WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**4469/19**
Applicant:	**Sean Francis Hayes**
Respondent:	**Andrew Kelly & Kevin French t/as Kelly & French Painting Contractors**
Date of Determination:	**30 October 2019**
Citation:	**[2019] NSWWCC 352**

The Commission determines:

1. The applicant sustained injury to his neck arising out of or in the course of his employment with the respondent on 28 January 1998.

2. The applicant's employment was a substantial contributing factor to his injury.

3. The anterior cervical discectomy and fusion performed by Dr Winder, and associated expenses, was reasonably necessary treatment as a result of the injury arising out of or in the course of his employment with the respondent on 28 January 1998.

The Commission orders:

4. Claim for weekly compensation and medical expenses is adjourned.

5. I remit this matter to the Registrar for referral to an Approved Medical Specialist pursuant to section 321 of the *Workplace Injury Management and Workers Compensation Act 1998* for assessment due to injury sustained on 28 January 1998 as follows:

   (a) Table of Disabilities:

      (i) permanent impairment of the neck;
      (ii) loss of use of the right arm at or above the knee including any loss below the elbow, and
      (iii) loss of use of the left arm at or above the knee including any loss below the elbow.

   (b) Whole Person Impairment for the purpose of a determination as to whether the applicant is a worker with high or highest needs:

      (i) cervical spine;
      (ii) right upper extremity, and
      (iii) left upper extremity.

6. The documents to be reviewed by the Approved Medical Specialist are:

   (a) Application to Resolve a Dispute and attachments;
   (b) Reply with attached documents;
   (c) Application to Admit Late Documents received on 21 October 2019, and
   (d) Application to Admit Late Documents received on 21 October 2019.

7. The matter is to be listed for a telephone conference before me once the Medical Assessment Certificate is issued to the parties to deal with the balance of the claim.

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

Glenn Capel
Senior Arbitrator

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

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Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Sean Francis Hayes (the applicant) is 52 years old and was employed by Andrew Kelly & Kevin French t/as Kelly & French Painting Contractors (the respondent) as a painter. Details of the period that he was employed by the respondent are unknown.

2. The applicant submitted a claim form on 2 March 1998 alleging that he injured his head and neck when a scaffold plank slipped and fell on him on 28 January 1997 [sic 1998]. He was apparently off work for two or three weeks and then resumed his normal duties. It is unclear whether any weekly compensation or medical expenses were paid.

3. A claim for weekly compensation, medical expenses and lump sum compensation was made in 2001 and proceedings were filed in the Compensation Court on 14 November 2001.

4. On 4 December 2002, the respondent agreed to pay the applicant $10,000 in respect of 25% permanent impairment of the neck pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act), $3,000 pursuant to s 67 of the 1987 Act and medical expenses pursuant to s 60 of the 1987 Act due to injury sustained on 28 January 1998. There was an award for the respondent in respect of the claims for loss of use of the arms and the claim for weekly compensation was withdrawn.

5. A further lump sum claim was made on 29 December 2011 and this was resolved on 29 February 2012. The applicant received compensation in respect of a further 5% permanent impairment of the neck,15% loss of use of the left arm at or above the elbow including any loss below the elbow and 5% loss of use of the right arm at or above the elbow including any loss below the elbow together with compensation for further pain and suffering.

6. Curiously, on 17 December 2014, the prior insurer, CGU Workers Compensation NSW Ltd (CGU) issued a notice pursuant to s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act), disputing that the applicant had sustained an injury to his neck or an aggravation of a disease on 28 January 1998 and that his employment was a substantial contributing factor to his condition. It denied that the surgical treatment proposed by Dr Winder was reasonably necessary. It cited ss 4, 9A and 60 of the 1987 Act. In the alternative, it alleged that the applicant had recovered from any injury.

7. On 1 May 2015, the applicant's solicitor served a Notice of Claim on CGU with respect to weekly compensation. Proceedings commenced in the Workers Compensation Commission (the Commission) for weekly compensation, medical expenses and proposed surgery. These proceedings were discontinued on 14 July 2016 after an Approved Medical Specialist (AMS), Dr Stubbs, provided a non-binding opinion that the surgery proposed by Dr Winder was not reasonably necessary.

8. On 28 May 2019, the applicant's solicitor served a Notice of Claim for weekly compensation, medical expenses and lump sum compensation on AAI Ltd t/as GIO (the insurer) who had taken over management of the applicant's claim.

9. On 19 June 2019, the insurer issued a notice pursuant to s 78 of the 1998 Act, disputing that the applicant's employment was the main contributing factor to a disease or an aggravation of a disease. It denied that the applicant was incapacitated and that it was liable to pay for medical expenses. It also disputed that the surgery undertaken by Dr Winder was reasonably necessary. It cited ss 4(b), 33, 59 and 60 of the 1987 Act. In the alternative, it alleged that the applicant had no entitlement to weekly compensation because he had been in receipt of maximum weekly compensation for another injury.

10. On 12 August 2019, the insurer issued a further dispute notice pursuant to s 78 of the 1998 Act in similar terms. It also alleged that the applicant's claim for weekly compensation had not been duly made and that he did not pass the threshold for the purposes of a claim for Work Injury Damages. It cited ss 4b, 33, 59, 60, 66 and 151H of the 1987 Act and ss 71 and 282 of the 1998 Act.

11. By an Application to Resolve a Dispute (the Application) registered in the Commission on 30 August 2019, the applicant claims weekly compensation, medical expenses and lump sum compensation due to injury sustained to his neck and arms on 28 January 1998.

ISSUES FOR DETERMINATION

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

    (a) whether the cervical discectomy and fusion was reasonably necessary as a result of the injury sustained on 28 January 1998;

    (b) extent and quantification of the applicant's entitlement to weekly compensation;

    (c) the respondent's liability in respect to medical expenses, and

    (d) quantification of lump sum compensation.

PROCEDURE BEFORE THE COMMISSION

13. 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

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

    (a) The Application and attached documents;
    (b) First Respondent's Reply and attached documents;
    (c) Application to Admit Late Documents received 21 October 2019, and
    (d) Application to Admit Late Documents received 21 October 2019.

