WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**6244/20**
Applicant:	**Kerrie Kernan**
Respondent:	**QF Cabin Crew Australia Pty Limited**
Date of Determination:	**18 February 2021**
Citation No:	**[2021] NSWWCC 51**

The Commission determines:

1. The applicant has sustained consequential conditions of her lumbar spine and left knee as a result of an injury to her right ankle on 5 November 2017.

2. The matter is remitted to the Registrar for referral to an Approved Medical Specialist for assessment of permanent impairment as a result of injury to the right lower extremity (right ankle); consequential conditions of the left lower extremity (left knee) and lumbar spine; and TEMSKI scarring on 5 November 2017.

3. The Approved Medical Specialist is to be provided with the following documents:

   (a) Application to Resolve a Dispute and attachments;
   (b) Reply and attachments, and
   (c) Application to Admit Late Documents dated 20 January 2021 and attachments.

4. The respondent is to pay the applicant's medical 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.

Kerry Haddock
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 KERRY HADDOCK, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

L Golic

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

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Kerrie Kernan, was employed by the respondent, QF Cabin Crew Australia Pty Limited, as a long-haul flight attendant.

2. It is not disputed that Ms Kernan sustained an injury on 5 November 2017, when she rolled her right ankle in a pothole while returning to her hotel in Hong Kong. She had worked on a fight from Sydney to Hong Kong and was rostered to work on the return flight that evening. Liability for the injury to the applicant's right ankle has been accepted.

3. The applicant claims that as a result of the injury to her right ankle, she has sustained consequential aggravation, acceleration, exacerbation and deterioration of a disease process in respect of her lumbar spine and left knee.

4. On 2 October 2019, the respondent's insurer, Allianz Australia Workers Compensation (NSW) Limited (Allianz) issued the applicant with a notice pursuant to section 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act). It disputed liability for an Elixr gym membership and further allied health practitioner management, on the basis that the treatment was not reasonably necessary as a result of the injury.

5. By letter dated 16 March 2020, the applicant made a claim on Allianz pursuant to section 66 of the *Workers Compensation Act 1987* (the 1987 Act) for $26,360 in respect of 12% whole person impairment (WPI) as a result of injury to her right ankle, left knee, lumbar spine and TEMSKI scarring. The assessment is in fact 13% WPI, and this was later corrected by the applicant's independent medical examiner.

6. Allianz issued the applicant with a further section 78 notice on 29 June 2020. It disputed that she was entitled to compensation for permanent impairment as her accepted injury had not resulted in more than 10% impairment, as required by section 66(1) of the 1987 Act. Allianz also disputed that Ms Kernan's "claimed consequential condition" resulted from her accepted injury. While the notice is not well drafted, it states that Allianz does not accept that the applicant has sustained a consequential left knee or lumbar spine injury as a result of the injury to her right foot/ankle.

7. On 24 September 2020, Allianz issued the applicant with a further section 78 notice, disputing that further physiotherapy was reasonably necessary medical treatment, pursuant to section 60 of the 1987 Act.

8. The applicant lodged an Application to Resolve a Dispute (the Application) on 28 October 2020. She claims pursuant to section 66 of the 1987 Act the sum of $29,410 in respect of 13% WPI as a result of injury to her right lower extremity; left lower extremity; lumbar spine; and TEMSKI scarring.

9. The respondent lodged its Reply on 18 November 2020. It confirmed that the issues in dispute were those previously notified to the applicant, although it did seek to raise issues that ultimately do not require determination in these proceedings.

10. At the telephone conference held on 25 November 2020, the Application was amended by consent to claim a general order for medical expenses pursuant to section 60 of the 1987 Act.

11. The parties agree that, if the claim for consequential condition is determined in the applicant's favour, the medical dispute is to be referred to an Approved Medical Specialist (AMS) for assessment. If she is unsuccessful in that claim, the assessment of WPI on which she relies with respect to the injury to her right ankle is insufficient to permit referral to an AMS.

12. The parties also agree that, if an order for payment of medical expenses is made, it is appropriate to make a general order.

ISSUES FOR DETERMINATION

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

    (a) Whether the applicant has sustained a consequential condition of her left knee and/or lumbar spine as a result of the injury to her right ankle; and

    (b) Whether the applicant is entitled to an order for medical expenses pursuant to section 60 of the 1987 Act.

PROCEDURE BEFORE THE COMMISSION

14. The matter was listed for conciliation/arbitration hearing by telephone on 28 January 2021. Mr McManamey of counsel, instructed by Mr Michael Hyland, appeared for the applicant, who was present; and Mr Beran of counsel, instructed by Ms Belinda Walsh, appeared for the respondent. Ms Stephanie Small of iCare also attended.

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.

EVIDENCE

Documentary Evidence

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

    (a) The Application and attached documents;
    (b) Reply and attached documents, and
    (c) Application to Admit Late Documents and attached documents, dated 20 January 2021, filed by the applicant and admitted by consent.

Oral Evidence

17. There was no oral evidence. The parties' submissions were sound recorded; and a copy is available to the parties.

FINDINGS AND REASONS

Applicant's Evidence

18. Ms Kernan's evidence is contained in a statement dated 3 August 2020.

19. The applicant states that she underwent left anterior cruciate ligament (ACL) reconstruction surgery in 2002 but made a full recovery and returned to her usual very active lifestyle. This included running, hiking and skiing. Between 2006 and 2017 she had intermittent periods of back pain, which she effectively managed with physiotherapy.

