WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **1242/20**
Applicant: **Ranjith Pathirage Don**
Respondent: **The Secretary, Ministry of Health NSW**
Date of Determination: **8 May 2020**
Citation: **[2020] NSWWCC 145**

The Commission determines:

1. The applicant sustained injuries to his face, right shoulder, neck and back, and he suffered a primary psychological injury arising out of or in the course of his employment with the respondent on 5 January 2018.

2. The applicant's employment was a substantial and/or the main contributing factor to his injury.

3. The applicant requires medical treatment as a consequence of his injury and the respondent is liable to pay reasonably necessary medical expenses.

4. The proposed L4/5 laminotomy and decompression, and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of the applicant's employment with the respondent on 5 January 2018.

The Commission orders:

5. The name of the respondent in amended to The Secretary, Ministry of Health NSW.

6. The respondent is to pay the applicant's reasonably necessary medical expenses with respect to the proposed L4/5 laminotomy and decompression, and associated expenses, pursuant to section 60 of the *Workers Compensation Act 1987*.

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

Glenn Capel
Senior Arbitrator

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

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Ranjith Pathirage Don (the applicant) is 64 years old and commenced employment with The Secretary, Ministry of Health NSW (the respondent) as a social worker/ mental health clinician in approximately 2008.

2. There is no dispute that the applicant injured his face, right shoulder, neck and back, and he suffered a primary psychological injury, when he was assaulted at work on 5 January 2018. Liability was accepted by Employers Mutual Ltd (the insurer). I understand that the applicant is working for two days per week at the Redfern Mental Health and he is still receiving some weekly payments and medical expenses in respect of his psychological injury.

3. On 17 May 2019, the applicant's treating neurosurgeon, Dr Rao, sought approval from the insurer to perform an L4/5 laminotomy and decompression. There is no dispute that the condition in the applicant's back is such that the proposed surgery is reasonably necessary.

4. On 4 September 2019, the insurer issued a notice pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act), disputing that it was liable for the payment of weekly compensation and medical expenses in respect of his physical injuries. The insurer also disputed that it was liable for the cost of the proposed lumbar surgery. It cited ss 33, 59 and 60 of the *Workers Compensation Act 1987* (the 1987 Act).

5. On 1 October 2019, the insurer reviewed its decision pursuant to s 287A of the 1998 Act and informed the applicant that it maintained its position. A notice dated 27 September 2019 appears to have a draft version that was not sent to the applicant.

6. On 5 February 2020, the applicant's solicitor requested the insurer to review its decision. It appears that there was no response to this request.

7. By an Application to Resolve a Dispute (the Application) registered in the Workers Compensation Commission (the Commission) on 5 March 2020, the applicant claims medical expenses for proposed medical treatment pursuant to s 60 of the 1987 Act due to injury sustained on 5 January 2018.

ISSUES FOR DETERMINATION

8. The parties agree that the following issue remains in dispute:

    (a) whether the proposed L4/5 laminotomy and decompression is reasonably necessary as a result of the injury sustained on 5 January 2018 – s 60 of the 1987 Act.

PROCEDURE BEFORE THE COMMISSION

9. 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

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

    (a) The Application and attached documents, and
    (b) Reply and attached documents.

Oral evidence

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

REVIEW OF EVIDENCE

12. Much of the evidence in this matter relates to the other parts of the applicant's body that were injured in the assault. Given the nature of the dispute, I will focus my review on the evidence concerning the applicant's lumbar spine. I will not refer to the complaints, treatment or opinions relating to the applicant's other injuries.

Applicant's statements

13. The applicant provided a detailed statement on 28 February 2020. He described the circumstances of his injury on 5 January 2018 when he was assaulted by a psychiatric patient. He suffered injuries to his head, face, tongue, neck, shoulders and back.

14. The applicant stated that he had an MRI scan on 27 April 2018. He experienced pain in his lower back radiating down his left leg. In June 2018, he was referred to Dr Rao who diagnosed left sacroiliac joint dysfunction related to the assault. The doctor recommended injections.

