WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **5432/19**
Applicant: **Helen Thelma Laing**
Respondent: **Sydney Catholic Schools Limited**
Date of Determination: **14 January 2020**
Citation: **[2020] NSWWCC 19**

The Commission determines:

1. Award for the respondent.

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

Josephine Bamber
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 JOSEPHINE BAMBER, SENIOR ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A MacLeod

Ann MacLeod
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. There were a number of amendments made to the Application to Resolve a Dispute (ARD) as follows:

    (a) The name of the respondent was amended to Sydney Catholic Schools Limited;

    (b) The claim for past treatment expenses was deleted because the accounts and receipts had not previously been served on the respondent, and

    (c) The date of injury was amended to 23 March 2016.

2. The claim for compensation sought by Ms Laing in these proceedings is confined to a claim for a proposed left total knee replacement.

3. Ms Laing injured her left knee on 23 March 2016, when she was sitting at her work desk in the course of her employment with the respondent and she leant forward to pick up some documents from the floor. As she did so, she states that the legs of the chair slipped on a plastic carpet protector, the chair tilted, and she fell to the floor twisting her knee.

4. The respondent concedes that Ms Laing sustained injury to her left knee in this incident. However, it disputes liability under section 60 of the *Workers Compensation Act 1987* (the 1987 Act) that as a result of Ms Laing's injury on 23 March 2016 a left total knee replacement is reasonably necessary treatment.

5. At the telephone conference on 17 November 2019 the respondent's solicitor conceded section 59A of the 1987 Act did not apply to this claim following the decision in *Pacific National Pty Ltd v Baldacchino*[1]*.*

PROCEDURE BEFORE THE COMMISSION

6. A conciliation conference/arbitration hearing was held on 20 December 2019. Mr Ross Stanton, counsel, instructed by Ms Patterson, solicitor, appeared for Ms Laing. The respondent was represented by Mr David Saul, counsel, instructed by Mr Thomas Murray, solicitor and Ms Allison Edwards from the respondent.

7. 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

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

    (a) ARD and attached documents;

[1] [2018] NSWCA 281

(b) Reply and attached documents, noting that the report of Dr Maxwell dated 30 March 2017 was admitted only in relation to the history contained therein and not in relation to the opinion, and

(c) Application to Admit Late Documents dated 17 December 2019 filed by the respondent.

Oral evidence

9. There was no oral evidence. Both counsel made oral submissions which were sound recorded. A copy of the recording is available to the parties.

FINDINGS AND REASONS

Ms Laing's statement

10. Ms Laing is aged 68. She works as a teacher at John the Baptist Catholic Primary School in Bonnyrigg. In her statement dated 20 December 2018 she says she had a pre-existing left knee injury in 2006 when she fell down some stairs at the school. She was treated by Dr Ireland, orthopaedic surgeon, who performed an arthroscopy of her left knee. She states that about a year after that surgery she had a Synvisc gel injection into the knee, which was effective relieving her pain. She says before the injury on 23 March 2016 she only experienced occasional discomfort in her knee, but she often avoided stairs.

11. Ms Laing describes the injury that occurred on 23 March 2016 when the chair moved from under her and it fell landing on its left side with her still seated in it. She says when the chair tipped she fell completely sideways, and her left knee and left leg got caught on the table leg. She adds that her left side landed on the arm of the chair. She was in pain and took time to get up. She says upon falling she felt a twist and sharp pain on the side of her knee, which was instantaneous and severe.

12. Ms Laing describes her subsequent treatment in her statement.

Dr Jelinek

13. Dr Maria Jelinek is Ms Laing's general practitioner. In a report (which appears to be incorrectly dated 5 October 2015[2]) she advises that Ms Laing had recovered well from her 2006 knee injury until the 2016 injury. She opines that the 2016 injury could have aggravated her prior condition, which was osteoarthritis of the knee secondary to a previous knee injury. Dr Jelinek's consultation note for 25 May 2016 is reproduced in her report. The doctor noted that Ms Laing was able to walk without a limp and had tenderness on examination of the medial collateral ligament and there was positive Apley's test for the meniscus[3].