20. The applicant then provides details of the injury to her right ankle on 5 November 2017. She states that her right ankle rolled in a pothole and gave way. She fell suddenly and heavily to the ground, face first. She had bruising and soreness to both elbows, particularly the right, as well as to her left shoulder, upper arm and left hip.

21. Ms Kernan underwent treatment in Hong Kong and her foot was placed in a brace. She returned to Sydney as a passenger that evening.

22. The statement refers to subsequent treatment. The applicant underwent right ankle reconstruction surgery on 24 April 2018. She states that she regularly attended physiotherapy and exercise physiology, in accordance with her treating specialist's recommendation and attempting to avoid a second surgery.

23. Between June 2018 and July 2018, the applicant began to experience very painful back spasms and had physiotherapy. The pain prevented her from completing exercises to promote rehabilitation of her ankle and assist with pain management.

24. The applicant states that in early October 2018, the pain and swelling in her ankle persisted and she had swelling and sharp pain in her left knee, which was caused by constantly shifting her weight to her left leg, to avoid placing further stress on her right ankle.

25. Ms Kernan continued to consult her physiotherapist and exercise physiologist and felt her symptoms were slowly being managed. However, she was not able to return to her pre-injury duties. She ceased work for the respondent by medical resignation on 14 October 2018 and is now working as a teacher, which she finds less physically demanding.

26. The applicant states that in about November 2018 she attended weekly exercise physiology sessions at Vision PT Personal Training, recommended by Ms [Sandy] Sher, exercise physiologist. Due to pain in her lower back, she struggled with movement and could not perform the exercises as required. Her membership expired and she could not afford to renew it. Her left knee pain was persistent as a result of constant weight bearing when shifting her weight off her right leg; and this also limited the type of exercise she could perform.

27. Ms Sher recommended a six-month membership at Elixr, to begin an exercise program to promote strength and rehabilitation in the applicant's right ankle and left knee. Allianz rejected funding for gym membership and Ms Sher advised the applicant to continue similar exercises at home.

28. In about April 2019, Ms Kernan stopped attending physiotherapy as she felt her symptoms were effectively managed through her exercise physiology program. After two or three months, her left knee pain continued, so she was limited in the types of exercises she could perform at home. She therefore felt she was not receiving the full benefit of the exercise physiology program.

29. On or about 29 July 2019, the applicant's physiotherapist submitted a further request to Allianz for approval of Elixr membership for continued ankle rehabilitation. Ms Kernan received a letter from Allianz on 2 October (the first section 78 notice), confirming that this membership would not be funded; and her allied health treatment, including exercise physiology and physiotherapy, would no longer be funded.

30. The applicant states that the constant aching pain in her right ankle and the pain and swelling in her left knee have not resolved. Her ankle becomes painful and swollen if she wears heels or walks for long distances. She cannot walk, sit or stand continuously for longer than 30 minutes without pain. She has painful cramps in her left knee after periods of inactivity. Pain in her right ankle wakes her. Her back aches for several days after any moderate to heavy physical activity, which makes housework difficult.

31. Ms Kernan states that she led a very active lifestyle before the accident. Her hobbies included running, swimming, hiking, bushwalking, snow and water skiing and golf. Since the accident, she has been unable to continue these activities as pain in her right ankle and left knee worsens after any moderate to heavy physical activity and she needs to rest with no physical activity for several days after.

Medical Evidence

Dr Leo Pinczewski – Orthopaedic Surgeon

32. Dr Pinczewski reported on 27 August 2004 to the applicant's then general practitioner.

33. Dr Pinczewski recorded a history that the applicant, a keen hockey player and skier, had injured her left knee while skiing in 1986. It "blew up" and was very painful for a few weeks. She had recovered with conservative treatment, but two years earlier had again twisted her knee while coaching hockey. Her knee was painful and swollen the next day; and she had pain and swelling after exercise over the past few months.

34. Dr Pinczewski opined that the applicant had most likely ruptured her ACL in 1986 and this had led to a medial meniscal tear. He recommended ACL reconstructive surgery and treatment of the medial meniscus at the same time.

35. On 18 October 2004 Dr Pinczewski reported that the applicant had that day undergone arthroscopic left ACL reconstruction with medial meniscectomy.

Dr Peter Lam – Orthopaedic Surgeon; Foot and Ankle Specialist

36. Dr Lam reported to Dr Chan on 30 January 2018, when the applicant was 12 weeks post-injury. She was making good progress with physiotherapy, but the improvement in ankle movement had plateaued over the last three weeks. Her ankle stiffness was worse when she first got up.

37. Dr Lam suggested that the applicant would benefit from a trial of ultrasound cortisone injection but may require arthroscopy if she did not respond.

38. On 27 February 2018 Dr Lam reported that the applicant had very good pain relief from cortisone injection and was making good progress with physiotherapy. He noted that since Ms Kernan had increased her walking, she had noticed increased ankle instability on uneven ground. She was concerned that this would cause difficulty when she returned to wearing high heels.

39. Dr Lam referred the applicant for an MRI scan. He advised her that she would benefit from ankle arthroscopy to address anterolateral soft tissue impingement; and lateral ligament reconstruction to address ankle instability.