15. The applicant stated that he had a bone scan and CT scan in March 2019 that showed facet joint arthritis at L4/5 level. On 20 May 2019, he told Dr Rao that he had tingling in his back and legs that restricted his ability to walk. Dr Rao recommended lumbar surgery, but the applicant was concerned about the risks associated with the procedure.

16. The applicant stated that he saw Dr Rao on 13 December 2019. He reported that he had ongoing pain and a restricted range of movement in lower back, together with sciatica. The doctor referred him to Dr Gambhir for review with the possibility of spinal surgery to relieve his leg symptoms. The need for surgery was supported by Dr Lai.

17. The applicant stated that he ceased having physiotherapy because the insurer was no longer paying for it. He continued to take analgesic medication for his pain, but this only provided short-term relief.

18. The applicant stated that the constant back pain and restrictions impacted on his day to day activities. He had a restricted range of movement, pain and tingling sensations in his lower back and both legs and numbness in left leg. He had difficulty with self-care, carrying, bending, sitting, pushing, pulling, twisting, kneeling squatting, stooping, driving, ascending and descending stairs and lifting items above shoulder height. He was no longer able to participate in recreational, domestic and leisure activities, such as bushwalking and gardening, due to his neck and low back symptoms.

19. The applicant stated that he was keen to have the surgery because he had exhausted all other treatment options and he had no choice but to have the surgery in order to relieve his pain and leg symptoms, and to allow him to return to his pre-injury duties.

Clinical notes of Canterbury Hospital

20. The clinical notes of Canterbury Hospital confirm that the applicant attended on 5 January 2018 following the assault at work. He was tender in his lower back at L4/5, but there was no evidence of bruising. X-rays revealed no abnormality in the lumbar spine.

Clinical notes of Stanhope Medical Centre

21. The clinical notes of the Stanhope Medical Centre commence on 17 October 2009 and conclude on 7 January 2020. The first reference to any low back pain was at the consultation with Dr Amjad on 6 January 2018, the day after the assault.

22. The applicant attended the practice on a regular basis for his various injuries, and he complained of left sided low back pain at most of the consultations in 2018 and 2019.

23. In a report dated 18 May 2018, Dr Amjad advised that the insurer had ceased paying for physiotherapy treatment. The applicant was still taking Endone and Panadeine Forte, and the doctor indicated that the applicant still required physiotherapy.

Reports and clinical notes of Dr Rao

24. Dr Rao reported on 25 June 2018. He recorded that the applicant had low back and left leg pain, and he was taking medication including Panadeine Forte and Endone. Physiotherapy had provided “fantastic” relief, but this was only short-lived. He suspected that the applicant had left sacroiliac joint dysfunction as a result of the assault. He arranged a bone scan.

25. In a report dated 11 February 2020, Dr Rao stated that the applicant had never complained of back pain prior to the significant assault at work and he had previously not taken any medication. He indicated that the applicant suffered significant injuries and the pathology related to the assault. He could not understand how Dr Maxwell could attribute the applicant’s symptoms to a pre-existing condition in the absence of a history of previous reports of pain and appropriate radiological testing.

26. Dr Rao stated that he did not think that the applicant’s back pain was coming from the lumbar facet joint. He acknowledged that the sacroiliac joint could be a source of significant pain although the current diagnostic criteria was controversial.

27. In reports dated 17 May 2019 and 20 May 2019, Dr Rao stated that the applicant had spinal stenosis and degenerative discs at L4/5 with facetal hypertrophy and narrowing. He considered that the applicant was a good candidate for surgery, and he sought approval from the insurer to perform an L4/5 laminotomy and decompression to prevent a worsening of the applicant’s symptoms. On 13 December 2019, the doctor advised that he had referred the applicant to Dr Gambhir for review and management as a public patient at Nepean Hospital.

