WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**139/20**
Applicant:	**Peter Davies**
Respondent:	**Ausgrid Management Pty Ltd**
Date of Determination:	**10 March 2020**
Citation:	**[2020] NSWWCC 68**

The Commission determines:

1. The applicant sustained injury to his lumbar spine in the course of his employment with the respondent on 4 July 2018.

2. The applicant's employment was a substantial 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 lumbar spine surgery, namely, an anterior lumbar interbody fusion with disc spacers at L4/5 and L5/S1 augmented by posterior pedicle screw fixation at L5/S1 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 4 July 2018.

The Commission orders:

5. The respondent to pay the applicant's reasonably necessary medical expenses with respect to the proposed lumbar spine fusion at L4/5 and L5/S1 as recommended by Dr Coughlan 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.

Carolyn Rimmer
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 CAROLYN RIMMER, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. On 15 January 2020, Peter Davies (Mr Davies) lodged an Application to Resolve a Dispute (the Application) in the Workers Compensation Commission (the Commission). Mr Davies' employer at the relevant time was Ausgrid Management Pty Ltd (the respondent). The respondent was self-insured at the relevant time.

2. Mr Davies claimed medical expenses for proposed medical treatment pursuant to s 60 of the *Workers Compensation Act 1987* (the1987 Act) due to injury sustained on 4 July 2018.

3. Mr Davies, in the course of his employment with the respondent as a linesman, sustained an injury to his lumbar spine on 4 July 2018 when he was directed by a supervisor to form a "tug of war" team with six other workers and manually pull cables because the winch had broken. Mr Davies had rope tied around his torso, when one of his colleagues dislocated his shoulder and other colleagues let go of the rope, causing Mr Davies to be suddenly dragged forward, jolting his back.

4. There was no dispute that Mr Davies injured his lumbar spine on 4 July 2018. Liability was accepted by the insurer and weekly compensation and medical expenses paid.

5. On 6 September 2018, a request was made for medical expenses, namely, a claim for proposed surgery by Dr Coughlan being an anterior lumbar interbody fusion with disc spacers at L4/5 and L5/S1 augmented by posterior pedicle screw fixation at L5/S1.

6. On 23 January 2019, the respondent 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 medical expenses. The insurer issued a further s 78 Notice on 17 July 2019 again declining liability.

7. The respondent maintained the declinature in respect of the request for surgery in a Review Notice dated 5 December 2019 on the basis that the risk-benefit profile of the surgery has not been sufficiently clarified by Dr Coughlan, and that based on the opinion of Dr Coroneos, the surgery was not appropriate nor reasonably necessary. The respondent repeated and confirmed its previous proposal that it was prepared to assist Mr Davies with a weight loss program, to provide the assistance of a dietician and a guided exercise program as this is likely to improve his recovery from his compensable injury, as well as assist with his non-compensable conditions that were impacting on his current status.

ISSUES FOR DETERMINATION

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

   (a) whether the proposed lumbar spine surgery, in the form of a fusion with anterior lumbar interbody disc spacers L4/5 and L5/S1 augmented by posterior pedicle screw fixation at L5/S1 is reasonably necessary as a result of the injury sustained on 4 July 2018 (s 60 of the 1987 Act).

PROCEDURE BEFORE THE COMMISSION

9. The parties attended a conciliation conference and arbitration hearing on 2 March 2020. The proceedings in the Commission were sound recorded and a copy of the recording is available to the parties. Mr Davies was represented by Mr R Hanrahan, who was instructed by Mr M Manokarathas of Slater & Gordon, Lawyers. The respondent was represented by Mr T Grimes, who was instructed by BBW Lawyers.

10. 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

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

    (a) Application and attached documents, and

    (b) Reply and attached documents.

Oral evidence

12. Mr Hanrahan made an application to call further evidence from Mr Davies in respect of the examination of Mr Davies by Dr Coroneos. Mr Grimes objected to this course arguing that issues concerning the examination by Dr Coroneos had not been raised in Mr Davies' statement of 13 January 2020 nor referred to in the telephone conference on 12 February 2020. Mr Grimes submitted that the respondent would be prejudiced as it could not put any evidence in reply to further evidence provided by Mr Davies concerning the examination by Dr Coroneos. I refused to give Mr Hanrahan leave to call Mr Davies, noting that Mr Davies could discontinue these proceedings and commence further proceedings that included such evidence. I accepted the arguments put by Mr Grimes that the respondent would be prejudiced by permitting the applicant to give further evidence at this stage.

FINDINGS AND REASONS

Mr Davies' statement

13. In a statement dated 13 January 2020, Mr Davies said that on 4 July 2018 at about 7.00 pm, he was replacing a fallen electrical wire near Wollongong Road in Arncliffe Park, when he sustained an injury to his back. He stated that as the winch machine was not working, they were unable to perform the usual practice of winching the wire up. He said he was directed by his supervisor to form a tug-o-war team with six other colleagues and had a rope tied around his torso to manually pull the cables. Mr Davies said that during this procedure, one of his colleagues dislocated his shoulder and everyone let go of the cable. He stated that he was suddenly dragged forward and jolted his back.

