WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **2324/19**
Applicant: **Sharron McCartney**
Respondent: **Evergreen Lifecare Limited**
Date of Determination: **21 August 2019**
Citation: **[2019] NSWWCC 280**

The Commission determines:

1. The applicant did not suffer an injury to the right knee on 6 November 2014 within the meaning of sections 4(a) and 9A of the *Workers Compensation Act 1987*.

2. The applicant did not suffer an injury to the right knee on 6 November 2014 within the meaning of section 4(b) of the *Workers Compensation Act 1987*.

3. The applicant did not suffer a consequential injury to the right knee as a result of the accepted injury to the lumbar spine on 6 November 2014.

4. The applicant had a current work capacity during the period 1 November 2015 to 25 April 2017 in relation to the accepted lumbar spine injury on 6 November 2014 within the meaning of section 32A of the *Workers Compensation Act 1987* in suitable employment at the rate of $162 per week.

The Commission orders:

5. Award for the respondent in relation to the alleged injury to the right knee on 6 November 2014.

6. Award for the respondent in relation to the alleged consequential injury to the right knee as a result of the accepted injury to the lumbar spine on 6 November 2014.

7. The respondent is to pay the applicant weekly compensation in respect of the accepted lumbar spine injury on 6 November 2014 as follows:

    (a) $478.80 per week from 1 November 2015 to 25 April 2017 pursuant to section 37(3) of the *Workers Compensation Act 1987*.

    (b) The respondent to be given credit for any payments made.

    (c) Liberty to apply within 14 days in relation to the calculation of weekly benefits.

8. The respondent is to pay the applicant's reasonably necessary medical and related expenses as a result of the accepted lumbar spine injury on 6 November 2014 pursuant to section 60 of the *Workers Compensation Act 1987*.

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

Anthony Scarcella
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 OFANTHONY SCARCELLA, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Mrs Sharron McCartney, is a 57-year-old woman who was employed by Evergreen Lifecare Limited (the respondent) as an aged care assistant.

2. On 6 November 2014, Mrs McCartney alleges that, whilst attempting to transfer a patient from a chair to the toilet in the course of her employment with the respondent, she sustained injuries to her lumbar spine and right knee.

3. Mrs McCartney submitted a claim for weekly benefits and reasonably necessary medical treatment and related expenses pursuant the *Workers Compensation Act 1987* (the 1987 Act).

4. On 23 July 2015, the respondent issued a Dispute Notice pursuant to section 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) disputing that Mrs McCartney suffered an injury to her right knee injury on 6 November 2014 within the meaning of sections 4, 9A, 15 and/or 16 of the 1987 Act; any incapacity within the meaning of section 33 of the 1987 Act; and liability for medical treatment and related expenses within the meaning of sections 59 and 60 of the 1987 Act.[1]

5. On 30 October 2015, the respondent issued a Dispute Notice pursuant to section 74 of the 1998 Act disputing that Mrs McCartney's current lumbar spine condition was related to the injury on 6 November 2014 and relied on sections 4, 9A, 33, 59 and 60 of the 1987 Act.[2]

6. On 27 January 2017, the respondent issued a Dispute Notice pursuant to section 74 of the 1998 Act in response to Mrs McCartney's request for review maintaining the disputes notified on 23 July 2015 and 30 October 2015.[3]

7. On 2 January 2018, the respondent issued a further Dispute Notice pursuant to section 74 of the 1998 Act in response to Mrs McCartney's further request for review and disputed that Mrs McCartney suffered an injury to her right knee injury on 6 November 2014 within the meaning of sections 4, 9A, 15 and/or 16 of the 1987 Act; any incapacity within the meaning of section 33 of the 1987 Act; and liability for medical treatment and related expenses within the meaning of sections 59 and 60 of the 1987 Act.[4]

8. On 16 May 2018, Mrs McCartney underwent a total right knee replacement at St Vincent's Hospital, Sydney.[5]

9. The Application to Resolve a Dispute (ARD) dated 13 May 2019 was registered in the Commission.

10. The Reply dated 5 June 2019 was received in the Commission.

ISSUES FOR DETERMINATION

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

    (a) Whether Mrs McCartney suffered an injury to her right knee on 6 November 2014 within the meaning of sections 4(a) and 9A of the 1987 Act.

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[1] ARD at pages 7-9
[2] ARD at pages 10-14
[3] ARD at pages 15-20
[4] ARD at pages 23-26
[5] ARD at pages 63-64

(b) Whether Mrs McCartney suffered a disease process to her right knee on 6 November 2014 within the meaning of section 4(b)(i) of the 1987 Act.

(c) Whether Mrs McCartney suffered an aggravation, acceleration, exacerbation or deterioration of any disease process to her right knee on 6 November 2014 within the meaning of section 4(b)(ii) of the 1987 Act.

(d) In the alternative, whether Mrs McCartney suffered a consequential injury to her right knee as a result of the accepted lumbar spine injury on 6 November 2014.

(e) Whether Mrs McCartney is entitled to weekly payments pursuant to section 37 of the 1987 Act for total or partial incapacity within the meaning of section 33 of the 1987 Act arising from her accepted lumbar spine injury and the alleged right knee injury and whether she had a current work capacity to work in suitable employment within the meaning of section 32A of the 1987 Act during the periods claimed.

(f) Whether Mrs McCartney's medical and related treatment expenses were reasonably necessary as a result of injury within the meaning of section 60 of the 1987 Act.

Matters previously notified as disputed

12. The issues in dispute were notified in Dispute Notices pursuant to section 74 of the 1998 Act dated 23 July 2015, 30 October 2015, 27 January 2017 and 2 January 2018.

Matters not previously notified

13. No other issues were raised.

PROCEDURE BEFORE THE COMMISSION

14. The parties attended a conciliation conference/arbitration in Wyong on 6 August 2019. Mr Bill Lucas of counsel appeared for Mrs McCartney and Mr Josh Beran of counsel appeared for the respondent.

15. During the conciliation phase the parties agreed as follows:

(a) Injury to the lumbar spine is not in issue.

(b) Mrs McCartney's relevant pre-injury weekly earnings (PIAWE) are $801.

(c) The second entitlement period ended on 25 April 2017.

(d) Mrs McCartney's claim for weekly benefits compensation is made pursuant to section 37 of the 1987 Act and is for the closed period 1 November 2015 to 25 April 2017.

(e) If Mrs McCartney's claim is successful, then a general order for reasonably necessary medical and related treatment expenses as a result of injury within the meaning of section 60 of the 1987 Act should be made.

16. 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

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

    (a) ARD dated 13 May 2019 and attached documents;
    (b) Reply dated 5 June 2019 and attached documents, and
    (c) Respondent's Application to Admit Late Documents dated 16 July 2019 and attached documents.

Oral evidence

18. Neither party sought leave to adduce oral evidence from or to cross-examine any witness.

AN ANALYSIS OF THE EVIDENCE

Mrs Sharron McCartney

19. In evidence, there is a statement by Mrs McCartney dated 19 November 2018. I will now refer to the relevant parts of Mrs McCartney's statement.

20. Mrs McCartney stated that since leaving school, she had predominantly worked as an aged care worker across numerous facilities. She commenced employment with the respondent as an aged care worker in 2013 on a permanent part-time basis of 7.5 hours per day, four to five days per week. Her usual duties involved assisting residents with personal care and medication. Her role involved standing for the duration of her shifts, frequent bending and pushing and pushing heavy items.

21. Mrs McCartney stated that, on 7 February 2011, she underwent an x-ray of her pelvis and left hip and a CT scan of her lumbar spine as a result of an episode of back pain. She did not suffer continuing back pain and was able to perform her duties at work.

22. Mrs McCartney stated that, on 6 May 2014, she underwent an x-ray of her right knee due to some right knee discomfort after squatting at work when removing and replacing a resident's shoes and socks.

23. Mrs McCartney corrected an injury description taken by Dr Higgs involving her right knee which occurred at work in late October 2014. Mrs McCartney stated that the correct version of events was that she was rolling a resident in bed and felt a burning pain on the side of her right knee. She did not think anything of it and completed her shift. She did not experience any swelling to her right knee at that time.

24. Mrs McCartney described her pre-6 November 2014 lower back and right knee symptoms as "minimal" and "well under control".[6]

[6] ARD at page 2 at [14]

25. Mrs McCartney described the incident on 6 November 2014 as follows:

> "On 6 November 2014, I injured my back and right knee at work. A colleague and I were attempting to transfer a resident from a chair to the toilet using a mobile hoist. The resident weighed around 130 kg. During the process of manipulating the hoist which bore the resident's weight, I felt the onset of severe pain in my lower back and extending into the left leg. The pain was a burning sensation and quite intense. I was not aware of any symptoms in my right knee on this date. I was overwhelmed by the severe pain in my lower back and worried about a possible back injury."[7]

26. Mrs McCartney stated that she was able to complete her shift on 6 November 2014 by performing only administrative duties due to continuing back pain. She was rostered off for the next two days and her back pain continued to increase.

27. On 7 November 2014, Mrs McCartney consulted her general practitioner, Dr Peter Jones at the Wyoming Medical Centre. Dr Jones referred her for CT and MRI scans and prescribed pain-relieving medication. She did not notice any symptoms in her right knee at that time.

28. On or about 19 November 2014, Mrs McCartney noticed pain and swelling developing in her right knee. Mrs McCartney stated:

> "21. Over the next month or so the pain in my right knee got progressively worse, until it became so swollen and painful I could not fully extend or bend it. I experienced locking and weakness, leading to instances of my knee giving way.
>
> 22. I sought advice from my GP on my worsening knee problem [sic] 19 January 2015. He advised me that it is probable the damage to my knee was caused by gait problems stemming from my lower back injury."[8]

29. On 6 February 2015, Mrs McCartney underwent an MRI scan of her lumbar spine. On 11 February 2015, she consulted Dr Benjamin McGrath. In the same month, she commenced hydrotherapy for a couple of months but derived little benefit from it. On 12 March 2015, she was referred to Dr Marc Russo to assist with pain management relating to her back and right knee. On 3 March 2015, she consulted Dr Richard Ferch.

30. On 14 April 2015, Mrs McCartney underwent an MRI scan of her right knee which demonstrated a medial meniscus tear and joint effusion. She stated her belief that her right knee symptoms were due to her constant bending, squatting and twisting at work and that symptoms were significantly worsened by her back injury.

31. On 9 July 2015, Mrs McCartney consulted Dr Richard Powell at the request of the respondent's insurer.

32. On 12 July 2017, Mrs McCartney consulted Professor Youssef Ghabrial.

33. On 16 May 2018, Mrs McCartney underwent a total right knee replacement performed by Dr Khoo.

34. Mrs McCartney stated that she remained unemployed from 6 November 2014 and was unable to return to any form of employment thereafter due to the pain in her lower back and right knee.

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[7] ARD at page 2 at [15]
[8] ARD at page 3 at [21]-[22]

35. Mrs McCartney is not undertaking any structured treatment program and has not done so since September 2015. She takes Targin and Lyrica for pain relief and Tramal when required. Mrs McCartney described her current symptoms as follows:

> "41. I suffer from ongoing severe low back pain which radiates down my left leg into my foot and into my left buttock region. It is niggling, throbbing and sharp in nature. My range of motion is restricted and I experience stiffness and tenderness. I have reduced sensation in all of my left leg down to my toes. I often experience 'pins and needles' in both of my feet as well as swelling in both feet and ankles. I have had sciatic pain in my left leg since the injury on 6 November 2014.
>
> 42. My pain is aggravated if I sit for longer than 5-10 minute periods or if I stand for more than three minutes. I can only walk comfortably for a distance of less than 100 metres. I use a walking stick for assistance and I walk slowly with a limp."[9]

36. Mrs McCartney stated that she is no longer able to do any cooking, cleaning or yard work at home and that her husband and daughter assist her with those domestic duties. She is assisted by her husband with showering and dressing. Since 6 November 2014, she has been unable to drive and is driven around by others when required. Such travel is limited to 20 minutes at a time in order to reduce the discomfort and pain associated with sitting. Her sleep is disrupted due to the constant pain and discomfort she experiences.

Diagnostic imaging

37. On 6 May 2014, Mrs McCartney underwent a right knee x-ray by Dr C Lewis, Radiologist. Dr Higgs, in his report dated 4 May 2016, referred to the x-ray report of Dr Lewis as demonstrating marginal degenerative osteophytosis.[10]

38. On 12 November 2014, Mrs McCartney underwent a left leg venous Doppler ultrasound by Dr Leila Dekker.[11] Dr Decker concluded that there was a possible dissecting tear at the medial aspect of the gastrocnemius muscle between the medial compartment and the middle muscular bundle (left calf muscle tear).

39. On 12 November 2014, Mrs McCartney underwent a CT scan of her lumbar spine which demonstrated degenerative changes and some disc bulging.[12]

40. On 28 January 2015, Mrs McCartney underwent an x-ray of both knees and an ultrasound of the right knee by Dr Ronald Norman.[13] The x-ray of the right knee demonstrated no evidence of joint space loss; a moderate sized effusion within the suprapatellar bursa; and minor degenerative spur at the patellofemoral compartment. The right knee ultrasound demonstrated a large knee joint effusion; mild prepatellar bursitis; and mild tendinosis affecting the distal peri insertional region of the patella tendon.

41. On 6 February 2015, Mrs McCartney underwent an MRI scan of her lumbar spine by Dr Alan Chai.[14] The clinical notes in the MRI scan report referred to low back pain in both buttocks and hips and the left thigh. The clinical notes also referred to a CT scan three years prior as demonstrating multiple levels of bulging discs. Further, the notes recorded possible stress fracture L5/S1 and L3/4 and L4/5 disc bulging with nerve impingement symptoms. Dr Chai

[9] ARD at page 5 at [41]-[42]
[10] Reply at page 30
[11] ARD at page 28
[12] ARD at page 27
[13] ARD at page 32
[14] ARD at page 34

concluded that the scan demonstrated minor spondylitic change in disc pathology in the mid to lower lumbar spine, most marked at L4/5 where there was mild right foraminal stenosis.

42. On 14 April 2015, Mrs McCartney underwent an MRI scan of her right knee by Dr James Christie.[15] Dr Christie concluded that there had been a medial meniscal tear with subsequent early osteoarthritis; joint effusion and synovitis; and minor lateral compartment osteochondral irregularity.

43. On 7 November 2016, Mrs McCartney underwent an x-ray of her right knee. The radiologist reported knee joint osteoarthritis with predominant involvement of the medial condylar joint; fairly severe joint space loss at the medial condylar joint with associated varus deformity; and a small effusion in the suprapatellar bursa.[16]

44. On 28 March 2017, Mrs McCartney underwent an MRI scan of her right knee, which Dr Rooney opined demonstrated extensive tri-compartmental osteoarthritis with tears in the medial meniscus, discoid lateral meniscus and the lateral meniscus appeared to be flipped over.[17]

Dr Peter Jones, General Practitioner and Wyoming Medical and Dental Centre

45. In evidence there are copies of Mrs McCartney's clinical records produced by Wyoming Medical & Dental Centre.[18] I will now refer to the relevant parts of the clinical records taken to me by counsel.

46. On 24 July 2007, Mrs McCartney consulted Dr Mala for back pain review.[19]

47. On 3 February 2011, Mrs McCartney consulted Dr Peter Jones in relation to her lower back for the purpose of following up the results of an x-ray taken one month previously. The entry recorded that the x-rays demonstrated "a bit of spondylosis".[20] Persisting pain was reported especially at the lumbo-sacral joint area with persistent pain into the left buttock, groin and down the medial thigh to the leg. A CT scan of the lumbosacral spine and x-ray of the pelvis was arranged.

