WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **2319/19**
Applicant: **Samantha Jeffcoat**
Respondent: **Robert Koltai**
Date of Determination: **15 November 2019**
Citation: **[2019] NSWWCC 367**

The Commission determines:

1. The proposed surgery by way of anterior interbody fusion at the lumbosacral level is declared to be reasonably necessary treatment resulting from injury to the lumbar spine on 6 January 2010.

2. The respondent is to pay the costs of and incidental to the proposed surgery pursuant to section 60 of the *Workers Compensation Act 1987*.

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

W Dalley
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 WILLIAM DALLEY, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Samantha Jeffcoat (Ms Jeffcoat/the applicant) suffered an injury to her lumbar spine in the course of her employment with Robert Koltai (the respondent) on 6 January 2010 (the subject injury). Ms Jeffcoat was aged 18 at the time of the subject injury.

2. Ms Jeffcoat subsequently made a claim for lump-sum compensation pursuant to section 66 of the *Workers Compensation Act 1987* (the 1987 Act). She was examined by an Approved Medical Specialist (AMS), Dr Mastroianni, who issued a Medical Assessment Certificate dated 12 September 2011 assessing Ms Jeffcoat as suffering 7% whole person impairment as a result of the subject injury.

3. The parties subsequently entered into a Complying Agreement pursuant to section 66A of the 1987 Act giving effect to that assessment.

4. Ms Jeffcoat was subsequently referred to an orthopaedic surgeon, Dr Geoffrey Rosenberg, who recommended conservative treatment, noting surgery by way of lumbosacral discectomy and fusion as an alternative if the symptoms became "unmanageable".

5. Ms Jeffcoat returned to see Dr Rosenberg in January 2012 with continuing symptoms. Ms Jeffcoat did not wish to proceed with the surgical option at that time. In June 2012 she returned to see Dr Rosenberg who described her symptoms as "unmanageable". Surgery was discussed and Dr Rosenberg sought approval for anterior interbody fusion at the lumbosacral level (the proposed surgery) from the insurer.

6. The insurer declined to accept liability for the proposed surgery. Ms Jeffcoat commenced proceedings in the Commission seeking a "general order for future treatment expenses and payment of spinal disc fusion surgery." The respondent filed a Reply disputing liability, but the proceedings were subsequently discontinued.

7. In October 2018 Ms Jeffcoat was taken by ambulance to Shoalhaven District Memorial Hospital following an incident at her home when she had fallen when her left leg gave way. Ms Jeffcoat was managed in the Shoalhaven Hospital for a week and was then discharged. Her general practitioner then referred her to the Accident and Emergency Department at The Wollongong Hospital.

8. Ms Jeffcoat was again referred to Dr Rosenberg who ultimately again recommended surgery. The insurer again declined liability stating that:

> "[T]he surgery recommended by Dr Rosenberg is not reasonably necessary treatment as a consequence of the injuries you sustained on 6 January 2010 in the course of her employment with Robert Koltai. We therefore maintain the dispute previously raised the surgery proposed by Dr Rosenberg is not reasonably necessary."

9. Ms Jeffcoat's solicitors filed an Application to Resolve a Dispute (the Application) in the Commission seeking payment of weekly compensation and a declaration pursuant to section 60(5) of the 1987 Act that the proposed surgery constituted reasonably necessary treatment in respect of the subject injury.

10. The respondent maintained the denial of liability on the ground set out in the Dispute Notice and further sought to rely upon an allegation that it was not the last employer on risk liable for the applicant's alleged injury pursuant to sections 15 and 16 of the 1987 Act and notifying reliance on section 59A of that Act.

11. The matter proceeded to a conciliation conference at Wollongong on 7 August 2019. Consent orders were entered into amending the claim for weekly payments and referring the issue of whether the proposed surgery constitutes reasonably necessary treatment resulting from the subject injury to the AMS, Dr Mastroianni, for nonbinding assessment.

12. The applicant consented to an award for the respondent in respect of the claim for weekly payments, but agreement was reached providing for voluntary payments to be made pursuant to section 37 of the 1987 Act from 31 October 2018 to 23 July 2019 at the rate of $625 per week. The issue of liability of the respondent for the proposed surgery was stood over for hearing following receipt of the Medical Assessment Certificate.

13. The documents to be provided to the AMS in support of the referral of a general medical dispute included the Application, the Reply, the documents attached to the Application to Admit Late Documents by the applicant dated 29 July 2019 and the documents attached to the Application to Admit Late Documents by the respondent dated 29 July 2019.

14. The AMS provided a Medical Assessment Certificate by way of assessment of a general medical dispute dated 17 September 2019. The AMS noted:

> "The following documents were referred by the Commission for this assessment:
>
> - The Application and documents listed in, and attached to, the Application.
>
> - The Reply and documents listed in, and attached to, the Reply."

15. The AMS made no mention of the documents attached to the respective Applications to Admit Late Documents which had been included in the documents to be provided to the AMS. At the request of the parties the Commission confirmed that the late documents had been supplied to the AMS and the AMS had affirmed in answer to an enquiry by the Commission that he had received and considered the additional documents.

ISSUES FOR DETERMINATION

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

    (a) Is the proposed surgery reasonably necessary treatment in respect of the applicant's lumbar spine?

    (b) If so, does the requirement for the proposed surgery result from the subject injury?

Matters previously notified as disputed

17. The respondent appropriately conceded that the proposed defence pursuant to section 59A of the 1987 Act was no longer maintainable in view of the agreement for voluntary payment of weekly compensation up to 23 July 2019. The respondent did not press the allegation of injury pursuant to section 15 or 16 of the 1987 Act fixing liability upon a subsequent employer.

PROCEDURE BEFORE THE COMMISSION

18. 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

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

    (a) Application and attached documents;

    (b) Reply and attached documents excluding the reports of Dr George Kalnins dated 24 August 2012 and 17 February 2014;

    (c) documents attached to the Application to Admit Late Documents by the applicant dated 29 July 2019;

    (d) documents attached to the Application Admit Late Documents by the respondent dated 29 July 2019, and

    (e) Medical Assessment Certificate of Dr Mastroianni dated 17 September 2019.