14. Extracts of Dr Jelinek's clinical notes are in the ARD and Reply and have been considered by me but do not need to be summarised in full. On 24 November 2016 there is an entry that Ms Laing came in due to left knee pains "sports activity in school, twisted her knee again, now in pains, had steroid injection before"[4]. On 11 November 2016[5], 8 February 2017[6],

[2] ARD page 50
[3] ARD page 51
[4] ARD page 87
[5] ARD page 147
[6] ARD page 123

13 March 2017[7], 13 May 2017[8], 8 July 2017[9], and 11 August 2017[10] WorkCover NSW-certificates of capacity were issued by Dr Jelinek, which refer to the treatment given in 2016 and 2017 for the left knee from the injury on 23 March 2016. Similar certificates were issued on 4 October 2017[11] and 29 November 2017[12]. On 6 December 2017 Dr Jelinek recorded in her clinical notes that Ms Laing had not had a fall or injury since the last time an MRI was done. She states, "started to have the pains again after she came back from holidays where she did a lot of walking".[13]

15. Dr Jelinek referred Ms Laing to Dr Ireland and then sought a second opinion from Dr Laird. Thereafter, it would seem that most of Ms Laing's specialist treatment has been from Dr Ireland.

Dr Laird

16. Dr Martin Laird, orthopaedic surgeon, reported to Dr Jelinek on 5 August 2016[14]. Dr Laird was of the following opinion:

> "She has only had an MRI which does show some generalised chondral loss consistent with arthritis, no clear meniscal tear and in general degenerative changes and I think that her symptoms represent an exacerbation of her arthritis which has certainly been longstanding. At this stage her symptoms are manageable but at some point she may need a knee replacement. Therefore I have recommend non-operative management including regular analgesia as required, weight control by diet and low impact exercise, physiotherapy potentially for strengthening of her knee muscles and certainly an injection of steroid and anaesthetic is an option especially given the limited nature of her symptoms, this can sometimes get her over the exacerbation although it is only a short to medium term solution in most cases.
>
> She may down the track come to need knee replacement when she can no longer put up with her symptoms…"

17. Dr Laird reviewed Ms Laing again and issued a further report dated 9 December 2016[15]. He noted that Ms Laing had some short-term relief from a steroid injection into the knee. She had some quadriceps weakness and some limitation in her range of motion. But Dr Laird said as she was improving at that stage she should continue non-operatively. He sets out other treatment options such as analgesia, physiotherapy, and weight loss.

Associate Professor Ireland

18. Associate Professor John Ireland has been Ms Laing's treating orthopaedic specialist for many years. Some reports are available for the pre-injury period. On 18 February 2008, Dr Ireland reported that he gave Ms Laing her first Synvisc injection[16], on 28 February 2008 another injection was given[17] and a third injection on 14 March 2008[18].

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[7] ARD page 127
[8] ARD page 131
[9] ARD page 135
[10] ARD page 189
[11] ARD page 193
[12] ARD page 197
[13] ARD page 100
[14] ARD page 53
[15] ARD page 55
[16] ARD page 61
[17] ARD page 62
[18] ARD page 63

19. On 15 October 2010, Dr Ireland reviewed Ms Laing recording that she noticed persisting pain into the left knee and over the lateral aspect of the thigh with radiation down to the lateral ankle. On examination she had mild generalised tenderness about the knee with some patellofemoral crepitus evident and a positive McMurray's test. There was also pain into the posterior aspect of her right leg and tenderness over the lumbosacral region. Dr Ireland advised the general practitioner, Dr Chiew, that it was hard to know how much of her current problems were related to nerve root irritation and how much due to the knee, so he suggested an MRI scan be obtained[19]. Dr Ireland reported further on 10 November 2010 that the MRI scan revealed pronounced degenerative disc and joint facet disease at the L4/5 level contributing to some spinal stenosis. He stated that he thought this explained a lot of Ms Laing's symptoms in the left thigh and he recommended she consult Dr Etherington a spinal surgeon[20]. As noted later in these reasons, Ms Laing had a fusion at L4/5 in 2012 performed by Dr Abraszko.

20. Dr Ireland saw Ms Laing at the request of Dr Maria Jelinek in June 2016 regarding the left knee injury at work on 23 March 2016. In a report to Dr Jelinek dated 30 June 2016, Dr Ireland records that Ms Laing found her left knee stiff and sore and occasionally it catches. He says she has difficulty walking for more than 15 minutes and tries to avoid stairs. He states that she has noticed intermittent swelling[21].

21. In his report dated 10 May 2019, Dr Ireland sets out his history of this injury[22]. He says he saw Ms Laing on 20 June 2016 and on his examination Ms Laing had no major restriction of motion and no significant swelling. He says the MRI scan showed no evidence of a meniscal tear and tricompartmental degenerative changes. He advised that at that stage he did not believe her symptoms were severe enough to warrant any surgical intervention and he recommended a Synvisc injection.