48. On 9 February 2011, Dr Peter Kemp recorded the outcome of the CT scan as minor bulging disc and probable sacroiliitis.[21]

49. On 11 November 2014, Mrs McCartney consulted Dr Jones complaining of low back pain into the left leg without thigh pain, paraesthesia or numbness.[22] The entry also recorded minor disc protrusion at L2 to S1 without nerve compression or impingement; some degenerative changes of the lower two levels in the articulations and a lump of the mid-calf posterolaterally.

50. On 17 November 2014, Mrs McCartney consulted Dr Jones advising that she had decided to make a claim for workers compensation because her worsening back problems were related directly to her work. Dr Jones recorded that:

[15] ARD at page 47
[16] ARD at page 57
[17] ARD at page 61
[18] ARD at pages 75-101 and Respondent's Application to Admit Late Documents dated 16 July 2019 at pages 1-363
[19] Respondent's Application to Admit Late Documents dated 16 July 2019 at page 48
[20] Respondent's Application to Admit Late Documents dated 16 July 2019 at page 42
[21] Respondent's Application to Admit Late Documents dated 16 July 2019 at page 42
[22] Respondent's Application to Admit Late Documents dated 16 July 2019 at page 41

> "Main exacerbation of pain began on about the 6/11/14. Has been doing reasonably heavy lifting at work and although cannot remember exact time this began her pain did start at work with sharp burning pain off the back and into the L leg."[23]

51. On 19 January 2015, Mrs McCartney consulted Dr Jones complaining of swelling of the right knee and pain of the knee anteriorly, anterolaterally, anteromedially and posteriorly. Dr Jones recorded the following in relation to the right knee complaints:

> "Gait problems associated with the disc lesions of the lower back appeared to have aggravated this."[24]

Dr Jones appeared to refer to Mrs McCartney's lower back and related pain as workers compensation pain (W/C pain) and her right knee pain and swelling as "non-W/C" throughout the clinical records. However, it is clear that he formed the view that her gait problems were associated with the disc lesions in her lower back and that such gait aggravated her right knee condition.

52. On 19 May 2015, Mrs McCartney consulted Dr Jones complaining of worsening low back pain with increased numbness and tingling to the left thigh and leg collaterally and on to the foot and under the foot. Dr Jones recorded that Mrs McCartney was walking awkwardly due to the pain.[25]

53. On 6 August 2015, Mrs McCartney consulted Dr Jones who recorded that there had been no real change in her condition. The entry referred to Dr Powell's report as follows:

> "Have read Dr Powells [sic] statement and note several questionable comments – states at least 5 yrs has had problem with the R knee. Sharon [sic] states this is incorrect but there was discomfort of the knee prior to the back and the L leg injury, however, there was no swelling or acute pain. The MRI of the knee shows lig tearing along with degen changes as he noted but as he did not have the scan report or the images he was in no position to comment regarding this. Even if there was pain prior to the injuries the excessive pain swelling and tenderness of the knee was not present prior to injury and because of the severe muscle injury of the left calf any problem of the R knee would have been overshadowed by this for some time. Again, there would have been a lot more strain on the R leg and knee due to the spinal injury and the left calf muscle tear."[26]

Dr Benjamin McGrath, Orthopaedic Surgeon

54. On 11 February 2015, Mrs McCartney consulted Dr Benjamin McGrath, Orthopaedic Surgeon on the referral of Dr Jones.

55. In evidence, there is a report by Dr McGrath dated 11 February 2015.[27] I will now refer to the relevant parts of that report.

56. Dr McGrath referred to Mrs McCartney as being plagued by two problems, namely, her back and her right knee. He noted that she was consulting him about her right knee.

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[23] Respondent's Application to Admit Late Documents dated 16 July 2019 at page 40
[24] Respondent's Application to Admit Late Documents dated 16 July 2019 at page 37
[25] ARD at page 92
[26] ARD at page 91
[27] ARD at pages 35-36 and Reply at pages 77-78

57. Mrs McCartney provided Dr McGrath with a history which included pain in her right knee since November 2014; that there was no specific event that initiated the pain; that in the past two months she had been suffering recurrent episodes of locking and a sensation of giving way; and considerable swelling of the right knee which had failed to settle.

58. On examination, Dr McGrath observed that Mrs McCartney had an antalgic gait; failed to achieve full extension on the right side due to the large effusion; and tenderness over the lateral joint line.

59. Dr McGrath viewed the available imaging, including an x-ray demonstrating well preserved bone joint spaces and an ultrasound demonstrating some mild pre-patella bursitis and some mild tendinosis around the insertion of the patella tendon. Neither of these findings correlated clinically. Dr McGrath opined that she may have a meniscal injury.

60. Dr McGrath proposed an MRI scan of the right knee and an ultrasound-guided steroid and local injection into the right knee.

Dr Richard Ferch, Neurosurgeon/Spinal Surgeon

61. Mrs McCartney consulted Dr Richard Ferch, Neurosurgeon/Spinal Surgeon on the referral of Dr Jones.

62. In evidence there are reports by Dr Ferch dated 3 March 2015[28] and 7 April 2015.[29] I will now refer to the relevant parts of those reports.

63. In his report dated 3 March 2015, Dr Ferch took the following history from Mrs McCartney:

> "As you know, Sharron has a long history of symptoms related to her back. She initially developed low back pain in 2011. This was predominantly experienced diffusely across her back. In November 2014, she was transporting a resident in an aged care facility from a chair to a toilet, utilising a standing aid. This triggered pain across her back and into her right lower limb. The pain radiates from the buttock down the posterior aspect of her thigh and into her calf and is, at times, associated with a feeling of numbness and tingling. She rates her typical back pain at 8/10 and her typical right leg pain at 6/10."[30]

64. On examination, Dr Ferch observed marked restriction of movement about Mrs McCartney's back and negative straight leg raising bilaterally. On neurological examination, Dr Ferch observed normal tone and power with brisk symmetrical reflexes and down going plantar responses; peripheral circulation was normal; and passive movement of the hips and knees did not cause tenderness.

65. On review of Mrs McCartney's MRI scan dated 6 February 2015, Dr Ferch opined that it demonstrated a capacious spinal canal; degenerative change at L3/4 and L4/5; evidence of disc bulging into the foramen and lateral recess on the right; the L5 nerve root did not appear particularly compromised but the changes could have been irritating the exiting L4 nerve root.

[28] ARD at pages 37-38
[29] ARD at pages 45-46
[30] ARD at page 37

66. In relation to the future management of her back symptoms, Dr Ferch felt that Mrs McCartney may respond to physiotherapy-based treatments and provided her with an exercise program, which he hoped would be helpful. He thought that she could benefit from a transforaminal steroid injection and noted that he intended to obtain insurer approval for the same.

67. On 7 April 2015, responding to the respondent insurer's correspondence enclosing Dr Casikar's report, Dr Ferch responded to questions put to him. Dr Ferch referred to Dr Casikar's report and noted that the latter had taken a different history to the one that he had obtained. Dr Ferch repeated the history he recorded in his report dated 3 March 2015 and referred to the findings in the MRI scan dated 6 February 2015. In particular, he noted that Dr Casikar had only recorded low back pain and no lower limb symptoms and that, therefore, the advice that Dr Casikar provided was different to his recommendation. Further, Dr Ferch opined:

> "Ms McCartney's persistent low back and right lower limb symptoms were triggered by her work incident and therefore are secondary to it. Dr Casikar has recorded the presence of degenerative change and episodic low back pain in the past and Ms McCartney would be vulnerable to pain on the basis of pre-existing degenerative change."[31]

68. In relation to Mrs McCartney's current work capacity, Dr Ferch opined that it would be best to restrict her to a graduated return to work as tolerated, commencing four hours per day on alternate days with a lifting restriction of less than 5 kg, which could be increased as tolerated.

Dr John Rooney, Orthopaedic Surgeon

69. Mrs McCartney consulted Dr John Rooney, Orthopaedic Surgeon on the referral of Dr Neil Davidson, General Practitioner, also of Wyoming Medical and Dental Centre.

70. In evidence, there are reports by Dr Rooney dated 9 November 2016,[32] 29 March 2017[33] and 23 May 2017.[34] I will now refer to the relevant parts of those reports.

71. On 9 November 2016, Dr Rooney reported that Mrs McCartney worked in healthcare where she sustained a work-related injury affecting her lumbar spine two years previously. He referred to some question about the right knee and that it had not been pursued as a WorkCover claim but understood that the lumbar spine was covered by WorkCover.

72. On clinical examination on 9 November 2016, Dr Rooney observed that Mrs McCartney walked into the consulting room extremely slowly; held her lumbar spine flexed; held her knees flexed in a crouching type of gait; held a walking stick in her left-hand; held her right knee more flexed when standing to avoid taking weight on it; no effusion was detected; range of movement was 0°-100°, passively increased to 120° and uncomfortable at the end of range; fine patello-femoral joint crepitus with some irritability; ligamentously stable; and McMurray's provocation test was positive.

73. Dr Rooney opined that Mrs McCartney had early arthritic change in her left knee and more moderate osteoarthritis in her right knee with meniscal pathology (complex tear).

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[31] ARD at page 45
[32] ARD at pages 58-60
[33] ARD at page 61
[34] ARD at page 62

74. In relation to Mrs McCartney's lumbar spine, Dr Rooney noted that she complained of paraesthesia affecting both feet intermittently and he encouraged her to consult Dr Mark Winder for a surgical opinion.

75. On 29 March 2017, Mrs McCartney consulted Dr Rooney who reviewed her right knee MRI scan dated 28 March 2017. He explained the findings, namely, that the complex tear to the medial meniscus was still present and extruded and that arthritis was affecting the medial tibio-femoral compartment. He recommended that she continue with weight loss and also recommended an injection of local anaesthetic and cortico-steroid into the right knee. He opined that she would eventually undergo surgery to the knee.

76. On 23 May 2017, Mrs McCartney consulted Dr Rooney and reported that the injection of local anaesthetic and cortico-steroid into her right knee joint was of no great benefit. Dr Rooney explained the available options which included medication for pain relief, use of a walking stick, weight loss, analgesia or a knee replacement. Mrs McCartney expressed a preference for a surgical solution.

St Vincent's Hospital

77. In evidence, there is a St Vincent's Hospital, Sydney Discharge Summary Referral.[35]

78. The St Vincent's Hospital Discharge Summary Referral confirmed that Mrs McCartney underwent a total right knee replacement on 16 May 2018 and was discharged home on 23 May 2018.

Professor Youssef Ghabrial, Orthopaedic and Spinal Surgeon

79. On 12 July 2017, Mrs McCartney consulted Professor Youssef Ghabrial, Orthopaedic and Spinal Surgeon at the request of her current lawyers.

80. In evidence, there are two reports by Professor Ghabrial dated 12 July 2017.[36] I will now refer to the relevant parts of those reports.

81. Professor Ghabrial took a history from Mrs McCartney, the relevant parts of which may be summarised as follows:

    (a) Mrs McCartney injured her lower back on 6 November 2014 in the course of her employment whilst attempting to transfer a patient from a chair to a toilet and developed severe pain in the lower back and two weeks later, developed pain in the right knee.

    (b) Mrs McCartney experienced back pain and referred pain into her left leg.

    (c) Mrs McCartney underwent treatment which included physiotherapy, medications, spinal injections and a pain management program.

    (d) Mrs McCartney's back pain, back stiffness and referred left leg pain continued. She consulted Dr Ferch who did not recommend surgery.

    (e) Mrs McCartney consulted an orthopaedic surgeon, who advised that at some stage she would require a total right knee replacement.

[35] ARD at pages 63-64
[36] ARD at pages 67-71

(f) Mrs McCartney was diagnosed with bulging discs in the lower lumbar region in 2011 but experienced minimal symptoms and no major problems until the injury on 6 November 2014.

(g) Mrs McCartney sustained no previous injuries to her back or right knee.

(h) Mrs McCartney had not been involved in any form of employment since the injury.

82. On examination of Mrs McCartney's back, Professor Ghabrial observed a protected sitting and standing attitude; a limp whilst walking; normal postural curves; spinal movements markedly decreased with flexion from the fingertips to above the knee; extension, lateral bending and rotation were decreased with pain; moderate paraspinal lumbar spasm; straight leg raising in the short sitting and supine positions was 80° on the right and 60° on the left with a negative sciatic stretch on the right side and a positive sciatic stretch on the left side; no motor or reflex defects; bilateral feet numbness; marked tenderness at the L4-S1 level of the lumbar midline; femoral stretch was negative; sacroiliac tests were normal.

83. Professor Ghabrial noted that Mrs McCartney's lumbar spine MRI scan dated 6 February 2015 demonstrated a L4/5 generalised disc bulge with right focal bulging to the foramen causing right foraminal stenosis with potential impingement on the nerve root.

84. On examination of Mrs McCartney's right knee, Professor Ghabrial observed a mild varus deformity; mild swelling; mild effusion; quadriceps muscle wasting; marked tenderness all over the right knee; range of motion between 20°-100°; mild crepitations; normal ligaments; pain in the patello-femoral joint; normal sensation, flexion power and extension.

85. Professor Ghabrial noted that Mrs McCartney's right knee MRI scan dated 14 April 2015 demonstrated a medial meniscal tear with osteoarthritic changes in the medial compartment associated with joint effusion and synovitis. There were minor lateral compartment osteoarthritic changes. The x-rays of Mrs McCartney's right knee dated 7 November 2016 demonstrated evidence of marked osteoarthritic changes in the medial compartment with cartilage interval of 1 mm.

86. In relation to Mrs McCartney's lumbar spine, Professor Ghabrial opined that she had sustained a severe injury in an incident at work on 6 November 2014 suggestive of an L4/5 foraminal disc bulge. However, whilst she experienced some sensory changes in her feet, Professor Ghabrial could not find evidence of radiculopathy.

87. In relation to Mrs McCartney's right knee, Professor Ghabrial opined that, on 6 November 2014, she had sustained an injury to the medial meniscus with the subsequent development of degenerative changes in the medial compartment of the right knee, which continued to deteriorate. He also opined that she would require a total right knee replacement within a year.

88. As to restrictions caused by the injury to her lumbar spine, Professor Ghabrial opined that Mrs McCartney remained restricted indefinitely for activities involving any lifting over 5 kg, excessive bending and excessive twisting of the back.

89. As to restrictions caused by the injury to her right knee, Professor Ghabrial opined that Mrs McCartney remained restricted for activities involving running, climbing ladders, ascending and descending stairs, walking on uneven ground, prolonged standing, prolonged walking, kneeling and squatting.

90. Based on the history provided to him, Professor Ghabrial opined that employment was the main contributing factor to Mrs McCartney's present clinical features, disabilities and impairment.

91. Professor Ghabrial produced a second and shorter report dated 12 July 2017.[37] However, that report related to an assessment of Mrs McCartney's whole person impairment, which is irrelevant for the purposes of these proceedings.

92. On 22 September 2017, Professor Ghabrial produced a supplementary report in response to a letter from Mrs McCartney's lawyers dated 19 September 2017.[38] The supplementary report dealt with in an amendment to Professor Ghabrial's whole person impairment assessment and, as such, is irrelevant for the purposes of these proceedings.