Oral evidence

20. No application was made to adduce oral evidence or to cross examine any witness.

FINDINGS AND REASONS

Issue 1 – reasonably necessary treatment

21. There was no dispute that the proposed surgery constituted “medical treatment” for the purposes of section 60 of the 1987 Act.

22. Counsel for the applicant submitted that the proposed surgery met the criteria referred to by Burke CCJ in *Rose v Health Commission (NSW)*[1] (*Rose*). The proposed surgery was appropriate and competent to alleviate the effects of the injury. Alternative treatments had not successfully relieved the pain resulting from the injury to the lumbar spine.

23. Counsel for the respondent submitted that reports of clinical examination of Ms Jeffcoat established that the complaints of symptoms were not organic and were unreliable as indicators of the need for treatment. Radiological examination did not support a requirement for surgery.

24. Burke CCJ, in *Pelama Pty Ltd v Blake*[2], summarised the matters to be considered in determining whether treatment was reasonably necessary identified in *Rose* to be:

    (a) Appropriateness;
    (b) Alternatives;
    (c) Cost;

[1] [1986] NSWWCC 2; 2NSWWCCR 32.
[2] [1988] NSWWCC6 .

(d) Effectiveness, and
(e) Acceptance by the medical profession.

25. Deputy President Roche in *Diab v NRMA Ltd*[3] (*Diab*) noted that the treatment must be "a reasonable necessity" having regard to all the relevant matters set out in *Rose* according to the criteria of reasonableness. The Deputy President said: "depending on the circumstances, a range of different treatments may qualify as 'reasonably necessary' and a worker only has to establish that the treatment claimed is one of those treatments" (at [86]).

26. Accepting that guidance, I accept the submission of the applicant for the reasons set out below.

27. A number of statements by Ms Jeffcoat were in evidence. The statement dated 30 August 2011 says that it is to be read in conjunction with an earlier statement dated 7 March 2011. That earlier statement does not appear to be in evidence and was not referred to. The statement dated 30 August 2011 deals with a suggestion that Ms Jeffcoat had previously suffered a back injury "when she was thrown from a bull at a rodeo". Ms Jeffcoat said there had been no such fall and the incident referred to was in fact one where she had slipped from the back of a "potty calf" [sic ? poddy calf]. The material in that statement does not bear upon the issues before the Commission in the present proceedings.

28. Ms Jeffcoat's next statement[4] is undated but was attached to the Application to Resolve a Dispute filed on Ms Jeffcoat's behalf in January 2013, suggesting that it was prepared for the purpose of those proceedings, probably in late 2012. Ms Jeffcoat states that she was at that time aged 20 which supports that dating.

29. In that statement Ms Jeffcoat described the activities she was performing which led to her suffering the subject injury. She described treatment, including physiotherapy which she said was beneficial. The physiotherapy however was terminated by the insurer and Ms Jeffcoat said that the pain in her left leg which had been assisted by the physiotherapy then returned with worsening pain in the back. She said that she had been referred to Dr Rosenberg who had discussed surgical options with her, recommending an L5/S1 spinal disc fusion. Ms Jeffcoat said:

> "it has been well over two years since the accident, and it appears I have reached maximum improvement without surgical intervention, I feel I cannot go on with the incapacitating symptoms that I am currently experiencing. I have tried many treatment options but have found them to be of no benefit."

30. Ms Jeffcoat said that the treatment methods had included physiotherapy, hydrotherapy, massage therapy and exercise routines. Ms Jeffcoat noted that the insurer had declined liability for surgical treatment considering that "a conservative exercise program would be most beneficial".

31. Ms Jeffcoat stated that she was then currently taking Nurofen as required and Panadeine Forte at night. She provided an extensive list of the problems with activities of daily living that she was then experiencing[5].

32. The third statement is dated 10 April 2019 at which time Ms Jeffcoat was aged 27. Ms Jeffcoat noted that she was currently living with her parents. She had given birth to three children since the subject injury. The children were born in 2011, 2015 and 2016.

[3] [2014] NSWWCCPD 72.
[4] ARD p 623.
[5] ARD p 625, par 27.

33. Ms Jeffcoat again described the circumstances of her employment and the subject injury. She said that she had no prior injuries to her back and her general health was good at the time she commenced employment with the respondent.

34. Ms Jeffcoat said that she had not been able to return to work with the respondent following the subject injury. She detailed employment that she found with the assistance of a rehabilitation provider, working two or three days per week. She said that she found that her back was getting worse and her employment was terminated. She said she undertook physiotherapy and was referred to an exercise physiologist who developed back strengthening exercises for her.

35. Ms Jeffcoat noted that she had seen Dr Rosenberg who had suggested surgery. She said that she understood that the proposed surgery would not eliminate the pain but had the potential to reduce its severity. Ms Jeffcoat said that her symptoms were becoming "more and more unmanageable". After two years from the subject injury Ms Jeffcoat said that she could no longer manage her symptoms and wished to undergo surgery.

36. Ms Jeffcoat noted the refusal of the insurer to approve the surgery and said that she did not wish to go on the public waiting list because she preferred to rely on Dr Rosenberg. Ms Jeffcoat said:

> "I decided that I would try to learn to live with the pain and survive on pain medication if necessary. I would do basic stretches on my back when it was sore and would also frequently change sitting positions to try and find a comfortable position."

37. Ms Jeffcoat detailed her personal circumstances and her attempts at obtaining further qualifications. She developed problems with her relationship with her partner leading to separation in 2012.

38. She said that in 2014 she had obtained work in a nursing home, but this had aggravated her back pain during the trial period. She had then found work at a different care centre, but this work involved lifting and bending which had aggravated her back pain. Ms Jeffcoat detailed her continuing problems with her back. She noted that the back became worse during her pregnancies.