Oral evidence

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

REVIEW OF EVIDENCE

Applicant's statements

16. The applicant provided a statement on 20 December 2011. He confirmed that he injured his head and neck when he was struck by an aluminium plank on 28 January 1998. He attended Orange Base Hospital and x-rays were taken of his cervical spine. The applicant was treated with physiotherapy and he was off work for three or four weeks. He returned to his usual duties.

17. The applicant stated that he continued to experience neck pain so he consulted Dr Matthews, who prescribed anti-inflammatory medication. He was referred to Dr Worsley on 17 January 2001 and he prescribed injections which provided some relief.

18. The applicant stated that he worked for another company from 1999 to 2005. He then obtained employment with Wayne Wilson Painting. He suffered a back strain in April 2007, a fractured elbow and a hip injury on 14 May 2008, and on 1 July 2008, he suffered an injury to his left knee and back when scaffolding collapsed from under him. He attended Orange Base Hospital and consulted Drs Leslie, Cooney and Mutton.

19. Dr Mutton referred him for a CT scan of his neck and MRI scans of his thoracic and lumbar spines. He ceased work on 16 July 2009 and on 6 October 2009, the doctor performed an L3/4 discectomy. On 25 August 2010, Dr Ashton performed a left knee reconstruction.

20. The applicant indicated that he had always experienced pain in his neck extending into his shoulders and arms since his injury and he had developed headaches earlier in the year. He had pain and stiffness in his neck, weakness in his right arm and his symptoms caused problems with his sleep.

21. In his statement dated 19 December 2014, the applicant confirmed that he had experienced pain and stiffness in his neck and soreness and stiffness in the back of his shoulders and numbness and pain in his arms. He confirmed that he wished to undergo the surgery proposed by Dr Winder. He took issue with the history recorded in the report of Dr Casikar and also questioned the manner in which the doctor conducted the consultation and his opinion. The applicant confirmed that he had not performed his pre-injury duties until his 2008 injury.

22. In his statements dated 10 November 2015 and 9 December 2015, the applicant advised that there had been no change in his condition. He confirmed that he only injured his back and left knee in 2008 and he had not injured his neck. His neck pain was persistent and was getting worse. His arm symptoms had been present since 1998 and were not aggravated in 2008.

23. In his statement dated 16 May 2016, the applicant stated that he was directed to avoid overhead painting and his duties were restricted to prepping, cutting in and working low to the ground. He did similar work at his next employer and with Wayne Wilson Painting. He stated that he had suffered no further injury to his neck since 1998 and he had tried to avoid flexing and moving his neck due to pain. He had seen Dr Winder on 12 May 2016 and he had strongly recommended surgery.

24. Finally, in his statement dated 27 August 2019, the applicant stated that he had taken a number of his radiological tests to the appointment with Dr Casikar, but the doctor had only viewed two scans. He indicated that Dr Casikar had questioned Dr Winder's motives for the surgery. The doctor told the applicant that his neck injury was not work related and he declined to look at earlier medical evidence because his machine was not working.

Clinical notes and reports of Dr Matthews Dr Worsley and Dr Smith

25. The clinical notes of Dr Matthews commence on 4 June 1993 and conclude in November 2006. On 11 February 1998, Dr Matthews recorded that the applicant had been struck by a plank on the head two weeks earlier and he had neck pain and stiffness. He was prescribed medication and was referred for physiotherapy. There were further complaints of neck pain and morning stiffness on 12 June 1998.

26. On 1 May 2000, Dr Matthews recorded that the applicant had pain in the mid cervical spine referred into his shoulders, but there was no paraesthesiae. On 5 June 2000, the doctor recorded that the applicant had neck pain and he noted the results of diagnostic tests.

27. There were further entries relating to neck pain on 4 May 2001 after rolling ceilings and painting windows, 20 July 2001, 5 May 2002 after a day's work, on 12 January 2004 after a "mva roll over". The remaining entries are illegible.

28. On 15 January 2001, Dr Matthews referred the applicant to Dr Worsley. In the letter of referral, the doctor noted that the applicant had been troubled by occipital pain and headaches after looking up when painting ceilings. This was on the background of a head and neck injury 2.5 years earlier.

Reports of Dr Worsley and Dr Smith

29. In a report dated 17 January 2001, Dr Worsley noted that following the incident, the applicant had experienced constant cervical pain and pain in his lower thoracic region. He also had bi-occipital headaches.

30. Dr Worsley believed that the applicant had developed some cervical facet joint arthritic degeneration and he gave the applicant a steroid injection to the C3/4 and C4/5 apophyseal joints.

31. In his report dated 9 July 2002, Dr Worsley noted that the applicant had recurrent right cervical pain and right cervicogenic headaches. He experienced headaches on flexion and extension of his neck, particularly when painting ceilings. He had intermittent right arm pain and he was tender over the right C4/5 apophyseal joint.

32. Dr Robert Smith was qualified by CGU and reported on 26 July 2001. He recorded that the applicant was off work for two weeks following the incident. He performed light duties for four months and he then resumed his normal work. He ceased working for the respondent in 1999 due to insufficient work. He had subsequently worked on a fulltime basis for other painting companies.

33. Dr Smith considered that the applicant had recovered from the injury sustained in 1998 and that he was fit for full work.

Report of Dr Mutton and Associate Professor Siddle

34. Dr Mutton reported on 24 November 2010. He noted that the applicant was struck by a falling plank on his head, neck and back in 1997 [sic 1998]. X-rays were normal and the applicant had physiotherapy.

35. Dr Mutton reported that the applicant injured his right elbow, hip and back when he fell from a ladder on 14 May 2008. He was prescribed medication and returned to work. On 2 July 2008, a trestle collapsed and he fell onto his left knee and struck his shoulder and head on a brick wall. He attended Orange Base Hospital and consulted Dr Leslie. Dr Bosanquet performed a left anterior cruciate ligament reconstruction in 2007 and a repeat procedure was performed by Dr Ashton in August 2010.

36. Dr Mutton noted that a CT scan dated 5 May 2008 showed minor posterior disc bulges and mild facet joint degeneration. He also noted the findings of the scans of the applicant's lumbar spine and the treatment that he had received for his low back injury. He doubted that the applicant would be able to work due to his back condition.

