WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**6541/20**
Applicant:	**Sonia Nunan**
Respondent:	**Kirrana Community Services**
Date of Determination:	**20 January 2021**
Citation No:	**[2021] NSWWCC 21**

The Commission determines:

1. The applicant sustained injury to her left knee arising out of or in the course of her employment on 15 October 2003.

2. The left total knee replacement surgery proposed by Dr P Kilby in his report dated 15 May 2019 is reasonably necessary as a result of such injury.

3. Pursuant to s 60 of the *Workers Compensation Act 1987* the respondent is to pay the costs of and incidental to such surgery and associated treatment and rehabilitation expenses.

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

Brett Batchelor
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 BRETT BATCHELOR, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

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Lucy Golic
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Sonia Nunan (the applicant/Ms Nunan) seeks compensation pursuant to s 60 of the *Workers Compensation Act 1987* (the 1987 Act) for the cost of left total knee replacement surgery as a result of injury sustained on 15 October 2003 arising out of or in the course of her employment as a disability support worker employed by Kirrana Community Services (the respondent).

2. On 15 October 2003, the applicant was driving her car after taking part in a first aid course at work. She was involved in a head on collision with a van which attempted to overtake a semi-trailer travelling in the opposite direction to her vehicle. As a result of the collision the engine of the applicant's vehicle came through the dash board and struck both of her knees in the seated position. Her chest struck the steering wheel which broke and her head struck the windscreen.

3. Ms Nunan was conveyed to Lithgow Hospital via ambulance following the accident where she remained for two days. Radiological investigations at the hospital did not reveal and fractures. The applicant experienced severe pain in her lower back, right hip and both knees. After discharge from hospital, she underwent multiple sessions of physiotherapy and hydrotherapy, which did not provide any effective improvement.

4. On 24 July 2006, the applicant was examined by Dr Kalev Wilding, orthopaedic surgeon, for the purpose of an assessment of whole person impairment (WPI). In a medical assessment certificate dated 3 August 2006 (MAC)[1] Dr Wilding recorded that the applicant had sustained 10% WPI; 6% in respect of injury to the cervical spine and 2% WPI for each of the right and left knees as a result of the direct trauma to both knees from the engine block.

5. Between July 2007 and May 2014, the applicant came under the care of Dr S Raj Sundaraj, pain management specialist, who treated her primarily for lower back problems. The treatment consisted of right lower lumbar facet joint injection therapy, an epidural, a right greater trochanter bursa injection and a daily exercise routine. On 6 May 2014, Dr Sundaraj referred the applicant to Dr Simon Coffey, orthopaedic surgeon, with a history of bilateral knee pain that had troubled her since the motor vehicle accident 11 years previously. The doctor noted that the lower back problem was manageable at that time, but that Ms Nunan was finding it increasingly difficult to manage independently with the "most troublesome" lower limb knee problem.

6. Dr Coffey saw the applicant on 5 June 2014, found that she had symptoms of post traumatic chondropathy of both patellae and recommended MRI examination and corticosteroid injection of the right knee. He thought that there may be a role for arthroscopic debridement and/or tubercle osteotomy depending on the results of the scan. He wished to avoid surgery if at all possible.

7. The applicant was then apparently treated by Dr Lachlan Post, orthopaedic surgeon, in 2016 who ordered an MRI scan of the left knee on 24 August 2016[2]. This revealed retropatellar chondral fissuring.

8. On 27 June 2016, Dr Coffey reviewed the applicant and noted that she continued to have irritating crepitus in the right knee more so that the left. He suggested that she was a candidate for arthroscopic inspection and debridement, noting that surgery was planned in the coming weeks following spinal injections. This arthroscopy did not take place.

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[1] Application to Resolve a Dispute (the Application) p 13.
[2] Application p 61.

9. It appears that the applicant continued to consult Dr Host who referred her for an MRI of the left knee on 17 February 2019[3]. This revealed a large radial tear in the posterior horn of the medial meniscus and a large focus of SONK (spontaneous osteonecrosis) of the knee.

10. Since 27 February 2019, the applicant has been treated by Dr Peter Kilby, orthopaedic surgeon for her left knee problem. By June 2019 Dr Kilby could not see any treatment other than a left total knee replacement that would improve the applicant's pain or function, or that would facilitate her mobility or ability to seek future improvement. He recommended the surgery and noted that the applicant was awaiting approval from WorkCover to go ahead with this surgery.