40. On 9 March 2018, Dr Lam reported that the applicant would require surgery. If arthroscopy revealed damage to the chondral surface of the talar dome, she would need to avoid running, jumping and dancing type activities for about six months. Her ankle would swell for several months after the surgery.

41. The applicant underwent surgery on 24 April 2018. Dr Lam reported that this consisted of arthroscopic debridement of the right ankle; modified Brostrom lateral ligament reconstruction of the right ankle; posterior subtalar arthroscopy; and excision of the os trigonum. He noted, among other findings, mild chondromalacia of the posteromedial talar dome.

42. On 11 May 2018, Dr Lam reported that the applicant was two weeks post-surgery. Her back slab had been removed and a short Vacoped boot had been applied to protect the reconstruction. She was referred to Mr Kelly for physiotherapy.

43. Dr Lam reported on 19 June 2018 that Ms Kernan was making good progress with physiotherapy. Her ankle felt stable, but she still had swelling, especially along the posterior aspect.

44. Dr Lam opined that the applicant needed to continue physiotherapy, to consolidate her achievements and work on her proprioceptive retraining and peroneal muscle strengthening.

45. On 2 October 2018 Dr Lam reported that Ms Kernan was making progress with physiotherapy and had been referred to an exercise physiologist. She had returned to light duties with the respondent and had also returned to teaching. The applicant reported persistent intermittent right lateral ankle pain and swelling. Dr Lam referred her for an MRI scan.

46. On 9 October 2018 Dr Lam reported that the MRI scan showed subchondral bone marrow oedema that was not present on the applicant's pre-surgery MRI. This implied that the medial talar dome lesion had destabilised since the surgery and was the likely cause of her ongoing ankle pain.

47. Dr Lam had advised the applicant that her options were to "wait and see", continuing with physiotherapy and exercise physiology; or have an ankle arthroscopy to debride the lesion. He noted that 20% of patients continue to have ongoing pain following this surgery. The applicant planned to discuss treatment options with Mr Kelly, her physiotherapist.

Mr David Kelly – Physiotherapist

48. On 26 February 2018 Mr Kelly reported that the applicant had had immediate improvement in her ankle after a cortisone injection three weeks before. There was almost complete resolution of her pain and swelling and a reduction in the "blocking" she had described when trying to increase her range of motion.

49. The applicant had complained of more easily rolling her ankle on uneven surfaces. She felt the effect of the injection may have been wearing off, with some stiffness after a 60-minute walk, and aching afterwards.

50. Mr Kelly noted that the applicant walked with a normal gait. Her balance on her right side was "at best fair". He opined that her stability and mild posterior impingement arc were the main obstacles to her resuming her full duties and normal exercise routine.

51. On 24 July 2018 Mr Kelly referred Ms Kernan to Ms Sher.

52. Mr Kelly told Ms Sher that the applicant had "tried tirelessly" to rehabilitate conservatively but had required a lateral ligament reconstruction in April 2018. She had made steady progress and had recently commenced jogging, but had ongoing stiffness, lateral tenderness and decreased confidence relating to her ankle.

53. Mr Kelly reported that the applicant was extremely fit and active before her injury and came from a background of elite sport. As her injury/recovery was "dragging on", she found her general strength and fitness had markedly reduced, compounding the effect of the ankle injury and causing "other aches and pains".

54. Mr Kelly stated that WorkCover had been difficult, as it was slow to act on a number of issues and preferred to use its associated health services. He had suggested that Ms Sher assist the applicant with upgrading/progressing her general rehabilitation, as well as assisting with her ankle.

55. On 21 January 2019 Mr Kelly reported that he had reviewed the applicant, having not seen her since October 2018. She had continued to train with Ms Sher and was working as a teacher.

56. The applicant felt that progress with her ankle had plateaued. She continued to experience stiffness in the morning and was unable to run or wear high heels. She avoided prolonged periods of walking or standing where possible. She was able to manage her left knee symptoms if she avoided impact or single leg activities and reduced the depth of weight-bearing exercises.

57. Mr Kelly noted that the applicant was "understandably not keen" to have further surgery. He had stressed that she needed to continue to work on her ankle and knee strength and stability, as tolerated, but also felt that a podiatric review may assist her.

58. On 23 April 2019, Mr Kelly reported that the applicant's last consultation had been on 21 January 2019. He understood that her absence was partly due to the demands of her work as a teacher and partly due to satisfaction managing her symptoms with the help of her exercise physiologist. She had been discharged from his care.

59. Mr Kelly next reported on 29 July 2019. The applicant had returned for review. She reported little progress in her symptoms. She had been able to perform only a limited version of the program devised by her exercise physiologist. This was due to a combination of the lapse of her gym membership and chronic left knee pain that restricted her weightbearing and impact activities. Mr Kelly noted that she had previously managed her knee pain with her pre-injury exercise regime.

60. Mr Kelly reported that the applicant was taking a "wait and see" approach to the option of further surgery. This consisted of ongoing exercise rehabilitation provided by physiotherapy and exercise physiology. He opined that her inability to participate fully was a significant factor in her lack of progress. He also felt that her prolonged disability and lack of exercise had contributed to the development of mental health issues, a 15-kilogram weight increase and lower back pain that further impacted her ability to exercise.