93. In response to a letter from Mrs McCartney's lawyers dated 20 September 2018, Professor Ghabrial produced a further supplementary report dated 2 October 2018.[39] It is apparent from the report that, in the 20 September 2018 letter, Professor Ghabrial was informed that Mrs McCartney had undergone total right knee replacement surgery on 16 May 2018 and that further matters contained in his initial report were raised for clarification. Professor Ghabrial responded as follows:

> "Mrs McCartney sustained a frank injury to her lower back on 6 November 2014. I believe that she injured her right knee at the same time. I cannot explain the delayed onset of symptomatology in the right knee but due to the severity of her back pain at that time her knee symptoms may not have been a priority. This is not uncommon.
>
> I sincerely hope that I have clarified the points raised in your letter."[40]

Dr Robin Higgs, Orthopaedic Consultant, Biomedical and Forensic Engineer

94. On 4 May 2016, Mrs McCartney consulted Dr Robin Higgs, Orthopaedic Consultant, Biomedical and Forensic Engineer at the request of her former lawyers.

95. In evidence, there are two reports by Dr Higgs dated 4 May 2016.[41].

96. In Dr Higgs' shorter report dated 4 May 2016, he provided an assessment of Mrs McCartney's whole person impairment and, as such, that report is irrelevant for the purpose of these proceedings, except that he confirmed the following opinion expressed in his longer report of the same date:

> "Mrs McCartney also suffers from an impairment of her right lower extremity function. I have formed the conclusion that this impairment is not associated, in a cause sense, with any workplace incident."[42]

97. I will now refer to the relevant parts of Dr Higgs' longer report dated 4 May 2016.

98. Dr Higgs took a detailed history from Mrs McCartney, the relevant parts of which may be summarised as follows:

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[37] ARD at pages 70-71
[38] ARD at pages 72-73
[39] ARD at page 74
[40] ARD at page 74
[41] Reply at pages 19-33
[42] Reply at page 20

(a) In late October 2014, Mrs McCartney suffered an injury at work whilst manoeuvring (rolling) a patient in bed when she suffered pain and swelling at the right knee. In her evidentiary statement, Mrs McCartney corrected Dr Higgs' history by stating that she felt a burning pain on the side of her right knee. She did not think anything of it and completed her shift. She denied any swelling to her right knee at that time.

(b) Between 5.30 pm and 6.00 pm on 6 November 2014, Mrs McCartney suffered from a sudden onset of severe burning low back pain whilst, with the assistance of a colleague, she was endeavouring to transfer a resident from a chair to a toilet. Following the incident, she continued to work performing only documentary work activities until 10.00 pm. She suffered right knee joint pain and swelling approximately two weeks following the incident on 6 November 2014.

(c) On 7 November 2014, Mrs McCartney consulted her general practitioner, Dr Jones. A number of investigations were performed, including CT and MRI scans.

(d) Mrs McCartney underwent a treatment program under the care of Dr Jones including physiotherapy and hydrotherapy.

(e) Mrs McCartney consulted Dr Ferch, Neurosurgeon, Dr McGrath, Orthopaedic Surgeon and Dr Russo, Pain Management Specialist.

(f) Mrs McCartney was not currently undertaking any structured treatment program.

(g) Mrs McCartney remained under the care of Dr Davidson, General Practitioner.

(h) Mrs McCartney's current medications for pain relief included Targin and Lyrica.

(i) Mrs McCartney used a walking stick to support the low back and right knee conditions.

(j) Mrs McCartney described continuing niggling low back pain rated at between 8/10 and 10/10 on the visual analogue scale. The pain was aggravated by sitting in excess of 10 to 15 minutes; by standing in excess of three minutes; and attempting to perform normal activities of daily living, including domestic activities. Such activities also caused pain to be referred into the left buttock region. She was only able to comfortably walk for distances of less than 30 to 50 metres.

(k) Mrs McCartney described continuing aching and sharp right knee joint pain localised to the medial aspect of the right knee rated at between 8/10 and 10/10 on the visual analogue scale. The right knee pain was aggravated when negotiating stairs; by prolonged standing; by prolonged sitting; by prolonged walking; and when lying down.

99. Dr Higgs conducted a review of the diagnostic imaging referred to above. However, in addition to the diagnostic imaging referred to above, he reviewed x-rays of Mrs McCartney's lumbar spine performed on 24 July 2007 by Dr Dutt, Radiologist. Dr Higgs noted that Dr Dutt reported a lumbar spinal scoliosis from multilevel degenerative pathology. Dr Higgs thereby concluded that age caused degenerative lumbar spinal spondylosis was observed to be present at all levels from L3 to L5 inclusive.

100. On physical examination, Dr Higgs observed Mrs McCartney to walk extremely slowly with the aid of a walking stick in her left hand. She was also observed to walk without the use of the walking stick and when she did so, she appeared to have a limping derangement of gait that was evident on the right side. Mrs McCartney stood with a forward flexion leaning posture of the spinal region of 20°, which relieved pressure on the low back. Mrs McCartney was observed to stand to relieve her worsening low back pain and she was not entirely comfortable when seated. She did not demonstrate any discomfort when standing from the seated position. She sat to undress and dress to negotiate her lower body garments and footwear. She was able to get on and off the examination couch normally and appeared comfortable when lying supine. She was unable to roll over to the prone lying position.

101. On examination of Mrs McCartney's lumbo-sacral spine, Dr Higgs observed, amongst other things, posture was associated with a forward flexion of 20°; there was tenderness to palpation; no evidence of any paraspinal resting or motion muscle spasm; forward flexion was restricted to a range of 20° to 40°; ability to reach with both hands to the upper thigh level only; and asymmetric restriction of lumbo-sacral spine rotation.

102. Neurological examination revealed entirely normal lower extremities; no evidence of any verifiable radiculopathy; normal spinal reflexes; no sensory perception impairment; normal motor function; grade V power of muscle function; no evidence of any weakness; normal coordination of extremity movement; straight leg raising restricted to 15° on the right and to 25° on the left and causative of low back pain aggravation; negative sciatic stretch test; limitation of straight leg raising was not of any neurological significance.

103. On examination of Mrs McCartney's lower extremities, Dr Higgs observed a swollen right knee joint; right knee flexion restricted through a range of 15° to 60°; tenderness to palpation of the medial joint line region of the right knee joint; no evidence of any ligamentous laxity at the right knee joint; stable knee in both the antero-posterior and medio-lateral planes; and a palpable Baker's cyst at the posterior regions of the right knee joint.

104. In relation to Mrs McCartney's lumbar spine, Dr Higgs opined:

> "Mrs McCartney suffered an injury to her low back region when she was at work on 6 November 2014. It is evident that Mrs McCartney has suffered from permanent aggravation of pre-existing multilevel degenerative lumbo-sacral spinal pathology."[43]

105. In relation to Mrs McCartney's right knee, Dr Higgs opined:

> "My consideration of the evidence has caused me to form the conclusion that Mrs McCartney has also been identified as suffering a tear of the medial meniscus of the right knee joint. My consideration of the evidence has caused me to form the conclusion that this right knee injury was probably not suffered in the accident that has been described as occurring on or about 06/11/14. It is evident that Mrs McCartney has suffered from age caused degenerative knee joint osteoarthritic pathology. It is permissible to conclude that the tear to the meniscus of the right knee joint is probably associated, in a cause sense, with the attrition to the meniscus that is frequently suffered in those that have developed degenerative osteoarthritis of the knee joint."[44]

106. Later in his report, Dr Higgs further elaborated his opinion in relation to Mrs McCartney's right knee condition as follows:

[43] Reply at page 31
[44] Reply at page 24

> "Since approximately two weeks following the injury incident, Mrs McCartney has suffered from right knee pain. It is evident that Mrs McCartney has previously suffered from degenerative osteoarthritis of her right knee joint. X-rays have demonstrated the presence of this pathology. … Mrs McCartney has been demonstrated as suffering from a tear of the right medial meniscus and from radiologic evidence of established degenerative right knee joint pathology. As far as can be determined, Mrs McCartney did not suffer from any definite injury during the incident that occurred on or about 06/11/14. Notwithstanding this, Mrs McCartney does suffer from a flexion deformity of her right knee joint and from a restricted range of right knee motion. It is evident that Mrs McCartney does suffer from an impairment of her right knee function. Unfortunately, I have been unable, with any certainty, to attribute Mrs McCartney's right knee joint condition with any work place injury incident that occurred on or about 06/11/14.
>
> … The degenerative osteoarthritis of the right knee joint is associated also with the suffering of a tear of the right medial meniscus."[45]

107. In relation to Mrs McCartney's current work capacity, Dr Higgs opined that work would be therapeutic for Mrs McCartney but that she was unfit for her full-time pre-injury duties. He further opined that she was only fit for part-time restricted work of a clerical and/or supervisory nature in an office environment. He concluded that she should be able to work between six to nine hours per week, but for not any more than two to three hours on any single occasion. He recommended that any such return to work should be on a graduated basis and under the care and supervision of her general practitioner.

108. Dr Higgs cautioned that Mrs McCartney ought to avoid any of the following work activities:

    (a) Any work activity that was known by her to aggravate her symptoms.

    (b) Any work that required any repetitive and/or frequent need to perform bending, stooping and/or twisting manoeuvres with the lumbosacral spine.

    (c) The negotiation of steps, stairs, slopes, ladders and uneven ground.

    (d) Any work that requires frequent and/or repetitive kneeling, squatting and/or stooping activities.

    (e) Any prolonged standing and walking.

Dr Vidyasagar Casikar, Neurosurgeon

109. On 5 December 2014, Mrs McCartney consulted Dr Vidyasagar Casikar, Neurosurgeon at the request of the respondent's insurer.

110. In evidence, there is a report by Dr Casikar dated 5 December 2014.[46] I will now refer to the relevant parts of that report.

111. Dr Casikar took a history from Mrs McCartney, the relevant parts of which may be summarised as follows:

[45] Reply at page 31
[46] Reply at pages 68-73

(a) On 6 November 2014, Mrs McCartney was transporting a 130-kg client in a standard lifter to the toilet. On completion of the task, Mrs McCartney felt a burning sensation in her back. She did not inform her supervisors because it was not very bad. However, over the next two or three days the pain increased.

(b) Mrs McCartney consulted her family physician, Dr Jones, who informed her that she had sustained a work-related injury and provided her with a certificate.

(c) Dr Jones arranged for Mrs McCartney to undergo a CT scan of her lumbar spine and prescribed Tramadol, Lyrica and Panadeine Forte for pain control.

(d) Mrs McCartney had not returned to work.

(e) Mrs McCartney had not undergone any physiotherapy.

(f) Mrs McCartney felt that she was not getting better.

(g) Three years ago, she experienced an episode of back pain and a CT scan at the time indicated bulging discs and a congenital scoliosis in the thoracolumbar segment. Symptoms resolved within a short period.

112. It would appear that Mrs McCartney made no complaint about her right knee and, accordingly, Dr Casikar did not examine it.

113. On physical examination, Dr Casikar observed that Mrs McCartney stood at a height of 5'7" and weighed 96 kg. She was able to walk on her heels and toes without difficulty. Her gait was normal. Movements of the back were within normal limits.

114. Neurological examination of Mrs McCartney's lower limbs suggested an SLR ranging between 70° and 75°; there was no dermatomal hypoaesthesia or motor weakness; and deep tendon reflexes were normal.

115. Dr Casikar reviewed Mrs McCartney's lumbar spine CT scan dated 12 November 2014 and noted age-related changes; scoliosis in the thoracolumbar segment with convexity to the right; endplate changes on the right side at the L45 segment, probably related to the scoliosis.

116. Dr Casikar diagnosed mechanical back pain, congenital scoliosis and workplace aggravation.

117. Dr Casikar opined:

> "With appropriate physiotherapy and home-based exercises, I expect her problem to resolve in about two months. However, it is very likely that Mrs McCartney would have further episodes of back pain because of the nature of her employment and the pre-existing pathology in the back. If the problems were to recur frequently, a permanent modification of her work within the aged care organisation may be useful.
>
> Mrs McCartney has worked in the aged care set up for most of her life. This job generally involves lifting and caring for heavy, disabled patients. Therefore, it is reasonable to accept that there has been some contribution from her employment to her degenerative disease. The scoliosis is congenital and does not relate to her employment."[47]

[47] Reply at page 70

118. Dr Casikar also opined that employment was the main contributing factor to the symptoms in Mrs McCartney's lumbar spine.

119. In relation to Mrs McCartney's current work capacity, Dr Casikar agreed with Dr Jones that at that point in time, she did not have any capacity to work. However, he felt that with appropriate treatment, he would expect her to be fit for suitable duties on pre-injury hours in about two months' time.

Dr Richard Powell, Orthopaedic Surgeon

120. On 8 July 2015, Mrs McCartney consulted Dr Richard Powell, Orthopaedic Surgeon at the request of the respondent's insurer.

121. In evidence, there is a report by Dr Powell dated 9 July 2015.[48] I will now refer to the relevant parts of that report.

122. Dr Powell took a history from Mrs McCartney, the relevant parts of which may be summarised as follows:

    (a) On 6 November 2014, Mrs McCartney sustained an injury to her lower back whilst attempting to transfer a patient from a chair to the toilet using a hoist. The patient was suspended in the hoist and she attempted to move the frame and in doing so, felt the immediate onset of burning pain in her lower back. She was able to complete the shift.

    (b) Mrs McCartney presented to Dr Jones several days later complaining of low back pain. She was referred for an MRI scan which identified evidence of spondylitic change and degenerative disc disease at L3/4 and L4/5.

    (c) Mrs McCartney was referred to Dr Ferch, who recommended conservative management.

    (d) Mrs McCartney commenced physiotherapy without any particular benefit.

    (e) Mrs McCartney underwent an injection of local anaesthetic and corticosteroid without sustained benefit.

    (f) Mrs McCartney had been totally unfit for work since the date of injury.

    (g) Mrs McCartney became aware of the development of right knee symptoms about one week after the workplace incident. Right knee symptoms developed in an insidious fashion whilst at home. She could not recall a specific precipitating incident. The knee was swollen and painful. She was referred for an MRI scan of the right knee which demonstrated evidence of degenerative change and a large effusion.

    (h) Mrs McCartney had a history of lower back pain going back four years.

    (i) Mrs McCartney had been aware of bilateral knee pain for over five years. Symptoms were intermittent. There was no specific cause. The issue had been managed by her general practitioner without specialist review.

[48] Reply at page 60-66

123. On examination of Mrs McCartney's lumbosacral spine, Dr Powell observed that she had an antalgic gait with a shortened stance phase on the right side; used a stick in her left hand; was able to stand on her heels and toes; focal tenderness to palpation of the posterior bony elements of the lumbar spine between L4 and S1 was present; no paraspinal muscle spasm; range of motion was restricted with forward flexion to the knees, lateral flexion was to the junction of the middle and distal thirds of the thigh bilaterally and rotation was one quarter of the normal range bilaterally; and sciatic stretch tests were negative.

124. Neurological examination of the lower limbs revealed normal tone, power and sensation; and deep tendon reflexes were present, equal and symmetrical.

125. On examination of Mrs McCartney's right knee, Dr Powell observed that she stood with the right knee slightly flexed, which represented a fixed flexion deformity of less than 5°; otherwise normal alignment; the knee was irritable to examine; there was marked diffuse swelling; moderate effusion; no crepitus; Clark's test was positive; marked tenderness to palpation of the medial and lateral patellar facets, the medial joint line and the medial tibial plateau; range of motion was from the fixed flexion position of less than 5° to 95°; and the knee was ligamentously stable.