22. Dr Ireland reviewed Ms Laing again on 21 December 2017 and stated that the request for the injection had been refused by the insurer. Dr Ireland advised that Ms Laing had noticed a further deterioration and a more up to date MRI scan showed a meniscal tear and increasing signs of arthritis. Dr Ireland says notwithstanding the further deterioration he did not feel Ms Laing's symptoms were severe enough for surgery and he made a further request for a Synvisc injection, which was undertaken on 24 January 2018.

23. On 5 April 2018, Dr Ireland further reviewed Ms Laing and states that the knee was causing her increasing pain, predominantly around the anterior aspect and he suggested she try physiotherapy.

24. In the report dated 10 May 2019 to Ms Laing's solicitors, Dr Ireland diagnosed that Ms Laing sustained an aggravation of underlying osteoarthritis of her left knee in the work injury and that her employment was a substantial contributing factor to the injury. Dr Ireland answered a series of questions posed by Ms Laing's solicitors including that she "will require a total knee replacement in view of the progression in her arthritis and the exacerbation and aggravation associated with her work injury". He estimated the total cost including post-operative rehabilitation would be in the vicinity of $30,000. In his report dated 10 May 2019 Dr Ireland says he includes copies of the MRI scan reports.

25. However, Dr Ireland did not re-examine Ms Laing for the purposes of providing the report dated 10 May 2019. It seems that his last examination of Ms Laing was on 5 April 2018.

[19] ARD page 64
[20] ARD page 65
[21] Reply page 37
[22] ARD page 46

MRI left knee 31 May 2016

26. This MRI scan was requested by Dr Jelinek. The clinical notes state "Fall landing on left side twisting injury. Tender medial collateral ligament. Rule out meniscal tear". The radiologist's findings included a "mild high signal in the posterior horn of the medial meniscus in keeping with degenerative signal. No evidence of a meniscal tear". The radiologist commented that there was an "old PCL injury. Tricompartmental degenerative arthrosis most marked in the patellofemoral joint.[23]"

Ultrasound/x-ray left knee 23 October 2017

27. An ultrasound/x-ray of Ms Laing's left knee was performed at the request of Dr Jelinek on 23 October 2017, it showed medial bulging of the mid body of the medial meniscus which the radiologist stated raised the possibility of an underlying medial meniscal tear and he recommended an MRI be undertaken[24].

MRI left knee 5 December 2017

28. This MRI report says it was requested on 26 October 2017 and taken on 4 December 2017. The clinical history is "?meniscal tear on ultrasound". The conclusion of the radiologist was that there was an undisplaced multidirectional tear involving the posterior horn of the lateral meniscus and lateral compartment chondromalacia. There was also a focal area of full thickness chondral loss involving the central weightbearing surface of the medial femoral condyle with associated subchondral osteophyte formation[25].

Dr Giblin

29. Dr Matthew Giblin, orthopaedic surgeon, provided a medico-legal report for Ms Laing dated 29 August 2018[26]. He noted that she was under the care of Dr Ireland who had informed Ms Laing that in the long term she would need a total knee replacement. Dr Giblin expressed the view that,

> "Surgical intervention is not anticipated in the immediate future, but long term she is likely to require a total knee replacement…If her symptoms continue to deteriorate, then the reason for the total knee replacement in the future will be due to the fall, as the fall has most likely hastened the need for it."

30. Dr Giblin also opined that her injury is consistent with the injury she described on 23 March 2016 and that she had suffered an aggravation of underlying degenerative change in her left knee.

31. In coming to these opinions, Dr Giblin took a history about the fall and her subsequent treatment and also about Ms Laing's work-related left knee injury in 2006. In relation to the 2006 injury Dr Giblin stated that Ms Laing was not having any treatment for it in the form of medication or other source at the time on the injury on 23 March 2016. Dr Giblin considered Ms Laing's present disabilities such as that it affects her with climbing stairs, squatting, kneeling, walking distances and on uneven ground. Some of these disabilities occur at her work and in the home. It is noted she has assistance with some of her housework.

[23] ARD page 72
[24] ARD page 56
[25] ARD pages 57/58
[26] ARD page 42

32. Dr Giblin records his examination findings that she has a slight limp, 1 cm wasting of the left thigh when compared to the right, retropatella crepitus, but no pain. Dr Giblin also considered the radiology including the MRI scans of 2 June 2016 and 4 December 2017 and x-rays on 22 August 2016 and 23 October 2017.

Gaetano Milazzo

33. Gaetano Milazzo provided an Independent Physiotherapy Consult for the insurer and report dated 2 November 2017[27]. Meniscal tests were unremarkable on examination. Minor restriction was found in the left knee flexion mobility and marked strength and postural control impairments in the left knee. It was also found that the incident on 23 March 2016 at work had aggravated the pre-existing left knee injury and pre-existing degenerative changes. It was recommended that Ms Laing be approved for limited additional physiotherapy to implement, monitor and progress a program of home-based exercise. Four sessions were recommended for this purpose.