Ms Sandy Sher – Exercise Physiologist

61. Ms Sher reported on 8 August 2018.

62. Ms Sher recorded a history that the applicant had not been able to get back to her pre-injury levels of activity, including running. She had a pre-existing lower back injury that had resolved before the injury to her right ankle but had recently flared up due to her favouring one leg and being unable to undertake regular exercise for a prolonged period.

63. Ms Sher reported that the applicant was generally deconditioned and demonstrated weak pelvic and ankle stability, specifically on the right leg. There were also many psycho-social factors that impacted on her recovery.

64. Ms Sher recommended that the applicant start with a general health and well-being program at her gym and then address a graded return to work on suitable duties. She noted that the insurer had agreed to the program.

Dr Wan Kum Chan – General Practitioner

65. On 14 October 2018, Dr Chan referred the applicant to Dr Tim Musgrove, orthopaedic surgeon. He noted that she had pain and swelling of her left knee since the upgrade of rehabilitation for her work-related right ankle injury.

66. Dr Chan wrote that the applicant's physiotherapist and exercise physiologist agreed that her left knee pain and swelling was a compensatory problem due to the right ankle injury.

67. On 3 May 2020, Dr Chan requested Allianz to approve continued physiotherapy with Mr Kelly; continued exercise physiology with Ms Sher; and a six-month membership of Elixr. Dr Chan noted that Ms Kernan had chosen a "wait and see" approach to avoid a second ankle surgery. This decision was supported by Mr Kelly and Ms Sher. He reported that previous requests for ongoing medical treatment had been ignored for a lengthy period; and opined that the ongoing management plan was necessary and appropriate.

Dr Tim Musgrove – Orthopaedic Surgeon

68. Dr Musgrove reported to Dr Chan on 19 November 2018. He recorded a history of increasing issues with the applicant's left knee, after increased rehabilitation required for her right ankle. He noted that she had undergone left ACL reconstruction by Associate Professor Leo Pinczewski in 2002, following an established ACL disruption in 1986.

69. Dr Musgrove reported that Ms Kernan had remained active with regard to her left knee after the reconstruction. This included running, until recent flares in her knee had precluded impact activity.

70. Dr Musgrove reported that the applicant's left knee MRI scan showed a synovitis on the background of the anticipated previous medial meniscal resection, with a relatively intact lateral compartment. There was ganglionic change throughout the tibial tunnel, which may have been related to post-surgical change or bioabsorbable screw.

71. Dr Musgrove opined that it was unlikely the applicant would reliably benefit from left knee surgery; and the patellofemoral changes may be provoking reactive effusions when increasing the load through the knee.

72. Finally, Dr Musgrove recommended that the applicant have weight-bearing exercises of the knees and ankles; and inflammatory blood screen would be appropriate.

Dr James Bodel – Orthopaedic Surgeon

73. Dr Bodel was qualified by the applicant.

74. On 22 January 2020, Dr Bodel reported after his examination of Ms Kernan on 21 January 2020.

75. Dr Bodel recorded a consistent history of the injury to the applicant's right ankle and her subsequent treatment. He summarised her injuries as forced inversion injury to the region of the right foot and ankle; and consequential aggravation of pre-existing pathology in the left knee and lower back.

76. The applicant was initially treated conservatively. Dr Bodel recorded that during this period, the swelling in her ankle diminished a little but never completely resolved; the pain improved but never completely resolved; and she continued to have pain over the anterolateral aspect of her ankle, just below the tip of the lateral malleolus and posteriorly in the posteromedial aspect.

77. At this stage, the applicant had ongoing functional disability in her ankle; and could not wear high heels or go jogging. She had always been very fit and played hockey at elite level for many years. She had jogged four or five times per week, for 10 kilometres at a time. Dr Bodel noted that she had very significant physical and psychological difficulties.

78. Dr Bodel recorded the applicant’s subsequent treatment and investigations. She came to surgery by Dr Lam. This was followed by extensive physiotherapy with Mr Kelly, after a period of immobilisation.

79. The applicant told Dr Bodel there had been gradual improvement in clinical function, with a decrease in pain and swelling and improved range of movement. She was still very disappointed in the outcome of the surgery because she cannot wear high heels, has not been able to run and still has significant pain, even when standing and walking.

80. Dr Bodel noted that the applicant had post-operative physiotherapy and was referred to Ms Sher. By about October (2018) there was an increase in the “amount of work to be done”, at Dr Lam’s request. This included gymnasium-based work activities.

81. Dr Bodel recorded that the applicant completed treatment approved by the respondent toward the end of December 2018. Other matters intervened in January (2019) and she was unable to get back to work. Dr Lam and Ms Sher advised her to attend a different facility for a gymnasium-based program, but the insurer declined to fund it in about May 2019. The applicant eventually signed up for a special introductory offer at Virgin Fitness Centre.

82. Dr Bodel reported that the applicant’s pain had remained fairly stable and static. She had “not really been able” to do what she would like by way of rehabilitation in 2019 because of lack of support from the insurer. She was very disappointed that she could not go running. She said she had become deconditioned, which was a “vicious circle”, as she became less mobile. This further aggravated her back, her left knee and in particular her ankle.

83. The applicant complained of continuing back and left knee pain. The latter was an aggravation of long-standing ACL reconstruction. She had consulted Dr Musgrove due to ongoing pain in her back, left knee, right foot and ankle.