39. Ms Jeffcoat had tried general office work in 2017 but only lasted three weeks. She said that in about September 2018 her leg pain had started to worsen with difficulty standing, getting up and getting on or off the toilet. On 22 October 2018 Ms Jeffcoat said she was standing in the lounge room when her left leg suddenly collapsed, and she fell to the ground. She said that she had no strength in the leg and was unable to get up. The next day Ms Jeffcoat said she was no better and an ambulance was called, and she was admitted to the Shoalhaven Hospital for a week. On discharge she was returned to the care of her general practitioner, Dr Morgan and was again referred to Dr Rosenberg.

40. Dr Rosenberg had suggested participation in a trial of a form of treatment by way of injection of a substance into the spine which Ms Jeffcoat declined. She said that the only alternative offered by Dr Rosenberg was by way of surgery.

41. Ms Jeffcoat said that following her discharge from Shoalhaven Hospital her partner had terminated their relationship and she had taken an overdose of her pain medication together with Seroquel which had been prescribed for her father. She was taken by ambulance to Shoalhaven Hospital where she remained for a month.

42. Ms Jeffcoat said she continued to have pain and difficulty in her activities of daily life. She provided the same list as that in her earlier statement referred to above. Ms Jeffcoat said that she wished to undertake the surgery in the hope that it would assist with reduction of her symptoms.

North Nowra Medical Centre

43. Clinical records from North Nowra Medical Centre were in evidence detailing attendances from 18 November 2009 to 31 October 2018. The records in evidence exceed 500 pages and largely deal with health issues other than Ms Jeffcoat's lumbar spine. Counsel for the applicant identified a number of pages relevant to the issues in dispute in the current proceedings.

44. Ms Jeffcoat was examined by Dr Graham Morgan, general practitioner, on 2 March 2011[6]. The general practitioner noted a history of injury to the low back while lifting a heavy load. Dr Morgan noted a history of "persistent back and left leg pain aggravated by straight leg raising ligamentous laxity (L) hip". Dr Morgan referred Ms Jeffcoat to Dr Rosenberg and requested an MRI scan. He noted that Ms Jeffcoat was requiring Panadeine Forte at night to sleep.

45. Subsequent entries on 6 April 2011 note persisting low back pain and record that the MRI has not been carried out due to pregnancy. Pain management was discussed. On 20 April 2011, Dr Morgan noted "(L) sided sciatica due to L5/S1 disc prolapse".[7]

46. On 20 July 2011 general practitioner noted "chronic (L) leg pain nerve entrapment not sleeping analgesic options limited due to pregnancy". On 21 September 2011 the general practitioner noted the history of injury to the lumbar spine with persistent low back pain associated with left-sided nerve root pain. He noted that Ms Jeffcoat was now six weeks postpartum and proposed an MRI scan[8].

47. On 28 December 2011 Dr Morgan noted that Ms Jeffcoat had been examined by Dr Rosenberg and was considering lumbosacral discectomy and fusion. The doctor recorded; "child is only 5/12 old and will wait." On 25 January 2012 Dr Morgan discussed anterior fusion with Ms Jeffcoat. He noted that Ms Jeffcoat was "anxious agitated" and found it difficult to discuss problems.[9].

48. On 20 June 2012 Dr Morgan recorded that he participated in a telephone conference at which the interbody fusion proposed at L5/S1 had been discussed. He noted "Home circumstances preclude this."[10]

49. On 10 October 2012 the general practitioner noted "weak protruding desiccated disc L5/S1[11]". On 3 September 2013 another general practitioner, Dr Kok, noted "disc prolapse L5 S1 since 2010 – pain still, limited mvt [scil movement]." Examination disclosed lower back pain at L5/S1, with straight leg raising limited to left 30°, right 60°.[12]

50. On 13 November 2013 Dr Morgan recorded "incapacitating back pain" and "holding herself uncomfortably."[13] Dr Hok on consultation on 28 February 2014 noted "back pain persist [sic] and stable".[14] Dr Hok noted on 28 April 2014 that Ms Jeffcoat "still suffered lower back pain" which radiated to the left leg.[15]

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[6] ARD p 66.
[7] *Ibid.*
[8] ARD p 67.
[9] ARD p 68.
[10] ARD p 70.
[11] ARD p 71.
[12] ARD p 74.
[13] ARD p 77.
[14] ARD p 78.
[15] ARD p 81.

51. On 9 July 2014, Dr Morgan noted “disabled by back and left leg pain” and reduced his assessment of Ms Jeffcoat’s capacity for employment to two days per week[16].

52. Consultations in 2015 and 2016 relate to other health issues. On 26 October 2016 Dr Morgan recorded “back pain long history has used Panadeine Forte suggest cease and trial regular paracetamol[17].”

53. Consultations in 2017 relate to other health issues although there is a note of “L5/S1 disc pathology”. On 21 February 2018 recorded; “suffering chronic back and leg pain discogenic back pain needs assessment”[18]. On 12 September 2018 Dr Morgan recorded “Patient unfit for work of any kind for the foreseeable future due to lumbosacral discogenic back and (L) leg pain. Her pain is steadily worsening. She has had discectomy and fusion proposed by orthopaedic surgeon Dr Geoffrey Rosenberg”[19].

54. On 31 October 2018, Dr Morgan recorded; “Possible cauda equina syndrome has developed urge incontinence since exacerbation of disc prolapse has paraesthesia and weakness (L) leg”[20].

55. The remaining records were not referred to in submissions. They include the referral letters to Dr Rosenberg and a substantial number of pathology results relating to other health conditions unrelated to the present issues.

56. Certificates of capacity issued by Dr Morgan from October 2018 record ongoing pain and note that Dr Rosenberg had suggested pain relief surgery and that there had been a referral to a pain specialist, Dr Ferris.

Wollongong Hospital

57. Records produced by Wollongong Hospital were in evidence. The records include a discharge summary on 22 November 2018 following Ms Jeffcoat’s “intentional overdose, on a background of multiple psychosocial stressors.” The presentation was said to have been “triggered by relationship breakdown, chronic pain, eviction notice from our housing and financial stressors”[21].