Report of Dr Lai

28. Dr Lai reported on 28 January 2020. He recorded that the applicant had low back pain radiating down his legs to his knees following the assault. He was referred to Dr Rao for treatment of his back symptoms, and an MRI scan dated 27 April 2018 showed an L4/5 disc bulge with severe facet joint arthropathy and flaval hyperplasia, and moderately severe central foraminal stenosis abutting the L4 nerve root. There was also a broad based disc bulge at L3/4 and mild to moderate foraminal stenosis. A bone scan dated 8 March 2019 showed moderately severe facet joint arthritis at L4/5.

29. Dr Lai noted that Dr Rao diagnosed left sacroiliac joint dysfunction due to trauma and he recommended conservative treatment including physiotherapy. In May 2019, Dr Rao recommended an L4/5 microdiscectomy to treat his on-going pain, because medication and physiotherapy had not alleviated his symptoms. The applicant complained of low back pain radiating into his buttocks and legs, together with paraesthesia. He was taking Tramal for his pain.

30. Dr Lai diagnosed a traumatic aggravation of lumbar spondylosis. The applicant had no prior low back or leg symptoms. The doctor stated that the applicant had compression of his spinal nerve roots resulting in the radiation of pain to his buttocks and knees. His symptoms had not improved with alternative treatment, and the proposed procedure was particularly effective to relieve leg pain caused by foraminal stenosis, with a reported 80% success rate.

Report of Dr Maxwell

31. Dr Maxwell reported on 7 August 2018. He recorded details of the assault and noted that the applicant experienced low back pain. He was prescribed Panadeine Forte and Endone by Dr Amjad, and he had been receiving physiotherapy treatment which was assisting his symptoms.

32. Dr Maxwell noted that the applicant's low back pain was on the left side, in the region of the left sacroiliac joint. He had stiffness in his back and some aching in his left thigh with prolonged sitting. He was no longer able to mow the lawns and he was only able to walk one kilometre before he experienced low back pain.

33. Dr Maxwell stated that it was unlikely that the applicant injured his sacroiliac joint in the assault, and he felt that it was more likely that the symptoms were coming from the L5/S1 facet joint, which might partly be due to a direct injury but probably due to some diffuse changes which had developed. There was no radiculopathy. He considered that the changes were pre-existing and there was constitutional spinal stenosis at L4/5. He recommended that the applicant be encouraged to return to normal physical activity levels.

Report of Dr Cochrane

34. Dr Cochrane reported on 26 August 2019. He recorded a consistent history of the incident and noted that the applicant had no relevant pre-existing symptoms in his lower back. The applicant complained of low back pain that impacted on his sleep and his ability to stand, walk and perform domestic tasks. He was working two days a week.

35. Dr Cochrane considered that the applicant suffered a soft tissue or musculoligamentous injury to the lumbar spine which likely caused a temporary aggravation of lumbar spondylosis. He stated that the radiological studies were consistent with pre-existing spondylosis, and moderate to marked degenerative canal stenosis at L4/5. There were moderate restricted lumbar movements without verifiable radiculopathy, and no overt neurological dysfunction.

36. Dr Cochrane considered that the soft tissue injuries and the aggravation of lumbar spondylosis had resolved, and he felt that the applicant's symptoms were due to age-related degenerative or constitutional changes. The effects of arthropathy were the predominant cause of ongoing back symptoms and represented a progressive degenerative condition. Therefore, the applicant's employment was not a substantial contributing factor to his current symptoms.

37. Dr Cochrane stated that the applicant "very reasonably" described significant pain and soft tissue injuries and there were no inconsistencies. However, his symptoms could not be attributed to the work-related injury and were more likely due to a manifestation of the underlying degenerative condition. He indicated that decompressive surgery at the L4/5 level would not be addressing the effects of work injury, but the pre-existing degenerative condition.

38. Dr Cochrane stated that the applicant might benefit from pain management treatment and rehabilitation, and he confirmed that his lumbar spinal condition might respond to surgery although this would be treating the pre-existing condition. He understood Dr Rao's rationale for the operation to treat the applicant's current symptoms and pathology. He reported that the applicant was reluctant to have surgery.