84. Dr Bodel noted that the applicant had developed the gradual onset of left knee pain and lower back pain because of the residual effects of the injury to her right foot and ankle.

85. While the applicant had recently joined the Elixr gym, she told Dr Bodel she had never been a “gym girl” and felt she needed the exercise physiologist to put together an appropriate program. In addition to running, she had played golf and enjoyed hiking, snow and water skiing. She had not returned to those activities.

86. Dr Bodel noted that the applicant walked with a mild flat-footed gait pattern on the right, which was slightly worse in bare feet. There was mild tenderness on palpation at the lumbo-sacral junction and some guarding on the right side. There was also some asymmetry of back movement, but no evidence of nerve root irritability. The applicant had a full range of hip movement but lacked left knee movement. Dr Bodel found evidence of early arthritic change in the left knee, with a small effusion and tenderness over the medial joint line.

87. Dr Bodel recorded that the applicant wanted to go with “option one” of the alternatives suggested by Dr Lam in October 2018, that is to continue with physiotherapy and exercise physiology, but this was not available as the insurer would not approve the transfer of her treatment protocol to Elixr.

88. Dr Bodel opined that the applicant had developed consequential problems in her left knee and the lower part of her back, where there had been some aggravation, acceleration, exacerbation and deterioration of a disease process, that is degenerative disc disease in the lumbosacral region and the old ACL reconstruction, with patellofemoral osteoarthritic change. He was satisfied that her employment was the main contributing factor to ongoing pathology in all those areas.

89. As regards treatment, Dr Bodel opined that the applicant was having minimal treatment and needed an exercise physiologist to put together an appropriate program and supervise her. The treatment that had been undertaken was reasonably necessary.

90. In a supplementary report, also dated 22 January 2020, Dr Bodel opined that the applicant had a consequential condition of her left knee. She had developed painful retropatellar crepitus because she was favouring that side to protect her injured right side. This had caused aggravation, acceleration, exacerbation and deterioration of underlying patellofemoral arthritic change that arose as a result of her knee reconstruction nearly 20 years ago.

91. Dr Bodel also opined that the applicant had mechanical backache. There had been aggravation, acceleration, exacerbation and deterioration to underlying degenerative disc disease, due to Ms Kernan's abnormal gait pattern after her right foot and ankle injury.

92. Dr Bodel assessed Ms Kernan's WPI as 12%, including assessments of her left lower extremity (knee) and lumbar spine.

93. On 21 October 2020, Dr Bodel corrected an error in his previous report. He had omitted to add 1% WPI for scarring, so his assessment was increased to 13% WPI.

Dr Graeme Doig – Orthopaedic Surgeon

94. Dr Doig was qualified by the respondent and reported on 14 May 2020.

95. Dr Doig recorded a consistent history of the injury and the applicant's subsequent treatment.

96. The applicant complained of pain and stiffness at her right ankle. She had suffered a tear to the soleus (calf) muscle while "rehabilitating in recent times". She had also been experiencing lower back pain "since this incident", with a past history of lower back problems. The applicant had ongoing pain and instability at her left knee, where she had undergone previous ACL reconstruction.

97. Dr Doig noted that the applicant's physiotherapy had finished. She attended a gym to improve her core strength. She had been unable to return to playing golf, hockey, jogging, hiking or skiing.

98. On examination, Dr Doig found no asymmetrical muscle atrophy. The applicant's main restrictions were at the sub-talar joint, where she had less than 10 degrees of inversion and eversion, respectively. There were no restrictions in toe movement and no neuro-vascular compromise of the lower limb.

99. Dr Doig reported that the applicant's lower back was non-tender. She was able to forward flex to her lower shins with symmetrical lateral flexion and rotation and 20 degrees of extension. Hip examination was satisfactory. Straight leg raising was full, with no negative nerve root tension signs and no neurological deficit of the lower limbs. The applicant could walk on her heels and toes satisfactorily.

100. Dr Doig also noted the scarring of the applicant's right ankle and left knee.

101. Dr Doig diagnosed lateral collateral ligament complex disruption of the applicant's right ankle, requiring ligament reconstruction; a talar dome lesion requiring arthroscopic debridement; and excision of a de-stabilised os-trigonum. The diagnosis of the lumbo-sacral spine was degenerative disc disease as a result of previous problems; and of the left knee previous ACL injury requiring reconstructive surgery, with ongoing mild laxity on clinical examination.

102. Dr Doig reported that the applicant denied injuring her lower back or left knee on 5 November 2017. She said her left knee had never returned to normal since the date of the injury. She had suffered longstanding intermittent lower back problems. Her back pain had deteriorated since March 2020, as a result of a soleus tear while trying to exercise to maintain overall fitness.

103. Dr Doig opined that the applicant's left knee and lower back conditions were unrelated to the incident of 5 November 2017. He assessed 3% WPI as a result of injury to her right lower extremity and scarring.

Mr Gaetano G Milazzo – Physiotherapist

104. Mr Milazzo reported to Allianz on 23 August 2019, having been asked to conduct a Stage 2 Review of Allied Health Provider treatment. A Stage 2 Review does not involve examining the worker but is based on a review of available documents and discussion with the treating physiotherapist.

105. Mr Milazzo told Ms Sher that he did not support exercise membership as he did not consider it would provide any specific functional or work-related goal. He also did not support additional exercise physiology if the applicant had been able to self-manage since December 2018 (which was when she was last seen by Ms Sher).