37. In a report dated 7 June 2011, Associate Professor Siddall recorded that the applicant had experienced neck pain since his injury in 2000 [sic 1998]. The applicant described continuous stabbing pain extending to the elbows and paraesthesiae in his hands. He stated that the applicant had some possible facet joint involvement and secondary muscle changes in his neck. He recommended a pain management programme.

Report of Dr Ellis

38. Dr Ellis reported on 15 November 2011. His focus was on the applicant's back injuries, but he noted that the applicant had suffered intermittent pain in his neck since the incident on 28 January 1998. He was off work for about four months and he had been able to return to normal work. The applicant's neck pain had increased over the past nine months and he had felt a crunching sensation, with pain extending down his left shoulder and upper arm. He had numbness and paraesthesiae in his hands. There had been no further neck injury. The applicant had ceased all work on 16 July 2008 following the last back injury.

39. Dr Ellis noted the radiological tests, with an MRI scan dated 1 November 2002 showing minor bulging at C5/6 and C6/7 with no apparent neurological compromise. The earlier tests showed no gross abnormality. He assessed 15% permanent impairment of the neck, 10% loss of use of the left arm at or above the elbow including any loss below the elbow and 10% loss of use of the right arm at or above the elbow including any loss below the elbow due to injury sustained on 28 January1998.

Report of Dr Sheehy

40. Dr Sheehy provided a brief report on 4 August 2012. He advised that he saw no indication for surgery based on the radiological reports that he had reviewed. He had not examined the actual films and scans.

Medical Assessment Certificate

41. Dr Stubbs provided a non-binding opinion in a Medical Assessment Certificate (MAC) on 1 March 2016. He recorded a detailed history of the neck injury in 1998 and the back and left knee injuries in 2008. He noted that the applicant's neck symptoms increased in 2008. The applicant complained of neck pain and stiffness, together with headaches.

42. Dr Stubbs did not believe that the applicant had any evidence of radiculopathy or spinal instability and he agreed that the scans showed no evidence of compression. Accordingly, the AMS considered that the proposed C5/6 and C6/7 decompression and fusion was not reasonably necessary.

Reports of Dr O'Keefe

43. Dr O'Keefe was qualified by CGU and reported on 15 February 2012. He recorded details of the three work incidents and the surgical treatment. The applicant denied that he injured his neck in the incidents in 2008 and he had not worked since the last injury. The applicant told the doctor that he had experienced further neck pain extending into his left shoulder over the last two years for no apparent reason.

44. Dr O'Keefe indicated that the applicant's worsening neck symptoms were due to arthritic deterioration following his injury on 28 January 1998 and his employment was still a substantial contributing factor to his left shoulder and neck conditions. The doctor felt that the applicant was suffering from an on-going aggravation. He assessed 25% permanent impairment of the neck, 15% loss of use of the left arm at or above the elbow including any loss below the elbow and 5% loss of use of the right arm at or above the elbow including any loss below the elbow due to injury sustained on 28 January1998.

45. Dr O'Keefe provided a report for the applicant's former solicitor on 21 February 2013. The focus of this report was on the injuries sustained to his left knee and back in 2008. The doctor merely noted that the applicant had injured his neck in 1998. He stated that the applicant was only fit for sedentary work and he assessed 25% whole person impairment.

46. Dr O'Keefe re-examined the applicant and reported on 4 March 2015. He noted details of the three incidents and the nature of the applicant's left knee and back surgery. The applicant complained that he had headaches and neck aches extending down his arms as well as low back pain and sciatica in his legs. An MRI scan dated 18 July 2012 revealed cervical spondylosis at C5/6 without compression.

47. Dr O'Keefe diagnosed cervical disc problems with neurological signs in his upper limbs and hyperflexia in his lower limbs, suggestive of spinal cord compression. This pathology was due to the incident on 28 January 1998. He considered that a two-level anterior interbody fusion was appropriate, although at that stage, Dr Winder had only recommended a decompression.

48. Dr O'Keefe noted the views of Dr Casikar, but observed that the doctor's opinion was based on an earlier MRI scan. There had been a deterioration in the applicant's condition since that time, and Dr Casikar had failed to comment on the hyperflexia in the applicant's legs that suggested spinal cord compression of myelomalacia.

49. Finally, in his report dated 27 June 2016, Dr O'Keefe took issue with the opinion of the AMS, Dr Stubbs. He agreed that the applicant did not have instability or radiculopathy in his neck, but the surgery proposed by Dr Winder was to address myelopathy. Such a condition was the domain of a neurosurgeon, and any opinion regarding the proposed surgery should have been provided by a neurosurgeon, not an orthopaedic surgeon.

Reports of Dr Winder

50. Dr Winder initially reported on 9 April 2014. He did not record a history of the neck injury in 1998, but he was concerned that the applicant might have myelopathy due to cord compression. He referred the applicant for an MRI scan.

51. In his reports dated 24 April 2014, 11 August 2014 and 22 August 2014, Dr Winder advised that the scan showed protrusions at C5/6 and C6/7 and he suspected that this was the cause of the pins and needles in the hands and the hypereflexic changes consistent with myelopathy. He attributed the pathology to the injury sustained in 1998. He recommended a cervical decompression to address these issues.

52. In a report dated 12 May 2016, Dr Winder indicated that the applicant was hyperflexive and had weakness in his upper limbs consistent with cervical myelopathy.

53. Although Dr Winder had recommended a decompression in 2014, the quote that he provided on 1 December 2015 related to a decompression, fusion and rhizolysis.

54. Finally, Dr Winder reported on 20 October 2017. He advised that the applicant had undergone a two-level anterior discectomy and fusion through the public system. He reported that the applicant's condition had been reasonable and there had been some improvement in his leg reflexes, but he had pain in his neck, shoulder and thoracic spine after the long drive to the appointment. He referred the applicant for a MRI scan to rule out any cord compression.

Reports of Dr Casikar

55. Dr Casikar reported on 22 October 2014. He recorded a consistent history, but he commented that the applicant returned to normal work after the 1998 injury and remained working in that capacity until 2008. The doctor notes that Dr Winder had indicated that there was evidence of signal changes in the cervical spine and cord compression. However, Dr Casikar did not have access to the most recent MRI scan and his opinion was based on the scan dated 18 July 2012. This scan is not in evidence.