APPLICANT'S SUBMISSIONS

39. The applicant's counsel, Mr Morgan, submits that Dr Cochrane indicated that he fully understood Dr Rao's rationale for the surgery, and he supported the treatment, although he did not accept that the need for the operation was due to the work injury. He thought that it was likely that the applicant had aggravated the lumbar spondylosis, but this had resolved. The surgery would not be addressing the effects of his work injury. A similar opinion was expressed by Dr Maxwell. This is the nature of the current dispute.

40. Mr Morgan submits that the applicant has provided a comprehensive history in his statement. He stated that there were no past back injuries, and following the assault, he had an MRI scan and sought treatment from Dr Amjad and Dr Rao.

41. Mr Morgan submits that the clinical notes of the Stanhope Medical Centre contain continuing complaints of back pain since the work incident. Absent any explanation why the complaints were continuing, the respondent must fail. Dr Cochrane reported that the applicant had left side low back pain, and this was also mentioned in Dr Amjad's notes. Dr Amjad reported on 18 May 2018 that the applicant was making progress with physiotherapy, but the insurer had stopped this treatment. The applicant continued to take Endone for his pain.

42. Mr Morgan submits that Dr Rao diagnosed left sacroiliac joint dysfunction post trauma, and in his report dated 11 February 2019, the doctor confirmed that the applicant had no prior back pain and he had not taken any medication. He questioned how Dr Maxwell could describe the applicant's condition as pre-existing, on a background of no previous reports of pain and without appropriate imaging. Dr Rao disagreed that the applicant's pain was coming from the lumbar facet joint, and he felt that it was coming from the applicant's left sacroiliac joint.

43. Mr Morgan submits that in his report dated 20 May 2019, Dr Rao recorded that the applicant's sacroiliac pain had settled quite well, but he still had symptoms such as tingling in his legs. Dr Rao identified the pathology at L4/5 as shown on the MRI scan and he recommended a laminotomy and decompression. On 13 December 2019, he reported that the applicant still had on-going back pain with radicular symptoms.

44. Mr Morgan submits that the applicant was initially reluctant to have surgery, and he had an injection, but in December 2019, he was referred to Dr Gambhir for review and to perform surgery.

45. Mr Morgan submits that Dr Lai supports the relationship between the pathology and the need for surgery, and the clinical notes confirm that the applicant still has on-going back pain. The notes demonstrate a continuity of complaints on a background of no prior problems, and the applicant has exhausted conservative treatment. Dr Cochrane has not provided a reasoned explanation as to why the aggravation had ceased, and the rest of the evidence says otherwise. The proposed treatment is reasonably necessary as a result of the work injury.

RESPONDENT'S SUBMISSIONS

46. The respondent's solicitor, Mr Kennedy, submits that the respondent relies on the views of Drs Maxwell and Cochrane, who both said that the need for surgery was due to the pre-existing condition in the applicant's back. They accepted that the applicant suffered an injury to his back in the assault, but the effects of his injury had resolved. The applicant suffered a soft tissue injury, and this was reflected in the discharge summary from Canterbury Hospital, where it was noted that there was soft tissue swelling, but no bruising. This might reflect that the injury was not particularly serious.

47. Mr Kennedy submits that Drs Cochrane and Maxwell indicated that the x-rays and MRI scan taken shortly after the assault showed well established spondylosis, and they said that the need for surgery was to address the degenerative spondylosis, because any work related aggravation had resolved fairly soon after the incident.

Is the proposed treatment reasonably necessary as a result of the injury sustained during the course of the applicant's employment?

48. Section 60 of the 1987 Act provides:

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

49. What constitutes reasonably necessary treatment was considered in the context of s 10 of the *Workers Compensation Act 1926* in *Rose v Health Commission (NSW)*[1], Burke CCJ stated:

> "Treatment, in the medical or therapeutic context, relates to the management of disease, illness or injury by the provision of medication, surgery or other medical service designed to arrest or abate the progress of the condition or to alleviate, cure or remedy the condition. It is the provision of such services for the purpose of limiting the deleterious effects of a condition and restoring health. If the particular 'treatment' cannot, in reason, be found to have that purpose or be competent to achieve that purpose, then it is certainly not reasonable treatment of the condition and is really not treatment at all. In that sense, an employer can only be liable for the cost of reasonable treatment."[2]

50. Further, His Honour added:

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

[1] (1986) 2 NSWCCR 32 (*Rose*).
[2] *Rose*, [42].