126. In relation to Mrs McCartney's lower back, Dr Powell diagnosed a musculo-ligamentous injury on a background of well-established pre-existing multilevel degenerative disc disease in a workplace incident on 6 November 2014.

127. In relation to Mrs McCartney's right knee, Dr Powell opined:

> "In addition, she reported the insidious onset of right knee symptoms a week after the workplace incident. Clinically she has an irritable knee, symptoms most likely reflecting some underlying degenerative pathology possibly in association with a medial meniscal tear. There is no evidence that her current right knee condition is related to her employment and the specific workplace incident of November 2014 involving the lower back. She has a clear history of pre-existing symptoms involving both the lower back and right knee."[49]

128. In response to a question posed to him by the respondent's insurer as to whether Mrs McCartney had suffered a disease injury, Dr Powell responded:

> "Based on the available evidence I believe it would be reasonable to conclude that Ms McCartney is suffering from a disease process involving the right knee. This represents constitutional degenerative pathology."[50]

129. In relation to Mrs McCartney's current work capacity, Dr Powell opined:

> "Based on my examination today I do not believe Ms McCartney is fit to return to her pre-injury duties. Her current incapacity is the result of both her lower back and right knee conditions. Limiting my opinion to her work-related lower back condition, I would suggest she be placed on suitable duties with a lifting restriction of 10 kg and instructions to avoid repetitive bending, lifting or twisting manoeuvres. She should limit periods of prolonged standing and walking. She should alternate her tasks where possible and have the opportunity for regular breaks. I would recommend reduced hours, for example, five to six hours a day, four to five days a week.

[49] Reply at pages 63-64
[50] Reply at page 65 at [7]

If one were to also take into account Ms McCartney's non-work related right knee condition, then her capacity for work would decrease further. The combination of the two means, based on today's examination, she is probably not fit to return to the workforce as she is unlikely to tolerate travel to and from work, prolonged walking, standing or sitting."[51]

Dr Andrew Keller, Occupational Physician

130. On 25 September 2015, Mrs McCartney consulted Dr Andrew Keller, Occupational Physician at the request of the respondent's insurer.

131. In evidence, there is a report by Dr Keller dated 25 September 2015.[52] I will now refer to the relevant parts of that report.

132. On 25 September 2015, Dr Keller took a detailed history from Mrs McCartney, the relevant parts of which may be summarised as follows:

    (a) Mrs McCartney was employed by the respondent as a nurse aide from 2013. She worked on a permanent part-time basis, 7.5 hours per day, five days per week. Her duties involved assisting residents with personal care and medications and required her to stand all day, lift up to 10 kg and she was involved in heavy pushing and pulling, as well as frequent bending.

    (b) On 6 November 2014, Mrs McCartney was assisting with the transfer of a resident from a chair to a bathroom using a mobile hoist with a strap around the resident. Once the resident had been elevated to his feet, Mrs McCartney was required to push and manipulate the hoist including the resident's weight. It was during this process that she experienced sudden burning mid back pain. She completed her shift and was rostered off work for the following two days.

    (c) Mrs McCartney consulted her general practitioner, who arranged for a lumbar CT scan. She was subsequently referred to physiotherapy and to Dr Ferch, who arranged for a cortisone injection into her lumbar spine, which was of no benefit.

    (d) Mrs McCartney's current medications consisted of Tramadol, Lyrica, Panadeine Forte and she was about to commence taking Norspan and Endone.

    (e) About one week or more following the incident on 6 November 2014, Mrs McCartney was troubled by right knee pain and swelling. She underwent a right knee MRI scan which revealed a medial meniscal tear, large effusion and degenerative changes. The right knee condition had been deemed a non-work injury and she was currently awaiting specialist review to consider surgical intervention.

    (f) Mrs McCartney denied any previous back injuries, investigations, treatments or claims.

[51] Reply at page 66 at [11]
[52] Reply at pages 50-54

133. Dr Keller recorded Mrs McCartney's present complaints. The complaints included constant throbbing lower back pain with intensity aggravated by walking and standing and radiation into the left leg with associated pins and needles, swelling in both feet and swelling in both ankles. There was a constant sharp right knee pain.

134. Dr Keller recorded Mrs McCartney's self-stated capacities to include sitting for 10 minutes; standing for three minutes; walking for three to four minutes; lifting up to 2 kg; and an inability to drive since injury.

135. On examination of Mrs McCartney's lumbar spine, Dr Keller observed minimal range of motion in any axis including forward flexion being around 10°; however, there was an ability to pull her trousers down resulting in flexing to at least 45°; normal sensation to light touch in the right lower limb and reduced in all of the left lower limb from the hip flexure down to and including all of the toes, crossing multiple dermatomes (unexplained by the available investigations to date); and an ability to lift heels and toes briefly.

136. On examination of Mrs McCartney's right knee, Dr Keller observed a widened joint; mild instability on lateral pressure consistent with osteoarthritic change; and a large effusion. The right knee was too tender to formally examine.

137. Dr Keller provided a summary of his telephone conversation with Mrs McCartney's general practitioner, Dr Jones.

138. Dr Keller diagnosed Mrs McCartney as having suffered a back strain in the incident on 6 November 2014. Whilst the available diagnostic imaging revealed multilevel degenerative changes with possible nerve root impingement, there was no explanation as to why symptoms had not significantly improved in the 11 months following the incident. Dr Keller felt that there were inconsistencies on examination as to Mrs McCartney's reported altered sensation crossing multiple dermatomes, as well as other matters.

139. In relation to Mrs McCartney's current work capacity, Dr Keller opined that, in relation to the lower back strain only, at the time of examination, she should have been able to work at least three hours per day, five days per week in a sedentary role. Dr Keller further opined that the main factor affecting Mrs McCartney's capacity for work was her right knee and, in that regard, she was genuinely totally unfit for work. It was not clear to him as to whether Mrs McCartney would recover any work capacity following surgical intervention to her right knee.

140. On 23 October 2015, Dr Keller produced a supplementary report in the form of a file review to the respondent's insurer.[53] I will not refer to the supplementary report as it addressed matters which were either not in evidence or not referred to by counsel. The surveillance report referred to by Dr Keller was not referred to or relied upon by counsel. The supplementary report apparently produced by Dr Casikar and dated 12 October 2015 is not in evidence.

Initial notification

141. In evidence, there is a CGU Workers Compensation Initial Notification of Injury form submitted on 18 November 2014 at 4:59 pm.[54] I will now refer to the relevant parts of that form.

142. The form contains the particulars of the notifier, the injured worker, employment details, employer details, injury details, treating doctor details and treatment details relating to Mrs McCartney's incident at work on 6 November 2014.

[53] Reply at page 55-57
[54] Reply at pages 74-75

143. The last entry in the form contains a descriptor entitled “Additional Information”, which records the following:

> “Worker rang Facility Manager 13/11 and stated hurt back – no reference to worker [sic] comp”.[55]

Certificates

144. In evidence, there are Certificates of Capacity and ordinary medical certificates issued by medical practitioners of Wyoming Medical & Dental Centre.[56] Only two of the certificates were pro forma Certificates of Capacity.

145. The certificates purported to cover the period 3 November 2015 to 30 April 2017 and variously certified Mrs McCartney as having either “no current work capacity” or “unfit for work”. The certificates varied in their references to the condition/s suffered by Mrs McCartney. The two Certificates of Capacity referred to disc lesion with right foraminal stenosis, L4 sciatica on nerves L4/5, L5/S1, right knee medial meniscal tear and osteoarthritis. The ordinary medical certificates variously recorded Mrs McCartney as suffering from medical illness; chronic lumbar back pain with associated dysfunctional right knee pain; chronic lumbar disease; medical condition; back injury with disc lesions and sciatica; acute back injury with disc lesions and sciatica.

146. Due to the matters referred to above and the fact that counsel made no reference to the certificates in their respective submissions, I give them no weight.

SUBMISSIONS

147. The parties made oral submissions at the arbitration hearing which were sound recorded. The sound recording is available to the parties.

The respondent’s submissions

148. The respondent’s submissions, through its counsel, Mr Beran, may be summarised as follows:

(a) The Initial Notification of Injury form, which was prepared by the respondent, referred to Mrs McCartney telephoning the respondent’s facility manager on 13 November 2014 advising that she had hurt her back. No injury description was recorded and there was no reference to an injury to her knee.

(b) The clinical records produced by Wyoming Medical and Dental Centre disclosed Mrs McCartney as having previously suffered back pain in 2007 and 2011, which is no longer an issue in these proceedings. The entry in the clinical records on 11 November 2014, some five days following the alleged date of injury, referred to pain of the lower back to the left leg mainly; no thigh pain; no parasthesiae or numbness; a lump in the mid-calf posterolaterally; but there was no reference to the right knee at all. The entry in the clinical records on 17 November 2014 referred to Mrs McCartney having decided to make a workers’ compensation claim due to worsening back problems related to her work, with the main exacerbation of pain commencing on 6 November 2014 at work. However, there was no reference to the right knee.

[55] Reply at page 75
[56] ARD at pages 102-117

(c) The first clear reference to Mrs McCartney's right knee in the Wyoming Medical and Dental Centre clinical records was in an entry by Dr Jones on 19 January 2015, where he referred to non-workers' compensation swelling of the right knee anteriorly, anteromedially and posteriorly. The right knee problem was first recorded more than two months after the alleged date of injury. Dr Jones also recorded that Mrs McCartney's gait problems associated with the disc lesions to her lower back, appeared to have aggravated her right knee. Dr Jones, a general practitioner, consistently associated the right knee problems with the altered gait caused by Mrs McCartney's back injury. However, he was the only medical practitioner to do so. He is not an orthopaedic surgeon. Dr Jones did not comment as to whether the problem with Mrs McCartney's right knee was causing issues with her gait.

(d) In a Certificate of Capacity issued by Dr Jones on 17 November 2014, he provided Mrs McCartney with a diagnosis of work-related injury/disease to the lower back. He made no reference to her right knee.

(e) Mrs McCartney's evidentiary statement referred to an x-ray of her pelvis and left hip and a CT scan of her lumbar spine on 7 February 2011 following an episode of back pain and an x-ray of her right knee on 6 May 2014. The latter x-ray was not in evidence but was referred to by Dr Higgs. There were clearly symptoms in Mrs McCartney's right knee in May 2014.

(f) Mrs McCartney's evidentiary statement described the incident at work with the respondent on 6 November 2014. She stated that she felt the onset of severe pain in her lower back into her left leg and that she was not aware of any symptoms in her right knee at that time. She stated that, on or about 19 November 2014, she began to notice pain developing and swelling in her right knee. In fact, she did not raise the issue of symptoms in her right knee with Dr Jones until her consultation on 19 January 2015.

(g) Mrs McCartney's evidentiary statement went on to refer to a progressive worsening of her right knee and described the symptoms. However, she did not provide any evidence of an altered gait. The first evidence of an altered gait came from Dr Jones in the entry in his clinical records on 19 January 2015.

(h) The respondent does not say that Mrs McCartney did not have right knee symptoms from 19 January 2015, nor that she did not require a right knee replacement as a result of those symptoms.

(i) Mrs McCartney's medical evidence is quite sparse.

(j) On 11 February 2015, Dr McGrath, Orthopaedic Surgeon, reported that Mrs McCartney denied any specific event initiating her right knee pain but that she had been experiencing recurrent episodes of locking and a sensation of giving way since November 2014. On examination, Dr McGrath observed that Mrs McCartney had an antalgic gait. The respondent submits that such gait was clearly due to her right knee problems. Dr McGrath diagnosed a right meniscal injury, which is not in issue.

(k) On 3 March 2015, Dr Ferch, Neurosurgeon, took a history from Mrs McCartney relating to the incident in November 2014, which did not include any reference to the right knee. Nor did he record any history of an altered gait as a result of Mrs McCartney's lower back symptoms.

(l) On 14 April 2015, Mrs McCartney underwent a right knee MRI scan which found a complex tear of the medial meniscus and degenerative changes.

(m) On 7 November 2016, Mrs McCartney underwent a right knee x-ray where severe osteoarthritis was identified in her knee.

(n) Dr Rooney diagnosed Mrs McCartney as suffering from severe osteoarthritis in the right knee. Dr Rooney provided no link whatsoever between the right knee condition and an altered gait caused by her lower back injury. On 29 March 2017, Dr Rooney confirmed that a recent right knee MRI scan demonstrated extensive tri-compartmental osteoarthritis with tears in the medial meniscus, discoid lateral meniscus and the lateral meniscus being flipped over. By this stage, Mrs McCartney had advanced osteoarthritic changes in her right knee which eventually resulted in a total right knee replacement.

(o) The issue for determination is the cause of the osteoarthritic changes in Mrs McCartney's right knee. The medical evidence does not provide the answer.

(p) On 5 December 2014, Dr Casikar, Neurosurgeon, observed on examination that Mrs McCartney's gait was normal. The respondent does not rely on the opinion of Dr Casikar in relation to the lumbar spine as its position is contrary to it.

(q) On 8 July 2015, Dr Powell, Orthopaedic Surgeon, took a history from Mrs McCartney that, in addition to her lower back pain, she became aware of the development of right knee symptoms about one week after the workplace incident; symptoms in the right knee developed in insidious fashion whilst at home; she could not recall the specific precipitating incident; she had been aware of bilateral knee pain for over five years. Dr Powell opined that Mrs McCartney's knee symptoms most likely reflected some underlying degenerative pathology, possibly an association with a meniscal tear; there was no evidence that her current right knee condition was related to her employment and specific workplace incident of November 2014 involving the lower back; she had a clear history of pre-existing symptoms involving both a lower back and right knee; there was no specific injury or incident involving the right knee. Dr Powell further opined that the disease process involving Mrs McCartney's right knee represented a constitutional degenerative pathology. The latter opinion was consistent with that of Dr Higgs.

(r) In relation to the issue of current work capacity, Dr Powell opined that, in relation to Mrs McCartney's lower back condition, she should be placed on suitable duties with a lifting restriction of 10 kg and instructions to avoid repetitive bending, lifting or twisting manoeuvres. If the non-work-related right knee condition was taken into account, then her capacity for work would decrease further.

(s) Dr Keller, as an Occupational Physician, is best placed to provide an opinion in relation to Mrs McCartney's capacity for work. On 25 September 2015, Dr Keller opined that Mrs McCartney should be able to work at least three hours per day, five days per week in a sedentary role. Such opinion was provided on the background of him finding a lower back strain only and not including the right knee condition. If injury to the right knee were accepted, then Mrs McCartney would be totally unfit for work.

(t) Dr Higgs opined that his consideration of the evidence caused him to form the conclusion that Mrs McCartney's right knee injury was probably not suffered in the incident described on or about 6 November 2014. Rather, it was evident that she had suffered from age caused degenerative knee joint osteoarthritic pathology. It would be permissible to conclude that the ear to the meniscus of the right knee joint was probably associated, in a causal sense, with the attrition to the meniscus that is frequently suffered in those that have developed degenerative osteoarthritis of the knee joint. Dr Higgs observed Mrs McCartney as having a limping derangement of gait that was evident on the right side. The conclusion that one should draw from such observation is that it was caused by her right knee condition and not her lower back condition. Dr Higgs had reviewed, at least, the right knee x-ray report of 6 May 2014 by Dr Lewis, Radiologist, where degenerative osteophytosis was reported. Dr Higgs was the only independent medical examiner who had access to Dr Lewis' x-ray report, being a pre-injury scan of the right knee and this is a good reason for accepting his opinion in relation to the right knee over that of all the other medical practitioners.