58. The discharge summary records:

> “Samantha has chronic back pain from the workplace injury sustained in 2009 [sic]. She is known to Dr Rosenberg (neurosurgeon) in Sydney for this problem and has been recommended spinal fusion at some stage for this. She was recently (four weeks ago) in Nowra Hospital with an acute episode of back and leg pain and urinary incontinence, and admitted under the neurological team.”

59. Ms Jeffcoat was recorded as stating:

> “She said she felt fed up with her continual pain and not able to be as good a mother as she would like to be. Additionally, she wants to challenge her ex-partner to see if he would give her attention, however, this did not occur. This relationship breakdown occurred within the last month, and had been together for the last six years.”

[16] ARD p 83.
[17] ARD p.96
[18] ARD p.98
[19] ARD p.99
[20] ARD p.101
[21] AALD (Respondent) 29 July 2019 p.19

60. An admission on 31 October 2018 is recorded with the presenting problem “left leg weakness/incontinence”. The discharge summary records:

> “Acute on chronic lower back pain:
>
> - pt has experienced worsening of chronic lower back pain
> - pt had been experiencing worsening lower back pain since 25/10/2018
> - initially hurt her back on the job in 2010 while falling backwards over rocks carrying a heavy bag of fertiliser
> - pt just recently discharged from SDMH for lower back pain
> - note that patient had a narcotization episode in SDMH that had to be reversed with 200 µg naloxone
> - pt then sent in by GP due to ongoing issue with reduced mobility/worsening lower back pain/left LL paraesthesia + urinary incontinence”.

61. The history records:

> “- Sunday two weeks ago – leg gave out on her
> - Had pain when she got up
> - Describes not being able to ‘feel her leg’
> - four weeks prior had some back pain → more than usual
> - Normally feels pain in lower back – into the back of her leg
> - Pain doesn’t travel down her entire leg – till knee (LEFT)
> - Describes ‘pulling sensation’ in back – when lifting RIGHT knee[22]”.

62. The summary records that while the MRI “shows a cause for potentially some back pain – however doesn’t explain any radiculopathy/radiological finding of compression on the nerves”. Under the heading “Candidacy for surgery” the notes record that Dr Pitham had explained to Ms Jeffcoat; “it would be extremely unwise for patient to have surgery” because “it would begin a spiral of visits with neurosurgeons for more back surgeries in the future”. The doctor explained to Ms Jeffcoat “that fusion surgeries would put more strain on other discs, leading to more fusion surgery”. The treating doctor at the hospital recommended that Ms Jeffcoat explore physiotherapy as a treatment option.

63. MRI examination of the lumbar spine was reported as showing; “at L5/S1 level, there is disc desiccation. There is minimal posterior annular disc bulge without focal disc protrusion, significant central canal or subarticular stenosis otherwise.” The “COMMENT” is in similar terms; “L5/S1 disc desiccation associated with minimal posterior annular disc bulge. Otherwise no focal disc protrusion, central canal, sub articular, foraminal stenosis or focal nerve root compression is identified.”

64. The presenting complaint is recorded:

> “chronic lower back pain second (sic) to workplace injury 2010 – chronic pain management has been well until two weeks ago – sustained a fall 2nd to paraesthesia in left lower limb and subsequently giving way – nil resolution of pain and was admitted to Shoalhaven Hospital for pain management – discharged two days ago with outpatient plans in situ for chronic pain team referral etc – noted by GP today to have had urinary incontinence and lower limb sensory deficits”.[23]

[22] Ibid p.82
[23] Ibid p.80

65. The Progress Notes record the opinion of the medical officer that back pain does not always require surgery and that the process of dealing with workers compensation "can be draining and focuses attention on to a problem → can make it seem worse than it is". The medical officer commented "current scans look good → will not require surgery at the moment." The medical officer noted that radiologically it was common to find one disc 'worn out' and that with an operation "there might be a small chance that things would improve but also a chance that things will get worse."[24]. The plan on discharge is for physiotherapy, mobilisation and chronic pain management.

Dr Geoffrey Rosenberg, orthopaedic surgeon.

66. A number of reports from the treating orthopaedic surgeon, Dr Geoffrey Rosenberg, were in evidence. In his initial report to the general practitioner, Dr Morgan, Dr Rosenberg noted the mechanism of injury; "whilst lifting a heavy 35 kg bag of fertiliser". He noted the onset of pain in the back and into the left leg and noted that "despite conservative management she is not improving and if anything is worsening." Dr Rosenberg reported that Ms Jeffcoat appeared "very stiff and uncomfortable with limited mobility" and was markedly tender in the lower spine and left buttock. On examination he noted positive straight leg raise, an absent ankle jerk, weakness of the left foot and weakness of the left hamstrings.

67. Dr Rosenberg recommended further investigation but noted that this had to be postponed as Ms Jeffcoat was then pregnant.

68. Ms Jeffcoat was reviewed by Dr Rosenberg on 19 October 2011. In his report dated 21 October 2011 Dr Rosenberg noted that Ms Jeffcoat's back pain was continuing to trouble her "quite significantly" but that her leg pain had improved "somewhat". Dr Rosenberg noted the report of the MRI scan which he said shows "a desiccated disc with some loss of height and a small central bulge." He noted that the scan was taken with Ms Jeffcoat lying down but that she was "far worse with sitting and standing". He said, "There must be a significant inflammatory component and I believe that with loading her spine and disk is weak and more protruding than is immediately apparent." Dr Rosenberg recommended conservative treatment at that time including "core strengthening, regular low impact exercise and ongoing analgesics and anti-inflammatories." He said the only alternative should the symptoms become "unmanageable" is to offer surgery by way of lumbosacral discectomy and fusion.

70. On review in January 2012 Dr Rosenberg reported that Ms Jeffcoat's condition remained unchanged. She was taking Panadeine Forte and Nurofen. He noted that Ms Jeffcoat had pain "most of the time". Dr Rosenberg said the only treatment that he could offer would be by way of surgery, but that Ms Jeffcoat did not wish to proceed with that option at the time.