14. Mr Davies stated that he finished his shift at 9.00 pm and went home to sleep. He said that on the next morning, he felt severe pain with muscular spasms radiating down the back of his left leg to the knee and down his left leg with pins and needles on the top of his foot and a slight foot drop.

15. Mr Davies stated that he attended his general practitioner, Dr Jessica Allen, who certified him as unfit for work for two weeks. He then returned to work on graduated light duties.

16. Mr Davies stated that Dr Allen later referred him to Dr Marc Coughlan, neurosurgeon, who recommended an anterior lumbar interbody spacer at L4/5 and L5/S1 augmented by posterior pedicle screw fixation at L5/S1. Mr Davies said that Dr Allen also referred him to Dr Ralph Mobbs, Neurosurgeon, who made a diagnosis of a Grade 1 spondylolisthesis with pars defects at L5/S1 with left foraminal disc herniation and degenerative disease at L4/5.

17. Mr Davies stated that prior to the injury on 4 July 2018, he had no problems with his back. He said that he had no issues with leg pain or foot drop prior to the incident on 4 July 2018.

18. Mr Davies described his current symptoms as including a combination of back, buttock and predominantly left-sided leg pain with foot drop. He said that despite time, physiotherapy, hydrotherapy and medication, his low back pain, sciatica and left leg pain continued. Mr Davies wrote:

> "Considering I am a sizeable gentleman and put significant stress on the two lower joints in my back, with instability at L5/S1, I am desperate to undergo an anterior lumbar interbody fusion along with pedicle screw fixation."

Medical Evidence

Reports of treating doctors

19. Dr Grace Bryant, sports and exercise physician, in a report dated 8 October 2018, noted that she had reviewed Mr Davies on 4 October 2018 in relation to his lower back pain which commenced on 4 July 2018. She reported that Mr Davies had been thrown backwards when a cable recoiled under tension and he sustained a left L5/S1 foraminal disc protrusion compressing the left L5 nerve root. She had referred Mr Davies for an MRI scan and then for an image directed cortisone injection to the left L5 nerve root.

20. In a report dated 8 November 2018, Dr Bryant noted that Mr Davies had improvement for five days following the injection but then the symptoms returned. She reported that neural symptoms in the left foot had decreased but he reported a numbness in the left foot. Dr Bryant suggested referral to a neurosurgeon given the poor progress.

21. In a report dated 26 March 2019, Dr Bryant noted that Dr Coughlan had recommended surgery, but this had not been approved by the insurance company. She reported that Mr Davies remained symptomatic said he experienced left sided lower back pain and left leg neural symptoms in an L5 distribution. She noted that he had fallen twice recently and was catching his left toes.

22. In a report dated 6 May 2019, Dr Bryant noted that Mr Davies was awaiting a second opinion from Dr Mobbs. Mr Davies told Dr Bryant that his back symptoms had slightly improved but the shooting pain down his left leg still occurred but was less frequent. She noted that Mr Davies continued to experience pain on walking and more so on stairs and that pain at night disturbed his sleep.

23. In a report dated 27 June 2019, Dr Bryant noted that back symptoms were similar to those outlined in the prior consultation and sitting tolerance was restricted. She reported that Mr Davies had continued his dieting and had now lost 7 kg.

24. In a report dated 6 December 2018, Dr Marc Coughlan, treating neurosurgeon, noted that Mr Davies injured his back in a work related accident and had very significant ongoing severe back pain and left sided foot drop. He reported that the back pain tended to eclipse the neuropathic leg pain and this had got progressively worse. Dr Coughlan noted that Mr Davies was also walking with a limp.

25. Dr Coughlan noted that the CT scan confirmed the MRI scan findings of bilateral pars defects at L5/S1 and spondylolisthesis at L5/S1 and a very collapsed disc space and vacuum phenomenon at that level. He commented that there was also quite marked sclerosis around the disc space and also significant collapse at L4/5.

26. Dr Coughlan wrote:

> "The situation is very complex and I don't think he would do well with decompressive surgery given the instability at L5/S1. In my hands he would be best placed having anterior lumber interbody spacers placed at L4/5 and L5/SI. This would distract the disc space and allow for reconstruction and reconstitution of disc heights. I would then augment this via posterior pedicle screw fixation given that he is a very large man and that he has obvious instability at L5/SI."

27. Dr Coughlan noted that Mr Davies was really struggling to work with the foot drop and the pain but was very motivated in the long term to return to his work which he loved doing and had done so for many years. Dr Coughlan commented that whether or not this was attainable after significant surgery remained to be seen, but certainly thought given his foot drop and his progressive pain this surgery should be done as soon as possible.