(u) In relation to the issue of current work capacity, Dr Higgs opined that Mrs McCartney should be able to work between six to nine hours per week but not for more than two to three hours on any single occasion; she should avoid work that requires repetitive and/or frequent need for bending, stooping and/or twisting manoeuvres with the lumbar-sacral spine.

(v) On 12 July 2017, Dr Ghabrial opined that he could find no evidence of radiculopathy associated with Mrs McCartney's lower back, which was in contrast to Dr Jones' opinion that the radiculopathy was essentially the cause of her altered gait. Dr Ghabrial took no history of an altered gait. Dr Ghabrial also opined that Mrs McCartney injured her right medial meniscus on 6 November 2014 and subsequently developed degenerative changes in the medial compartment of the right knee which continued to deteriorate. He does not opine that the right knee condition is a consequential condition to the lower back injury. He does not opine that there was an aggravation of a pre-existing degenerative condition of the right knee. Dr Ghabrial is the only doctor who opined that she had sustained a frank injury to her right knee. He did not have available to him the pre-injury diagnostic imaging. There was no fair climate for him to come to such opinion.

(w) There is just no evidence of a frank injury to Mrs McCartney's right knee. There is no evidence to support that the cause of the meniscal tear, if there was one, was the cause of the ongoing process under section 4(b)(i) of the 1987 Act.

(x) In relation to the right knee being consequential to the accepted lumbar spine injury, there must be a common sense evaluation of the causal chain and where an issue lies outside the realm of common knowledge and experience, it falls to be determined by reference to expert medical evidence. Reference was made to *Kirunda v State of New South Wales (No 4)*[57] (*Kirunda*). The expert evidence in this matter overwhelmingly supports the fact the right knee condition was neither caused by work nor was it a consequential condition. There is no evidence, apart from Dr Jones, that there was even a material contribution to the right knee condition or the progression of the symptoms. There is only the evidence of Dr Ghabrial opining a frank injury to the right meniscus.

[57] *Kirunda v State of New South Wales (No 4)* [2018] NSWWCCPD 45 at [136]

(y) There was no evidence of frank injury to the right knee within the meaning of section 4(a) of the 1987 Act. There was no evidence of a disease process to the right knee within the meaning of section 4(b)(i) of the 1987 Act. There was no evidence of an aggravation of a disease process to the right knee within the meaning of section 4(b)(ii) of the 1987 Act. Mrs McCartney has failed to meet the onus of proof on the balance of probabilities.

(z) In relation to Mrs McCartney's claim for weekly benefits, it is indisputable that there was some form of incapacity in relation to her accepted back injury. If the knee injury is found not to be compensable, then there would have to be a significant deduction from the entitlement to weekly benefits. The respondent submits that there were 9 hours to 15 hours of capacity per week at the minimum wage rate of $18 or $19 per hour in suitable employment within the meaning of section 32A of the 1987 Act. If the right knee is not compensable, then any entitlement to weekly benefits ought to be reduced by 15 hours per week. Dr Ghabrial provided no restriction in hours. Dr Keller opined nine hours of capacity. Dr Higgs opined 15 hours of capacity. The minimum would be nine hours of capacity per week at, say, $20 per hour for ease of calculation. The maximum would be 40 hours per week at $20 per hour.

Mrs McCartney's submissions

149. Mrs McCartney's submissions, through her counsel, Mr Lucas, may be summarised as follows:

(a) The starting point is to analyse Mrs McCartney's history of complaints. In her evidentiary statement, Mrs McCartney provided a history that she underwent a CT scan of her lumbar spine and hip on 7 February 2011 and that the symptoms in her lumbar spine and hip did not affect her ability to work. The clinical records in evidence demonstrate that any treatment she received was transitory and she returned to full-time work, which was heavy work and included lifting patients. Mrs McCartney commenced her employment with the respondent in 2013 without any incident.

(b) In relation to Mrs McCartney's right knee, she underwent an x-ray on 6 May 2014. Mrs McCartney stated that the symptoms in her right knee occurred in the course of her employment with the respondent whilst squatting taking off a resident's shoes. The x-ray demonstrated minimal marginal osteophytic spiking but good preservation of the knee-joint spaces. She returned to work with the respondent and her right knee symptoms did not cause any incapacity.

(c) The touchstone in this case is incapacity. Whether any of Mrs McCartney's injuries or pre-existing injuries were capable of causing any incapacity and what was the real cause of the incapacity. It should be accepted that anything that occurred to Mrs McCartney's right knee prior to 6 November 2014 was transitory in nature. Such a proposition is supported by the absence in the clinical records of any significant pre-existing problems.

(d) It is to Mrs McCartney's credit that she stated she was not aware of any symptoms in her right knee at the time of the incident on 6 November 2014 when she and a colleague were attempting to transfer a resident from a chair to the toilet using a mobile hoist. However, she did state that she was overwhelmed by the severe pain in her lower back and worried about a possible back injury.

(e) The evidence is that for a short period of time Mrs McCartney was using a walking stick and, at one time, was confined to a wheelchair because of the severe pain in her lower back and left leg. On 7 November 2014, she consulted a general practitioner and was prescribed pain-relieving medication for her back pain but did not notice any symptoms in her right knee at that point.

(f) On or about 19 November 2014, Mrs McCartney began to notice pain and swelling in her right knee. That was about two weeks following the incident at work. It should be accepted that the symptoms in Mrs McCartney's right knee were the subject of gradual decline from 6 November 2014 because she stated that over the next month or so the pain in her right knee became progressively worse, until it became so swollen and painful that she could not fully extend or bend the knee; experienced locking and weakness; and instances of giving way. She then presented to her general practitioner on 19 January 2015 complaining of worsening right knee symptoms.
Mrs McCartney sustained a severe injury at work to her lumbar spine with pain radiating into her left leg. This is consistent with her experiencing problems in her right knee over the course of the next two months due to her altered gait arising from the severe injury to her lumbar spine. Mrs McCartney may well have had some pre-existing osteoarthritic changes in her right knee but it never resulted in any incapacity for work.

(g) Mrs McCartney's evidence is that, on 19 January 2015, she consulted her general practitioner, who advised her that it was probable the damage to her right knee was caused by gait problems stemming from her lower back injury. The latter is the most compelling explanation of the cause of her right knee symptoms. It accords with Mrs McCartney's evidence. It accords, in general terms, with the early diagnoses in evidence. The history obtained by Dr McGrath on 11 February 2015 was consistent with Mrs McCartney's evidence. On examination, Dr McGrath observed that she had an antalgic gait. This is consistent with the proposition that it is Mrs McCartney's lower back causing her antalgic gait and not the other way around.

(h) The entry in the clinical records of Dr Jones on 19 January 2015 referred to gait problems associated with the disc lesions of the lower back as having aggravated Mrs McCartney's right knee. Therefore, it is not the right knee symptoms causing the antalgic gait. It is a contemporaneous record. There is a compelling chain of evidence which supports the claim that Mrs McCartney's right knee injury is a consequential injury to that of her lumbar spine. Alternatively, it is an aggravation of an asymptomatic pre-existing degenerative condition in the right knee by the incident on 6 November 2014.

(i) Dr Jones' position is that the antalgic gait is what has caused the ongoing problems in the right knee. Whilst Mrs McCartney's right knee did have a pre-existing issue, it was not causative of any incapacity. She had an osteoarthritic right knee, which had some flare-ups from time to time but caused no incapacity for work. It is only after the onset of the antalgic gait, which is a consequence of the injury to the lumbar spine, that the condition of the right knee then becomes causative of any incapacity for work.

(j) On 19 May 2015, Dr Jones' clinical records recorded lower back pain with more numbness and tingling to the left thigh and leg laterally and onto the foot and some under the foot. It also recorded that Mrs McCartney was walking awkwardly due to pain.

(k) On 6 August 2015, Dr Jones' clinical records referred to the report of Dr Powell and its several questionable comments, including that Mrs McCartney had experienced problems with her right knee for at least five years. The latter statement was not supported by the evidence and Dr Powell clouded the issues. There are two propositions put by Dr Jones in the entry on 6 August 2015. The first proposition was that the severe injury to Mrs McCartney's lumbar spine, the radiation of pain into the left leg and the left calf muscle tear, caused an antalgic gait which was making the right knee worse. The second proposition was that there was a masking of the right knee pain by the lumbar spine injury, the radiation of pain into the left leg and the left calf muscle tear. The latter proposition is consistent with Dr Ghabrial's conclusion.

(l) At first blush, Dr Ghabrial provided a non-compelling opinion that Mrs McCartney sustained a frank injury to her lower back and right knee on 6 November 2014. He could not explain the delayed onset of symptomatology in the right knee but explained that due to the severity of her back pain at that time, her knee symptoms may not have been a priority. He also opined that this was not uncommon.

(m) The tear of the right meniscus is said to be a complex tear. A series of tears. The meniscal tear is consistent with both propositions referred to above.

(n) Dr Higgs is the outrider. It is not known whether Dr Higgs' letter of instructions included the consideration of the question of a consequential injury. Dr Higgs was unable to attribute Mrs McCartney's right knee joint condition with any workplace incident on or about 6 November 2014. He opined that the degenerative osteoarthritis of the right knee joint was associated with the suffering of a tear of the right medial meniscus. Dr Higgs' latter conclusion is not necessarily inconsistent with the suffering of a tear of the right medial meniscus on 6 November 2014, which progressively became worse overtime. The tear may have only been slight and was made worse over time.

(o) There is a compelling evidence to consider that Mrs McCartney's symptoms and complaints are all work related based on the submissions referred to above.

(p) If the right knee injury is accepted, then it is clear that Mrs McCartney was totally incapacitated for work for the period claimed.

(q) If the right knee is not accepted, then Mrs McCartney would begrudgingly accept the respondent's approach to the calculation of her weekly benefits. Although, it is open to consider that Mrs McCartney is totally incapacitated, even if the right knee is not accepted. That is, she has no residual earning capacity. In the alternative, it would be appropriate to adopt the opinion that puts forward the least residual earning capacity.

The respondent's submissions in reply

150. The respondent's submissions in reply may be summarised as follows:

(a) Mrs McCartney's submissions are not based on actual evidence. The case needs to be determined on the available evidence.

(b) There is no expert evidence supportive of Mrs McCartney having suffered a consequential injury to her right knee. The evidence in support comes from her general practitioner, Dr Jones. It is accepted that Dr Jones was a treating doctor. However, Dr Higgs, who is also a biomedical and forensic engineer, the orthopaedic surgeons and the neurosurgeons did not support the proposition that Mrs McCartney had suffered a consequential injury to her right knee. Recourse should be had to the expert medical opinions in this matter.

(c) In relation to the submission that it was unclear as to whether Dr Higgs had been asked to consider a consequential injury to the right knee, the response is that it is the applicant who has to make out her case and not the respondent.

(d) In relation to the submission that there was a slight tear in the right meniscus which became worse over time, where is the evidence to support such submission? There is no medical evidence of a small right meniscal tear which became worse.

(e) The only evidence of a frank injury to the right knee is provided by Dr Ghabrial, who cannot explain the late onset of symptomology, whereas other doctors have done so.

(f) There is no evidence of Mrs McCartney's knee problems being transient. The only evidence is that she had problems in May 2014 and there is no evidence that those problems went away. Mrs McCartney's own evidentiary statement does not say that her right knee symptoms went away.

(g) In relation to the submission that the touchstone of this case was when the incapacity arose, seeks to conflate a temporal connection. The fact that incapacity arose from the right knee close to the date of an accepted injury, is not the test for causation. A temporal connection with an injury of other symptoms is not causation. Causation is either a discrete pathological change, being the section 4(a) argument or a consequential condition. Neither of which are supported by the evidence.

Mrs McCartney's submissions in reply

151. Mrs McCartney's submission in reply may be summarised as follows:

(a) The x-ray dated 6 May 2014 referred to by Dr Higgs makes no mention of a meniscal tear at that point. However, in the MRI scan report dated 14 April 2015, the meniscal tear is present.

FINDINGS AND REASONS

152. I have carefully considered the evidence and the oral submissions made by the parties.

Whether Mrs McCartney suffered an injury to her right knee within the meaning of section 4 of the 1987 Act

153. The relevant legislation and legal principles are outlined below.

154. Section 4 of the 1987 Act provides:

> "In this Act:
>
> 'injury':
>
> (a) means personal injury arising out of or in the course of employment,
>
> (b) includes a 'disease injury', which means:
>
> (i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and
>
> (ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, and
>
> (c) does not include (except in the case of a worker employed in or about a mine) a dust disease, as defined by the *Workers' Compensation (Dust Diseases) Act* 1942, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined."

155. The onus of establishing injury falls upon Mrs McCartney and the standard of proof is on the balance of probabilities, meaning that I must be satisfied to a degree of actual persuasion or affirmative satisfaction: *Department of Education and Training v Ireland*[58] (*Ireland*) and *Nguyen v Cosmopolitan Homes*[59] (*Nguyen*).

156. The issue of causation must be based and determined on the facts in each case. Until recently, the accepted view regarding causation was set out in *Kooragang Cement Pty Ltd v Bates*[60] (*Kooragang*). In *Kooragang*, in perhaps the most commonly cited passage on causation, Kirby P said:

> "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 death or injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a 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."[61]

157. The High Court of Australia, in *Comcare v Martin*[62] (*Martin*), raised some concerns about the *Kooragang* common sense evaluation of the causal chain test. *Martin* involved the definition of injury under section 5A in the *Safety, Rehabilitation and Compensation Act 1988* (the SRC Act). The High Court of Australia's conclusion commences with a caution concerning the use of the "common sense" test:

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[58] *Department of Education and Training v Ireland* [2008] NSWWCCPD 134
[59] *Nguyen v Cosmopolitan Homes* [2008] NSWCA 246
[60] *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796
[61] *Kooragang Cement Pty Ltd v Bates* (1994) 10 NSWCCR 796 at 810
[62] *Comcare v Martin* [2016] HCA 43

> "Causation in a legal context is always purposive. The application of a causal term in a statutory provision is always to be determined by reference to the statutory text construed and applied in its statutory context in a manner which best effects its statutory purpose. It has been said more than once in this Court that it is doubtful whether there is any 'common sense' approach to causation which can provide a useful, still less universal, legal norm. Nevertheless, the majority in the Full Court construed the phrase 'as a result of' in s 5A(1) as importing a 'common sense' notion of causation. That construction, with respect, did not adequately interrogate the statutory text, context and purpose.[63]

158. As I understand it, when referring to applying "common sense", Kirby, P in *Kooragang* was not suggesting that it be applied "at large" or that issues were to be determined by "common sense" alone but by a careful analysis of the evidence. Therefore, the legislation must be interpreted by reference to the terms of the statute and its context in a fashion that best effects its purpose. Such a concept is not new. Sections 4(b), 9A and 11A of the 1987 Act contain specific requirements and the provisions need to be interpreted using standard principles of interpretation. This does not mean that the common sense approach has no place in the application of the legislation to the facts of the case.

159. In order to establish that a "personal injury" has been suffered within the meaning of section 4(a) of the 1987 Act, Mrs McCartney must establish, on the balance of probabilities, that there has been a definite or distinct "physiological change" or "physiological disturbance" in her right knee for the worse which, if not sudden, is at least, identifiable: *Kennedy Cleaning Services Pty Ltd v Petkoska*[64] (*Kennedy*) and *Military Rehabilitation and Compensation Commission v May*[65] (*May*). The word "injury" refers to both the event and the pathology arising from it: *Lyons v Master Builders Association of NSW Pty Ltd*[66] (*Lyons*). While pain may be indicative of such physiological change, it is not itself a "personal injury".