56. Dr Casikar diagnosed cervical spondylosis and stated that he was unable to indicate whether the applicant required surgery without reviewing the MRI scans. He found no clinical evidence of any neurological abnormality and he doubted that there would have been any significant changes since the 2012 MRI scan which showed no evidence of nerve root compression. He advised that the proposed surgery was unlikely to make any spectacular improvement in the applicant's capacity.

57. Dr Casikar considered that the description of the applicant's injury was not consistent with his presentation and the radiological investigations and he found it difficult to accept that the surgery was related to the injury on 1998. He thought that it was more likely that the symptoms related to underlying degenerative disease and its natural progression. He concluded that the applicant had not suffered any injury or medical condition solely related to the incident in 1998.

58. In his report dated 1 August 2019, Dr Casikar noted that the applicant had a two-level anterior cervical discectomy and fusion on 6 August 2015, but this did not result in any improvement in the applicant's symptoms. Dr Winder performed a second anterior cervical fusion on 25 August 2018 with a similar outcome.

59. Dr Casikar reported that the applicant had a burning sensation in his feet and hands and a third operation had been recommended by Dr Winder. The doctor examined three radiological DVDs and noted that the MRI scans dated 13 May 2016 and 11 May 2017 showed disc degeneration ay C6/7 and a central protrusion.

60. Dr Casikar diagnosed failed back and cervical spine syndrome and spastic quadriparesis. He stated that the indications for surgery were unclear and the fusions had failed to improve the applicant's symptoms. The doctor was again hampered by the absence of the radiological films. The doctor noted the features of non-compressive neuropathy and he recommended a neurological opinion.

61. Dr Casikar indicated that it was difficult to justify the two spinal fusions undertaken 17 years after the work injury and he advised against any further surgery. He agreed with Dr Dan that disc material extrusion could take time to occur, but he felt that it was difficult to extend this logic to a period of 17 years. He took issue with Dr Dan's opinion regarding causation of the neck condition, but he acknowledged that he did not have access to the x-rays and that he was handicapped by their absence.

62. Dr Casikar stated that extruded discs usually shrunk over time and therefore it would be hard to support Dr Dan's opinion that the 1998 injury was responsible for the surgery 17 years later and if the protrusion was the cause of the applicant's symptoms, the surgery would have given him some relief. In the circumstances, he felt that there were other factors other than the injury in 1998 which were responsible for his present condition.

63. Dr Casikar assessed 30% permanent impairment of the neck, 10% loss of use of the left arm at or above the elbow including any loss below the elbow and 10% loss of use of the right arm at or above the elbow including any loss below the elbow due to injury sustained on 28 January1998. He also assessed 28% whole person impairment, but this was predominantly due to the failed surgery and the pre-existing degenerative condition.

64. The applicant relies on a transcript of a recording taken by the applicant during the appointment with Dr Casikar. I have reviewed this evidence and do not propose to discuss this here.

Radiological tests

65. The x-rays taken on 28 January 1998 showed some narrowing at C4/5 and C5/6 that may have been traumatic in origin, and a loss of lordosis, consistent with muscle spasm.

66. A CT scan dated 26 May 2000 showed no evidence of any gross abnormality, whilst an MRI scan dated 1 November 2002 merely showed minor bulging at C5/6 and C6/7.

67. A CT scan was performed on 20 June 2011. It was noted that the applicant had experienced worsening neck pain over a period of six weeks together with morning occipital headaches, left trapezial and deltoid radiation and bilateral finger and hand tingling. The scan showed minor left sided protrusions at C5/6 and C6/7 with slight indentation but there was no visible cord compression.

68. A CT scan dated 12 April 2012 reported similar findings, but there was mild left sided compression at C5/6 and the protrusion at C6/7 was reported as "probably contacting the ventral cord surface without compression".

69. An MRI scan dated 24 April 2014 confirmed that the protrusion at C5/6 was in contact with the cord, but there was no compression. There was degenerative spondylosis at C5/6 and at C6/7 and osteophyte formation at C6/7 without cord compression.

70. Finally, the MRI scan dated 13 May 2016 showed bulging at C5/6 without impingement and a protrusion at C6/7 that was in contact and distorted the spinal cord. There was stenosis and a potential impingement on the C7 nerve. There were no imaging features of myelomalacia.

Reports of Dr Dan

71. Dr Dan reported on 8 April 2019 and 10 May 2019. He recorded a consistent history of the incident on 28 January 1998 and noted that the applicant was off work for two weeks. He eased back into work and avoided carrying, lifting and looking upwards. The doctor noted that the applicant had fallen when a trestle collapsed in July 2008 and had sustained an injury to his left knee and back. He noted that the applicant had undergone cervical surgery in 2015 and in May 2016.

72. Dr Dan recorded that the applicant experienced significant headaches, throbbing and stiffness in his neck and aching in his shoulders. The doctor disagreed with the comments of the AMS regarding the surgery. He stated that the applicant was a poor historian and he described symptoms of radiculopathy. The doctor stated that the applicant had a large disc protrusion which was compressing on the cord. An anterior approach to remove the sequestrated disc and protruding disc material, followed by a fusion, was appropriate. The surgery was not undertaken to address instability.

73. Dr Dan stated that there was no doubt that the applicant suffered a cervical injury on 28 January 1998 and he had developed headaches consistent with occipital neuralgia. The disc protrusion, upper limb symptoms and hyperflexia reflected a spinal cord dysfunction. He also considered that the injury in 2008 would probably have exacerbated it. He confirmed that the need for the surgery performed by Dr Winder was due to the 1998 injury and that the procedure was reasonably necessary.

74. Dr Dan assessed 40% permanent impairment of the neck and 20% loss of use of the arms, or 45% whole person impairment of the applicant's cervical spine. It is unclear whether he meant 10% or 20% loss of use of each arm at or above the elbow including any loss below the elbow.

75. In his report dated 3 July 2019, Dr Dan indicated that he did not believe that the aggravation in 2008 was temporary, but he stated that the primary dysfunction was caused by the injury sustained in 1998. There was an accumulative effect in 2008, but the underlying pathology related to the 1998 injury. He agreed that the need for surgery flowed from the 1998 injury.