106. Mr Kelly told Mr Milazzo that the applicant had attended physiotherapy very intermittently. He had not provided any hands-on therapy for about 10 months and mainly reviewed her exercise program. Mr Milazzo did not support ongoing physiotherapy; and he also told Mr Kelly that he did not consider exercise facility membership as reasonably necessary.

SUBMISSIONS

107. The submissions of counsel have been recorded, and I do not propose to reiterate them in these reasons. I set out below a summary of counsel's submissions.

108. Mr McManamey, for the applicant, submitted that Ms Kernan's statement provided details of the effects of the injury and the treatment she underwent on her return to Australia. This was a significant injury, involving seriously invasive treatment and had a significant effect on her ankle and her gait.

109. The applicant has tried to avoid further surgery with conservative treatment. She has given evidence of back spasms that prevented her from completing exercises designed to promote rehabilitation and assist with pain management. She had swelling and sharp pain in her left knee, due to constantly shifting her weight to her left leg. This also limited the type of exercise she could perform.

110. Mr McManamey submitted that it does not appear that the respondent disputes that the applicant has symptoms, but rather the issue goes to causation. The applicant does not claim there was a direct injury to her lumbar spine and left knee in the fall. The onset of pain came later.

111. Dr Lam's report of 30 January 2018 provides a description of the applicant's ongoing problems. Her improvement had plateaued. This was before the surgery.

112. Mr McManamey submitted that, after surgery, the applicant was in a boot for a number of weeks, altering the way she walked and her movement. She has complied with all her medical restrictions and worked hard to recover. Mr Kelly was reasonably optimistic but reported on 26 February 2018 that the applicant complained of more easily rolling her ankle. Her stability and mild posterior impingement were the main obstacles to her returning to both her full duties and her normal exercise routine, including jogging.

113. Mr Kelly referred to the applicant's left knee problems in his report dated 29 July 2019. He associated her left knee pain with changes that had occurred in her right ankle, and her back pain with an increase in weight due to lack of exercise. Her lower back pain further impacted her ability to exercise. Mr McManamey submitted that the weight gain, which was associated with the applicant's right ankle injury, would also have an impact on her left knee. She had previously been very active, with a high degree of fitness.

114. Mr McManamey also referred to the evidence of Ms Sher. The applicant's pre-existing low back injury had flared up because she was favouring one leg and unable to exercise. Her opinion was similar to that of Mr Kelly.

115. Dr Musgrove referred to the applicant having remained active after her left knee reconstruction, including running, until recent flares had precluded impact activity. He has made no other comment on causation. He was aware of the ACL surgery.

116. Mr McManamey submitted that Dr Bodel was aware of the applicant's pre-existing issues. He took a history at length, including her functional disabilities; and highlighted their extent and the change in her routine. She was still very disappointed with the result of surgery.

117. Mr McManamey referred to Dr Bodel's findings on examination, which included that the applicant was deconditioned; had an uneven gait; and there was a lack of movement in her left knee. He submitted that there were clear signs of problems with her left knee and lumbar spine.

118. Mr McManamey submitted that Dr Bodel had provided an explanation of the causation of the applicant's consequential problems in his substantive report and further explanation in his supplementary report. His opinion was clearly set out. The mechanism of such conditions is well-known to the Commission and there is no reason not to accept his evidence.

119. Mr McManamey submitted that Dr Doig did not address the question of whether the applicant's injury contributed to the consequential conditions. It is not disputed that she had underlying degenerative changes. There may be more than one cause of the condition – *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49.

120. Mr McManamey further submitted that if Dr Doig was suggesting that the applicant's soleus tear was responsible for her back condition, then that would mean it was a consequential condition, as it was related to her exercising to maintain fitness as a result of her ankle injury.

121. Mr McManamey finally submitted that Dr Doig does not seem to have obtained a correct history; and he did not take the history recorded by the applicant's treating doctors. He seems to have worked on the history that Ms Kernan always had problems with her left knee and back and they have continued. He has not engaged with the history of altered gait; weight gain; and other factors. We are left with Dr Bodel's opinion; and the mechanism of injury is well-understood.

122. Mr Beran, for the respondent, submitted that the commonsense test referred to in *Kooragang Cement Pty Ltd v Bates* (1994) 10 NSWCCR 796 (*Kooragang*) should be applied. The applicant's allied health providers have opined on what may have caused her condition, but Dr Bodel does not agree. The commonsense cause is the degenerative changes on their own.

123. Mr Beran submitted that there was an eight-year history of an untreated knee injury. The applicant has significant and longstanding pathology in her knee, referred to by Dr Musgrove. This is the cause of her left knee symptoms.

124. Mr Beran submitted that Mr Kelly reported that the applicant was able to manage her left knee symptoms if she avoids impact or single leg activities and reduces the depth of weight bearing activities. He did not say her knee condition was caused by anything, including her right ankle injury. The need to avoid the use of her left knee flies in the face of favouring her *right* ankle.

125. Mr Beran submitted that Ms Sher reported that the applicant's back injury had resolved, but there is no evidence of this. This "resolved injury" required an MRI in 2015. Dr Musgrove obtained a history of increasing issues with the applicant's left knee but provided no opinion as to causation.