71. Dr Rosenberg saw Ms Jeffcoat again on 27 June 2012 when Ms Jeffcoat reported that her symptoms were "unmanageable". Dr Rosenberg recorded that Ms Jeffcoat was complaining of "at times, disabling back and left leg pain." Dr Rosenberg again raised the possibility of surgery and on this occasion, Ms Jeffcoat said she was keen to proceed. On review on 17 October 2012 Dr Rosenberg noted that Ms Jeffcoat was continuing to experience back and left leg pain which was worse with standing and walking. He noted that the request for surgery had been declined by the insurer but did not know the basis upon which that decision had been made.

72. Dr Rosenberg, in his report to the treating general practitioner, Dr Morgan noted that "the management of mechanical back pain due to disc injury is a controversial and difficult problem." He said that "at times I find there is minimal collegiate support". Dr Rosenberg commented:

[24] *ibid* p.83

> "Samantha has been consistent and constant in her complaints and strikes me as very genuine. She in fact, is mother of a young child and does not have time to struggle like this. I could send her for a provocative discogram, and I can't see the point of inflicting more pain. I could send her for an upright MRI scan taken with her sitting and standing flexing and extending to see if this will show more disease. Once again I certainly don't feel it is necessary."

73. Dr Rosenberg added; "I can't see how any conservative treatments would be of great benefit at this stage. My experience over the years has been that cortisone injections in this age group are a fleeting benefit only."

74. Dr Rosenberg again saw Ms Jeffcoat on 7 March 2018. Dr Rosenberg noted that Ms Jeffcoat was taking Panadeine Forte, up to eight a day and that on occasions her left leg would give way. He noted complaint of pain down to the back of the knee. He reported; "It is obvious she has ongoing problems due to the lumbosacral disc." He recommended further standing x-ray and MRI scan.

75. Dr Rosenberg noted that the MRI scan showed that; "the lumbosacral disc is slightly diminished in height, it is desiccated and there is a left-sided annular tear". He noted that Ms Jeffcoat continued to have back and left leg pain which he felt was referred from the lumbosacral disc. He said, "the only surgery to address this problem is a large undertaking consisting of a discectomy and fusion."

76. Dr Rosenberg mentioned that he was involved in a pilot study involving the injection of collagen into the annulus of an affected disc, but that trial was at that time waiting ethics approval. Dr Rosenberg examined Ms Jeffcoat on the 20 September 2018. He noted continuing complaints of pain. He said: "At this stage, many years down the track, non-operative measures have not helped. Her options are either to continue to put up with her symptoms, or contemplate surgery."

77. The report of the MRI scan requested by Dr Rosenberg and performed on 21 January 2019 was in evidence. The report with respect to the L5/S1 disc is as follows:

> "**Neutral (sitting) imaging:** There is a 1 mm retrolisthesis. The disc is showing some minor signs of desiccation. There is a small herniation centrally/left paracentral any and it just contacts the left S1 nerve root**.**
>
> **Flexion/extension (sitting) imaging:** the herniation is a little more pronounced with extension.
>
> **Neutral standing/flexion extension (standing) imaging:** No significant change."

78. In the report to Ms Jeffcoat's solicitors dated 13 February 2019 Dr Rosenberg reported that he had sought approval to proceed with surgery for Ms Jeffcoat, but that liability had been denied. He noted the history of injury and ongoing complaints of back and left leg pain. Dr Rosenberg said that on review in January 2019 he had the advantage of a dynamic MRI scan which revealed a small protrusion to the left adjacent to the S1 nerve root. He stated that Ms Jeffcoat:

> "has been consistent in her symptoms as well as her examination. She remains symptomatic because of an injury to her lumbosacral disc. She has failed all non-operative measures. This being the case, I thought on many occasions that it was reasonable to offer her surgical intervention."

He said that he anticipated a 60% to 80% improvement in symptoms with the surgery.

79. A report to Dr Rosenberg in respect of MRI scan performed on 19 July 2018 was also in evidence. That MRI scan provided a basis for comparison with the earlier scan on 11 February 2014. The report concludes “Small broad-based posterior disc protrusion at L5/S1 without convincing evidence of nerve root compression. Overall appearances are stable relative to 2014.”

80. In a report to Ms Jeffcoat’s solicitors dated 24 July 2019 Dr Rosenberg noted injury to the lumbosacral disc in 2010 and the continuance of back and leg pain since that time. He said; “she has tried non-operative treatment and I believe it reasonable to offer her surgical intervention. Appropriate surgery in her, involves a lumbosacral discectomy and fusion.” Dr Rosenberg said that the disc was unstable and the only way to overcome that problem was to stabilise it “by excising it and fusing it” in the manner described in his report.

Dr Mark Ryan, Cardiologist.

81. Ms Jeffcoat was examined by Dr Mark Ryan, cardiologist, at the request of Ms Jeffcoat’s general practitioner, Dr Morgan, in the course of her hospitalisation between 23 October 2018 and 29 October 2018 at the Shoalhaven Hospital. Dr Ryan reported that Ms Jeffcoat had been admitted with back pain. He noted the history of injury in 2010 and that “a recent MRI had shown some disc protrusion”. He noted complaints of pain in both legs but particularly “with some sciatic type pain radiating down the left”. He noted that Ms Jeffcoat had difficulty walking but that there were no bowel or bladder symptoms.

82. Dr Ryan reported “When I saw her sensory changes were non-dermatomal, reflexes were brisk and all present with toes down going. The rest of the examination was unremarkable. Power was limited by pain.” Dr Ryan noted that pain had been treated with “regular paracetamol, low-dose Targin, Ibuprofen and PPI cover”. He reported that Ms Jeffcoat had improved with physiotherapy and after mobilisation had been discharged home in the care of her general practitioner. He said; “There didn’t seem to be an obvious precipitant on this occasion and we’ll just have to see how she progresses.”

Dr Alan Searle, orthopaedic surgeon.