APPLICANT'S SUBMISSIONS

76. The applicant's counsel, Mr Morgan, submits that the relevant test was whether the applicant's neck injury materially contributed to the need for surgery in accordance with the principles discussed in *Murphy v Allity Management Services Pty Ltd*[1].

77. Mr Morgan submits that there was no dispute that the applicant injured his neck on 28 January 1998. He completed a claim form, attended Orange Base Hospital where he had x-rays, and he consulted Dr Matthews on 11 February 1998. The clinical notes recorded complaints of neck pain from February 1998 to May 2002. This was consistent with the history of persistent symptoms.

78. Mr Morgan submits that Dr Worsley recorded that the applicant was troubled by constant cervical pain and bi-occipital headaches and crepitus in January 2001. The doctor considered that the applicant had developed cervical facet joint arthritis. The applicant still had recurrent pain and headache in July 2002. Therefore, the treating doctors accepted that the applicant had an entrenched degenerative process and Dr Winder attributed the need for surgery to this degenerative process.

79. Mr Morgan submits that Dr Smith considered that the applicant had completely recovered from his neck injury in July 2001, but this was on a background of a continuity of complaints. Further, the applicant received lump sum compensation in respect of 25% permanent impairment of the neck in 2002.

80. Mr Morgan submits that Dr Mutton reported that a CT scan date 5 May 2008 showed some minor bulges and facet joint degeneration in the applicant's cervical spine. This scan is not in evidence. In June 2011, Associate Professor Siddall noted that the applicant had experienced continuing neck pain since his work injury and Dr Ellis recorded a history of an increase in the applicant's neck pain during 2011. In June 2011, the applicant was referred for a CT scan and he had physiotherapy treatment to treat cervicogenic headaches. There were further referrals in late 2011.

81. Mr Morgan submits that Dr O'Keefe recorded a history of neck pain in the last two years and he believed that the applicant had worsening neck symptoms due to an on-going aggravation and osteoarthritic deterioration following the injury in 1998. Dr O'Keefe stated that the applicant only required conservative treatment, and the need for any treatment would be due to the 1998 injury. The insurer paid compensation based on Dr O'Keefe's assessment.

82. Mr Morgan submits that Dr O'Keefe accepted that there was nerve compression based on the applicant's symptoms and he thought that surgery was warranted. Dr Winder recommended a decompression due to the applicant's symptoms and the possibility of myelopathy. In May 2016, he referred to the urgent need for surgery.

83. Mr Morgan submits that the applicant's qualified specialists recorded a consistent history with respect to the applicant's neck injury and symptoms. Dr Casikar recorded an incorrect history when he indicated that the applicant returned to work after his 1998 injury without restriction.

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[1] [2015] NSWWCCPD 49 (*Murphy*).

84. Mr Morgan submits that Dr Casikar did not report a history of persisting complaints, the radiological tests, the physiotherapy treatment and the need for pain management. He was unsure whether the applicant needed surgery because he did not have access to the radiological tests and he could not say whether the need for surgery was related to the injury in 1998. The transcript of the appointment shows that the doctor did not consider all of the radiology in his possession and he looked no further than the MRI dated 30 May 2016. His opinion was expressed on a paucity of information.

85. Mr Morgan submits that Dr Stubbs took a more conservative view, but his opinion was compromised by the lack of the appropriate radiology. He acknowledged the existence of spondylosis, but stated that this made no contribution. The doctor's opinion was rejected by Dr O'Keefe.

86. Mr Morgan submits that Dr Dan, who is a neurosurgeon, had the benefit of all of the radiology and he obtained a complete history. The doctor supported the need for surgery.

87. Mr Morgan submits that according to the applicant's statements, he constantly reported his neck pain and it was not a sudden manifestation. There was no other cause for the need for surgery.

88. Mr Morgan submits that the weight of evidence from Drs Winder, O'Keefe and Dan supports the need for surgery and one can be easily satisfied that there was a material contribution from his neck injury. There was no novus actus interveniens. The only credible explanation was the deteriorating condition identified by Dr Worsley and the applicant's presentation over the years. The surgery was reasonably necessary.

89. In reply, Mr Morgan submits that the transcript of the interview between the applicant and Dr Casikar shows that the doctor had a jaundiced view of the history and he did not record an increase in the applicant's pain in the period from 2008 to 2014. The doctor questioned Dr Winder's motives and suggested that the applicant should not trust him because he only wanted to make money. There was no basis for such a comment.

90. Mr Morgan submits that the applicant suffered an injury and he had treatment. The need for surgery was supported by Drs O'Keefe, Dan and Winder and the applicant accepted the recommendation to have surgery. Dr Sheehy did not see the applicant and he suggested that he come back for a consultation if his pain increased. Dr O'Keefe was initially qualified by the insurer and he accepted the need for surgery. There was a direct relationship, not just a material contribution.

RESPONDENT'S SUBMISSIONS

91. The respondent's counsel, Mr Adhikary, submits that the applicant was discharged from hospital after two hours and the radiological tests showed no gross abnormality. There was some minor bulging shown in the MRI scan taken on 1 November 2012, but there were no issues. The scans showed minor protrusions at C5/6 and C6/7 and degenerative changes with some slight compression in April 2012.

92. Mr Adhikary submits that the MRI scan dated 24 April 2014 showed no evidence of cord compression and the MRI scan dated 20 May 2016 showed degenerative changes and no features of myelomalacia. There was some worsening of the condition since 2011, but this was many years after the incident.

93. Mr Adhikary submits that the applicant had symptoms and pain on 5 June 200, but Dr Matthews reported that there was no abnormality and the scans showed no evidence of a protrusion. Although Dr Worsley reported that with the passage of time, there had been some arthritic degeneration, the radiology did not show this. Dr Worsley did not mention the need for surgery in his report dated 9 July 2002. In 2010, Dr Mutton described mild neck symptoms and did not suggest that the applicant needed an operation. Similarly, Dr Sheehy saw no need for surgery in August 2012.

94. Mr Adhikary submits that Dr Winder suspected that the applicant had myelopathy and compression in April 2014, but the MRI scan dated 24 April 2014 showed no evidence of compression. Nevertheless, Dr Winder advised that the scan showed protrusions at C5/6 and C6/7 and he thought this had caused symptoms consistent with myelopathy. He recommended a cervical decompression, but in his post-operative report, he advised that the applicant still had symptoms. The doctor performed the surgery when there was no radiological evidence to support the procedure. Accordingly, the surgery was not reasonably necessary.