28. In a report dated 30 January 2019, in answer to the respondent's email dated 14 December 2018, Dr Coughlan noted that Mr Davies was unfit for duties because he was really struggling to work with the foot drop and the pain he was experiencing.

29. Dr Coughlan wrote:

> "4. Peter injured his back in a work-related accident and has had very significant ongoing severe back pain and left sided foot drop. The back pain tends to eclipse the neuropathic leg pain and this has got progressively worse. He is also walking with a limp.
>
> His CT scan confirms the MRI scan findings of bilateral pars defects at L5/S1, spondylolisthesis at L5/S1 and a very collapsed disc space and vacuum phenomenon at that level. There is also quite marked sclerosis around the disc space. There is also significant collapse at L4/L5.
>
> 5. I do feel that the injury is directly related to the workplace event. In my opinion, the symptoms that he is experiencing he has never had before, I do not feel that he would have required surgery without the incident taking place.
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> 6. The foot drop is related to the compression of the nerve between the collapsed disc. As I said previously, in my hands he would be best placed having anterior lumber interbody spacers placed at L4/5 and L5/S1. This would distract the disc space and allow for reconstruction and reconstitution of disc heights, freeing the nerve and improving the foot drop and current symptoms.
>
> …He requires surgery to address the findings, without surgery he will not get better and may get worse especially given he has foot drop. It will be a 12-16 week process of recovery and then a gradual return to work and activities, which Peter is very keen for."

30. In answer to the question "Are there any alternative treatment options to the proposed surgery?" Dr Coughlan replied "No, unfortunately with the current finding a surgical option would be the only way to address the problem."

31. In a supplementary report dated 8 April 2019, Dr Coughlan noted that he had received the report of Dr Coroneos but did not agree with his opinion. Dr Coughlan stated that Mr Davies' CT scan confirmed the MRI scan findings of bilateral pars defects at L5/SI and spondylolisthesis at L5/SI and a very collapsed disc space and vacuum phenomenon at that level. He noted that there was also quite marked sclerosis around the disc space and significant collapse at L4/5. Dr Coughlan considered that the situation was very complex and recommended that Mr Davies have an anterior lumbar interbody fusion along with pedicle screw fixation as he is a very large man and has obvious instability at L5/S1. He considered that although a weight loss strategy would certainly benefit Mr Davies' recovery, he did not believe this would address his mechanical spinal issue.

32. In a report dated 6 June 2019, Dr Ralph Mobbs, neurosurgeon, noted that Mr Davies presented with a combination of back, buttock and predominantly left-sided leg pain with foot drop. Dr Mobbs made a provisional diagnosis of L5/S1 grade I spondylolisthesis with pars defects, left foraminal disc herniation, early disc degeneration at L4/5. Dr Mobbs noted that he discussed options with Mr Davies. He noted that current symptoms included pain down the left leg and partial foot drop was the primary issue with back pain a secondary issue.

33. Dr Mobbs reported that the duration of symptoms was "since his injury approximately eleven months ago". He commented that Mr Davies said that from a general health perspective, he struggled with weight and was hypertensive, a type 2 diabetic and had undergone a previous right nephrectomy for cancer.

34. On examination, Dr Mobbs noted that Mr Davies had intact, although reduced, knee and ankle reflexes, and a partial foot drop on the "left 3/5". Dr Mobbs observed that Mr Davies walked with an abnormal gait pattern.

35. Dr Mobbs reviewed the MRI scan and commented that Mr Davies had a Grade 1 spondylolisthesis at L5/S1, a left-sided foraminal disc herniation impinging the exiting left L5 nerve that would be contributing to his foot drop, and a degree of disc degenerative disease at L4/5.

36. Dr Mobbs wrote:

> "Peter presents with a complex issue of being a sizeable gentleman, weighing close to 150 kg, in addition to having significant back problems. It is likely that his underlying spondylolisthesis was suddenly made significantly worse with his sudden traction injury sustained eleven months ago. He likely sustained the disc herniation at that same time as there were no issues with leg pain or foot drop prior to the incident.
>
> He has sought a number of opinions and generally these include a fixation of the spondylolisthesis and a decompression of the L5 nerve. This can be performed via several methods: anterior, posterior or a combination of both.
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> In general, I agree with the opinion as provided by Dr Marc Coughlan, in that a combination anterior/posterior decompression and fixation would be sensible, especially considering that Peter is a large gentleman and would be putting significant stress through the lower two joints in his back.
>
> Peter is struggling with his activities of daily living and is desperate to get something done as soon as possible. This letter is to be used as a request to the insurer for approval for a combination anterior/posterior decompression and fixation. It is proposed to do the ALIF first and a couple days later the posterior fixation.
> …

> If he were to go down the path of surgery, my recommendation would be the same as the other surgeons that he has seen. It would be helpful that he lose at least 10kg of weight before surgery."