11. The respondent's insurer, GIO General Limited (GIO), referred the applicant for an independent medical examination (IME) by Dr Stephen Rimmer on 28 June 2019[4]. In a report dated 10 July 2019, Dr Rimmer expressed the opinion that the SONK revealed on the MRI of 17 February 2019 bore no relationship to the motor vehicle accident of 2003. On the basis of this report on 19 July 2019 GIO issued to the applicant a notice pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) in which it disputed liability for the cost of the total left knee replacement recommended by Dr Kilby in his report dated 15 May 2019[5].

12. The applicant was independently medically examined by Dr P Endrey-Walder, general and trauma surgeon, on 26 August 2019 who produced a report of that date[6] in which he expressed the belief that it was inevitable that Ms Nunan would eventually come to a left total knee replacement. In a subsequent report dated 17 September 2019[7] he said that he believed that the injury suffered by the applicant in the motor vehicle accident is a substantial contributing factor to the need for a left total knee replacement procedure.

13. These reports were submitted to the GIO which then issued a notice pursuant to s 287A of the 1998 Act dated 20 October 2019[8] confirming the denial of liability in the s 74 notice dated 19 July 2019. In that notice the GIO also referred to a report it had requested from Dr Kilby dated 11 June 2019[9] in which the doctor declined to answer a question as to whether the applicant's employment with the respondent is a substantial contributing factor to the need for surgery.

ISSUES FOR DETERMINATION

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

    (a) Is the applicant's claim for the cost of left total knee replacement surgery pursuant to s 60 of the 1987 Act compensable?

    (b) Is the pathology revealed in the applicant's left knee by the MRI scan dated 17February 2019 a result of injury sustained in the motor vehicle accident dated 15 October 2003 or a separate condition?

[3] Application p 64.
[4] Reply p 10.
[5] Application p 27.
[6] Application p 36.
[7] Application p 45.
[8] Application p 33.
[9] Application p 50.

PROCEDURE BEFORE THE COMMISSION

15. 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.

16. The parties attended a conciliation/arbitration hearing on 13 January 2021 conducted by telephone conference. Mr W Carney appeared for the applicant instructed by Ms A Tavianatos. The applicant attended on a separate line. Mr L Robison appeared for the applicant instructed by Mr M Van der Hout.

EVIDENCE

Documentary evidence

17. 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

18. There was no application to adduce oral evidence or to cross-examine the applicant.

SUBMISSIONS

19. The submissions of the parties are recorded in the Transcript (T) of the arbitration hearing and will not be repeated in full. In summary, they are as follows.

Applicant

20. The applicant emphasises the severity of the motor vehicle accident on 15 October 2003 as set out in her statement dated 30 November 2020[10], and the subsequent treatment for injuries to the lower back and both knees. It is apparent that she suffered symptoms in both knees from the date of the accident, a matter confirmed by the history recorded by Dr K Wilding in his MAC dated 3 August 2006 and by his finding therein that Ms Nunan sustained traumatic chondromalacia patellae in both knees in the accident.

21. The applicant notes that the only disputed factual issue is whether she told Dr Rimmer at the IME on 28 June 2019 that approximately 10 months previously she twisted her left knee whilst playing with her children sustaining a medial meniscus tear. Ms Nunan staunchly denies this in the history she gave to Dr Endrey-Walder on 26 August 2019 and submits that the tenor of all of the evidence in respect of this claimed incident mitigates against a finding of a specific injury at that time.

22. The applicant notes that when she first was seen by Dr Kilby on 27 February 2019,[11] he recorded a presenting complaint of left knee trouble for 15 years since the car accident. The doctor also recorded the treatment offered by Dr Coffey, a knee arthroscopy, which did not proceed, and the fact she saw Dr Lachlan Host in Bathurst for a similar condition. It is apparent that she suffered a sever increase in pain in June 2018.

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[10] Application p 2.
[11] Application p 57.

23. The applicant submits that Dr Kilby's comment in his report dated 27 February 2019, that the SONK finding on the MRI dated 17 February 2019 "…is probably a new injury or a new disease change in the last year", must be read in conjunction with his subsequent report to the GIO dated 6 March 2019 to the GIO[12] after he reviewed the long 2005 letter from Dr Burgess who treated her at that time. Dr Burgess concluded that the applicant did have "condromalasia" [sic, chondromalacia] of both patella after a significant dashboard type injury and noted that the applicant may come to develop post traumatic arthritis in the future. The applicant submits that Dr Kilby considered the report of Dr Burgess significant.