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

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

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

5. In so deciding, the Court will have regard to medical opinion as to the relevance and appropriateness of the particular treatment, any available alternative treatment, the cost factor, the actual or potential effectiveness of the treatment and its place in the usual medical armoury of treatments for the particular condition."[3]

51. His Honour considered the relevant factors relating to reasonably necessary treatment under s 60 of the 1987 Act in *Bartolo v Western Sydney Area Health Service*[4] and stated:

> "The question is should the patient have this treatment or not. If it is better that he have it, then it is necessary and should not be forborne. If in reason it should be said that the patient should not do without this treatment, then it satisfies the test of being reasonably necessary."[5]

52. In *Diab v NRMA Ltd*[6], Deputy President Roche questioned this approach and cited *Rose* with approval. He provided a summary of the principles as follows:

> "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:
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> (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.
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> 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.

[3] *Rose*, [47].
[4] (1997) 14 NSWCCR 233 (*Bartolo*).
[5] *Bartolo*, [238].
[6] [2014] NSWWCCPD 72 (*Diab*).

> While the above matters are 'useful heads for consideration', the 'essential question remains whether the treatment was reasonably necessary' (*Margaroff v Cordon Bleu Cookware Pty Ltd* [1997] NSWCC 13; (1997) 15 NSWCCR 204 at 208C). Thus, it is not simply a matter of asking, as was suggested in *Bartolo*, is it better that the worker have the treatment or not. As noted by French CJ and Gummow J at [58] in *Spencer v Commonwealth of Australia* [2010] HCA 28, when dealing with how the expression 'no reasonable prospect' should be understood, '[n]o paraphrase of the expression can be adopted as a sufficient explanation of its operation, let alone definition of its content'".[7]

53. Whether the need for reasonably necessary treatment arises from an injury is a question of causation and must be determined based on the facts in each case. The accepted view regarding causation was set out in *Kooragang Cement Pty Ltd v Bates*[8], where Kirby J stated:

> "The result of the cases is that each case where causation is in issue in a workers compensation claim must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from' is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a common sense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation."[9]

54. It is accepted that a condition can have multiple causes, but the applicant must establish that the injury materially contributed to the need for surgery. This was confirmed by Deputy President Roche in *Murphy v Allity Management Services Pty Ltd*[10], where he stated:

> "Moreover, even if the fall at Coles contributed to the need for surgery, that would not necessarily defeat Ms Murphy's claim. That is because a condition can have multiple causes (*Migge v Wormald Bros Industries Ltd* (1973)47 ALJR 236; *Pyrmont Publishing Co Pty Ltd v Peters* (1972) 46 WCR 27; *Cluff v Dorahy Bros (Wholesale) Pty Ltd* (1979) 53 WCR 167; *ACQ Pty Ltd v Cook* [2009] HCA 28 at [25] and [27]; [2009] HCA 28; 237 CLR 656). The work injury does not have to be the only, or even a substantial, cause of the need for the relevant treatment before the cost of that treatment is recoverable under s 60 of the 1987 Act.
>
> Ms Murphy only has to establish, applying the commonsense test of causation (*Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796), that the treatment is reasonably necessary 'as a result of' the injury (see *Taxis Combined Services (Victoria) Pty Ltd v Schokman* [2014] NSWWCCPD 18 at [40] – [55]). That is, she has to establish that the injury materially contributed to the need for the surgery (see the discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716)."[11]

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[7] *Diab*, [88] to [90].
[8] (1994) 35 NSWLR 452; 10 NSWCCR 796 (*Kooragang*).
[9] *Kooragang* [463].
[10] [2015] NSWWCCPD 49 (*Murphy*).
[11] *Murphy*, [57] to [58].