95. Mr Adhikary submits that in his report dated 15 February 2012, Dr O'Keeffe indicated that the radiological evidence was unremarkable and he attributed the applicant's symptoms to the deterioration of the osteoarthritis following the applicant's injury. He recommended conservative treatment. In March 2015, Dr O'Keefe observed that the applicant had spondylosis without compression, but the imaging did not support this. He agreed that surgery was required, but no weight can be given to his opinion as the tests were normal. The doctor also dismissed the views of Dr Stubbs, but he did not explain his reasons, so no weight can be given to his comments.

96. Mr Adhikary submits that Dr Stubbs indicated that the x-rays showed the development of degenerative changes in the applicant's cervical spine, and he found no evidence of radiculopathy or instability. There was no radiological evidence of compression and he concluded that there was no reason for the applicant to have surgery.

97. Mr Adhikary submits that no weight can be given to the evidence of Dr Dan because there was no evidence that the applicant had a large cervical protrusion and there was no evidence of a neck injury in 2008. The applicant denies that he injured his neck in 2008, the radiological tests do not support this and no other doctor has recorded a history of a neck injury at that stage.

98. Mr Adhikary concedes that Dr Casikar indicated that he was unsure whether the surgery was reasonably necessary as a result of the 1998 injury, and the doctor acknowledged that he only had access to one MRI scan. However, he did not record a history of worsening symptoms since 2012, so there is no reason to reject the doctor's opinion. He stated that the mechanism of injury was not consistent with the applicant's presentation, so there was no nexus between the applicant's condition and his injury. The doctor explained why there was no need for surgery and how the injury could not have created the need for the operation.

99. Mr Adhikary submits that Dr Casikar questioned the views of Dr Dan regarding the disc extrusion occurring 17 years after the injury and he attributed the applicant's incapacity to the surgery, rather than the incident.

100. Mr Adhikary submits that all of the evidence shows that the two operations were not causally related to the injury sustained in 1998. There were no neurological signs or cord compassion. The applicant still has pain and the surgery constituted a novus actus. Accordingly, the surgery was not reasonably necessary as a result of the work injury.

REASONS

Was the treatment reasonably necessary as a result of the injury sustained during the course of the applicant's employment with the respondent?

101. Section 60 of the 1987 Act provides:

> "60 (1) If, as a result of an injury received by a worker, it is reasonably necessary that:
>
> (a) any medical or related treatment (other than domestic assistance) be given, or
> (b) any hospital treatment be given, or
> (c) any ambulance service be provided, or
> (d) any workplace rehabilitation service be provided,
>
> the worker's employer is liable to pay, in addition to any other compensation under this Act, the cost of that treatment or service and the related travel expenses specified in subsection (2)".

102. There is no dispute that the applicant injured his neck on 28 January 1998 during the course of his employment with the respondent. The question then arises as to whether the need for the surgery arose as a result of the accepted neck injury. This is a question of causation.

103. The issue of causation must be determined based on the facts in each case and even though some concerns were raised by the High Court in *Comcare v Martin*[2], the common-sense evaluation of the casual chain discussed in *Kooragang Cement Pty Ltd v Bates*[3] still has application in the Commission.

104. In *Kooragang*, Kirby J stated:

> "The result of the cases is that each case where causation is in issue in a worker's compensation claim must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from' is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent 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."[4]

105. What constitutes reasonably necessary treatment was considered in the context of s 10 of the *Workers Compensation Act 1926* in *Rose v Health Commission (NSW)*[5]. Burke CCJ stated:

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[2] [2016] HCA 43 (*Martin*).
[3] (1994) 35 NSWLR 452; 10 NSWCCR 796 (*Kooragang*).
[4] *Kooragang* [463].
[5] (1986) 2 NSWCCR 32 (*Rose*)

"Treatment, in the medical or therapeutic context, relates to the management of disease, illness or injury by the provision of medication, surgery or other medical service designed to arrest or abate the progress of the condition or to alleviate, cure or remedy the condition. It is the provision of such services for the purpose of limiting the deleterious effects of a condition and restoring health. If the particular 'treatment' cannot, in reason, be found to have that purpose or be competent to achieve that purpose, then it is certainly not reasonable treatment of the condition and is really not treatment at all. In that sense, an employer can only be liable for the cost of reasonable treatment."[6]

106. Further, His Honour added:

"1. *Prima facie*, if the treatment falls within the definition of medical treatment in section 10(2), it is relevant medical treatment for the purposes of this Act. Broadly then, treatment that is given by, or at the direction of, a medical practitioner or consists of the supply of medicines or medical supplies is such treatment.

2. However, although falling within that ambit and thereby presumed reasonable, that presumption is rebuttable (and there would be an evidentiary onus on the parties seeking to do so). If it be shown that the particular treatment afforded is not appropriate, is not competent to alleviate the effects of injury, then it is not relevant treatment for the purposes of the Act.

3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.

4. It is reasonably necessary that such treatment be afforded a worker if this Court concludes, exercising prudence, sound judgment and good sense, that it is so. That involves the Court in deciding, on the facts as it finds them, that the particular treatment is essential to, should be afforded to, and should not be forborne by, the worker.

5. In so deciding, the Court will have regard to medical opinion as to the relevance and appropriateness of the particular treatment, any available alternative treatment, the cost factor, the actual or potential effectiveness of the treatment and its place in the usual medical armoury of treatments for the particular condition."[7]

107. His Honour considered the relevant factors relating to reasonably necessary treatment under s 60 of the 1987 Act in *Bartolo v Western Sydney Area Health Service* [8] and stated[9] :

"The question is should the patient have this treatment or not. If it is better that he have it, then it is necessary and should not be forborne. If in reason it should be said that the patient should not do without this treatment, then it satisfies the test of being reasonably necessary."

[6] *Rose*, [42].
[7] *Rose*, [47].
[8](1997) 14 NSWCCR 233 (*Bartolo*).
[9] *Bartolo*, [238]

108. In *Diab v NRMA Ltd* [10] Deputy President Roche questioned this approach and cited *Rose* with approval. He provided a summary of the principles as follows[11]:

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

109. A condition can have multiple causes, but the applicant must establish that the injury materially contributed to the need for surgery. This was confirmed by Deputy President Roche in *Murphy*, where he stated:

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

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[10] [2014] NSWWCCPD 72 (*Diab*).
[11] *Diab*, [88] to [90]
[12] *Murphy*, [57] to [58].