24. The applicant acknowledges that Dr Kilby did not help her case when he declined to answer the question put to him by the GIO in his report dated 11 June 2019 but notes that, in any event, he was asked the wrong question in respect of employment being a substantial contributing factor to the need for surgery.

25. The applicant refers to her treatment by Dr Coffey in 2014[13] and 2016[14], and the substantial intake of analgesic medication recorded by him.

26. The applicant notes that by the time she was seen by Dr Rimmer in 2019, she had been treated by three orthopaedic surgeons, Dr Coffey, Dr Host and Dr Kilby in respect of her knee injury. All of these doctors recorded a gradual increase in pain. The applicant submits that Dr Rimmer in expressing his opinion does not refer to her condition treated by these doctors, nor does he refer to the treatment of Dr Burgess, notwithstanding the fact that he had reports from Dr Burgess and Dr Kilby. In short, while Dr Rimmer is probably correct in his opinion that there is no relationship between the knee injury suffered in 2003 and the SONK condition, he has not considered the course of her treatment from 2003 onwards.

27. The applicant submits that Dr Endrey-Walder has a full history of her treatment from the date of the accident and her complaints of pain and does acknowledge the findings on the 2016 and 2019 MRI scans. He does not skirt the issue of the SONK shown on the 2019 MRI scan, but considers the long history of treatment of the left knee injury and complaints are evidence of post traumatic changes in the knees and have contributed to the need for the surgery proposed by Dr Kilby.

28. The applicant submits that she has exhausted all conservative treatment on her knee, and that the surgery proposed by Dr Kilby is reasonably necessary as a result of the injury to the knee sustained on 15 October 2003.

Respondent

29. The respondent draws attention to the s 78 notice dated 19 July 2019 and the s 287A notice dated 20 October 2010 issued by the GIO, and in particular to the MRI scan of the applicant's left knee dated 24 August 2016[15], which reveals mild patella-femoral degeneration. This scan is to be compared with the MRI scan dated 17 February 2019 which reveals the SONK condition.

30. The respondent submits that the very nature of SONK, emphasising the fact that it is a spontaneous condition of unknown aetiology, makes it very difficult for the applicant to discharge the onus upon her to show that the left total knee replacement surgery is reasonably necessary as a result of injury to the left knee sustained on 15 October 2003.

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[12] Application p 51.
[13] Report dated 5 June 2014, Application p 48.
[14] Report dated 27 June 2016, Application p 49.
[15] Application p 61.

31. The respondent submits that the medial meniscal tear revealed on the MRI scan dated 17 February 2019, apparently caused (on the respondent's case) by the incident recorded by Dr Rimmer when the applicant told him that she twisted her knee approximately 10 months prior to examination, in any event has questionable relevance to the present need for surgery. The respondent does however question why Dr Rimmer would have recorded the incident if not conveyed to him by the applicant and submits that on that balance of probabilities the applicant did tell Dr Rimmer of this incident. The respondent submits that the meniscal tear revealed on the MRI scan dated 17 February 2019 is new pathology and has no connection with the 2003 knee injury.

32. Having made that submission, the respondent does however concede that it is understandable that the applicant, because of the significant symptoms she has experienced in the left knee since the car accident, would now honestly put forward the case that all of her current problems in that knee relate to the accident. For this reason, the respondent submits that the Commission should not put great weight on the applicant's lay evidence but should concentrate on the expert medical evidence. The respondent concedes that the applicant is genuine in her evidence that she had not experienced past injury to her knees.

33. The respondent submits that the Commission should not have regard to cases such as *Watts v Rake*[16] and *Purkiss v Crittenden*[17] when considering the question of causation of the need for surgery in this case. In making this submission, the respondent acknowledges that those cases dealt with common law claims for damages. The proposition that the applicant had no knee problems before the motor vehicle accident and has experienced significant problems since, should be looked at in the context of the long period between the accident in 2003 and the current claim for the cost of left knee surgery, and the availability of expert medical evidence on the question of causation of the acknowledged need for such surgery.

34. The respondent notes Dr Endrey-Walder's reference to the applicant's treatment by Dr Burgess in 2005 when the doctor noted that the applicant already had at that time post-traumatic changes in her knees attributed to the injury sustained in the motor vehicle accident. In the absence of report(s) from Dr Burgess the respondent submits that a *Jones v Dunkell*[18] inference should be drawn against the applicant because of the absence of direct evidence from Dr Burgess.