Dr Maxwell

34. Dr Maxwell is an orthopaedic surgeon who provided a medico-legal report for the insurer dated 30 March 2017[28]. Because of Regulation 44 of the Workers Compensation Regulation 2016 a party is limited to one forensic medical report. The respondent therefore opted not to rely upon the opinion of Dr Maxwell. The report was admitted only as to the history it contained.

35. The only parts of the history not recorded elsewhere are as follows. Dr Maxwell noted that Ms Laing had a fusion at L4/5 in 2012 performed by Dr Abraszko, which was successful. She has been diagnosed with fibromyalgia and has aching hands and feet and was seeing Dr White, rheumatologist. Dr Maxwell also has a history about some shoulder problems, aggravated after a trip overseas when she was carrying bags.

Dr Hitchen

36. Dr Paul Hitchen, orthopaedic surgeon, has provided medico-legal reports to the insurer dated 23 November 2017[29], 22 January 2018[30] and 11 December 2019[31]. In his first report Dr Hitchen has a history regarding the injury on 9 November 2006 when Ms Laing fell down stairs at work and subsequently having an arthroscopic chondroplasty performed by Dr Ireland. Dr Hitchen also records a history regarding the injury on 23 March 2016 and her subsequent treatment. He notes that she undertook hydrotherapy treatment until mid-2017 which helped ease, but not completely eliminate, her pain.

37. Dr Hitchen then refers to Ms Laing having travelled in September 2017 to Myanmar on a cruise boat and each day on shore trips she would walk for at least two hours. He notes that as a result Ms Laing had onset of worsening pain in her left knee, particularly medially. Dr Hitchen states Ms Laing found she was prone to limping. Dr Hitchen says on her return to Australia she saw her general practitioner who organised an x-ray which did not reveal any obvious abnormality and prescribed physiotherapy and that an MRI scan be conducted. Ms Laing continued to work with her normal duties.

[27] Reply page 42
[28] Reply page 50
[29] Reply page 31
[30] Reply page 35
[31] Late Documents page 1

38. In his discussion in his first report, Dr Hitchen says he did not have the opportunity to examine Ms Laing contemporaneously to her fall in March 2016. He referred to the radiology and stated that it is probable that the workplace injury was a transient aggravation of symptoms arising from an already mildly arthritic knee. He states any such aggravation "did cease, and in my opinion would have done so within a matter of months" after the fall in March 2016. He states that his opinion is that Ms Laing's knee pain throughout "2017 more so represents constitutional arthritis". He concluded that surgery would not be required on the basis of injury or aggravation. Dr Hitchen discussed why an MRI scan should be performed to exclude an insufficiency fracture, which can occur in an osteoporotic individual. He also states that the prognosis for her knee depends very much upon what the MRI shows.

39. Dr Hitchen was referred the MRI scan report from the scan undertaken on 4 December 2017 and asked to provide a supplementary report, which he did on 22 January 2018. Dr Hitchen says he did not view the films, but the report showed no sign of an insufficiency fracture. He noted some early arthritic change in the medial compartment and somewhat more established degenerative changes at the patellofemoral joint. He said there was an incidental finding of a tear on the lateral side, but he says historically and clinically she had no pain on the lateral side. He says the scan does not reveal evidence of acute injury and he adheres to his view that the workplace injury was a transient aggravation of the underlying arthrosis in the medial and patellofemoral compartments. Of the symptoms when on holiday, Dr Hitchen referred to them as "a flare up" of her knee condition.

40. Dr Hitchen examined Ms Laing again and provided a report to the insurer dated 11 December 2019. He noted at the time of the injury on 23 March 2016 Ms Laing was working full time and two years ago she dropped back to two days per week. Dr Hitchen noted since his last review Ms Laing said that Dr Ireland had treated her knee with a Synvisc injection, but this did not provide lasting pain relief.

41. Dr Hitchen recorded her present symptoms as including intermittent discomfort, aching predominantly in the anteromedial area, negotiating stairs or inclines gives pain, and feeling that knee may give way which caused her to fall a fortnight earlier. Ms Laing was taking Celebrex sometimes for a week and then has a break from it. She takes Panadol occasionally. Dr Hitchen was of the view that the walking on her overseas holiday precipitated a deterioration of her condition. Dr Hitchen adheres to his prior view that the work place injury on 23 March 2016 had resolved. He states:

> "Based on my history and examination and the review of documentation I believe she sustained an injury to her left knee on 23 March 2016. That was a symptomatic aggravation of symptoms from pre-existing arthritis. The aggravation in my opinion would not have altered the natural outcome for her knee and was transient. It would have lasted a matter of months. I note the original MRI did not show any articular cartilage lesions in the medial femoral condyle. The second MRI, that was undertaken after her holiday showed a deterioration in her knee condition. Hence I believe it is more likely than not that her deterioration was secondary to aggravation of her knee following her overseas holiday. In other words, I believe by 2017 her Work Place knee injury had resolved."