160. *Castro v State Transit Authority*[67] (*Castro*) provides a useful review of the authorities and makes it clear that what is required to constitute "injury" is a "sudden or identifiable pathological change". In *Castro*, a temporary physiological change in the body's functioning (atrial fibrillation: irregular rhythm of the heart), without pathological change, did not constitute injury.

161. I now turn to the application of the relevant legislation and the legal principles to the available evidence in this matter, bearing in mind that Mrs McCartney bears the onus of establishing her case on the balance of probabilities.

Section 4(a) of the 1987 Act

162. Firstly, I turn to the issue of whether Mrs McCartney sustained a personal injury to her right knee arising out of or in the course of employment with the respondent within the meaning of section 4(a) of the 1987 Act on 6 November 2014.

163. On 6 May 2014, after suffering some right knee discomfort squatting at work when removing and replacing a resident's shoes and socks, Mrs McCartney underwent a right knee x-ray by Dr Lewis, Radiologist, which demonstrated marginal degenerative osteophytosis.

164. In late October 2014, Mrs McCartney, whilst at work for the respondent, was rolling a resident in bed when she felt a burning pain on the side of her right knee without any swelling. She did not think anything of it and completed her shift.

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[63] *Comcare v Martin* [2016] HCA at [42]
[64] *Kennedy Cleaning Services Pty Ltd v Petkoska* [2000] HCA 45
[65] *Military Rehabilitation and Compensation Commission v May* [2016] HCA 19
[66] *Lyons v Master Builders Association of NSW Pty Ltd* (2003) 25NSWCCR 496
[67] *Castro v State Transit Authority* [2000] NSWCC 12; (2000) 19 NSWCCR 496

165. In her evidentiary statement, Mrs McCartney described her pre-6 November 2014 right knee symptoms as “minimal” and “well under control”.[68] Accordingly, I do not accept Mrs McCartney’s submission that anything that occurred to her right knee prior to 6 November 2014 was transitory in nature. Such submission is inconsistent with her own evidence.

166. On 6 November 2014, whilst transferring a patient from a chair to the toilet using a mobile hoist at work, Mrs McCartney felt the onset of a severe burning pain in her lower back extending into her left leg. At the time, she was unaware of any symptoms in her right knee.

167. The respondent’s Initial Notification of Injury form submitted on 18 November 2014 did not refer to an injury to Mrs McCartney’s knee on 6 November 2014. This is consistent with Mrs McCartney’s evidentiary statement where she stated that, on or about 19 November 2014, she first noticed pain and swelling developing in her right knee and that, over the next month or so, the right knee became progressively worse to the point where she could not fully extend it or bend it; experienced locking, weakness and giving way of the right knee. There was almost a two-week gap between 6 November 2014 and the date on which Mrs McCartney first became aware of the development of pain and swelling in her right knee.

168. The first reference to Mrs McCartney’s right knee condition in the Wyoming Medical and Dental Centre clinical records was an entry by her then general practitioner, Dr Jones, on 19 January 2015. This was also consistent with Mrs McCartney’s evidentiary statement. On 2 December 2014, Dr Jones recorded, amongst other things, that Mrs McCartney’s gait was not badly affected. That was the only reference to Mrs McCartney’s gait prior to 19 January 2015.

169. On 5 December 2014, Mrs McCartney consulted Dr Casikar, Neurosurgeon, who did not record a history of injury to the right knee on 6 November 2014. Dr Casikar made no reference to having examined Mrs McCartney’s right knee. Mrs McCartney’s consultation with Dr Casikar took place some two weeks after she first became aware of pain and swelling in her right knee. Dr Casikar recorded that Mrs McCartney’s gait was normal.

170. On 19 January 2015, Dr Jones recorded in Mrs McCartney’s Wyoming Medical and Dental Centre clinical records that her gait problems associated with her lumbar disc lesions appeared to have aggravated her right knee. However, on 6 August 2015, whilst critically analysing Dr Powell’s report, Dr Jones provided an alternative explanation, being that the severe muscle injury of the left calf would have overshadowed any problem in the right knee.

171. On 28 January 2015, Mrs McCartney underwent an x-ray of both knees and an ultrasound of the right knee by Dr Norman, Radiologist. The x-ray of the left knee demonstrated minor degenerative spur formation at the patellofemoral compartment. The x-ray of the right knee demonstrated no evidence of joint space loss; a moderate sized effusion within the suprapatellar bursa; and minor degenerative spur at the patellofemoral compartment. The right knee ultrasound demonstrated a large knee joint effusion; mild prepatellar bursitis; and mild tendinosis affecting the distal peri insertional region of the patella tendon.

172. On 11 February 2015, Mrs McCartney consulted Dr McGrath, Orthopaedic Surgeon in relation to her right knee symptoms. Dr McGrath took a history which included pain in Mrs McCartney’s right knee since November 2014 without any specific event having initiated it. Dr McGrath viewed the available imaging and opined that neither of the findings in the x-ray or ultrasound dated 28 January 2015 correlated clinically and opined that she may have suffered a meniscal injury. He proposed that she undergo an MRI scan of the right knee and undergo an ultrasound-guided steroid and local injection into the right knee. Dr McGrath provided no opinion as to the cause of Mrs McCartney’s right knee symptoms.

[68] ARD at page 2 at [14]

173. On 3 March 2015, Mrs McCartney consulted Dr Ferch, Neurosurgeon/Spinal Surgeon, who did not record a history of injury to the right knee on 6 November 2014. Dr Ferch made no reference to having examined Mrs McCartney's right knee. Dr Ferch focussed on Mrs McCartney's lumbar symptoms and provided no opinion as to the cause of Mrs McCartney's right knee symptoms.

174. On 14 April 2015, Mrs McCartney underwent an MRI scan of her right knee by Dr Christie, Radiologist. Dr Christie concluded that there had been a medial meniscal tear with subsequent early osteoarthritis; joint effusion and synovitis; and minor lateral compartment osteochondral irregularity.

175. On 8 July 2015, Mrs McCartney consulted Dr Powell, Orthopaedic Surgeon, who took a history of right knee symptoms having developed by Mrs McCartney in an insidious fashion whilst at home without any specific precipitating incident. Whilst there was no evidence that Mrs McCartney had been aware of bilateral knee pain for over five years, as reported by Dr Powell, the latter opined that Mrs McCartney had an irritable knee and that her symptoms most likely reflected some underlying degenerative pathology, possibly in association with a medial meniscal tear. However, he was of the opinion that there was no evidence that her current right knee condition was related to her employment and the specific workplace incident of November 2014 involving the lower back. Dr Powell opined that it would be reasonable to conclude that Mrs McCartney was suffering from a disease process involving the right knee which represented a constitutional degenerative pathology. Dr Powell's opinion is consistent with that of Dr Higgs.

176. On 25 September 2015, Mrs McCartney consulted Dr Keller, Occupational Physician. Dr Keller took a history that, about one week or more following the incident on 6 November 2014, Mrs McCartney was troubled by right knee pain and swelling and that the right knee pain was sharp and constant. On examination of Mrs McCartney's right knee, Dr Keller observed a widened joint; mild instability on lateral pressure consistent with osteoarthritic change; and a large effusion. He reported that the right knee was too tender to formally examine.

177. On 4 May 2016, Mrs McCartney consulted Dr Higgs, Orthopaedic Consultant, Biomedical and Forensic Engineer at the request of her former lawyers. Dr Higgs appeared to have been the only medical practitioner who referred to Mrs McCartney's 6 May 2014 right knee x-ray by Dr Lewis, Radiologist, which demonstrated marginal degenerative osteophytosis. Further, Dr Higgs appears to have been the only medical practitioner who took a history of the late October 2014 incident, when Mrs McCartney felt a burning pain on the side of her right knee whilst rolling a resident in bed. Dr Higgs took a detailed history from Mrs McCartney. He recorded, in some detail, the documents and diagnostic imaging he reviewed and commented on them. Dr Higgs' report was thorough and impressive. Dr Higgs concluded that, on the evidence, Mrs McCartney's right knee injury was probably not suffered in the incident on 6 November 2014. There was no "definite"[69] injury to the right knee in the incident on 6 November 2014. He opined that it was evident that Mrs McCartney had suffered from age caused degenerative knee joint osteoarthritic pathology, including a tear to the meniscus, which he concluded was probably causally associated with the attrition to the meniscus that is frequently suffered by those that have developed degenerative osteoarthritis of the knee joint.

178. On 7 November 2016, Mrs McCartney underwent an x-ray of her right knee by Dr Norman, Radiologist, who reported knee joint osteoarthritis with predominant involvement of the medial condylar joint; fairly severe joint space loss at the medial condylar joint with associated varus deformity; and a small effusion in the suprapatellar bursa.

[69] Reply at page 31

179. Mrs McCartney initially consulted Dr John Rooney, Orthopaedic Surgeon on 9 November 2016. Dr Rooney opined that Mrs McCartney had early arthritic change in her left knee and more moderate osteoarthritis in her right knee with meniscal pathology (complex tear).

180. On 28 March 2017, Mrs McCartney underwent an MRI scan of her right knee, which demonstrated extensive tri-compartmental osteoarthritis with tears in the medial meniscus, discoid lateral meniscus and the lateral meniscus appeared to be flipped over.

181. On 29 March 2017, Mrs McCartney consulted Dr Rooney who reviewed her right knee MRI scan dated 28 March 2017. He explained the findings, namely, that the complex tear to the medial meniscus was still present and extruded and that arthritis was affecting the medial tibio-femoral compartment. He recommended that she continue with weight loss and also recommended an injection of local anaesthetic and cortico-steroid into the right knee. He opined that she would eventually undergo surgery to the knee.

182. On 23 May 2017, Mrs McCartney consulted Dr Rooney and reported that the injection of local anaesthetic and cortico-steroid into her right knee joint was of no great benefit. Dr Rooney explained the available options which included medication for pain relief, use of a walking stick, weight loss, analgesia or a knee replacement. Mrs McCartney expressed a preference for a surgical solution. Dr Rooney's evidence provided no causal link between Mrs McCartney's right knee condition and the incident on 6 November 2014.

183. On 12 July 2017, Mrs McCartney consulted Professor Ghabrial, Orthopaedic and Spinal Surgeon at the request of her current lawyers. Apart from Dr Jones, who opined, as a second alternative, that Mrs McCartney had sustained an injury to her right knee on 6 November 2014, which was masked by the pain caused by the severe muscle injury to her left calf, Professor Ghabrial was the only medical practitioner who opined that Mrs McCartney had sustained an injury to her right medial meniscus on 6 November 2014 with the subsequent development of degenerative changes in the medial compartment of the right knee, which continued to deteriorate. In a second supplementary report, Professor Ghabrial could not explain the delayed onset of symptomology in the right knee but suggested that the severity of Mrs McCartney's back pain at that time may have been a priority and that such an occurrence was not uncommon. I found both Professor Ghabrial's explanation of back pain masking the right knee pain and Dr Jones' explanation of left calf pain masking the right knee pain unconvincing. There is no evidence to support these assumptions. It appeared that Professor Ghabrial did not have the benefit of reviewing either the x-ray or x-ray report by Dr Lewis dated 6 May 2014. He did not refer to the x-rays of both knees and the ultrasound of the right knee performed on 28 January 2015 by Dr Norman. Professor Ghabrial's initial report lacked the detail one would expect in a forensic medical report.

184. Rule 15.2(3) of the Workers Compensation Commission Rules 2011 provides that "evidence based on speculation or unsubstantiated assumptions is unacceptable." Further, it is well established in the authorities such as *Paric v John Holland (Constructions) Pty Ltd*[70] (*Paric*); *Makita (Australia) Pty Ltd v Sprowles*[71] (*Makita*); *South Western Sydney Area Health Service v Edmonds*[72] (*Edmonds*); and *Hancock v East Coast Timbers Products Pty Ltd*[73] (*Hancock*); that there must be a "fair climate" upon which a doctor can base an opinion. Whilst it is accepted that a doctor does not need to provide elaborate or detailed explanations for his conclusion, one needs more than a mere "ipse dixit" (an assertion without proof) and that seems to be precisely what Professor Ghabrial has done in this matter, as has Dr Jones in relation to his explanation of left calf pain masking the right knee pain. I agree with the respondent's submission that there was no "fair climate" upon which Professor Ghabrial could base his opinion of a frank injury to the right knee on 6 November 2014.

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[70] *Paric v John Holland (Constructions) Pty Ltd* [1985] HCA
[71] *Makita (Australia) Pty Ltd v Sprowles* [2001] NSWCA 305; 52 NSWLR 705
[72] *South Western Sydney Area Health Service v Edmonds* [2007] NSWCA 16; 4 DDCR 421
[73] *Hancock v East Coast Timbers Products Pty Ltd* [2011] NSWCA 11; 80 NSWLR 43

185. I prefer the opinion of Dr Higgs over that of Professor Ghabrial for the reasons referred to above, namely, that there was no injury to Mrs McCartney's right knee in the incident on 6 November 2014. Such opinion was consistent with that of Dr Powell, namely, that there was no evidence that Mrs McCartney's current right knee condition was related to her employment and the specific workplace incident of November 2014 involving the lower back.

186. Further, I accept Dr Higgs' opinion that Mrs McCartney had suffered from age caused degenerative knee joint osteoarthritic pathology, including a tear to the meniscus, which he concluded was probably causally associated with the attrition to the meniscus that is frequently suffered by those that have developed degenerative osteoarthritis of the knee joint. Such opinion was consistent with that of Dr Powell, namely, that Mrs McCartney was suffering from a disease process involving the right knee which represented a constitutional degenerative pathology.

187. There is no evidence to support Mrs McCartney's submission that she sustained a slight tear in the right medial meniscus on 6 November 2014, which became worse over time. I prefer and accept Dr Higgs' opinion of the tear being associated to the attrition to the meniscus suffered from her age caused degenerative knee joint osteoarthritic pathology.

188. On the basis of the above evidence and reasoning, Mrs McCartney has failed to discharge the onus she bears in establishing her case on the balance of probabilities.
189. Accordingly, I am not satisfied on the balance of probabilities, to a degree of actual persuasion or affirmative satisfaction, that Mrs McCartney has established that there was a definite or distinct physiological change or disturbance in her right knee in the form of a tear of the right medial meniscus or other physiological change or disturbance arising out of or in the course of her employment with the respondent on 6 November 2014 within the meaning of section 4(a) of the 1987 Act.

Section 4(b)(i) of the 1987 Act

190. I now turn to the issue of whether Mrs McCartney contracted a disease injury (process) arising out of or in the course of employment with the respondent within the meaning of section 4(b)(i) of the 1987 Act on 6 November 2014.