83. Ms Jeffcoat was examined by Dr Alan Searle, orthopaedic surgeon, at the request of her then solicitors on 9 March 2011. Dr Searle noted the history of injury on 6 January 2010. Dr Searle noted that Ms Jeffcoat had been prescribed Panadeine Forte and undertaken physiotherapy with temporary relief. He noted that Ms Jeffcoat had continued to carry out the exercises that had been prescribed for her.

84. Dr Searle recorded that there had been no further injury since 6 January 2010. Ms Jeffcoat complained of constant back pain aggravated by prolonged sitting, standing, bending or lifting. He noted pain extending into the left thigh intermittently and interference with activities of daily living.

85. Dr Searle found reduced range of motion on examination with pain at the extremes. Dr Searle noted that the CT scan of the lumbar spine dated 22 January 2010 showed an L5/S1 disc protrusion with no other obvious abnormality shown.

86. Dr Searle stated: “It appears to me that conservative treatment has failed this patient and however unpleasant the thought of surgery may be she requires a disc excision at the L5/S1 level.”

Dr Anthony Smith, orthopaedic surgeon

87. Ms Jeffcoat was examined by Dr Anthony Smith, orthopaedic surgeon, on 30 March 2011 at the request of the insurer. Dr Smith noted the circumstances of injury with the onset of immediate pain in the lower back and left leg. Dr Smith noted the conservative treatment offered including physiotherapy and medication with some improvement in symptoms. Dr Smith noted continuing complaints of pain in the lower back, left leg and thigh.

88. Dr Smith noted the CT scan from 22 January 2010 which he said showed all discs to be narrow in height with an annular bulge at L3/4, L4/5 and L5/S1. He noted arthritic changes in the facet joints at L3/4, L4/5 and L5/S1.

89. On physical examination he noted normal lumbar lordosis. He noted straight leg raising too painful from 0° on the left and 15° on the right. Dr Smith commented:

> "The restriction in back movements she exhibits is unphysiological. The restriction in straight leg raising is unphysiological. There is no reason for any restriction in straight leg raising in any event. There is no disc protrusion of note. She has degenerative bulging at multiple levels but there is no sign of any nerve root impingement anywhere in the CAT scan. It is inconsistent that she should have a restriction and hip flexion as well as straight leg raising and is also inconsistent that she can sit with the legs over the side of the bed with hips flexed at 90° and no discomfort.
>
> She is manufacturing physical signs."

90. Dr Smith was of the opinion that Ms Jeffcoat had recovered from the effects of the subject injury. He felt that the injury had resolved, and that Ms Jeffcoat would be able to return to work although he noted "she does have a very abnormal back, which she has inherited".

91. Dr Smith was of the opinion that there was no indication for any surgical procedure, and he was of the view that Ms Jeffcoat had recovered and was fit for work. He did not feel that any treatment was required. He said that "the symptoms from the injury would have lasted three months at the most and more likely only a few weeks".

92. Dr Smith was of the opinion that Ms Jeffcoat did not wish to work. He felt she was manufacturing her symptoms.

93. In a further report dated 5 May 2011 Dr Smith stated:

> "[Ms Jeffcoat] has an abnormal back and propensity to back injury and/or back symptoms from time to time without injury of note. She is also prepared to manufacture physical signs and exaggerate any symptoms she may have from time to time. It was my opinion that she had recovered from her injury on 6 January 2010."

Dr Robert Breit, orthopaedic surgeon

94. Ms Jeffcoat was examined by Dr Breit at the request of the insurer's solicitors on 13 June 2019. His report dated 20 June 2019 was in evidence. Dr Breit briefly noted Ms Jeffcoat's post injury employment history, the history of the subject injury and subsequent treatment. Dr Breit recorded complaints of pain in the low back and left side extending down the leg. Ms Jeffcoat said she was using a walking stick when her back was really bad and had only a short tolerance for walking. She could not do any lifting or carrying and was able to sit without too much difficulty.

95. On examination, Dr Breit noted straight leg raising to 30° bilaterally with the complaint of low back and buttock pain although he noted that Ms Jeffcoat was able to sit with her hips flexed at 90°. He said:

> "Puzzlingly, there did appear to be sciatic nerve root irritability on the left. There was however, a claim of global diminution of sensation in the left leg. There was no wasting, reflexes were normal and there was gross global weakness. Although she had been able to walk on tiptoe, I could readily overcome plantar flexion, on the left EHL strength was associated with cot wheeling, eversion strength was negligible, and I was readily able to overcome the extension and flexion when seated over the edge of the examination couch."

96. Dr Breit noted the report of the lumbar MRI scans on 20 July 2018 and 21 January 2019. Dr Breit stated that he considered Ms Jeffcoat's current condition to be causally related to the subject injury. Dr Breit was asked to provide details of "further alternative conservative treatment is available which may assist the worker". He replied that this would depend on the availability of services in the local area. He recommended psychological and psychiatric assessment as well as hydrotherapy.

97. Dr Breit said that he did not consider the proposed surgery to be reasonably necessary. He said;

> "although a lot of this lady's complaints have been reasonable from what I can determine in the past, the more recent events in the current situation is not of organic origin.
>
> Although there was some evidence of sciatic nerve root irritability, the weakness was inconsistent and to such extent that she should have great difficulty walking which was not the case.
>
> Global sensory loss in the lower extremity is not organic in nature. So those findings alone would make any surgical intervention inappropriate in my opinion."

98. Dr Breit said that the proposed surgery was unlikely to produce any benefit or allow Ms Jeffcoat to return to any employment. He noted her relative youth and the evidence of pathology in the disc above with "no real evidence that pain does originate in that area". Dr Breit commented that:

> "One would also have to consider that someone who states the pain during pregnancy was horrendous she subsequently gone on and had another two successfully pregnancies [sic] with young children she has to do a lot of lifting and carrying. It is not uncommon for young mothers to complaint [sic] of back pain."

Dr Tommasino Mastroianni, AMS

99. Ms Jeffcoat's claim for lump-sum compensation pursuant to section 66 was referred to an AMS, Dr Mastroianni, who examined Ms Jeffcoat on 8 September 2011. The Medical Assessment Certificate dated 12 September 2011 was in evidence.