55. There is no dispute that the applicant suffered an injury to his lower back in what appears to be a fairly vicious assault on 5 January 2018. According to the applicant, he has continued to experience pain in his back radiating down his legs. He has been treated with an injection and physiotherapy and he continues to take medication, but this has not provided any long term relief from his symptoms.

56. The applicant describes his pain as constant, and it has impacted on his ability to carry out the activities of daily living. He has thought hard about the surgery and is aware of the risks associated with the procedure. He said that he had exhausted all other treatment options and he was keen to have the surgery in order to relieve his pain and leg symptoms.

57. It is true that the Canterbury Hospital discharge summary referred to soft tissue swelling in the absence of bruising shortly after the assault, but that does not mean that the applicant did not suffer major trauma to his lower back, or that he did not develop bruising in the days following the assault. X-rays revealed no abnormality in the lumbar spine, but other radiological tests shortly afterwards showed pathology.

58. The clinical notes of the Stanhope Medieval Centre show no evidence of any prior back issues. Following the assault on 5 January 2018, the applicant complained of low back pain, and this continued throughout 2018 and 2019. There was no suggestion of any improvement or resolution of his symptoms. Dr Amjad continued to prescribe Endone for the pain that he experienced in various parts of his body.

59. When Dr Rao saw the applicant in May 2018, he recorded symptoms of low back and left leg pain that commenced following the assault. There was no history of past problems. Physiotherapy had provided some short term relief and the applicant was taking medication.

60. Dr Rao thought that the applicant's pain was coming from the left sacroiliac joint, but when that settled and the applicant still complained of leg symptoms, he considered that the source of his pain was at L4/5. The doctor recommended an L4/5 laminotomy and decompression to prevent a worsening of the applicant's symptoms. He rejected Dr Maxwell's suggestion that the pain was coming from the lumbar facet joint.

61. The applicant has the support of Dr Lai regarding the proposed procedure. He diagnosed traumatic aggravation of asymptomatic lumbar spondylosis, and he explained that the applicant had compression of his spinal nerve roots that caused pain in his buttocks and knees. He stated that the proposed surgery was an effective procedure to relieve leg pain and had a reported 80% success rate.

62. The respondent relies on two doctors who dispute that the need for surgery is due to the effects of the applicant's work injury. Dr Maxwell noted that the applicant's low back pain was centred on the left side, consistent with the history recorded elsewhere. The pain was located over the left sacroiliac region, consistent with the findings of Dr Rao, however, he did not believe that the applicant had suffered an injury to that joint, but rather the L5/S1 facet joint with some contribution from the changes that had developed.

63. According to Dr Rao, the sacroiliac pain had subsided when he saw the applicant on 16 May 2019, leaving the applicant with leg symptoms that seemed to come from L4/5. Such a history was not recorded by Dr Maxwell, but that is not surprising, given that Dr Maxwell only saw the applicant on one occasion in August 2018.

64. Dr Maxwell stated that the applicant only suffered soft tissue injuries with an expected resolution within four to six weeks. He noted the presence of the stenosis at L4/5, but he considered that this was a pre-existing constitutional condition.

65. Although the question was put to him, the doctor did not comment on the possibility of an aggravation of the pre-existing lumbar changes. This is the basis of the applicant's claim. Presumably he came to his conclusion regarding the source of the back pain because the applicant only complained of some aching in his left thigh on prolonged sitting, and there were no complaints of leg pain and numbness, which was recorded by Drs Rao and Lai. Had he received such a history, his opinion may have been different.

66. Dr Rao questioned how Dr Maxwell could attribute the applicant's problems to the pre-existing changes in the absence of complaints and tests. There is merit in such concerns. In any event, the doctor has not commented on the proposed surgery, which was not foreshadowed at the time of his examination. Therefore, for all of these reasons, his opinion can be distinguished and carries less weight than that of Drs Rao and Lai.