42. Dr Hitchen offers an opinion on the need for knee replacement surgery as follows:

> "With regard to further treatment, at this point in time I do not believe that she is sufficiently symptomatic to proceed to a full knee replacement. She is only taking medication intermittently. She has an excellent range of motion of her knee and no effusion. She can walk half an hour on the flat. Thus, whilst eventually she may come to a knee replacement in the years ahead, at this point in time I believe it is premature. Importantly however for reasons outlined in the preceding paragraphs I do not believe that the requirement for knee replacement is due to the effects of injury or aggravation.
>
> The long term prognosis for her knee is reasonable. She will eventually come to a knee replacement, but I believe this is best performed when she is close to bone on bone and has failed non-operative management including maximising medication."

Submissions

43. Both parties' submissions have been recorded, so I will not repeat them verbatim in these reasons.

44. The respondent submits that there is no doctor who says that Ms Laing requires a total knee replacement at the moment. It was submitted that Dr Giblin's report is over a year old and that his conclusion is not sufficient for the Commission to make an order that a total knee replacement is reasonably necessary. Counsel relied on Dr Giblin's opinion that "Surgical intervention is not anticipated in the immediate future".

45. In relation to Dr Ireland, the respondent submitted that his report dated 10 May 2019 is not based on an examination of Ms Laing at that time and it seems the doctor had not seen her since 5 April 2018. Counsel also submitted that the opinion expressed in 2019, that Ms Liang "will require a total knee replacement", also lacks specificity because he does not say when she will require such surgery. It was also submitted that in the report dated 5 April 2018 Dr Ireland was suggesting physiotherapy treatment and did not recommend then that surgery be undertaken.

46. The respondent referred to Dr Jelinek's clinical notes and to the entry on 24 November 2016 to "sports activity at school, twisted her knee again" and the entry on 6 December 2017 to pain in the left knee from walking on holiday. Counsel argued that Dr Ireland had not referred to the same and that such matters are relevant to consider in an aggravation of disease case.

47. The respondent submitted that in a temporal sense these two incidents are more likely to have caused the presence of the meniscal tear which is shown on the MRI scan taken on 4 December 2017 and was not present on the MRI scan of 31 May 2016.

48. Counsel submitted that Dr Hitchen is the only doctor who has the full history and he is of the view on causation that the injury on 23 March 2016 resolved. Furthermore, it was submitted that Dr Hitchen was of the firm opinion that Ms Laing's symptoms are not sufficient to require a total knee replacement. In summary, the respondent submitted that Ms Laing cannot establish on the balance of probabilities that at this point in time she requires a total knee replacement.

49. Ms Laing's counsel read out in detail Ms Laing's statement to illustrate that before the injury on 23 March 2016 she had mild symptoms, but afterwards her symptoms were utterly different in character, degree and severity. It was argued that Ms Laing had persisting pain, significant restrictions with inability to do domestic tasks, difficulty walking long distances and crouching at work, and that all of these issues are still present.

50. In response to the submissions and Dr Hitchen's comments about the MRI scans, Ms Laing's counsel drew attention to the radiologist's finding in the MRI scan dated 31 May 2016 that "there is a mild high signal in the posterior horn of the medial meniscus". It was submitted that this is the same part of the left knee where the tear was found in the MRI scan in October 2017. So, it was submitted that the tear had its origins in something which occurred in the injury on 23 March 2016.

51. Ms Laing's counsel did not disagree with the respondent's submission that the last time Dr Ireland actually examined Ms Laing seems to be on 5 April 2018. Counsel submitted that would be understandable given the insurer had denied liability. However, this somewhat misses the point the respondent was making. The case put by the respondent is that Dr Ireland on 5 April 2018 did not recommend a total knee replacement and his comments about the need for surgery in his report of 10 May 2019 have little probative force given the doctor had not re-examined Ms Laing after 5 April 2018.

52. Ms Laing's counsel also relied upon the opinion of Dr Laird that Ms Laing would down the track come to need knee replacement when she can no longer put up with the symptoms. Counsel submitted that Dr Laird's opinion supports the argument that the 2016 work injury has caused the aggravation or brought about the symptoms in the left knee, and that these types of symptoms were not present before 23 March 2016.