100. The AMS noted the history of injury and the subsequent attendance at the Accident and Emergency Department of the Bowral Hospital. He noted that Ms Jeffcoat had been prescribed medication and physiotherapy and had attended a strengthening program. He recorded that, at that stage, Ms Jeffcoat had not seen a specialist for treatment.

101. The AMS noted complaints of lower back pain radiating to the left buttock and the left leg intermittently. Ms Jeffcoat informed the AMS that her symptoms had worsened since giving birth. On examination the AMS found muscle tenderness and localised tenderness over the L5/S1 segment both to palpation and percussion. Flexion and extension were limited as was rotation and tilt. Movements were asymmetrical.

102. The AMS noted the report of the CT scan of the lumbosacral spine dated 25 January 2010. He diagnosed "chronic back pain and left sciatica" with no radiculopathy. He recorded that Ms Jeffcoat was "pain focused" but she appeared "quite genuine and there were no inconsistencies during the examination."

103. The AMS assessed Ms Jeffcoat as falling within DRE Lumbar Category II and assessed 7% whole person impairment including allowance for interference with activities of daily living.

104. In the current proceedings a general medical dispute was referred to Dr Mastroianni to address the question "is the surgery proposed, lumbosacral discectomy and fusion at L5/S1, reasonably necessary treatment as result of lumbar spine injury on 6 January 2010?" The AMS was supplied with the Application, Reply and the late documents admitted on behalf of the applicant and respondent respectively.

105. The AMS noted the history of injury and the continuing symptoms of back and left leg pain. The AMS reviewed a number of MRIs including the most recent dated 21 January 2019 which he concluded showed an L5/S1 disc protrusion. The AMS carried out physical examination and noted a slight limp favouring the left leg. He noted difficulty walking on heels and toes. There was normal spinal curve. On examination the AMS found postural muscle guarding but no muscle tenderness. There was marked tenderness at the L5/S1 level both to palpation and percussion.

106. Examination of the lower limbs showed global hypoaesthesia in the left leg both to light touch sharp stimuli. There was no difference detected in power in either leg. Reflexes were normal and symmetrical.

107. The AMS noted that Ms Jeffcoat's activities of daily living were affected as was her quality of life. He noted that Ms Jeffcoat had not responded to conservative treatment. The AMS considered that the proposed surgery is reasonably necessary as a result of the lumbar spine injury on 6 January 2010.

108. The AMS commented on the reports of Dr Searle and reports of Dr Kalnins (although the latter were not in evidence in the current proceedings). He made no comment on the reports of Dr Breit and did not directly address the Wollongong Hospital notes which recommended against surgery.

109. Counsel for the respondent submitted that the view of Dr Breit should be accepted. The view of Dr Breit was supported by the opinion of the Medical Officer at Wollongong Hospital where Ms Jeffcoat was seen by the neurology team. The various reports demonstrated inconsistencies in Ms Jeffcoat's presentation noted by Dr Breit and Dr Smith. It was likely that examination would not form a reliable base for the conclusion that surgery was required. The cardiologist, Dr Ryan, had also noted non-dermatomal sensory changes and did not suggest surgery as a treatment option.

110. The opinions of Dr Smith, Dr Breit and the neurological team at Wollongong Hospital and the opposing opinions of Dr Searle, Dr Rosenberg and the AMS bear upon the appropriateness of the proposed surgery, the effectiveness of the treatment and its acceptance by the medical profession.

111. In *Tudor Capital Australia Pty Ltd v Christensen*[25] McColl JA said:

> "[363] Nevertheless, '[a]lthough not bound by the rules of evidence, there can be no doubt that the [Workers Compensation] Commission is required to be satisfied that expert evidence provides a satisfactory basis upon which the Commission can make its findings' [quoting from *Kostas v HIA Insurance Services Pty Ltd*[26] and 'the question of the acceptability of expert evidence will not be one of admissibility but of weight.' [Noting *Hancock v East Coast Timber Products Pty Ltd*[27]]
>
> [364] The Commission is required to draw its conclusions from material that is satisfactory, in the probative sense, in order that it act lawfully and in order that conclusions reached by it are not seen to be capricious, arbitrary or without foundational material. [*Onesteel Reinforcing Pty Ltd v Sutton*[28]]. In cases where the experts differ, the lay tribunal must apply logic and common sense to the best of its ability in deciding which view is to be preferred or which parts of the evidence are to be accepted, an exercise which cannot be carried out without knowing the essential integers of the expert opinion.[*Makita (Australia) Pty Ltd v Sprowles*[29]."

112. Although there is a hiatus in the clinical records of the general practitioner with regard to complaints of pain in 2015, 2016 and 2017, I accept that Ms Jeffcoat has had a continuous history of low back pain since the subject injury and that the pain has intermittently extended into the left buttock and thigh depending on activity.

113. I accept that, following the request for surgery being declined, Ms Jeffcoat resolved to attempt to "get on with her life" and live with the pain. No treatment was offered to her and there would have been no point in complaining to her doctor.

114. More recent entries in the clinical notes record the long-standing nature of Ms Jeffcoat's symptoms and the general practitioner's notes in his referral letters accept the chronicity of the symptoms. I accept that evidence.

115. It is not in dispute that the subject injury gave rise to whole person impairment of 7% in the lumbar spine assessed as permanent. I accept that this level of impairment gave rise to significant interference with activities of daily living as recorded by the AMS in the Medical Assessment Certificate dated 12 September 2011.

116. Dr Smith did not accept that Ms Jeffcoat was continuing to suffer symptoms as a result of the subject injury. He was of the opinion that her symptoms were feigned. I do not accept that opinion. Dr Searle, Dr Rosenberg and the AMS of all accepted Ms Jeffcoat as reliable.

117. Dr Breit noted complaints described as non-organic but did agree that there was pathology in the lumbar spine caused by the subject injury which adversely affected Ms Jeffcoat's ability to work. He diagnosed lumbar spondylosis with non-verifiable radiculopathy.