35. In respect of the opinion given by Dr Endrey-Walder when commenting on Dr Rimmer's report[19], the respondent submits that this was a prime opportunity for Dr Endrey-Walder to give a different view as to the onset of the SONK pathology revealed in the MRI scan dated 17 February 2019.

36. The respondent submits that the opinion of Dr Endrey-Walder in his report dated 17 September 2020 should be rejected. The doctor acknowledges the "additional factor" of the applicant having developed a focus of SONK which would have been a contributing factor to the need for a total knee replacement recommended by Dr Kilby, then jumps to the conclusion without explanation that the injury in the motor vehicle is a "substantial contributing factor to the need for the TKR procedure."

37. The respondent submits that the report from Dr Kilby to GIO dated 11 June 2019 in which he declined to answer the question [1] posed to him as to whether the applicant's employment with the respondent was a substantial contributing factor to the need for surgery was does not assist the applicant's case. Dr Kilby should have answered the question and not side stepped it. He is the treating surgeon, and weight would be given to his opinion. The subsequent reports of Dr Kilby do not assist the applicant in discharging the onus upon her in the case. The respondent suggests that the reason Dr Kilby did not answer GIO's question is

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[16] [1960] HCA 58; (1960) 108 CLR 158.
[17] [1965] HCA 34; (1965) 114 CLR 164.
[18] [1959] HCA; (1959) 101 CLR 298.
[19] See p 8 of Dr Endrey-Walder's report dated 26 August 2020 at Application p 43.

that he was of the opinion that the applicant suffered a new injury or disease in about 2018 before she consulted him.

38. The respondent notes that Dr Rimmer, in giving his opinion, was well aware of the 2003 motor vehicle accident, but emphasises the doctor's reliance on the spontaneous aspect of the osteonecrosis condition revealed in 2019 which occurred 15 years after the motor vehicle accident and gives a good summary of the radiological investigations in respect of the left knee in his report.

39. The respondent concedes that the applicant has exhausted conservative measures for the treatment of her left knee condition and the need for surgery thereon but emphasises it is not reasonably necessary as a result of the injury that the applicant suffered to her left knee in 2003.

FINDINGS AND REASONS

Treatment of the applicant's left knee

40. When Dr K Wilding examined the applicant for the purpose of an assessment of WPI on 24 July 2006, he recorded the following complaints in the MAC:

> "The symptoms in both knees were Identical She complained that she experienced anterior knee pain after sitting for 2 hours or walking for 2 hours. Walking up and down stairs also precipitated. anterior knee pain and she took stairs one at a time.
> Neither knee became swollen. Neither knee locked nor gave way. She was aware of crepitus in both knees. She was unable to squat or kneel on either knee comfortably."

41. On examination on both knees, Dr Wilding found no effusion with a normal range of movement (0-140 degrees). There was retropatellar crepitus. The knees were stable. There was tenderness over the medial articular facet of the patella with positive patellar compression test. The doctor found that the applicant had sustained traumatic chondromalacia patellae in both knees and assessed 2% WPI in each knee.

42. When Dr Coffey first examined Ms Nunan on 5 June 2014, he noted complaints of persistent anterior knee pain made worse by activities such as stair climbing and walking longer distances. He found symptoms of post traumatic chondropathy in both patellae and suggested a possible role for arthroscopy and/or tibia tubercle osteotomy depending on the results of a scan. Dr Coffey noted that Ms Nunan was being treated with Oxycontin 20 mg two to three times a day depending on her levels of pain.

43. Dr Coffey reviewed the applicant on 27 June 2016, when he noted that she continued to have irritating crepitus in the right knee more so that the left knee. The MRI scan from two years previously confirmed some retropatellar chondropathy. Dr Coffey opined that Ms Nunan was a reasonable candidate for arthroscopic inspection and debridement with synovectomy, suggesting that there may be some loose bodies in the joint. This surgery did not take place.

44. Dr Host ordered the MRI scan of the applicant's left knee dated 17 February 2019. The applicant thereafter consulted Dr Kilby whose report to the GIO dated 11 June 2019 is referred to above at [13]. The doctor's other reports in evidence are as follows:

    (a) 27 February 2019 to Dr Biing Yin[20];
    (b) 6 March 2019 to Case Manager, GIO, referred to above at [23];
    (c) 6 March 2019 to Dr Biing Yin[21]

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[20] Application p 57.
[21] Application p 52.