37. In a report dated 9 September 2019, Associate Professor Paul Darveniza, Neurologist, noted that following the injury on 4 July 2018, Mr Davies' low back pain and sciatica continued and the left leg still felt weak despite time, physiotherapy, hydrotherapy and medications. He noted that in the past Mr Davies suffered from hypertension for about five years, atrial fibrillation for three or four years for which he takes one of the new oral anticoagulants, type 2 diabetes, right nephrectomy for cancer, surgery to the left thumb (1980), left knee arthroscopy (1987), left shoulder rotator cuff repair and tonsillectomy.

38. Associate Professor Darveniza noted on examination that Mr Davies was a very large man (weight approximately 145 kg), who hobbled in pain limping on his left leg. There was complete loss of the normal lumbar lordosis, marked restriction of back flexion with the hands just reaching the knees and numbness with pins and needles over the top of the left foot in the distribution of the left LS nerve root.

39. Associate Professor Darveniza reviewed the MRI scan of the lumbosacral spine of 2 October 2018, and noted it showed a Grade I spondylolisthesis at LS/SI with significant disc desiccation and a left foraminal disc protrusion compressing the left L5 nerve root.

40. Associate Professor Darveniza was of the view that Mr Davies was suffering from work-related symptomatic lumbosacral spondylosis with a left L5 radiculopathy with congruent imaging, leaving him with chronic back pain and a left L5 sciatica, limiting him in many ways. He considered that Mr Davies had an underlying probable congenital pars defect and Grade I spondylolisthesis.

41. Associate Professor Darveniza reported that Mr Davies told him that following heavy activities in the past he did get some short lived low back ache.

42. Associate Professor Darveniza concluded that surgical intervention as suggested by his neurosurgeons was indicated, that is, an anterior lumbar interbody spacer at L4/5 and L5/S1 augmented by posterior pedicle screw fixation at L5/S1, although there would be "some compensation for his pre-existing congenital anomaly". He noted that he had read the medicolegal opinion of Dr Coroneos, dated 6 February 2019, which recommended continuing conservative therapy including weight loss and weaning off opioids. Associate Professor Darveniza disagreed with this recommendation.

43. In a supplementary report dated 28 October 2019, Associate Professor Darveniza confirmed that Mr Davies has an L5 radiculopathy and surgical intervention would be reasonable as outlined by Dr Mark Coughlan. He also confirmed that the intervention would be reasonable and necessary and that the employment with Ausgrid was the main reason for the need for this surgical intervention to arise.

44. The Patient Health Summary from Bexley North Medical Clinic referred to a left lumbar radiculopathy on 20 May 2016.

45. In a report dated 5 June 2019, Dr Wong noted that Mr Davies' weight continued to improve albeit slowly.

46. The clinical notes of the treating general practitioner, Dr Allen, and other doctors include the following entries:

(a) On 5 July 2018: "Went to work as normal yesterday. Large tree came down in Arncliffe. Winch had broken down, had to pull cable in by hand. Hard work. No pain at the time. Pain came on at about 7pm when he got home. No pain relief taken for it. Has had back spasms before. No bladder/bowel changes. O/E: No midline tenderness. Muscles tight around lumbar spine. Neuro intact. Full ROM. A WorkCover certificate was issued and walking, swimming and gentle stretching recommended".

(b) On 9 July 2018 Dr Allen noted that Mr Davies was concerned that "yesterday also strained hamstring (jumped up out of bed last night, immediately painful)". Dr Allen noted: Still quite painful back. Painful to walk. A bit of stiffness in the morning, tends to be a bit better after exercise, getting going in the morning, Antalgic gait. On examination: lumbar spine - normal lordosis - no abnormal posture - Schober ve.Trendelenberg: +ve on left leg. Flexion: nad. Extension: nad. Lateral flexion: nad. Rotation: nad. No midline tenderness. Some lateral paraspinal muscle tenderness.

(c) On 12 July 2018: Back has improved. …still noting some pain in left leg with esp walking, sitting and standing…Gait improving, still stiff on standing or sitting. Management: pool, physio, movement as tolerated, TRW reduced hours, light duties.

(d) 18 July 2018: Still ongoing issues with back pain and new heel pain.

(e) 23 July 2018: Back pain - still has a few issues with this – worse in the morning, better with movement – still getting pain on one side... for home duties till Thursday then light duties for 4 hours.

(f) 30 July 2018: Has been back at work – is struggling a bit - went to physio Wednesday – did a pool session Saturday and after this noted that the left calf was a bit sore since then ... still has back pain – feels gradually improving.

(g) 6 August 2018: when doing exercise in pool did get a cramp, irritated at the time – had lots of pain through left leg after session – localises knee discomfort-also some degree of tightness in the hamstring…still walking with slight anatalgic gait.

(h) 21 August 2018: Physically getting better – back is getting better.

(i) 4 September 2018: Back is going really well – had a pool session movements getting better – almost no pain work...WC certificate completed – continue to gradually increase working hours.