126. Referring to the applicant's statement, Mr Beran submitted that she stated she shifted her weight to her left leg, but the medical reports say the exact opposite, that she avoided use of her left knee. She did not refer to her lumbar spine.

127. Mr Beran submitted that Dr Bodel did not have any scans of the applicant's left knee. He had "no idea what's going on there". In his second report, he provided his reasoning for finding consequential conditions, but that the applicant was favouring her left side "flies in the face of the evidence". He attributes her mechanical backache to altered gait, but none of the allied health providers says it; and nor does the applicant. That is the opinion on causation. Dr Bodel had the chance to comment on Dr Doig's opinion but did not do so.

128. Mr Beran further submitted that Dr Doig's findings on examination differed from those of Dr Bodel. The applicant had longstanding intermittent lower back problems. These were chronic problems, noting the multiple investigations. The applicant's soleus tear was related to her attempt to maintain overall fitness and had nothing to do with the injury. The applicant has had plenty of opportunity to provide evidence about this but has not done so.

129. Mr Beran finally submitted that the questions to be answered are: 1. What is the consequential condition; and 2. How was it caused or contributed to by the subject injury? He submitted that Dr Bodel's opinion could not be accepted; and common sense would lead to an acceptance of Dr Doig's opinion.

130. In reply, Mr McManamey submitted that Mr Kelly reported that the applicant could manage her left knee symptoms if she avoided impact or single leg activities, but she *cannot* avoid using it. Dr Bodel found evidence of altered gait; and the applicant has given evidence of it.

131. While the applicant had Dr Doig's report and could have responded to it, as he did not address the question, there was nothing to respond to.

DISCUSSION AND FINDINGS

132. The applicant claims that as a result of an accepted injury to her right ankle, she has developed consequential conditions of her left knee and lumbar spine. Those conditions are claimed to be due to the aggravation, acceleration, exacerbation and deterioration of a disease process.

133. The applicant does not need to establish that she has sustained injury to either her left knee or her lumbar spine arising out of or in the course of her employment, pursuant to section 4 of the 1987 Act, or that employment was a substantial contributing factor to the conditions, pursuant to section 9A of the 1987 Act. In accordance with the decision of Deputy President Roche in *Kumar v Royal Comfort Bedding Pty Ltd* [2012] NSWWCCPD 8 and the cases discussed therein, she need only establish on the balance of probabilities that the condition of her left knee and lumbar spine resulted from the accepted injury to her right ankle.

134. The principles of *Kooragang* have consistently been applied in the Commission. Kirby P, as his Honour then was, said (at 461G):

> "[f]rom the earliest days of compensation legislation, it has been recognised that causation is not always direct and immediate".

After referring to earlier English authorities, his Honour added (at 462E):

> "Since that time, it has been well recognised in this jurisdiction that an injury can set in train a series of events. If the chain is unbroken and provides the relevant causative explanation of the incapacity or death from which the claim comes, it will be open to the Compensation Court to award compensation under the Act."

135. His Honour went on to say that where causation is in issue, each case must be determined on its own facts; and (at 463-464) "what is required is a commonsense evaluation of the causal chain".

136. The test in *Kooragang* was discussed in *Comcare v Martin* [2016] HCA 43 (*Martin*), when doubt was raised as to its correctness and applicability. It should be borne in mind that *Martin* concerned the Commonwealth workers' compensation scheme.

The Court cautioned (at [42]):

> "Causation in a legal context is always purposive. The application of a causal term in a statutory provision is always to be determined by reference to the statutory text construed and applied in its statutory context in a manner which best effects its statutory purpose. It has been said more than once in this Court that it is doubtful whether there is any 'common sense' approach to causation which can provide a useful, still less universal, legal norm…"

137. In *Crosland v Gregelle Michory Pty Limited* [2017] NSWWCC 17 (at [34]), Arbitrator Sweeney provided the following useful summary of the effect of the decision in *Martin*:

> "Since the decision in *Comcare v Martin* [2016] HCA 43 (*Martin*), doubts have been expressed as to whether the 'common sense' approach to causation proposed by *Kooragang Cement* is still applicable. It is unlikely, in my opinion, that the decision in *Martin* alters the principles applicable to causation under the 1987 Act. While the phrase 'results from' appears in both the NSW and Commonwealth legislation, it must be read in its statutory context. Nonetheless, in determining causation issues, it is probably best to adopt the counsel of eminent judges during previous debates on the meaning of the phrase 'results from' and to apply the words of the Act, leaving exegesis of the phrase to the Presidential Unit of the Commission."

138. Having considered the evidence of the applicant and the medical evidence, I am satisfied that the applicant has met her onus of establishing that she has a consequential condition of both her left knee and her lumbar spine, as a result of the injury to her right ankle that occurred on 5 November 2017. Specifically, the applicant has sustained an aggravation, acceleration, exacerbation and deterioration of a disease process.

139. The applicant's evidence, which I accept, is that she made a full recovery from ACL surgery in 2002 and resumed her previous active lifestyle. This included regularly running 10 kilometres. It is consistent with the history obtained by Dr Musgrove.

140. The applicant concedes that she had intermittent periods of back pain between 2006 and 2017, which were effectively managed with physiotherapy. There is evidence of investigations of her lumbosacral spine in April 2006 and February 2015, before the injury to her right ankle, but the next investigation was an x-ray in February 2019.