(d) 15 May 2019 to Dr Biing Yin[22], and
(e) 25 June 2019 to Dr Biing Yin[23].

45. I agree with the applicant's submission in [23] that Dr Kilby's reports to Dr Biing Yin dated 27 February 2019 and to the GIO dated 6 March 2019 should be read together. In the earlier report Dr Kilby states that given the eight month history, what is shown on the MRI scan is probably a new injury or a new disease change in the last year. Here the doctor is referring to the extrusion of the meniscus and an area of SONK on the medial femoral condyle. The respondent submits that the revelation of the meniscal tear shown on the MRI of 17 February 2019 is not related to the left knee injury sustained in 2003 and the applicant does not submit otherwise. Similarly, the applicant does not submit that the SONK condition is causally related to the 2003 injury.

46. In the report to the GIO dated 6 March 2019, Dr Kilby has had the benefit of the report ("long letter") of Dr Burgess from 2005. Dr Burgess noted that in 2005 the applicant already had post traumatic changes which he (Dr Burgess) attributed to the injury, concluded that Ms Nunan did have chondromalacia of both patella after the significant dashboard injury of 2003, and suggested that she may come to develop post traumatic arthritis in the future. Dr Kilby does not appear to either agree or disagree with the opinion of Dr Burgess; he simply refers to it. In his report to Dr Biin Yin dated 6 March 2019 Dr Kilby foreshadowed the likelihood that the applicant would go to develop arthritis in the medial compartment of her left knee.

47. It is evident from the applicant's evidence in respect of her attendances on Dr Sundaraj and Dr Coffey in 2014, confirmed by Dr Coffey in his report dated 5 June 2014, that she was experiencing significant problems with her knees at that time for which she had to take strong analgesic medication. This is not disputed by the respondent. It appears from the report of Dr Kilby dated 27 February 2019, that the SONK condition, as well as the torn medial meniscus, arose or occurred about eight months before the applicant first consulted the doctor on 27 February. It appears from the report of the MRI scan dated 17 February 2019 that Ms Nunan was at that time suffering moderate medial compartment osteo arthritis and grade 2/3 chondromalacia patella.

The medico-legal reports

48. Dr Endrey-Walder had the benefit of a full history from the applicant, which he relates in his report dated 26 August 2020 and all of the relevant radiological investigations. He noted that the applicant could recall no significant injury in her past bar the motor vehicle accident. He said that:

> "There appears to have been little in the way of significant radiologically ascertainable damage at the knee joints until last year, when increasing symptoms led to a repeat MRI scan and the identification of medial meniscal pathology, a degree of flattening of the medial joint space of the knee, chondral damage at the back of the patella and, most importantly, development of spontaneous osteonecrosis of the medial femoral condyle of the left knee."

He went on to say that that there is little doubt that the applicant has had significant, ongoing, practically continuous symptoms at her knee joints, mostly attributed to the patella-femoral joint, and that the symptoms changed somewhat over late 2018. An MRI scan of the left knee in February 2019 highlighted a significant pathology at the medial femoral condyle of the knee which was certainly not in evidence when the MRI scan of the left knee was performed in August 2016.

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[22] Application p 53.
[23] Application p 56.

49. Dr Endrey-Walder noted Dr Rimmer's finding that there is no relationship with the motor vehicle accident of 2003 and the development of SONK 15 years later and acknowledged that the pathology is of relatively recent onset given the date of the accident. He also recorded that Ms Nunan flatly denied that that she had said anything to Dr Rimmer in respect of twisting on her left knee 10 months previously sustaining a medial meniscus tear. Given that the respondent submits that such tear revealed on the MRI scan of 17 February 2019 is unrelated to injury sustained in the motor vehicle accident and that the applicant does not submit otherwise, it is not necessary to make a finding whether or not Ms Nunan did make such a statement to Dr Rimmer.

50. In his supplementary report dated 17 September 2020, Dr Endrey-Walder says that as a consequence of the injury in the accident, the applicant had begun developing osteoarthritic changes in the knee, a bone scan in May 2014 acknowledging low grade arthritic changes in all three compartments of both knee joints. He acknowledges the additional factor of having developed SONK which he says would have to be considered as a contributing factor to the need for a total knee replacement recommended by Dr Kilby, then expresses the belief that the injury suffered in the motor vehicle accident is a substantial contributing factor to the need for a left total knee replacement. While this is the incorrect legal test expressed by Dr Endrey-Walder, his meaning is clear.