(j) 18 September 2018: Physiotherapist going well – then following day stiffens up – for sports physician review.

(k) 2 October 2018: Still taking endone for pain relief. Had MRI today – awaiting review. Still stiff in the morning - ongoing physiotherapy.

(l) 30 October 2018: Left sided back pain radiating down to leg.

(m) 20 November 2018: Review of letters with Dr Bryant – needs referral to neurosurgeon.

(n) 11 December 2018: Marc Coughlan has recommended surgery- not fit for any work.

(o) 10 April 2019: Case conference – Glen Shiels – Glen asked to explain relationship between knee and back - explained potential relationship as I understand it; altered gait from back injury and foot drop has led to change in biomechanics and aggravation of long standing knee pathology - is severely limiting his ability to exercise, do physio, rehabilitation.

(p) 16 July 2019: next WC form – to be referred under that to a dietician and exercise physiologist.

(q) 19 July 2019: "Bari Sx" denied, as is back surgery -so feels is in an impossible situation.

(r) 23 July 2018: Lumbar back pain. "Current case manager is Glenn Shiels. Letter to pt reviewed with Peter from Glenn- looks likely main obj to his case is surgery not indicated – not his wt – and his wt just worsens the prognosis. They are happy to pay for phys and dietician…Symps – ongoing pain L back down behind L knee upper calf, separate pain in knee too. Occ rad pain to foot, mainly dorsum. Describes more paraesthesia/numbness dorsum foot and sometimes sole too…definite weakness L DF foot..."

47. Dr Stathis referred Mr Davies to Ms Gerathy, dietician, on 25 July 2019 for weight control noting that liability for surgery was disputed but Ausgrid was happy for referral to a dietician. Dr Stathis referred Mr Davies to Dr Engel, exercise physiologist to assist with weight loss on 25 July 2019.

48. In a report dated 4 May 2018, Ms Sally Wood, physiotherapist, noted that Mr Davies attended for an initial assessment of the left lower limb and lumbar spine. She reported that he presented with a 15 year history of left knee pain and also presented with lower back pain. On examination she noted that his abdominal strength was lacking largely in part to the surgery he has had to remove his right lower abdominal organs. Ms Wood noted that Mr Davies also presented with an extensive past medical history, mainly hypertension and obesity, along with his knee pain which is limiting the amount of exercise that he is able to do, thus creating a vicious cycle of pain and inactivity. She made a diagnosis of knee osteoarthritis and postural dysfunction but made no diagnosis in respect of the lumbar spine. She recommended treatment to reduce knee pain. She did not recommend any specific treatment for the lumbar spine.

49. In a report dated 19 September 2018, Ms Wooley reported an overall improvement regarding lumbar spine pain. She noted that Mr Davies was still getting a lot of stiffness in the morning and occasional episodes where his lower back pain "grabs him". She stated that "Peter is no longer getting any lower limb pain or pins and needles." She considered that presentation was indicative of disc related pain.

Independent Medical Examiner's Report

50. In a report dated 6 February 2019, Dr Michael Coroneos, neurosurgeon, noted a medical history of tachycardia and various operations including a right nephrectomy for cancer in 2011. Mr Davies told Dr Coroneos that prior to the incident on 4 July 2018, he had no problems with his back and spine.

51. Under “Presenting history”, Dr Coroneos noted that Mr Davies said that on 4 July 2018 he was pulling cable at Arncliffe Park where electrical wires had come down and that he was pulling new wire while standing on the ground. Dr Coroneos noted that Mr Davies said that that he did not experience any symptoms at that time and the next day he experienced left lower back, left buttock, left back of thigh, left back of calf pain, VAS (defined) was "9/10" "blunt" with no right lower limb, bladder or bowel symptoms.

52. Dr Coroneos reported that current symptoms were central lower back pain VAS (defined) 6/10 to 8/10 “sharp”, pins and needles sensation down the back of the left leg to the left foot, no leg pain and pain in the front of the left knee.

53. On examination, Dr Coroneos noted that “all movements were smooth and symmetrical. No dysmetria. No spasm, guarding, or deformity.” He reported that Mr Davies reported “diminished sensation to all modalities of sensation below the left knee noting a segmental or peripheral nerve distribution. No trunk or suspended sensory level.”

54. Dr Coroneos reported that he could not identify any lumbar nerve tension sign with motor and reflex examinations being normal. He considered that the report of altered sensation below the left knee to all modalities of sensation was not in a segmental or peripheral nerve distribution. He noted that the MRI shows multilevel degeneration with bilateral LS pars interarticularis defects with LS/S1 spondylolisthesis and L4/5, L5/S1 degeneration and this included a small foraminal disc protrusion abutting and compressing the left L5 nerve root.