118. Dr Breit was of the opinion that the proposed surgery was unlikely to produce any benefit. He felt that the findings on examination "would make any surgical intervention inappropriate". This view was supported by the neurology team at Wollongong Hospital.

119. Dr Searle, who was the first specialist to examine Ms Jeffcoat, was of the opinion that surgery would be appropriate at the L5/S1 level. He expressed his view prior to Ms Jeffcoat seeing Dr Rosenberg. Dr Rosenberg preferred conservative treatment but when this failed,

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[25] [2017] NSWCA 260.
[26] (2010) 241 CLR 390; [2010] HCA 32 at [17].
[27] (2011) 80 NSWLR 43; [2011] NSWCA 11 (at [82]-[83]) per Beazley JA (Giles and Tobias JJA agreeing).
[28] [2012] NSWCA 282; (2012) 13 DDCR 351 (*Onesteel*) (at [3]) per Allsop P; see also (at [59]) per McColl JA; (at [79]) per Basten JA.].
[29] (2001) 52 NSWLR 705; [2001] NSWCA 305 (at [71]) per Heydon JA].

he was firmly of the opinion that the options were to deal with the pain by way of medication or to undergo the proposed surgery.

120. I accept that the symptoms of low back pain has continued for more than nine years and Ms Jeffcoat has reached a point where it is seriously impacting upon her well-being.

121. I accept that conservative treatment has not resolved or significantly reduced the pain which I accept is at a level where Ms Jeffcoat finds it difficult to carry on her activities of daily life without reliance on strong medication which is likely to bear upon her activities of daily living.

122. As noted above, Deputy President Roche in *Diab* said that "depending on the circumstances, a range of different treatments may qualify as 'reasonably necessary' and a worker only has to establish that the treatment claimed is one of those treatments".

123. I accept that the level of pain played a part in Ms Jeffcoat's admission to hospital following a deliberate overdose and I accept that pain is significantly impacting her emotional state.

124. Dr Searle, Dr Rosenberg and the AMS accept that the treatment is "reasonably necessary". They appear to accept that the proposed surgery is appropriate to attempt to reduce the level of symptoms, particularly in the left leg.

125. In considering the later Medical Assessment Certificate provided by the AMS I accept the submission of the respondent that the opinion expressed by the AMS is not binding and its weight is reduced by the absence of any reference to the opinions of Dr Breit or the neurological team at Wollongong Hospital.

126. Nevertheless, the report does support the views of Dr Searle and the treating specialist Dr Rosenberg. I prefer the view of those doctors as the proposed alternatives suggested by Dr Breit and the neurological team at Wollongong Hospital have not in the past provided effective lasting relief. I accept that there is a reasonable prospect that the proposed surgery will be effective to reduce the level of symptoms experienced by Ms Jeffcoat and therefore be appropriate in the circumstances, given the lengthy history of continuous pain and the failure of conservative measures.

127. No submissions were addressed to the cost of the procedure which I infer would be performed at the normal scheduled rates.

128. Dr Rosenberg drew attention to the difference of opinion between medical practitioners as to the acceptability of the proposed surgery. While the proposed surgery may not have the universal support of the appropriate specialists, I am satisfied that there is reasonable support within the profession as evidenced by the acceptance of the procedure by Dr Searle, Dr Rosenberg and the AMS.

129. Weighing the opinions of Dr Searle, Dr Rosenberg and the AMS against those of Dr Breit and the Neurology Team at the Wollongong Hospital and noting that Dr Ryan does not refer to surgery, it seems to me that the treatment options suggested by Dr Breit and the Neurology Team have previously been tried without ongoing benefit to Ms Jeffcoat who has been continuously in pain since 2010. The proposed surgery offers hope of an ongoing reduction of symptoms and I am satisfied that the proposed surgery does constitute reasonably necessary treatment in respect of the pathology in Ms Jeffcoat's lumbar spine.

Issue 2 – resulting from the subject injury

130. I accept that there is a continuing history of back pain and pain extending into the left buttock and thigh from the date of the subject injury to the present.

131. I accept Dr Breit when he says that the pathology observed in the lumbar spine is causally related to the subject injury. That view accords with the opinion of Dr Searle, Dr Rosenberg and the AMS.

132. Counsel for the respondent submitted that the chain of causation was not shown to be complete or unbroken. The applicant had suffered a fall at home in October 2018 and had herself recorded that work that she had performed for other employers had increased her symptoms. Other activities of daily life had contributed such as vacuuming and performing housework. The Wollongong Hospital records[30] established an increase in painful symptoms upon lifting a vacuum cleaner.

133. I do not accept that the activities referred to broke the chain of causation. I accept that, as a result of the subject injury, Ms Jeffcoat has suffered painful symptoms in her lumbar spine and left buttock and thigh which has from time to time been aggravated by activities of daily living but there appears to been no change in the level of pathology revealed by the reports of the MRI scans over the years. Although the level of symptoms has increased, I accept that it is probable that the activities of daily life and Ms Jeffcoat's employment tasks and domestic duties have from time to time aggravated the pathology caused by the subject injury.

134. To the extent that the present level of pathology has been increased by the activities of daily life, employment tasks subsequent to the subject injury and childbearing, I accept that there can be multiple causes for an existing level of pathology[31] but in this case it is unlikely that there would be any requirement for surgery if not for the disruption to the L5/S1 disc caused by the subject injury.

135. I am satisfied on the whole of the evidence that the pathology in the lumbar spine that gives rise to the proposal for surgery results from the subject injury.

136. Accordingly, the applicant is entitled to a declaration that the need the proposed surgery constitutes reasonably necessary treatment as a result of injury to the lumbar spine on 6 January 2010.

137. The respondent is to pay the costs of, and incidental to, the proposed surgery.

[30] AALD (Applicant) 29 July 2019 p 63.
[31] See *ACQ Pty Ltd v Cook*; *Aircair Moree Pty Limited v Cook* [2009] HCA 28 at [27].