51. I do not accept the respondent's submission that Dr Endrey-Walder has provided no basis for his final opinion on the need for surgery. Reading his reports as a whole, he has provided a sufficient basis for his opinion. It is the osteoarthritic changes in the left knee, which originated with the motor vehicle accident, that in his opinion have led to the reasonable necessity for surgery.

52. In giving his opinion, Dr Rimmer refers to the increasing pain experienced by the applicant over the nine months prior to his examination of the applicant and places emphasis on the findings recorded in the MRI scan of the left knee dated 17 February 2019, revealing the SONK condition, in comparison with the scan of 24 August 2016 which showed mild patellofemoral degeneration. He also notes that throughout the whole process Ms Nunan continued to work in the family business which she had been doing for the previous 12 years.

53. The documentation reviewed by Dr Rimmer include:

    (a) a report of Dr Burgess dated 16 November 2005;

    (b) the MAC of Dr Wilding dated 2 August 2006, and

    (c) reports of Dr Kilby dated 27 February 2019, 6 March 2019, 15 May 2019 and the surgery request dated 15 May 2019.

    Dr Rimmer notes the current treatment in the form of cortisone injections to the left knee, "…a daily cocktail of medications ie. Oxycontin (20mg x 3 daily), Panadol Osteo", and supervision of oral pain medication by a pain management specialist. He refers to the relevant radiological investigations.

54. Dr Rimmer states that there is no relationship with the motor vehicle accident of 2003 and the development of SONK 15 years later. This is not disputed by Dr Endrey-Walder, and the applicant does not assert otherwise. Dr Rimmer does not refer to anything said by Dr Burgess in her report dated 16 November 2005. He does not appear to have considered the developing osteoarthritic changes considered by Dr Endrey-Walder as having originated with the injury to the applicant's knees in the motor vehicle accident in 2003, as being a factor in the current need for the left total knee replacement surgery. Dr Rimmer does agree with Dr Kilby that all conservative measures have been exhausted, and that in general terms, the purpose of the total knee replacement surgery is to completely resolve pain and restore function to the knee.

The absence of report(s) from Dr Burgess

55. The respondent submits that a *Jones v Dunkel* inference should be drawn against the applicant because of her failure to tender evidence from Dr Burgess, an orthopaedic surgeon, who saw her in 2005. Dr Rimmer refers to a report from this doctor dated 16 November 2005 in the documentation he reviewed when preparing his report dated 10 July 2019. He makes no comment thereon. Dr Kilby refers to "…a long letter from 2005 from an orthopaedic surgeon Dr Burgess who reviewed [the applicant] with the findings of multiple joint pain following her car accident in 2003" in his report to the GIO dated 6 March 2019. Dr Endrey-Walder, in his report dated 26 August 2020, refers to attention received by the applicant from Dr Burgess in or about 2005, who acknowledged the applicant's joint pains following the accident. It is not clear from Dr Endrey-Walder's report if he actually saw a report from Dr Burgess or was referring to Dr Kilby's reference to the applicant's consultation(s) with Dr Burgess in his report dated 3 March 2019[24]. Dr Wilding also lists the report of Dr Burgess dated 16 November 2005 and a supplementary report from that doctor dated 31 January 2006 in the documentary evidence in his MAC dated 3 August 2006. Dr Wilding's comments on these reports are as follows:

> "Dr Burgess in his report dated 16/11/05 has assessed whole person impairment according to AMA 4. This is the incorrect table for this assessment.
>
> Dr Burgess in his report dated 31/1/06 has assessed whole person impairment according to AMA 5. He has assessed that Ms Nunan is suffering from an 8% whole person impairment due to her cervical injury and an 8% whole person impairment due to her lumbar injury."[25]

Dr Wilding also comments upon the WPI assessment by Dr Burgess as follows:

> "Dr Burgess has assessed her cervical impairment at 8%, the maximum allowable for DRE II. An 8% whole person impairment should be reserved for people with severe spinal pain and significant restriction of movement which significantly interferes with the activities of daily living. This clearly is not the case. Mrs Nunan is now pregnant with her second child. Since the accident she manages to do most of the housework around her home except the moping and cleaning of bathrooms. She also was able to manage a clerical job.
>
> I agree with Dr Burgess that there is a 2% whole person impairment for the injury to each knee."