191. As to the meaning of disease, in *Federal Broom Co Pty Ltd v Semlitch*[74] (*Semlitch*), Kitto J said:

> "In its ordinary meaning 'disease' is a word of very wide import, comprehending any form of illness; and there is no reason I can see for reading it in the present context as not extending to mental illness."[75]

192. In *Commissioner for Railways v Bain*[76] Windeyer J stated:

> "The word 'disease' seems to me apt to describe any abnormal physical or mental condition that is not purely transient …"[77]

[74] *Federal Broom Co Pty Ltd v Semlitch* [1964] HCA 34; (1964) 110 CLR 626
[75] *Federal Broom Co Pty Ltd v Semlitch* [1964] HCA 34; (1964) 110 CLR 626 at 632
[76] *Commissioner for Railways v Bain* [1968] HCA 5; 112 CLR 246
[77] *Commissioner for Railways v Bain* [1968] HCA 5; 112 CLR 246 at 272

193. In *Perry v Tanine Pty Ltd t/as Ermington Hotel*[78] (*Perry*), Burke CCJ held carpal tunnel syndrome to be a "disease," saying:

> "In general, it seems to me that carpal tunnel syndrome is a failure of an area of the body to cope with repeated stress imposed upon it and reacts to that stress by developing swelling, pain and loss of function as a consequence. That seems to me to be classically a disease process. Where work is the source of the relevant stress it connotes to me that the worker has received injury either by the contraction or aggravation of a disease."[79]

Perry was referred to with approval in the Court of Appeal by Mason P in *Fletcher International Exports Pty Ltd v Barrow*.[80]

194. Employment must be the main contributing factor to contracting the disease process that is contracted by a worker in the course of employment within the meaning of section 4(b)(i) of the 1987 Act. The word "main" in the phrase "main contributing factor" means "chief" or "principal".[81]

195. As the detailed review of the evidence above confirms, none of the medical opinions in evidence support the proposition that Mrs McCartney contracted a disease process to the right knee in the course of employment with the respondent to which employment was the main contributing factor. Professor Ghabrial opined that Mrs McCartney had sustained a frank injury or injury simpliciter to her right medial meniscus on 6 November 2014 with the subsequent development of degenerative changes in the medial compartment of the right knee, which continued to deteriorate. Dr Jones principally opined a consequential injury to the right knee due to the altered gait resulting from the accepted injury to her lumbar spine. Dr Powell opined that Mrs McCartney was suffering from a disease process involving the right knee which represented a constitutional degenerative pathology unrelated to her work with the respondent. Dr Higgs opined that Mrs McCartney had suffered from age caused degenerative knee joint osteoarthritic pathology, including a tear to the meniscus, which he concluded was probably causally associated with the attrition to the meniscus that is frequently suffered by those that have developed degenerative osteoarthritis of the knee joint and unrelated to her work with the respondent.

196. During the course of submissions, I enquired of counsel for Mrs McCartney, Mr Lucas, whether he pressed injury under the section 4(b)(i) of the 1987 Act. He responded that he could not abandon it. I then requested counsel to direct me to the evidence supporting injury under section 4(b)(i) of the 1987 Act. He did not address me in this regard. Nothing in Mrs McCartney's submissions prior or following my above-mentioned intervention led me to conclude that there was any compelling evidence in support of an injury within the meaning of section 4(b)(i) of the 1987 Act.

197. On the basis of the above evidence and reasoning, Mrs McCartney has failed to discharge the onus she bears in establishing her case on the balance of probabilities in relation to having contracted a disease process to the right knee in the course of employment with the respondent to which employment was the main contributing factor.

198. Accordingly, I am not satisfied on the balance of probabilities to a degree of actual persuasion or affirmative satisfaction, that Mrs McCartney contracted a disease process in her right knee in the course of her employment with the respondent to which such employment was the main contributing factor and I find accordingly.

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[78] *Perry v Tanine Pty Ltd t/as Ermington Hotel* [1998] NSWCC 14; (1998) 16 NSWCCR 253
[79] *Perry v Tanine Pty Ltd t/as Ermington Hotel* [1998] NSWCC 14; (1998) 16 NSWCCR 253 at [57]
[80] *Fletcher International Exports Pty Ltd v Barrow* [2007] NSWCA 244; (2007) 5 DDCR 247.
[81] *Meaney v Office of Environment and Heritage – National Parks and Wildlife Service* [2014] NSWWCC 339 at [138]-[147] and *Wayne Robinson v Pybar Mining Services Pty Ltd* [2014] NSWWCC 248 at [78]-[88]

Section 4(b)(ii) of the 1987 Act

199. I now turn to the issue of whether Mrs McCartney sustained an aggravation, acceleration, exacerbation or deterioration of any disease process arising out of or in the course of employment with the respondent within the meaning of section 4(b)(ii) of the 1987 Act on 6 November 2014.

200. In *Semlitch*, Kitto J said:

> "There is an exacerbation of a disease where the experience of the disease by the patient is increased or intensified by an increase or intensifying of symptoms. The word is directed to the individual and the effect of the disease upon him rather than being concerned with the underlying mechanism".[82]

201. In *Semlitch* Windeyer J said:

> "The question that each [aggravation; acceleration; exacerbation; deterioration] poses is, it seems to me, whether the disease has been made worse in the sense of more grave, more grievous or more serious in its effects upon the patient."[83]

202. In *Semlitch* Windeyer J also posed the following questions:

> "Was the applicant suffering from a disease? If so, was there an aggravation, acceleration, exacerbation or deterioration of it? If so, was her (or his) employment a contributing factor? If so, did a total or partial incapacity for work result from such aggravation, acceleration, exacerbation or deterioration?"[84]

Discussing whether there was "aggravation, acceleration, exacerbation or deterioration" Windeyer J said:

> "… the answer depends upon whether for the sufferer the consequences of his affliction have become more serious".[85]

203. Burke CCJ, applying *Semlitch* in *Cant v Catholic Schools Office*[86] (*Cant*) said:

> "The thrust of these comments is that irrespective of whether the pathology has been accelerated there is a relevant aggravation or exacerbation of the disease if the symptoms and restrictions emanating from it have increased and become more serious to the injured worker."[87]

204. The proper test is whether the aggravation impacted the individual concerned. It is not necessary for the particular disease to be made worse: *Cabramatta Motor Body Repairers (NSW) Pty Ltd v Raymond*[88] (*Raymond*) applying *Semlitch* and *Cant*. In *Raymond*, Roche ADP (as he then was) was satisfied that, on the whole of the evidence, it was open to the Arbitrator to conclude that the worker suffered an aggravation of his occupational asthma, in the sense that the symptoms increased and became more serious while employed.[89]

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[82] *Federal Broom Co Pty Ltd v Semlitch* [1964] HCA 34; (1964) 110 CLR 626
[83] *Federal Broom Co Pty Ltd v Semlitch* [1964] HCA 34; (1964) 110 CLR 626 at 639
[84] *Federal Broom Co Pty Ltd v Semlitch* [1964] HCA 34; (1964) 110 CLR 626 at 638
[85] *Federal Broom Co Pty Ltd v Semlitch* [1964] HCA 34; (1964) 110 CLR 626 at 637
[86] *Cant v Catholic Schools Office* [2000] NSWCC 37; (2000) 20 NSWCCR 88
[87] *Cant v Catholic Schools Office* [2000] NSWCC 37; (2000) 20 NSWCCR 88 at [17]
[88] *Cabramatta Motor Body Repairers (NSW) Pty Ltd v Raymond* [2006] NSWWCCPD 132; (2006) 6 DDCR 79
[89] *Cabramatta Motor Body Repairers (NSW) Pty Ltd v Raymond* [2006] NSWWCCPD 132; (2006) 6 DDCR 79 at [45-47]

205. Roche DP in *Kelly v Western Institute NSW TAFE Commission*[90] (*Kelly*), citing *Semlitch*, said:

> "An aggravation or exacerbation of a disease occurs where the experience of the disease by the applicant is increased or intensified by an increase or intensifying of symptoms."[91]

206. In response to Windeyer J's first question posed in *Semlitch*, there is no doubt on the evidence that Mrs McCartney was suffering from a disease process in her right knee. However, as the detailed review of the evidence above confirms, none of the medical opinions in evidence support the proposition that Mrs McCartney suffered an aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease process to her right knee to which such employment was the main contributing factor.

207. Professor Ghabrial opined that Mrs McCartney had sustained a frank injury or injury simpliciter to her right medial meniscus on 6 November 2014 with the subsequent development of degenerative changes in the medial compartment of the right knee, which continued to deteriorate. Dr Jones principally opined a consequential injury to the right knee due to the antalgic gait resulting from the accepted injury to her lumbar spine. Dr Powell opined that Mrs McCartney was suffering from a disease process involving the right knee which represented a constitutional degenerative pathology unrelated to her work with the respondent. Dr Higgs opined that Mrs McCartney had suffered from age caused degenerative knee joint osteoarthritic pathology, including a tear to the meniscus, which he concluded was probably causally associated with the attrition to the meniscus that is frequently suffered by those that have developed degenerative osteoarthritis of the knee joint and unrelated to her work with the respondent.

208. On the basis of the above evidence and reasoning, Mrs McCartney has failed to discharge the onus she bears in establishing her case on the balance of probabilities in relation to having suffered an aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease process to her right knee to which such employment was the main contributing factor.

209. Accordingly, I am not satisfied on the balance of probabilities to a degree of actual persuasion or affirmative satisfaction, that Mrs McCartney suffered an aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease process to her right knee to which such employment was the main contributing factor and I find accordingly.

Whether Mrs McCartney suffered a consequential injury to her right knee as a result of the accepted lumbar spine injury on 6 November 2014

210. I am required to conduct a common sense evaluation of the causal chain to determine whether the right knee symptoms complained of by Mrs McCartney have resulted from the accepted injuries to her lumbar spine on 6 November 2014.

211. The Commission has considered and explained the difference between an "injury" and a condition that has resulted from an injury in several decisions:

> *Moon v Conmah Pty Ltd* [92]; *Superior Formwork Pty Ltd v Livaja*[93] (*Moon*); *Cadbury Schweppes Pty Ltd v Davis*[94];

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[90] *Kelly v Western Institute NSW TAFE Commission* [2010] NSWWCCPD 71
[91] *Kelly v Western Institute NSW TAFE Commission* [2010] NSWWCCPD 71 at [66]
[92] *Moon v Conmah Pty Ltd* [2009] NSWWCCPD 134 at [43], [45] and [50]
[93] *Superior Formwork Pty Ltd v Livaja* [2009] NSWWCCPD 158 at [122]
[94] *Cadbury Schweppes Pty Ltd v Davis* [2011] NSWWCCPD 4 at [28]-[32] and [39]-[42]

North Coast Area Health Service v Felstead[95];
Australian Traineeship System v Turner[96];
Kumar v Royal Comfort Bedding Pty Ltd[97] (*Kumar*), and
Bouchmouni v Bakos Matta t/as Western Red Services[98].

212. It is unnecessary for me to determine whether Mrs McCartney's right knee symptoms are in themselves 'injuries' pursuant to section 4 of the 1987 Act. In *Moon*, Roche DP observed:

> "It is therefore not necessary for Mr Moon to establish that he suffered an 'injury' to his left shoulder within the meaning of that term in section 4 of the 1987 Act. All he has to establish is that the symptoms and restrictions in his left shoulder have resulted from his right shoulder injury. Therefore, to the extent that the Arbitrator and Dr Huntsdale approached the matter on the basis that Mr Moon had to establish that he sustained an 'injury' to his left shoulder in the course of his employment with *Conmah* they asked the wrong question.
>
> The test of causation in a claim for lump sum compensation is the same as it is in a claim for weekly compensation, namely, has the loss 'resulted from' the relevant work injury (see *Sidiropoulos v Able Placements Pty Limited* [1998] NSWCA 7; (1998) 16 NSWCCR 123; *Rail Services Australia v Dimovski & Anor* [2004] NSWCA; (2004) 1 DDCR 648)."[99]

213. Section 9A of the 1987 Act does not apply to a condition that has resulted from an injury: *Tiritabua v Bartter Enterprises Pty Ltd*[100].

214. In considering the difference between an "injury" and a condition that has resulted from an "injury", the Commission has consistently applied the principles in *Kooragang*.

215. The respondent drew my attention to *Kirunda v State of New South Wales (No 4)*[101] where Snell DP stated:

> "In *Kooragang Cement Pty Ltd v Bates* Kirby P said that causation 'is a question of fact to be determined on the basis of the evidence, including, where applicable, expert opinions'.[102] A finder of fact, dealing with issues of causation, is entitled to 'have some recourse' to 'the sequence of events and commonsense'.[103] However, where an 'issue lies outside the realm of common knowledge and experience' it 'falls to be determined by reference to expert medical evidence'.[104] In *Lithgow City Council v Jackson* the plurality said, of a finding on causation:
>
> > 'That proposition is not self-evident. To establish it would call for more than the application of 'commonsense' or the court's experience of ordinary life. The proposition turns on an inference from the nature of the respondent's injuries to their probable cause. That inference could only be drawn in the light of expert medical evidence.'"[105]

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[95] *North Coast Area Health Service v Felstead* [2011] NSWWCCPD 51 at [84]
[96] *Australian Traineeship System v Turner* [2012] NSWWCCPD 4 at [28] and [29]
[97] *Kumar v Royal Comfort Bedding Pty Ltd* [2012] NSWWCCPD 8 at [35]–[49] and [61])
[98] *Bouchmouni v Bakos Matta t/as Western Red Services* [2013] NSWWCCPD 4
[99] *Moon v Conmah Pty Ltd* [2009] NSWWCCPD 134 at [45-46]
[100] *Tiritabua v Bartter Enterprises Pty Ltd* [2008] NSWWCCPD 145 at [47]
[101] *Kirunda v State of New South Wales (No 4)* [2018] NSWWCCPD 45 at [136]
[102] (1994) 35 NSWLR 452, 464B.
[103] *Hevi Lift (PNG) Ltd v Etherington* [2005] NSWCA 42; 2 DDCR 271, [89] (per McColl JA, Mason P and Beazley JA agreeing).
[104] *Tubemakers of Australia Ltd v Fernandez* (1976) 50 ALJR 720, 724E (per Mason J, Barwick CJ and Gibbs J agreeing).
[105] *Lithgow City Council v Jackson* [2011] HCA 36; 244 CLR 352; 281 ALR 223; 85 ALJR 1130, [66].

216. Professor Ghabrial opined that Mrs McCartney had sustained a frank injury or injury simpliciter to her right medial meniscus on 6 November 2014 with the subsequent development of degenerative changes in the medial compartment of the right knee, which continued to deteriorate. Dr Powell opined that Mrs McCartney was suffering from a disease process involving the right knee which represented a constitutional degenerative pathology unrelated to her work with the respondent. Dr Higgs opined that Mrs McCartney had suffered from age caused degenerative knee joint osteoarthritic pathology, including a tear to the meniscus, which he concluded was probably causally associated with the attrition to the meniscus that is frequently suffered by those that have developed degenerative osteoarthritis of the knee joint and unrelated to her work with the respondent.

217. It was only Mrs McCartney's general practitioner, Dr Jones, who opined that she had sustained a consequential injury to the right knee due to her antalgic gait resulting from the accepted injury to her lumbar spine. In Dr Jones' opinion, Mrs McCartney's right knee symptoms "appeared"[106] to have been aggravated by the gait problems associated with the disc lesions to her lower back. On 2 December 2014, Dr Jones recorded, amongst other things, that Mrs McCartney's gait was not badly affected. That was the only reference to Mrs McCartney's gait prior to 19 January 2015. On 5 December 2014, Dr Casikar recorded that Mrs McCartney's gait was normal. Mrs McCartney submitted that Dr Jones provided a compelling contemporaneous chain of causation. I do not agree. I find Dr Jones' comments in the clinical records unconvincing. Then, on 6 August 2015, Dr Jones provided a second proposition, namely, that on 6 November 2014, there was a masking of the right knee pain by the lumbar spine injury, the radiation of pain into the left leg and the left calf muscle tear. Whilst the latter proposition was somewhat consistent with Dr Ghabrial's conclusion, I do not accept it for the reasons previously stated. There was no specialist medical evidence supporting the allegation that the right knee symptoms complained of by Mrs McCartney were consequential to the accepted injury to her lumbar spine on 6 November 2014.