110. According to the applicant's evidence, he has continued to experience neck pain and stiffness extending into his shoulders and arms since his suffered his injury in 1998. He was also troubled by numbness and pain in his arms. He was able to return to work and whilst he stated that he did not perform his pre-injury duties after 1998, the clinical notes show that he complained from time to time about worsening symptoms which coincided with overhead painting, such as when Dr Matthews referred him to see Dr Worsley in January 2001.

111. Dr Smith recorded that the applicant had returned to his normal work, so it would seem that the applicant still performed his usual duties, perhaps with some restrictions, prior to his back injury in 2008.

112. In January 2001, Dr Worsley indicated that the applicant had developed some cervical facet joint arthritic degeneration, but he did not comment on causation.

113. What transpired between 2001 and 2008 has not been addressed in any detail in the applicant's statements. The clinical notes show that he had intermittent flare ups of neck pain from time to time from 1998 to 2002. Headaches became a problem in early 2011.

114. Associate Professor Siddall reported the applicant had experienced neck pain since his injury. Like Dr Worsley, the Associate Professor suspected that he might have facet joint pathology. Dr Mutton's report is of little assistance to the current dispute as he focused on the 2008 injuries.

115. Dr Ellis recorded a history of intermittent neck pain since 1998, with an increase over a nine-month period in 2011. This seems consistent with the evidence of Dr Matthews and the referral for a further CT scan. He noted that there had been no further injury to the applicant's neck. He agreed that the radiological tests showed no apparent neurological involvement.

116. Surgery was not contemplated at this stage, and Dr Sheehy saw no need for same in 2012. This is not surprising as the radiological tests performed prior to 2011 showed no evidence of any major pathology, and the CT scan in June 2011 showed protrusions at C5/6 and C6/7 with slight indentation without visible cord compression. It is unclear whether Dr Sheehy had seen the report of the CT scan dated 12 April 2012 which referred to compression at C5/6 and probable contact with the cord at C6/7 without compression.

117. The applicant confirmed in his 2015 statements that there had been no change in his condition and he denied that he hurt his neck in 2008. When one considers the applicant's unchallenged evidence, coupled with the entries in the clinical notes, there seems little doubt that there was no neck injury in 2008 and his symptoms have worsened since 1998. The progressive deterioration was something that was foreshadowed by Dr Worsley in 2001.

118. The applicant's main support for the surgery being causally related to the injury in 1998 are the reports from Drs Winder, O'Keefe and Dan.

119. Dr Winder felt that the applicant had symptoms consistent with myelopathy caused by cord compression. The final scan dated 13 May 2016 referred to the protrusion at C6/7 being in contact and distorting the spinal cord and with the possibility of impingement, but there were no imaging features of myelomalacia.

120. As the scans showed that the protrusions were in contact with and were distorting the cord, one can understand why Dr Winder recommended surgery, particularly given the nature of the applicant's complaints. More weight can be given to his views as and he saw the applicant on a regular basis over a number of years and he would be best placed to provide an opinion on causation and the need for surgery. He attributed the need for surgery to the 1998 injury.

121. I am mindful that Dr O'Keefe was originally qualified by the insurer, so his support for the applicant is of significance. According to the doctor, the applicant's worsening neck symptoms were due to arthritic deterioration following his injury on 28 January 1998. This view confirms what Dr Worsley indicated when he saw the applicant in 2001.

122. Like Dr Winder, Dr O'Keefe saw the applicant on a number of occasions and he observed a worsening of the applicant's condition. He considered that despite the radiological findings, the applicant's symptoms were consistent with spinal cord compression and he agreed that a two-level fusion was warranted. He rejected the opinion of Dr Stubbs because the surgery was intended to treat myelopathy.

123. In my view, the reports of the highly regarded neurosurgeon, Dr Dan, carry a great deal of weight, even though he was convinced the applicant injured his neck in 2008. The applicant denied that he suffered any such injury and there is no contemporaneous evidence, or history provided by the applicant to the various doctors who have examined him, to support Dr Dan's opinion. Therefore, this aspect of Dr Dan's opinion carries little weight.

124. Dr Dan was convinced that the applicant's symptoms were consistent with radiculopathy and there was compression on the cord. He considered that a discectomy and fusion was appropriate to treat the cord compression. The doctor stated that the primary dysfunction and need for surgery was due to the 1998 injury, despite the accumulative effect of the alleged 2008 neck injury.

125. Therefore, it would appear that these three doctors support a diagnosis of cord compression based on the applicant's complaints and their clinical examinations, even though the diagnostic tests suggested otherwise.

126. The respondent primarily relies on the radiological scans and the reports of Drs Stubbs and Casikar.

127. According to Dr Stubbs, the applicant did not require surgery because the scans showed no evidence of compression and there was no evidence of radiculopathy or instability. He attributed the applicant's symptoms to constitutional cervical spondylosis. He did not diagnose cervical facet joint arthritis that was identified by Dr Worsley.

128. One can understand Dr Stubbs' conclusion, but his views are inconsistent with the opinion of Dr Winder, and they were rejected by Drs O'Keefe and Dan. Dr O'Keefe also questioned his expertise. Whilst one could expect that a neurosurgeon would be best placed to comment on the surgery, Dr O'Keefe's concerns regarding the doctor's expertise might equally apply to him, given that he is also an orthopaedic surgeon. In my opinion, the views of the neurosurgeons will be more persuasive.

129. The main concern with the opinion of Dr Casikar is that the doctor only had access to the MRI scan dated 18 July 2012 when he examined the applicant in 2014. His history is also deficient. The doctor described the scan as showing moderate cervical spondylosis, but there was no mention of the disc protrusions and cord contact that was shown in the CT scan taken on 12 April 2012. The doctor stated that it was difficult to accept that the need for surgery was due to the injury on 1998. However, he conceded that he was unable to express an opinion until he had seen the more recent scans. This concession makes the doctor's initial report of minimal probative value.