53. Counsel also submitted that the respondent's submission, that there were later injuries, should not be accepted. It was submitted there is no medical opinion that there were multiple later injuries and that Dr Hitchen only deals with the walking on holidays. It was argued that Dr Hitchen's opinion in that regard should not be accepted because it is inherently illogical. It was submitted that after the injury on 23 March 2016 one of the things Ms Laing complained about was difficulty with walking. Counsel argued that it was hardly surprising that when she perhaps did more walking on holiday she would be more troubled by symptoms, but this does not mean that they are new symptoms from a new injury.

54. Furthermore, Ms Laing's counsel argued that Dr Hitchen's opinion that the effects of the injury having resolved should not be accepted, because the evidence establishes that she, in fact, continued to have symptoms.

55. In terms of whether the surgery is reasonably necessary, Ms Laing's counsel submits that Dr Ireland's opinion can be relied upon. He submitted just because Dr Ireland says that Ms Laing *will* require knee replacement does not mean the opinion should not be accepted, because the claim is by its nature a claim for future surgery and that the use of the word "will" is in that context appropriate. Counsel noted that Dr Ireland gave a cost estimate for the surgery and that he gave a reason for it being needed as he added "in view of the progression in her arthritis and the exacerbation and aggravation associated with her work injury". Ms Laing's counsel also submitted that all the aspects of Judge Burke's decision in *Rose v Health Commission (NSW)*[32] are met in Ms Laing's case as the surgery proposal follows on other conservative treatment such as physiotherapy, hydrotherapy, medication and injections. It was further submitted that Ms Laing in her statement has given evidence that she is significantly impaired, as walking is difficult, as is working and needing relatives to help in the performance of domestic tasks.

56. Ms Laing's counsel also submitted that Dr Giblin supported that the surgery would be causally needed as a result of the injury on 23 March 2016, even if he said it would be needed long term. Counsel sought an order in Ms Liang's favour that the cost be paid by the respondent for the surgery.

[32] (1986) 2 NSWCCR 32, *Rose*

57. Mr Murray made submissions for the respondent in response in the absence of Mr Saul. He submitted that there was no medical evidence dealing with the point raised by Ms Laing's counsel about the MRI scan findings, that it was significant that the tear on the second scan was at the same place in the knee that a high intensity signal was found in the first scan. Secondly, it was submitted that while Ms Laing has given evidence in her statement about the continuation of her symptoms from the time of the injury on 23 March 2016, in the reports of Dr Ireland he records in June 2016 she had no major restriction of range of motion and no significant swelling and her symptoms were not severe enough to warrant surgical intervention.

58. It was also submitted that Ms Laing's statement is one year old and, as reflected in the evidence, her symptoms wax and wane. It was submitted the most up to date history is that of Dr Hitchen who says Ms Laing is only taking medication intermittently and she has an excellent range of motion in her knee and she can walk half an hour on the flat. It was submitted that, with this level of symptoms, one would not expect they would give rise to the need for a knee replacement.

59. Finally, it was submitted that Dr Ireland does not state when Ms Laing will require a total knee replacement, but it is clear from Dr Giblin who saw her after Dr Ireland and from Dr Hitchen that she does not require the surgery now.

Determination

60. The legal test to be applied when determining whether proposed treatment is *reasonably necessary* as a result of a work place injury as required by section 60 of the 1987 Act was considered in *Diab v NRMA Ltd* (*Diab*)[33] wherein Deputy President Roche cited the decision of Judge Burke in *Rose* with approval and stated:

> "[88] In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in *Rose* (see [76] above), namely:
>
> (a) the appropriateness of the particular treatment;
> (b) the availability of alternative treatment, and its potential effectiveness;
> (c) the cost of the treatment;
> (d) the actual or potential effectiveness of the treatment, and
> (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.
>
> [89] With respect to point (d), it should be noted that while the effectiveness of the treatment is relevant to whether the treatment was reasonably necessary, it is certainly not determinative. The evidence may show that the same outcome could be achieved by a different treatment, but at a much lower cost. Similarly, bearing in mind that all treatment, especially 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."

61. However, I find that the respondent's submission is compelling, that there is no doctor who says that Ms Laing requires a total knee replacement at the moment. This is not a case where there is evidence before the Commission that a treating surgeon has submitted a request for approval to the insurer for the surgery to be actually carried out. Dr Ireland has not proposed undertaking such surgery now. Furthermore, as the respondent has submitted, it does not appear that he has examined Ms Laing since 5 April 2018. While Dr Ireland is of

[33] [2014] NSWWCCPD 72, *Diab*

the opinion that eventually Ms Laing will require surgery, he does not even give a time frame when this could be. Surgery might not actually be required for many years.