56. From the references to Dr Burgess in the abovementioned reports, it is not clear whether Dr Burgess saw the applicant as a treating surgeon or in a medico-legal capacity. Dr Wilding agreed with the 2005 assessment of Dr Burgess that there was a 2% WPI for the injury to each knee.

57. The rule in *Jones v Dunkel* arises where a party fails to call or otherwise tender evidence that would have been expected to have been favourable to that party. The elements of the rule are as follows (omitting authorities):

    (a) the unexplained failure by a party to give evidence, to call witnesses or to tender documents or other errors may, not must, in appropriate circumstances lead to an inference that the uncalled evidence would not have assisted that party's case. The tribunal or court is not compelled to draw the inference;

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[24] Application p 37.
[25] Application p 19.

(b) the rule merely permits an inference that the untendered evidence would not have helped the party who failed to tender it and entitles the trier of fact to more readily draw any inference available to be drawn from other evidence. The rule does not permit an inference that the untendered evidence would in fact have been adverse to the party not tendering it and the rule cannot be used to create evidence;

(c) the rule only applies where a party is required to explain or contradict something. No inference can be drawn unless evidence is given to the facts requiring an answer;

(d) the rule does not apply where the evidence in privileged;

(e) the rule does not require a party to give merely cumulative evidence;

(f) the rule only applies where it would be natural for one party to call a witness and that party might reasonably be expected to have called the witness. The rule does not apply where the witness could have been called by either party, and

(g) the inference can only be drawn when the tribunal of fact is entitled to conclude that the witness would probably have a close knowledge of the facts. It is insufficient to conclude that the witness might have knowledge.

58. The respondent made its *Jones v Dunkel* submission notwithstanding the abovementioned references to evidence from Dr Burgess in other medical reports and acknowledging the fact that there is no property in witnesses. It submitted that in the absence of direct evidence from Dr Burgess the Commission does not know what else the doctor may have said about the applicant's injuries, and it is evidence that would be expected to be tendered by the applicant.

59. It is clear from the report of Dr Rimmer that the respondent had access at least to the report of Dr Burgess dated 16 May 2005. The MAC of Dr Wilding dated 3 August 2006 containing reference to this report and the doctor's later report dated 31 January 2006 was also available to the respondent. In my view there was nothing preventing the respondent from tendering direct evidence from Dr Burgess in its case if it were of the view that it would assist. Further, it is reasonably clear that the SONK condition upon which the respondent relies to deny liability for the surgery sought by the applicant did not develop until about mid-2018, about eight months before the applicant first saw Dr Kilby. The fact that the applicant developed traumatic chondromalacia patellae in both knees following the 2003 accident is uncontroversial. It was diagnosed by Dr Wilding in 2006 and also by Dr Burgess in 2005, who said (as related by Dr Kilby), that the applicant developed post traumatic changes in her knees attributed to the injury in the motor vehicle accident. Both Dr Burgess and Dr Wilding assessed the applicant as having sustained 2% WPI as a result if injury to each knee in the motor vehicle accident.

60. I do not think that any untendered evidence from Dr Burgess would not have helped the applicant, nor would it entitle the Commission to more readily draw any inference available to be drawn from other evidence. The applicant was not required to explain or contradict something by the tender of any evidence from Dr Burgess.

61. I do not draw any inference adverse to the applicant by any failure on her part to tender evidence from Dr Burgess.

Section 60 of the 1987 Act

62. Section 60(1) of the 1987 Act provides:

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

63. In *Diab v NRMA Ltd,*[26] Roche DP at [88] set out matters relevant to the assessment of the reasonable necessity of treatment pursuant to s 60 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:
>
> - (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."

The reference to *Rose* by Roche DP is to *Rose v Health Commission (NSW)*[27].

64. In this case, the respondent does not dispute that the treatment proposed by Dr Kilby is appropriate for the applicant's left knee condition or that any alternative treatment would be appropriate. No issue is raised in respect of the cost of the treatment, and Dr Rimmer notes that the purpose of the knee replacement surgery is to completely resolve pain and restore function to the knee. The question for determination by the Commission is whether it is the SONK condition in the applicant's left knee, which became apparent in about mid-2018, that requires the surgical attention proposed by Dr Kilby, or an injury other than that condition which occurred as a result of the motor vehicle accident in 2003 that has given rise to the reasonable necessity for surgery. The applicant does not put her case on the basis that the SONK condition from which she now suffers is causally related to injury to the left knee sustained in the accident.