55. Dr Coroneos made a diagnosis of a lumbar spine injury with possible left L5/S1 foraminal disc protrusion being caused by the injury with no ongoing leg pain and no evidence of ongoing radiculopathy in the setting of L4/5, L5/S1 degeneration, L5 pars interarticularis defects and L5/S1 spondylolisthesis, which are “non-work-related abnormalities.” Dr Coroneos did not believe that there was an indication for surgery as described by Dr Coughlan because there was no significant or progressive spondylolisthesis, no radiculopathy, no motor or reflex abnormality and the sensory disturbance described was noted in the segmental or peripheral nerve distribution and Mr Davies did not report sciatica or femoralgia.

56. Dr Coroneos was of the view that there was no indication for the proposed surgery and a bad outcome was predictable in a claimant with obesity (weight 146 kg). He noted that Mr Davies has a cardiac condition with tachycardia and opined that such surgery would be ill-advised. Dr Coroneos did not recommend surgical intervention at this point in time as Mr Davies reported no leg pain and had no evidence of radiculopathy.

57. Dr Coroneos wrote:

> “There is no indication to perform such major surgery both anterior and posterior in a male in the sixth decade of adult life with severe obesity with multiple medical comorbidities in the absence of any significant spondylolisthesis, any progressive spondylolisthesis or any significant radiculopathy or cauda equina compression. Weight loss and gradual weaning and cessation of S8 opioids are recommended. A physical therapy program with assessment by exercise physiologist/occupational therapist and occupational medicine specialist aiming at graduated return to work would be advised.”

58. He considered that Mr Davies was likely to continue to improve. He strongly recommended weight loss and weaning and cessation of opioids.

Discussion

59. Mr Grimes submitted that the findings of Dr Coroneos were supported by some of the medical evidence and that if I accepted that Mr Davies had no radiculopathy, the surgery was not reasonably necessary. Further, he submitted that the spinal fusion was not reasonably necessary treatment as there were risks in such surgery and alternative methods of treatments such as weight loss that should be undergone prior to any surgery.

60. Mr Davies needs to show that the injury materially contributed to the need for the lumbar spine fusion in accordance with the principles in *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49 (*Murphy*).

61. 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)* (1986) 2 NSWCCR 32 (*Rose*), Burke CCJ stated at [42]:

> "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."

62. Further, His Honour added at [47]:

> "1. *Prima facie*, if the treatment falls within the definition of medical treatment in section 10(2), it is relevant medical treatment for the purposes of this Act. Broadly then, treatment that is given by, or at the direction of, a medical practitioner or consists of the supply of medicines or medical supplies is such treatment.
>
> 2. However, although falling within that ambit and thereby presumed reasonable, that presumption is rebuttable (and there would be an evidentiary onus on the parties seeking to do so). If it be shown that the particular treatment afforded is not appropriate, is not competent to alleviate the effects of injury, then it is not relevant treatment for the purposes of the Act.
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> 3. Any necessity for relevant treatment results from the injury where its purpose and potential effect is to alleviate the consequences of injury.
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> 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."

63. Further, Burke CCJ considered the relevant factors relating to reasonably necessary treatment under s 60 of the 1987 Act in *Bartolo v Western Sydney Area Health Service* (1997) 14 NSWCCR 233 (*Bartolo*) 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."

64. In *Diab v NRMA Ltd* [2014] NSWWCCPD 72 (*Diab*), Deputy President Roche 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;
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> (b) the availability of alternative treatment, and its potential effectiveness;
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> (c) the cost of the treatment;
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> (d) the actual or potential effectiveness of the treatment, and
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> (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.
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> 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'".

65. 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* (1994) 35 NSWLR 452 where Kirby P stated at [463]:

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

66. 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 DP Roche in *Murphy*, where he stated at [57-58]:

> "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.
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> Ms Murphy only has to establish, applying the common sense 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)."

67. According to *Murphy*, a condition can have many causes, and all that the applicant needs to show is that the injury materially contributed to the need for surgery. The weight of the medical evidence, in my view, clearly establishes, that Mr Davies' injury has materially contributed to the need for surgery.

68. Mr Davies relied on the opinion of the two treating neurosurgeons and the treating neurologist.

69. Dr Coughlan noted that Mr Davies had injured his back in a work-related accident and had very significant ongoing severe back pain and left sided foot drop. Dr Couglan was of the opinion that the injury was directly related to the workplace event, and the symptoms that Mr Davies was experiencing he had never had before. Dr Coughlan was not of the view that Mr Davies would have required surgery without the incident taking place.

70. Dr Mobbs was of the opinion that it was likely that Mr Davies' underlying spondylolisthesis was suddenly made significantly worse with his sudden traction injury. He considered that Mr Davies likely sustained the disc herniation at that same time as there were no issues with leg pain or foot drop prior to the incident. Dr Mobbs noted that Mr Davies had sought a number of opinions and generally these included a fixation of the spondylolisthesis and a decompression of the L5 nerve. He noted that this could be performed via several methods: anterior, posterior or a combination of both.