67. I have similar concerns about the opinion of Dr Cochrane. Dr Cochrane had no issue with the applicant's truthfulness, and her reported that there were no inconsistencies. He was aware that the applicant had no prior back symptoms.

68. Dr Cochrane diagnosed a soft tissue injury to the lumbar spine that resulted in a temporary aggravation of pre-existing lumbar spondylosis. He considered that the applicant's symptoms were due to the pre-existing and progressive degenerative condition. Accordingly, he believed that the applicant's employment was not a substantial contributing factor to his current symptoms and the decompressive surgery at the L4/5 level would be addressing the pre-existing degenerative condition, not the work injury. He accepted that the applicant could gain some benefit from the surgery.

69. In my view, Dr Cochrane's opinion is lacking detailed reasons as to why he was of the view that the applicant had recovered from any aggravation of the pre-existing condition. He recorded that the applicant's had on-going symptoms, but he seemed to disregard what the applicant said to him regarding the persistence of his symptoms.

70. The evidence supports the fact that the applicant has been having treatment and taking medication since the incident, and since the time that Dr Cochrane saw him in August 2019. The fact that Dr Cochrane is of the view that the applicant's employment is not a substantial contributing factor to his symptoms is ill-conceived, as once it is accepted that there is an injury, then it follows that the employment is either the main contributing factor in terms of s 4(b)(i) or 4 (b)(ii) of the 1987 Act, or a substantial contributing factor to the injury in terms of s 9A of the 1987 Act. Injury is not in dispute.

71. In this matter, the evidence does not support a resolution of the aggravation. If there had been a resolution, then one would expect that the applicant would have returned to his pre-injury asymptomatic state. Therefore, in the absence of any detailed explanation for his conclusion, the opinion of Dr Cochrane can be discounted.

72. The fact that Dr Rao is the treating specialist, who has seen the applicant on a number of occasions, carries more weight because he is in the best position to assesses and comment on the applicant's symptoms, treatment and progress. The surgery that he has proposed is a significant invasive procedure and I doubt that he would be recommending such an operation if he had any concerns about the outcome. Dr Lai commented that the procedure had an 80% success rate.

73. Dr Maxwell did not express an opinion regarding the proposed surgery, and Dr Cochrane conceded that the surgery had the potential to address the degenerative condition in the applicant's back.

74. The weight of evidence does not suggest that the effects of the applicant's work injury have subsided. In the circumstances, I am satisfied that the evidence of the applicant and the opinions of Drs Rao and Lai should be preferred to that of Drs Maxwell and Cochrane.

75. I am satisfied that the surgery has the potential to alleviate the applicant's symptoms, is an appropriate treatment and is likely to be effective. There seems to be no alternative forms of treatment and the cost is not unreasonable. This satisfies the relevant factors discussed in *Rose* and *Diab*.

76. Accordingly, I am satisfied on the balance of probabilities that the treatment proposed by Dr Rao, namely an L4/5 laminotomy and decompression, and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of the applicant's employment with the respondent on 5 January 2018.

77. Whether the actual surgery is to be performed by Dr Rao or Dr Gambhir is unclear, but presumably the applicant will proceed through the private system under the care of Dr Rao now that the respondent has been held liable for the cost of the procedure. Who performs the surgery is immaterial, as long as the surgery is an L4/5 laminotomy and decompression.

FINDINGS

78. The applicant sustained injuries to his face, right shoulder, neck and back, and he suffered a primary psychological injury arising out of or in the course of his employment with the respondent on 5 January 2018.

79. The applicant's employment was a substantial and/or the main contributing factor to his injury.

80. The applicant requires medical treatment as a consequence of his injury and the respondent is liable to pay reasonably necessary medical expenses.

81. The proposed L4/5 laminotomy and decompression, and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of the applicant's employment with the respondent on 5 January 2018.

ORDERS

82. The name of the respondent in amended to The Secretary, Ministry of Health NSW.

83. The respondent is to pay the applicant's reasonably necessary medical expenses with respect to the proposed L4/5 laminectomy and decompression, and associated expenses, pursuant to s 60 of the 1987 Act.