62. Dr Giblin actually examined Ms Laing after Dr Ireland and he was of the view that surgical intervention is not anticipated in the immediate future, but long term she is *likely* to require a total knee replacement. He did not state that Ms Laing would definitely require surgery. Obviously much will depend on the state of her left knee over time.

63. Dr Hitchen opined that Ms Laing will eventually come to a knee replacement, but he believes this is best performed when she is close to bone on bone and has failed non-operative management including maximising medication. Clearly there is no time frame for this, all that is certain on Dr Hitchen's examination findings is that Ms Laing's symptoms are not, at this stage, severe enough to warrant surgery.

64. It is my view that the Commission should not make orders under section 60(5) of the 1987 Act without an actual proposal that surgery be undertaken, as to do so is too speculative. It is difficult for the criteria discussed in *Rose* and *Diab* to be properly considered at the present time. For instance, I cannot find on the available evidence that, at the present time, a total knee replacement is appropriate treatment. "Potential effectiveness" of surgery includes a consideration when such treatment is best to be performed and certainly no doctor suggests it is appropriate to be undertaken now. I consider the ARD has been filed prematurely.

65. For these reasons, I am making an award for the respondent. However, this is based on the evidence presently before the Commission and in the future, if there is appropriate additional evidence, it may well be a finding could be made that the surgery is reasonably necessary and the respondent should pay the cost of the same.

66. There was also considerable debate about whether the need for a total knee replacement is *as a result of* the work injury on 23 March 2016. I consider that this causal question is also more appropriate to be determined at the time of an actual proposal to conduct the surgery for the simple reason there may or may not be further relevant matters arising in the intervening period which would need to be taken into account.

67. However, for completeness sake and for the assistance of the parties, I find that weight should not be given to Dr Hitchen's opinion that the effects of the injury on 23 March 2016 would have ceased within a matter of months. Dr Hitchen acknowledges that he did not have the benefit of examining Ms Laing contemporaneously to that injury. In my view, there is an abundant body of evidence to suggest that Ms Laing's symptoms from that injury have been ongoing.

68. For instance, Dr Laird in August and December 2016 was treating Ms Laing for her left knee symptoms and indicated that he thought her symptoms were an aggravation of her longstanding arthritis. It is implicit from Dr Laird's first report that the aggravation he is referring to is that occurring from the work place injury on 23 March 2016 because that is the history he takes in the first paragraph of that report. I find that Dr Laird's findings in his reports demonstrate that Ms Laing had not recovered from that injury, as Dr Hitchen's suggests within months of 23 March 2016.

69. Furthermore, Dr Ireland had the benefit of seeing Ms Laing before her injury, although I have not relied on this fact as he seems to acknowledge he did not have all of his records from that time. But Dr Ireland did see Ms Laing in June 2016 so fairly contemporaneous to her March 2016 injury, and again on 21 December 2017, 24 January 2018 and 5 April 2018. He recommended the Synvisc injection in June 2016 and recommended the same in January 2018. I find this shows a continuity of treatment from the time of the workplace injury in March 2016, beyond the months of which Dr Hitchen speaks.

70. Also, the insurer's own independent physiotherapist in November 2017 had recommended the insurer fund further physiotherapy treatment. This is well over a year post injury. Dr Giblin also found on examination on 29 August 2018 that Ms Laing moved with a slight limp and had 1cm wasting of the left thigh.

71. I find all of the above evidence is consistent with Ms Laing continuing to have effects of the work injury on 23 March 2016 and so I reject the opinion of Dr Hitchen.

72. Dr Hitchen also places weight, as did the respondent's counsel and solicitor, on the fact that Ms Laing had an increase in symptoms after her cruise to Myanmar where she did more walking than usual. Dr Jelinek records in her clinical note dated 1 September 2017 that Ms Laing was going overseas on Monday, so that would have been on 4 September 2017. The next attendance on the doctor is on 4 October 2017 when she complained of knee pains.