71. Dr Mobbs stated that in general, he agreed with the opinion as provided by Dr Coughlan, in that a combination anterior/posterior decompression and fixation would be sensible, especially considering that Mr Davies was a large gentleman and would be putting significant stress through the lower two joints in his back.

72. Associate Professor Darveniza was of the view that Mr Davies was suffering from work-related symptomatic lumbosacral spondylosis with a left L5 radiculopathy with congruent imaging, leaving him with chronic back pain and a left L5 sciatica.

73. Associate Professor Darveniza expressed the opinion that surgical intervention would be reasonable as outlined by Dr Coughlan. He confirmed that the surgical intervention would be reasonable and necessary and that the employment with the respondent was the main reason for the need for this surgical intervention to arise.

74. The respondent relied on the opinion of Dr Coroneos, who examined Mr Davies once on 6 February 2019.

75. Dr Coroneos did not consider that there was an indication for the surgery proposed by Dr Coughlan because there was no significant or progressive spondylolisthesis, no radiculopathy, no motor or reflex abnormality and the sensory disturbance described was noted in the segmental or peripheral nerve distribution and because Mr Davies did not report sciatica or femoralgia.

76. It is significant that the findings on examination made by Dr Coroneos were inconsistent with the findings made by the other treating neurosurgeons and neurologist. On 6 December 2018 Dr Coughlan examined Mr Davies and noted left sided foot drop, very significant ongoing severe back pain and the neuropathic leg pain. On 30 January 2019, Dr Coughlan noted that Mr Davies was unfit for duties because he was really struggling to work with the foot drop and the pain he was experiencing. Dr Mobbs on 6 June 2019 noted that Mr Davies presented with a combination of back, buttock and predominantly left-sided leg pain with foot drop. On 9 September 2019, Associate Professor Darveniza noted on examination that there was complete loss of the normal lumbar lordosis, marked restriction of back flexion with the hands just reaching the knees and numbness with pins and needles over the top of the left foot in the distribution of the left L5 nerve root. Associate Professor Darveniza was of the view that Mr Davies was suffering from work-related symptomatic lumbosacral spondylosis with a left L5 radiculopathy with congruent imaging, leaving him with chronic back pain and a left L5 sciatica.

77. Dr Coroneos, in my view, took a short and inadequate history of incident on 4 July 2018. He did not report that Mr Davies was part of a team pulling the cable and that when the other workers dropped the cable Mr Davies was pulled some distance and jolted his spine causing a traction injury.

78. Mr Grimes submitted that there was some evidence to be found in the clinical notes of Dr Allen and the report of Ms Wooley that supported the findings made by Dr Coroneos. I accept that the clinical notes of 5 July 2018 did not refer to left leg pain. However, the clinical notes of 12 July 2018 referred to some pain in left leg with walking, sitting and standing. I accept that the clinical records showed some improvement in the level of back pain in August and September 2018 but these comments should be treated with some caution as Mr Davies was starting to take Endone to relieve pain and was then referred to Dr Bryant on 18 September 2018 because of “poor progress”. The clinical notes are quite brief and any inconsistency between those notes and Mr Davies’ evidence should be treated with caution (*Mason v Demasi* [2009] NSWCA 227).

79. Mr Davies' evidence was stated that on the next morning following the incident, he felt severe pain with muscular spasms radiating down the back of his left leg to the knee and down his leg with pins and needles on the top of his left foot and a slight foot drop. I accept the evidence of Mr Davies.

80. I accept that in a report dated 19 September 2018, Ms Wooley stated that "Peter is no longer getting any lower limb pain or pins and needles." However, she considered that his presentation was indicative of disc related pain. There is only one report in evidence from Ms Wooley. I would not place any significant weight on this one report from the physiotherapist after considering the findings made by Dr Bryant, Dr Coughlan, Dr Mobbs and Associate Professor Darveniza.

81. I do not consider that the evidence to be found in the clinical notes of Dr Allen and the report of Ms Wooley provided any real support for the findings made by Dr Coroneos. I accept the findings and opinions of Dr Coughlan, Dr Mobbs and Associate Professor Darveniza and prefer their evidence to that of Dr Coroneos for the reasons given above.

82. Mr Grimes also referred to reports of back pain that predated the injury on 4 July 2018. I accept that the Patient Health Summary from Bexley North Medical Clinic referred to a left lumbar radiculopathy on 20 May 2016. Ms Wood, on 4 May 2018, noted that Mr Davies attended for an initial assessment of the left lower limb and lumbar spine. She reported that he presented with a 15 year history of left knee pain and also presented with lower back pain. However, she made a diagnosis of knee osteoarthritis and postural dysfunction but no diagnosis in respect of the lumbar spine. The only recommended treatment was to reduce knee pain, and she did not recommend any specific treatment for the lumbar spine or investigation. I would infer from this that Ms Wood did not consider that there was any significant condition affecting the lumbar spine. Associate Professor Darveniza reported that Mr Davies told him that following heavy activities in the past he did get some short lived low back ache.