218. I prefer the opinion of Dr Higgs, an orthopaedic consultant, a biomedical and forensic engineer, who provided an analysis of his reasoning in reaching the conclusion he came to for the reasons previously stated. Dr Powell's opinion was consistent with that of Dr Higgs. It is in the light of Dr Higgs' expert medical evidence that I have concluded that I am not satisfied that Mrs McCartney has discharged the onus of proving, on the balance of probabilities, that there is a sufficient causal chain connecting the condition of her right knee to the accepted injury to the lumbar spine on 6 November 2014.

219. Therefore, having regard to the whole of the evidence, applying a common sense test and for the reasons referred to above, I am not satisfied that Mrs McCartney has discharged the onus of proving on the balance of probabilities that there is a sufficient causal chain connecting the condition of her right knee to the accepted injury to the lumbar spine on 6 November 2014 and I find accordingly.

Mrs McCartney's entitlement to weekly benefits under section 37 of the 1987 Act

220. Section 33 of the 1987 Act provides that if total or partial incapacity for work results from an injury, the compensation payable by the employer under the Act to the injured worker shall include weekly payments during the period of incapacity.

221. An assessment of Mrs McCartney's capacity as a result of her accepted lumbar spine injury involves a consideration of whether she had no current work capacity or a current work capacity as defined in section 32A of the 1987 Act during the closed period claimed.

[106] Respondent's Application to Admit Late Documents dated 16 July 2019 at page 37

222. Section 32A of the 1987 Act defines the relevant terms as follows:

> "**current work capacity**, in relation to a worker, means a present inability arising from an injury such that the worker is not able to return to his or her pre-injury employment but is able to return to work in suitable employment.
>
> **no current work capacity**, in relation to a worker, means a present inability arising from an injury such that the worker is not able to return to work, either in the worker's pre-injury employment or in suitable employment.
>
> **suitable employment**, in relation to a worker, means employment in work for which the worker is currently suited:
>
> a. having regard to:
>
> (i) The nature of the worker's incapacity and the details provided in medical information including, but not limited to, any certificate of capacity supplied by the worker (under section 44B), and
> (ii) the worker's age, education, skills and work experience, and
> (iii) any plan or document prepared as part of the return to work planning process, including an injury management plan under Chapter 3 of the 1998 Act, and
> (iv) any occupational rehabilitation services that are being, or have been, provided to or for the worker, and
> (v) such other matters as the WorkCover Guidelines may specify, and
>
> b. regardless of:
>
> (i) whether the work or the employment is available, and
> (ii) whether the work or the employment is of a type or nature that is generally available in the employment market, and
> (iii) the nature of the worker's pre-injury employment, and
> (iv) the worker's place of residence."

223. Section 43 of the 1987 Act in existence prior to the 2012 amending Act and the authorities suggested that regard was to be had to "the realities of the labour market in which the employee was working or might reasonably be expected to work".[107]

224. Since the 2012 amending Act, it is clear that "total incapacity" differs from "no current work capacity". "No current work capacity" requires a consideration of the worker's capacity to undertake not only his or her pre-injury duties, but also suitable employment, irrespective of its availability. This was confirmed by Roche DP in *Mid North Coast Local Health District v De Boer*[108]and in *Wollongong Nursing Home Pty Ltd v Dewar*[109] (*Dewar*).

225. In *Dewar*, Roche DP stated:

> "… employment for which the worker is currently suited is determined 'regardless of' whether the work or employment is 'available' and regardless of whether it is 'of a type or nature that is generally available in the employment market'. However, other aspects of *Lawarra Nominees* and *Woods* remain relevant in determining whether a worker is 'suited' for suitable employment.[110]

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[107] *Arnott's Snack Products Pty Ltd v Yacob* [1985] HCA 2; 155 CLR 171
[108] *Mid North Coast Local Health District v De Boer* [2013] NSWWCCPD 41
[109] *Wollongong Nursing Home Pty Ltd v Dewar* [2014] NSWWCCPD 55
[110] *Dewar* at [56]

> However, while the new definition of suitable employment has eliminated the geographical labour market from consideration, it has not eliminated the fact that 'suitable employment' must be determined by reference to what the worker is physically (and psychologically) capable of doing, having regard to the worker's 'inability arising from an injury'. Suitable employment means 'employment in work for which the worker is currently suited' … However, whether, under the new provisions, he or she would be found to have no current work capacity will depend on a realistic assessment of the matters listed at (a) and (b) of the definition of suitable employment. Depending on the evidence, it is difficult to see that work tasks that are totally artificial, because they have been made up in order to comply with an employer's obligations to provide suitable work under s 49 of the 1998 Act, and do not exist in any labour market in Australia, will be suitable employment."[111]

226. If Mrs McCartney has 'no current work capacity' as has been submitted by her counsel, I must assess whether she was able to return to both her pre-injury duties and suitable employment since 1 November 2015.

227. The preponderance of the medical evidence that expressed an opinion as to fitness for pre-injury duties (Dr Higgs, Dr Casikar and Dr Powell) concluded that, even only in relation to the injury to her lumbar spine, Mrs McCartney would have had no capacity for her pre-injury duties for the period claimed and beyond. I accept that Mrs McCartney would have had no capacity for her pre-injury duties for the period claimed and find accordingly.

228. The next matter for consideration is whether Mrs McCartney was fit for suitable employment as defined in section 32A of the 1987 Act. This requires a consideration of the nature of the incapacity and the details provided in medical information, the worker's age, education, skills and work experience, any return to work plan and any occupational rehabilitation services that have been provided, irrespective of whether the work is available to her or of a type or nature that is generally available in the employment market.

229. Mrs McCartney is a 57-year-old woman who, since leaving school had predominantly worked as an aged care worker in various facilities over the years. She had significant experience in aged care. Mrs McCartney's usual duties involved assisting residents with personal care and medication and was often involved in prolonged standing during the course of a shift, frequent bending and pushing of heavy items. On the day of her injury, she completed her shift by undertaking administrative duties.

230. There was no injury management plan, rehabilitation plan or other document prepared as part of a return to work planning process in evidence. The unchallenged evidence is that Mrs McCartney no longer undertakes any structured treatment program for her lower back and has not done so since September 2015. She currently takes Targin and Lyrica for pain relief and Tramal when required. Since 6 November 2014, she has been unable to drive a motor vehicle and experiences difficulty travelling in a motor vehicle for more than 20 minutes at a time due to the pain and discomfort associated with prolonged sitting. She suffers from ongoing severe low back pain radiating into her left buttock, left leg and left foot. She experiences a reduced range of motion and reduced sensation in her left leg down to her toes and regularly experiences 'pins and needles' in both feet together with swelling in both ankles.

[111] *Dewar* at [57]-[60]

231. On 7 April 2015, Dr Ferch opined that, in relation to her lumbar spine, it would be best for Mrs McCartney to be restricted to a graduated return to work as tolerated, commencing four hours per day on alternate days (12 hours per week) with a lifting restriction of less than 5 kg, which could be increased as tolerated.

232. On 12 July 2017, Professor Ghabrial opined that, in relation to her lumbar spine, Mrs McCartney remained restricted indefinitely for activities involving any lifting over 5 kg, excessive bending and excessive twisting of the back. He made no reference to her work capacity in terms of hours per week.

233. On 4 May 2016, Dr Higgs opined that, in relation to her lumbar spine, Mrs McCartney was only fit for part-time restricted work of a clerical and/or supervisory nature in an office environment at between six and nine hours per week, but for not more than two to three hours on any single occasion. Any such return to work should be on a graduated basis and under the care and supervision of her general practitioner. Dr Higgs cautioned that Mrs McCartney ought to avoid any activity that was known by her to aggravate her symptoms; repetitive and/or frequent bending, stooping and/or twisting manoeuvres of the lumbosacral spine; negotiating steps, stairs, slopes, ladders and uneven ground; frequent and/or repetitive kneeling, squatting or stooping activities; prolonged standing and walking.

234. On 9 July 2015, Dr Powell opined that, in relation to her lumbar spine, Mrs McCartney should be placed on suitable duties with a lifting restriction of 10 kg and instructions to avoid repetitive bending, lifting or twisting manoeuvres; prolonged standing and walking. He recommended that she alternate her tasks where possible and take regular breaks. He opined that reduced hours would be appropriate, namely, five to six hours per day, four to five days per week (20 hours to 30 hours per week).

235. On 25 September 2015, Dr Keller opined that Mrs McCartney should have been able to work at least three hours per day, five days per week in a sedentary role (15 hours per week).

236. Mr Beran, counsel for the respondent, quite properly conceded that it was indisputable that there was some form of incapacity in relation to Mrs McCartney's accepted back injury. Mrs McCartney submitted that there should be a finding of no residual earning capacity. However, in the alternative, it would be appropriate to adopt the medical opinion that puts forward the least residual earning capacity. The parties suggested that adopting the National Minimum Wage Order would be appropriate. The respondent initially suggested the appropriate rate as being $18 or $19 per hour in suitable employment within the meaning of section 32A of the 1987 Act but, later in submissions and for ease of calculation, put forward the rate of $20 per hour. The relevant Fair Work Commission National Minimum Wage Orders are those dated 1 July 2015 (being $656.90 per week or $17.29 per hour) and 1 July 2016 (being $672.70 per week or $17.70 per hour). I propose to average the latter two hourly rates ($17.50) and then round it up to $18 for the whole of the period claimed.

237. The evidence in relation to Mrs McCartney's current work capacity for the period claimed, ranged from six hours per week (Dr Higgs) to 30 hours per week (Dr Powell). I prefer the detailed opinion of Dr Higgs in this regard and accept the higher assessment in the range he provided of nine hours current work capacity per week. I find that Mrs McCartney had a current work capacity in suitable employment within the meaning of section 32A of the 1987 Act for part-time work of a clerical and/or supervisory nature in an office environment at nine hours per week at the rate of $18 per hour, being $162 per week.

238. Accordingly, having regard to Mrs McCartney's evidentiary statement, the medical evidence as to her capacity, her age, skills, work experience and the other relevant factors to be considered in accordance with section 32A of the 1987 Act, I am satisfied on the balance of probabilities that she had a current work capacity in the period 1 November 2015 to 25 April 2017 of nine hours per week in duties of a clerical and/or supervisory nature in an office environment.

239. Mrs McCartney has not worked since the incident on 6 November 2014. It appeared that she was paid weekly benefits compensation by the respondent's insurer until 31 October 2015. Mrs McCartney's claim for weekly benefits compensation is made pursuant to section 37(3) of the 1987 Act and is for the closed period 1 November 2015 to 25 April 2017, the latter date being the agreed end of the second entitlement period. The PIAWE was agreed at $801. This amount does not exceed the statutory maximum referred to in section 34 of the 1987 Act. The PIAWE is indexed every six months in accordance with section 82A of the 1987 Act.

240. The parties did not make any submissions in relation to any adjustment to be made in relation to pecuniary benefits (overtime and shift allowance) after 52 weeks in accordance with section 44C(1)(b) of the 1987 Act. There is no evidence before me of any non-pecuniary benefits.

241. Section 35(1) of the 1987 Act provides definitions of the terminology used in the quantification of an injured worker's weekly payments as follows:

> "**'AWE'** means the worker's pre-injury average weekly earnings.
>
> **'D'** (or a **'deductible amount'**) means the sum of the value of each non-pecuniary benefit (if any) that is provided by the employer to a worker in respect of that week (whether or not received by the worker during the relevant period), being a non-pecuniary benefit provided by the employer for the benefit of the worker or a member of the family of the worker.
>
> **'E'** means the amount to be taken into account as the worker's earnings after the injury, calculated as whichever of the following is the greater amount:
>
> (a) the amount the worker is able to earn in suitable employment,
>
> (b) the workers current weekly earnings.
>
> **'MAX'** means the maximum weekly compensation amount."

242. The second entitlement period is that of 117 weeks, postdating the initial 13 weeks. Weekly payments during the second entitlement period is governed by section 37 of the 1987 Act, which provides:

> "**37 Weekly payments in second entitlement period (weeks 14-130)**
>
> (1) The weekly payment of compensation to which an injured worker who has no current work capacity is entitled during the second entitlement period is to be at the rate of:
>
> (a) (AWE x 80%) – D), or
>
> (b) MAX – D,
>
> whichever is the lesser.
>
> (2) The weekly payment of compensation to which an injured worker who has current work capacity and has returned to work for not less than 15 hours per week is entitled during the second entitlement period is to be at the rate of:

(a) (AWE x 95%) – (E + D), or

(b) MAX – (E + D),

whichever is the lesser.

(3) The weekly payment of compensation to which an injured worker who has current work capacity and has returned to work for less than 15 hours per week (or who has not returned to work) is entitled during the second entitlement period is to be at the rate of:

(a) (AWE x 80%) – (E + D), or

(b) MAX – (E + D),

whichever is the lesser."

243. In accordance with section 37(3) of the 1987 Act, Mrs McCartney's entitlement to weekly compensation during the second entitlement period from 1 November 2015 to 25 April 2017 is as follows:

$801 x 80% = $640.80 – $162 + 0 = $478.80 per week

244. Mrs McCartney will be entitled to an award for the period claimed in accordance with the above calculations and the respondent will need to make the appropriate adjustments pursuant to sections 82A and 44C(1)(b) of the 1987 Act.

245. I grant the parties liberty to apply within 14 days in relation to the calculation of weekly benefits.

Mrs McCartney's entitlement to treatment expenses under section 60 of the 1987 Act

246. As Mrs McCartney has received an award in her favour in relation to the injury to her lumbar spine, she is entitled to recover the cost of reasonably necessary medical, hospital and related expenses pursuant to section 60 of the 1987 Act for the same and I make a general order in this regard.

SUMMARY

247. Mrs McCartney did not suffer an injury to the right knee on 6 November 2014 within the meaning of sections 4(a) and 9A of the 1987 Act.

248. Mrs McCartney did not suffer an injury to the right knee on 6 November 2014 within the meaning of section 4(b) of the 1987 Act.

249. Mrs McCartney did not suffer a consequential injury to the right knee as a result of the accepted injury to the lumbar spine on 6 November 2014.

250. Mrs McCartney had a current work capacity during the period 1 November 2015 to 25 April 2017 in relation to the accepted lumbar spine injury on 6 November 2014 within the meaning of section 32A of the 1987 Act in suitable employment at the rate of $162 per week.

251. Award for the respondent in relation to the alleged injury to the right knee on 6 November 2014.

252. Award for the respondent in relation to the alleged consequential injury to the right knee as a result of the accepted injury to the lumbar spine on 6 November 2014.

253. The respondent is to pay Mrs McCartney weekly compensation in respect of the accepted lumbar spine injury on 6 November 2014 as follows:

    (a) $478.80 per week from 1 November 2015 to 25 April 2017 pursuant to section 37(3) of the 1987 Act.

    (b) The respondent to be given credit for any payments made.

    (c) Liberty to apply within 14 days in relation to the calculation of weekly benefits.

254. The respondent is to pay Mrs McCartney's reasonably necessary medical and related expenses as a result of the accepted lumbar spine injury pursuant to section 60 of the 1987 Act.