73. The respondent's argument overlooks the fact that Dr Jelinek had issued WorkCover medical certificates on 11 November 2016, 8 February 2017, 13 March 2017, 13 May 2017, 8 July 2017 and 11 August 2017. These all record a consistent history of ongoing left knee symptoms and they are quite detailed about the treatment being given to Ms Laing. For instance, the certificate of 11 August 2017, so only a couple of weeks before the overseas trip, has the note:

> "…
> reviewed today 8.7.2017
> Had 4 sessions of hydrotherapy
> Pain reduced and more flexion with her knees
> Exercise physiotherapist has suggested she continues with
> Sessions for 3 months 2x week
>
> Reviewed today 11.8.2017
> Ongoing physiotherapy sessions
> Review after 1 month."[34]

74. Then in the next WorkCover- certificate of capacity dated 4 October 2017 Dr Jelinek adds:

> "Reviewed today 4.10.2017
> Complaining of pains over the medial aspect of the left knee
> Denies any recent injury or fall
> + tenderness over the medial aspect of the left knee"

75. It is important to bear in mind that Dr Jelinek has noted in the certificate on review on 13 March 2017:

> "has been undergoing physiotherapy
> however, pain still persistent over the left leg medial part"

76. So, one can conclude two important points from these records:

    (a) when Ms Laing departed for overseas she had not completed the plan for twice weekly physiotherapy for three months, and

    (b) the complaint of pain noted on her return, in the medial aspect of her knee, was not the first time the pain was recorded medially.

[34] ARD page 190

77. Dr Hitchen has not considered these records and these points, which are self-evident. Therefore, I find that I cannot accept his conclusion that Ms Laing sustained what the respondent's counsel has characterised as a new injury by virtue of Ms Laing walking more when overseas.

78. Ms Laing's counsel submitted that it was relevant that Ms Laing initially had reported to Dr Ireland that she had difficulty walking more than 15 minutes, so he submitted it was not surprising that when she walked more, she experienced more symptoms.

79. In *Albany City Council v Gunton*[35] it was stated that: "It does not follow that every worker with a pre-existing injury who carries out work and suffers pain would have an aggravation of his injury". Deputy President Roche in *Gunton* when making this statement was quoting from the observations of Evatt and Sheppard JJ in *Commonwealth of Australia v Beattie*[36] at [378]. However, as Roche DP goes on to state at [162] in *Gunton*:

> "Each case must depend on its own facts. The symptoms Mr Gunton experienced while doing light part-time work with Mr Harvey were more compatible with a revelation of an existing problem in his back than the genesis of any greater problem (*Middleton v Bergin Transport Pty Ltd*, Burke CCJ, unreported, Compensation Court of NSW, 19 June 2001)."

80. As in *Gunton*, I accept that it is more likely than not on the balance of probabilities that the scenario suggested in her counsel's submissions was a revelation of her existing problem with her left knee, rather than a new injury.

81. The other so-called "injury" that the respondent's counsel placed weight on was the entry in Dr Jelinek's notes on 24 November 2016 of "sports activity in school, twisted her knee again now in pains had steroid injection before."[37] Dr Hitchen did not consider this event nor did the other doctors, but I note that on 11 November 2016 she issued a WorkCover NSW-certificate of capacity. Again, the detail on this certificate is relevant as Dr Jelinek records:

> "Patient reviewed today 11.11.2016
> …
> Patient had the steroid injection with Dr Laird on 28.10.2016 (after getting the insurance approval)
> Pain better on the following week
> However, pain again started over the last week
> Patient still taking Panadol for pain".[38]

82. So shortly before the entry on 24 November 2016 Ms Laing had pains in the left knee despite the steroid injection. I note at one point the respondent's counsel referred to this incident as "non- work" related, but the entry does refer to it occurring at school; as indeed did the first injury in 2006. I took him to mean that Ms Laing has only relied upon the one work-related injury being 23 March 2016.

83. As I have stated above, a determination about the causation aspect of section 60, as to whether any total left knee replacement results from the injury on 23 March 2016, is more appropriately left to when the surgery is actually being proposed because that may be years off and there may or may not be other relevant matters to consider in that interval.

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[35] [2011] NSWWCCPD 68, *Gunton*
[36] [1981] FCA 88; (1981) 35 ALR 369, *Beattie*
[37] ARD page 87
[38] ARD page 147

84. Although, in terms of whether left knee replacement surgery is reasonably necessary *as a result of* the work-related injuries, the case of *Murphy v Allity Management Services Pty Ltd*[39] is authority for the proposition that a condition can have multiple causes and the work injury does not have to be the only, or even a substantial cause, before the treatment is recoverable under section 60 of the 1987 Act. Deputy President Roche stated in *Murphy* that a worker only has to establish that the treatment is reasonably necessary as a result of the injury; that is, did the work-injury materially contribute to the need for surgery. On the present evidence from the Dr Giblin and Dr Ireland it is likely the causation aspect would be resolved in Ms Laing's favour.

85. However, as stated previously in these reasons, I am making an award for the respondent based on the current evidence, because there is no actual proposal for the surgery to be undertaken at the present time.

[39] [2015] NSWWCCPD 49, *Murphy*