65. In my view, there is sufficient evidence to find that it is reasonably necessary that the applicant undergo the total left knee replacement surgery proposed by Dr Kilby as a result of the injury to the knee sustained in the motor vehicle accident on 15 October 2003. My reasons for this finding are as follows:

    (a) it was a significant accident in which the applicant was involved. Her vehicle was involved in a head on collision with an oncoming vehicle which caused the engine of her vehicle to be propelled through the dash board and impact upon her knees;

[26] [2014] NSWWCCPD 72.
[27] [1986] NSWCC 2; (1986) 2 NSWCCR 32.

(b) I accept that the applicant did not have a pre-existing injury or symptomatic condition in her knees;

(c) since the accident the applicant has experienced ongoing and increasing problems with her knees, causing significant disability, and requiring the intake of strong analgesic medication to control pain in her knees;

(d) in 2005, Dr Burgess reviewed the applicant and diagnosed that she had post traumatic changes in her knees at that time which she attributed to the injury sustained in the motor vehicle accident. Dr Burgess assessed Ms Nunan as having sustained 2% WPI as a result of injury to each knee;

(e) in 2006, Dr Wilding recorded that the applicant complained if anterior knee pain after sitting for two hours or walking for two hours. She had trouble with stairs and was unable to squat or kneel comfortably. The doctor diagnosed traumatic chondromalacia patellae in both knees and agreed with the assessment of Dr Burgess of WPI of 2% in each knee;

(f) the applicant received pain management treatment from Dr Sundaraj up until about 2014, primarily for pain in her lower back, but also for bilateral knee pain. He recorded that the applicant had been troubled with the knee pain since the date of the accident 11 years earlier, and referred her to see Dr Coffey for treatment of her knees;

(g) Dr Coffey treated the applicant for her persistent anterior knee pain in 2014 and 2016 and found that Ms Nunan had symptoms of post traumatic chondropathy of both patellae. He suggested arthroscopic surgery and/or tibia tubercle osteotomy surgery which did not take place;

(h) the applicant came under the care of Dr Kilby in February 2019 when, after a further MRI of the left knee on 17 February 2019, the SONK condition was diagnosed along with a large radial tear in the posterior horn of the medial meniscus. Neither this tear nor the SONK condition are causally related to the left knee injury in 2003;

(i) Dr Kilby is of the opinion that the applicant has exhausted all conservative treatment for her left knee and that total left knee replacement surgery is the only option for the applicant to address her ongoing pain and disability. The respondent concedes that the applicant has exhausted conservative treatment and that surgery is appropriate for the applicant, but asserts that it is the SONK condition which is unrelated to injury to the left knee in 2003 which has given rise to the need for surgery;

(j) Dr Endrey-Walder, the independent medico-legal specialist engaged by the applicant, undertook a complete review of the applicant's history and treatment since the accident, and concluded that as a consequence of the injury in that accident the applicant began developing osteoarthritic changes in the knee, noting the May 2014 bone scan acknowledging low grade arthritic changes in all three compartments of both knee joints. Dr Endrey-Walder acknowledged the additional factor of the development of the SONK condition and that it would have to be considered as a contributing factor to the need for the total knee replacement recommended by Dr Kilby. Nevertheless he expressed the belief that the injury suffered by the applicant is a substantial contributing factor to the need for surgery. Whilst Dr Endrey-Walder has expressed himself by reference to the incorrect legal test, his meaning is clear, and

(k) Dr Rimmer in assessing the applicant has focussed on the SONK condition, unrelated to injury sustained in the motor vehicle accident, as the reason why the applicant now needs to undergo the surgery proposed by Dr Kilby. He does not appear to have considered any other factor as giving rise to the necessity for surgery.

66. For the forgoing reasons, I find that the left total knee replacement surgery proposed by Dr Kilby in his report of 15 May 2019 is reasonably necessary as a result of injury to the left knee sustained by the applicant on 15 October 2003.

67. The respondent is to pay the costs of and incidental to such surgery and associated treatment and rehabilitation expenses.

SUMMARY

68. The applicant sustained injury to her left knee arising out of or in the course of her employment on 15 October 2003.

69. The total left knee replacement surgery proposed by Dr P Kilby in his report dated 15 May 2019 is reasonably necessary as a result of such injury.

70. Pursuant to s 60 of the 1987 Act the respondent is to pay the costs of and incidental to such surgery and associated treatment and rehabilitation expenses.