83. Mr Davies performed heavy physical duties in his employment as a linesman. Despite these reports of earlier back problems, he continued to perform his work duties. I am not persuaded that the earlier complaints of back pain were significant. It was only after the incident on 4 July 2018 that Mr Davies complained of pain extending down the left leg, numbness in the left foot and foot drop.

84. The next question to consider is whether the fusion surgery proposed by Dr Coughlan is reasonably necessary as a result of the work injury. The history of previous conservative treatment and opinions of the doctors as to potential treatment are obviously factors to be taken into account in determining if the proposed surgery is reasonably necessary.

85. The respondent has argued that the spinal fusion was not reasonably necessary treatment as Mr Davies needed to lose weight prior to surgery according to Dr Coroneos in his report of 6 February 2019 and there were risks associated with the surgery.

86. Dr Coroneos expressed the view that there was no indication for the proposed surgery and a bad outcome was predictable in a claimant with obesity. He noted that Mr Davies has a cardiac condition with tachycardia and opined that such surgery would be ill-advised. Dr Coroneos recommended weight loss and gradual weaning and cessation of S8 opioids. He commented that a physical therapy program with assessment by exercise physiologist/occupational therapist and occupational medicine specialist aiming at graduated return to work would be advised.

87. Mr Davies has lost some weight since February 2019. Dr Bryant in her report of June 2019 noted that he had lost 7 kg. He was referred to an exercise physiologist and a dietician in July 2019.

88. Dr Coughlan expressed the opinion that on the current findings a surgical option would be the only way to address the problems Mr Davies had and without surgery he will not get better and may get worse especially given he has foot drop. He considered that although a weight loss strategy would certainly benefit Mr Davies' recovery, this would not address the mechanical spinal issue. Dr Coughlan noted that he had received the report of Dr Coroneos but did not agree with his opinion.

89. Dr Mobbs agreed in general with the opinion as provided by Dr Coughlan, in that a combination anterior/posterior decompression and fixation would be sensible, especially considering that Mr Davies was a large gentleman and would be putting significant stress through the lower two joints in his back. He also commented that it would be helpful that Mr Davies lose at least 10 kg of weight before surgery.

90. Associate Professor Darveniza concluded that surgical intervention as suggested by his neurosurgeons was indicated, that is, an anterior lumbar interbody spacer at L4/5 and LS/SI augmented by posterior pedicle screw fixation at L5/S1. He noted that he had read the report of Dr Coroneos dated 6 February 2019, which recommended continuing conservative therapy including weight loss and weaning off opioids, and disagreed with this recommendation.

91. On balance, I am comfortably satisfied that an anterior lumbar interbody fusion with disc spacers at L4/5 and L5/S1 augmented by posterior pedicle screw fixation at L5/S1 could help alleviate the pain experienced by Mr Davies, address the foot drop and stabilise his lumbar spine. The evidence from Dr Coughlan, Dr Mobbs and Associate Professor Darveniza supported this conclusion.

92. I prefer the evidence of Dr Coughlan, Dr Mobbs and Associate Professor Darveniza to the evidence of Dr Coroneos on the question of whether there are other acceptable treatment methods. I am satisfied that Mr Davies has exhausted conservative treatment options. Whilst there are risks attached to the proposed surgery, Mr Davies stated that he wanted to go ahead with the operations.

93. The cost of the surgery for the anterior lumbar interbody fusion with disc spacers at L4/5 and L5/S1 augmented by posterior pedicle screw fixation at L5/S1 appeared to be in the vicinity of $35,000. Whilst this is costly, Mr Davies is unable to work because of pain and the fusion, if reasonably successful, could assist him to return to some form of work, alleviate his pain and improve his quality of life. Without the surgery, it is possible that Mr Davies may deteriorate further and have no prospect of returning to work.

94. I am satisfied on balance that the medical evidence supports the need for the anterior lumbar interbody fusion with disc spacers at L4/5 and L5/S1 augmented by posterior pedicle screw fixation at L5/S1 proposed by Dr Coughlan. I am not persuaded that the same potential outcome could be achieved by a different treatment such as further weight loss and weaning off opoids. To the extent that Dr Coroneos argues that the ongoing pain is due to degeneration and not to the injury on 4 July 2018, I reject that conclusion and for the reasons already given, prefer the opinions of Dr Coughlan, Dr Mobbs and Associate Professor Darveniza.

95. I am satisfied on the balance of probabilities that the treatment proposed by Dr Coughlan, namely, anterior lumbar interbody fusion with disc spacers at L4/5 and L5/S1 augmented by posterior pedicle screw fixation at L5/S1 and associated expenses, is reasonably necessary treatment as a result of the injury arising out of or in the course of Mr Davies' employment with the respondent on 4 July 2018.