial or main contributing factor have no place in establishing a causal link between a subject injury and a consequential condition.

74. I reject Mr Saul's contention that there was any ambiguity in the report by Dr Bodel of 16 April 2020. Mr Saul, with respect, approached the first answer to three questions asked of Dr Bodel at ARD page 17 with an eye too keenly attuned to the perception of error. When viewed in the context of the whole of his answers regarding causation it is clear that Dr Bodel found that the cause of the onset of the back condition was the antalgic gait caused by the injuries to the knees, and their subsequent treatment.

75. As was correctly submitted by counsel, the relevant standard of proof in cases concerning consequential conditions was stated by DP Roche in *Murphy v Allity Management Services Pty Ltd*.[22] The applicant in that case had suffered an unrelated fall at Coles, and DP Roche considered the implications from a causal perspective regarding the workers claim that she had suffered a consequential condition. At [57-58] the learned DP said:

> "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 common sense test of causation (*Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796), that the treatment is reasonably necessary 'as a result of' the injury (see *Taxis Combined Services (Victoria) Pty Ltd v Schokman* [2014] NSWWCCPD 18 at [40]–[55]). That is, she has to establish that the injury materially contributed to the need for the surgery (see the discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716)."

76. I am accordingly satisfied that Mr Lewis's back condition is a consequence of the injuries to the knees in the subject accident.

77. Mr Saul contended that, even if that causal connection were made, the evidence did not establish that the need for surgery resulted from the consequential condition. This submission again flowed from Mr Saul's primary position that the reports of the applicant's medical experts were contaminated because they did not have the prior history of injury to the back, nor the pre-existing degenerative pathology that had been revealed whilst that earlier condition was being treated.

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[22] [2015] NSWWCCPD 49 (*Murphy*). See also *Secretary, New South Wales Department of Education v Johnson* [2019] NSWCA 321.

78. I reject that submission. I am satisfied that the subject injury to the knees have materially contributed to the condition of the lumbar spine, and that therefore the need for surgery has resulted from the subject injury. In *Diab*, DP Roche said at [88]:

> "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.
>
> 89. 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 the up 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."

79. I accept that the treatment proposed is appropriate. Dr Harrington's opinion I do not accept. He thought that Mr Lewis was not a candidate for surgery because there were long-standing degenerative changes seen on the investigations, and no radiculopathy was detected at the time Dr Harrington examined him.

80. I do not accept that those reasons are the equivalent of an opinion that surgery would not alleviate Mr Lewis's condition, and therefore not be appropriate. Dr Harrington gave no explanation as to why a person with pre-existing long-standing degenerative change could not be a candidate for surgery, nor why the presence of radiculopathy was a prerequisite in Mr Lewis's case. Radiculopathy ("radiation") was found by A/Prof Papantoniou on 9 July 2019, although Dr Bodel on 24 July 2019 did not. Dr Bodel nonetheless accepted that the surgery was appropriate. On 16 April 2020 he said that Mr Lewis had undergone appropriate conservative care without any resolution of his back symptoms. He said the treatment offered was reasonably necessary to assist Mr Lewis in the management of his mechanical backache.[23]

81. No submissions were made as to whether any alternative treatment was available, and I accept Dr Bodel's opinion that Mr Lewis had undergone appropriate conservative care without success.

82. Similarly, no submissions have been made regarding the cost of the surgery which in the Commission's experience is not excessive.

[23] ARD page 17.

83. I have dealt with the question of whether the proposed treatment will be actually or potentially effective when discussing its appropriateness above. For the reasons given I reject Dr Harrington's opinion and I accept Dr Bodel's opinion that the recommended treatment would assist in the management of the back symptoms. That assistance I accept would be to do with the alleviation of Mr Lewis's symptoms.

84. There has been no suggestion that, as a generality, the recommended surgery is not accepted by medical experts as being appropriate and likely to be effective. In this particular case Dr Harrington expressed a negative view, which I have rejected for the reasons given above.

SUMMARY

85. The Commission finds:

    (a) The Commission has jurisdiction to decide this case.

    (b) The applicant's back condition is a consequence of the subject injury on 23 January 2013 in which both knees were injured, and liability accepted by the insurer.

    (c) The proposed surgery is reasonably necessary.

    (d) The need for surgery results from the subject injury.

86. The Commission orders:

    (a) The respondent will pay the cost of and associated with the surgery recommended by A/Prof Papantoniou in his report of 9 July 2019.