130. By the time that Dr Casikar re-examined the applicant in 2019, he had undergone two cervical fusions that had not relieved his symptoms. The doctor viewed MRI scans from 2016 and 2017, but he only described disc degeneration and a C7 protrusion. The 2017 scan is not in evidence, but the MRI scan dated 13 May 2016 showed a protrusion at C6/7 that was in contact with the spinal cord and there was potential impingement on the C7 nerve. The doctor did not comment on the significance of this pathology but curiously, he recommended that the applicant seek a neurological opinion regarding his symptoms.

131. Although Dr Casikar agreed with Dr Dan that a disc extrusion could take years to occur, he doubted that this was the situation in the applicant's case. Such a concession adds weight to Dr Dan's opinion.

132. Whilst Dr Casikar cavilled with Dr Dan's views on causation, he again conceded that he had not seen all of the diagnostic tests. This also detracts from his opinion. In that regard, it is clear that Dr Dan had access to a large number of the diagnostic tests, which seems to add further weight to his views.

133. Dr Casikar also suggested that there were other factors responsible for the applicant's condition, and he suggested that these were the natural progression of degenerative changes and the condition did not solely relate to the injury in 1998. He did not discuss the cervical fact joint arthritis. Overall, Dr Casikar's evidence is not persuasive.

134. The applicant has the support of Drs Winder, O'Keefe and Dan. I have raised concerns about the probative value of the views of Drs Stubbs and Casikar. According to *Murphy*, a condition can have many causes. Dr Dan addressed the *Murphy* test in his last report and stated that the need for cervical surgery was due to the injury sustained in 1998, even though he suggested that there was some contribution from a potential neck injury in 2008.

135. The applicant has tried various forms of treatment over the years and eventually came to surgery to repair the spinal cord compression. The only other potential cause of the applicant's symptoms was, according to Drs Casikar and Stubbs, the progression of constitutional degenerative changes. That may well have been a factor, but the applicant's medical evidence suggests that the need for surgery was caused by the 1998 injury.

136. In my view, applying the common-sense test of causation in *Kooragang*, the weight of evidence from Drs Winder, O'Keefe and Dan supports the applicant's case that his injury in 1998 materially contributed to the need for his discectomy and two-level spinal fusion undertaken in 2018.

137. The medical evidence supported the need for the operation to address the effects of the applicant's work injury. The condition was beyond conservative forms of treatment, given the nature and level of the applicant's symptoms and the radiological findings.

138. There was no novus actus interveniens, either in the form of a potential neck injury in 2008 or when Dr Winder performed surgery in 2015 and 2018. In my view, there was no break in the causal chain. The operation was performed to address the effects of the 1998 injury and there is no persuasive evidence to the effect the applicant had recovered from his injury prior to surgery.

139. I am satisfied that the surgery had the potential to alleviate the applicant's symptoms. Unfortunately, the surgery has not resulted in any improvement, but according to *Diab*, a poor outcome does not mean that the surgery was not reasonably necessary. It is an appropriate form of treatment for the management of the applicant's cervical pathology.

140. There seems to have been no alternative forms of treatment. I do not have details of the actual cost before me, but the estimated cost was not unreasonable. This satisfies the relevant factors discussed in *Rose* and *Diab*.

141. Accordingly, I am satisfied on the balance of probabilities that the surgery undertaken by Dr Winder on or about 25 August 2018 and associated expenses, was reasonably necessary treatment as a result of the injury sustained on 28 January 1998.

Weekly compensation and medical expenses

142. The applicant is currently in receipt of weekly compensation as a result of the back and left knee injury sustained in July 2008 on the basis that he has no current work capacity. This raises and issue as to whether the applicant is entitled to any weekly payments as a result of his injury in 1998. The evidence is lacking regarding any payments made in respect of the 1998 injury and the list of payments relating to the back and left knee injury which is attached to the Application is dated.

143. A further issue concerns the actual cost of the surgery in 2018. There may well be implications due to the effects of s 59A of the 1987 Act. No claim has been made regarding the early procedure.

144. During the conciliation conference, I discussed these issues with the parties and it was agreed to defer this aspect of the claim until after the applicant had been examined by an AMS. This will enable the parties to file further evidence, including the actual costs incurred for the surgery.

145. In the circumstances, I will order that the claim for weekly compensation and medical expenses will be addressed at a further telephone conference to be appointed before me after the MAC is issued to the parties.

Quantification of entitlement to lump sum compensation

146. I will remit this matter to the Registrar for referral to an AMS pursuant to s 321 of the 1998 Act for assessment of the permanent impairment of the neck and loss of use of both arms at or above the elbow including any loss below the elbow due to injury sustained on 28 January 1998.

147. Further, the AMS is to provide an assessment of whole person impairment of the applicant's cervical spine and both upper extremities for the purpose of determining whether the applicant is a worker with high or highest needs.

FINDINGS

148. The applicant sustained injury to his neck arising out of or in the course of his employment with the respondent on 28 January 1998.

149. The applicant's employment was a substantial contributing factor to his injury.

150. The anterior cervical discectomy and fusion performed by Dr Winder on or about 25 August 2018, and associated expenses, was reasonably necessary treatment as a result of the injury arising out of or in the course of his employment with the respondent on 28 January 1998.

ORDERS

151. The claim for weekly compensation and medical expenses is adjourned.

152. I remit this matter to the Registrar for referral to an AMS pursuant to s 321 of the 1998 Act for assessment due to injury sustained on 28 January 1998 as follows:

(a) Table of Disabilities:

(i) permanent impairment of the neck;
(ii) loss of use of the right arm at or above the knee including any loss below the elbow, and
(iii) loss of use of the left arm at or above the knee including any loss below the elbow.

(b) Whole Person Impairment for the purpose of a determination as to whether the applicant is a worker with high or highest needs:

(i) cervical spine;
(ii) right upper extremity, and
(iii) left upper extremity.

153. The documents to be reviewed by the AMS are:

(a) Application and attachments;
(b) Reply with attached documents;
(c) Application to Admit Late Documents received on 21 October 2019, and
(d) Application to Admit Late Documents received on 21 October 2019.

154. The matter is to be listed for a telephone conference before me once the Medical Assessment Certificate is issued to the parties to deal with the balance of the claim.