141. The applicant states that she began to have back spasms between June 2018 and July 2018. She does not attribute them to any particular cause. She attributes the onset of left knee pain and swelling to constantly shifting her weight to her left leg, to avoid placing further stress on her right ankle.

142. The medical evidence relied on by the applicant attributes the condition of her left knee and lumbar spine to various causes. As the applicant submits, a condition may have more than one cause.

143. Mr Kelly reported in February 2018 that the applicant had a normal gait. However, her balance on the right was "at best fair". Dr Bodel, some two years later, reported that Ms Kernan had a mild flat-footed gait pattern on the right. It would not be unexpected that her gait may alter over time, given the protracted course of her right ankle issues, and bearing in mind that she had surgery in April 2018, which was after Mr Kelly's report.

144. In July 2018, Mr Kelly reported that the applicant's injury/recovery was "dragging on" and she found her general strength and fitness had markedly reduced, compounding the effect of the injury and causing other aches and pains.

145. In July 2019, Mr Kelly reported that the applicant could only perform a limited version of her exercise program, partly because her gym membership had lapsed and partly because of chronic knee pain. Before the injury, she had managed her knee pain with exercise. I accept that the applicant's management of her knee pain was adversely affected by the injury.

146. Mr Kelly opined that the applicant's inability to participate fully in rehabilitation was a significant factor in her lack of progress. Her prolonged disability and lack of exercise had contributed to the development of mental health issues; a 15-kilogram weight increase; and lower back pain that further impacted her ability to exercise.

147. Ms Sher reported in August 2018 that the applicant had not been able to get back to her pre-injury levels of activity, including running. She noted that the applicant's pre-existing back injury had resolved. The respondent submits that the applicant's back condition cannot be said to have resolved, given that she had an MRI in 2015. I accept that the condition had not completely resolved, but the applicant's evidence, which I accept, is that periods of back pain were intermittent. This is consistent with the long periods between investigations of her back. It is also consistent with her being able to participate in active pursuits before the injury to her right ankle in 2017.

148. Ms Sher also recorded that the applicant's back condition had flared up due to her favouring one leg and being unable to exercise for a prolonged period. She opined that the applicant was generally deconditioned and demonstrated weak pelvic and ankle stability, specifically on the right leg.

149. Dr Bodel's report contains a detailed record of his examination, including that the applicant had an altered gait. This is in contrast to Mr Kelly's findings, which I have discussed above. Dr Bodel opined that the applicant had developed symptoms in her left knee because she was protecting her injured right side and in her lumbar spine because of her abnormal gait pattern.

150. Dr Doig recorded that the applicant had sustained a tear to her calf muscle while she had been rehabilitating. This is the only history of such an injury and the applicant did not refer to it in her evidence.

151. Dr Doig recorded that the applicant had had lower back pain, “since this incident”. It is impossible to know when the soleus tear occurred. However, as the applicant submits, if it resulted in her having lower back pain (which the rest of the evidence does not suggest), it was a consequential condition, as it was related to rehabilitation for her ankle injury.

152. Dr Doig reported that the applicant denied injuring her lower back or left knee on 5 November 2017. She does not claim to have injured either her back or left knee in the fall on that date. The claim she has made is that of consequential conditions. Dr Doig has recorded that the applicant has ongoing pain and instability in her left knee “where she has undergone a previous anterior cruciate ligament reconstruction” but has not recorded any other history relating to her left knee.

153. Dr Doig recorded that the applicant’s left knee had never returned to normal “since the date of the injury”. It is unclear to which injury he refers. He has not recorded any history of the original injury to the applicant’s left knee in 1986. He has immediately before this referred to the injury on 5 November 2017 (while recording that the applicant did not injure her knee or back at that time).

154. Dr Doig’s opinion is that the applicant’s left knee and lower back conditions are not related to the incident on 5 November 2017. He has not adequately explained his reasoning. While he has opined that the applicant’s lower back and left knee conditions were pre-existing and of long-standing, that is not in dispute. He has not addressed the questions of whether those conditions may have been aggravated, accelerated, exacerbated or deteriorated as a result of the injury to the applicant’s right ankle and the consequences that flowed from that injury.

155. I prefer the opinions of the applicant’s treating practitioners and Dr Bodel to that of Dr Doig. I accept that there were a number of reasons for the applicant’s consequential conditions. They include her altered gait; increased weight bearing on her left leg in an attempt to protect her injured right ankle; her reduced ability to exercise and maintain fitness, which had previously assisted in reducing the effects of her underlying back condition; and weight gain of 15 kilograms, which must have placed additional strain on at least her left knee and probably also on her back.

156. It is accurate to say, as Dr Bodel reported, that the applicant was in a “vicious circle” (it is unclear whether this is her interpretation or that of Dr Bodel). She became deconditioned due to the injury to her right ankle; surgery; and prolonged recovery. This in turn limited her ability to remain active and mitigate the effects of her underlying back condition and the injury to her left knee. When a “common sense” test is applied, the applicant’s consequential conditions resulted from the accepted injury to her right ankle.

157. I therefore determine that the applicant has sustained a consequential condition of her left knee and lumbar spine as a result of the injury to her right ankle on 5 November 2017.

158. The parties have agreed that if the dispute is determined in the applicant’s favour, it is appropriate to make a general order pursuant to section 60 of the 1987 Act.

159. The orders are set out in the Certificate of Determination.