WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **532/20**
Applicant: **Vicki Wilson**
Respondent: **Coles Group Limited**
Date of Determination: **15 May 2020**
Citation: **[2020] NSWWCC 158**

The Commission determines:

1. The applicant suffered an injury to her lumbar spine in the course of her employment with the respondent on 11 December 2007.

2. As a result of the injury referred to in (1) above, the applicant suffered injury to her right lower extremity (knee) on or about 20 June 2018.

3. The matter is remitted to the Registrar for placement in the pending list for referral to an Approved Medical Specialist to determine the degree of permanent impairment arising from the following:

    (a) Date of injury: 11 December 2007 (frank injury)
    (b) Body systems referred: lumbar spine, right lower extremity (knee), scarring (TEMSKI).
    (c) Method of assessment: whole person impairment.

4. The documents to be referred to the Approved Medical Specialist to assist with their determination to include the following:

    (a) This Certificate of Determination and Statement of Reasons;
    (b) Application to Resolve the Dispute and attached documents;
    (c) Reply and attached documents;
    (d) Respondent's Application to Admit Late Documents dated 25 February 2020 and attached documents.

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

Cameron Burge
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 CAMERON BURGE, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the **Registrar**

STATEMENT OF REASONS

BACKGROUND

1. On 11 December 2007, Ms Vicki Wilson (the applicant) was employed by Target Australia Pty Ltd, a division of Coles Group Limited (the respondent) when she suffered a fall and twisted her lower back, suffering a lumbar spine injury.

2. That injury is not in issue. In 2010, the applicant and respondent entered into a Complying Agreement pursuant to section 66A of the *Workers Compensation Act 1987* (the 1987 Act) for payment of permanent impairment compensation. In the same year, the applicant had nerve blocks administered at the L5 and S1 nerve roots. By that time, she was suffering left lower limb symptoms which have variously been described as a “foot drop", pain, numbness and weakness.

3. The applicant has made a claim alleging deterioration of her lumbar spine condition. The respondent alleges she has not suffered any deterioration since the Complying Agreement was entered into. The injury to the applicant's lumbar spine will therefore be referred to an Approved Medical Specialist (AMS) for determination of her degree of whole person impairment.

4. Additionally, the applicant claims that as a result of the loss of feeling in her left leg, on or about 20 June 2018 she suffered a fall when, unbeknown to her, a pool hose contacted her left foot, which she was unable to feel. She then tripped over and suffered an injury to her right lower extremity by way of a fractured knee, which required surgery.

5. On 6 December 2019, the respondent issued a section 78 Notice denying liability for any injury to the right lower extremity in addition to stating there had been no deterioration to the applicant's lumbar spine.

ISSUES FOR DETERMINATION

6. The parties agree the only issue for determination at the hearing was whether the applicant’s right knee fracture was as a result of her lumbar spine injury.

PROCEDURE BEFORE THE COMMISSION

7. The parties attended a hearing by way of telephone link before me on 7 April 2020. I am satisfied that the parties are aware of the consequence of the assertions made in the relevant pleadings and the consequences of proceeding to a hearing. I attempted to facilitate a resolution between the parties, however, was unsuccessful in doing so.

8. At the hearing, Mr R Hanrahan of counsel appeared for the applicant, Mr T Baker for the respondent.

9. As already noted, regardless of the outcome of the dispute before me, the applicant’s lumbar spine injury will be referred to an AMS for assessment of her degree of whole person impairment.

EVIDENCE

Documentary evidence

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

(a) Application to Resolve a Dispute (the Application) and attached documents;

(b) Reply and attached documents;

(c) The respondent's Application to Admit Late Documents (AALD) dated 25 February 2020 and attached documents.

Oral evidence

11. There was no evidence called at the hearing.

FINDINGS AND REASONS

Was the applicant's right knee fracture caused by her accepted lumbar spine injury?

12. The applicant bears the onus of proving that the right leg fracture is work-related by virtue of being caused by the symptoms which arose as a result of the accepted 2007 lumbar spine injury. In determining the cause of an injury, the Commission must apply a common-sense test of causation. In the workers compensation context, the appropriate test for causation was set out by Kirby P (as he then was) in the oft-cited passage in *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452 (*Kooragang*) where his Honour said:

> "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 death or 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." (at 810; emphasis added)

13. For the reasons which follow, the applicant has satisfied that onus.

14. Mr Hanrahan noted the applicant's left leg complaints were well documented following her 2007 lumbar spine injury, and that from time to time they have been described as a "foot drop". He submitted that whether the applicant's condition is properly described as a foot drop is open to argument, however, there is no question the applicant suffered radicular symptoms in her left leg following the 2007 workplace injury up to the time of the fall which caused the right knee fracture, including pain, loss of feeling, foot drop and numbness.

15. I agree with that submission. In my opinion, the contemporaneous evidence overwhelmingly supports a finding the applicant suffered symptoms in her left leg following the injury in 2007 which in turn caused the fall in which she injured her right knee.

16. Radiological investigations in December 2007 revealed an L5/S1 left posterior disc protrusion causing effacement of the thecal sac, while in February 2008, the applicant was referred to a specialist at Dubbo Hospital for lower back pain and left side sciatic pain.

17. In October 2008, the applicant provided a history to the respondent's then independent medical examiner (IME) Dr Davies of having developed "excruciating pain" in her lower back and pain radiating to her left leg. At page 146 of the Application, Dr Davies noted the applicant had a left leg limp and that the applicant's disc protrusion was consistent with the lumbar spine injury and with reports of both back and left leg pain. Mr Hanrahan submitted this opinion, which was relied upon by the respondent in or about 2010, is tantamount to an admission that the left leg complaints are linked to the lumbar spine injury.

18. There are copious treating doctor records which have been produced in this matter. They revealed, as one would expect, periodic complaints of lower back and left leg problems by the applicant between 2008 and 2018.

19. Dr Clare Sui, treating consultant in rehabilitation medicine has provided reports as part of the clinical records. On 17 October 2018, Dr Sui reported to the applicant's general practitioner at the Health Service and, as part of the history she took recorded the following:

> "She was previously offered operation for radiculopathy of her left leg, but it was explained that the operation would not fix the back pain and therefore Vicki did not have the operation. I understand Vicki developed foot drop recently with numbness on the top of her foot between the first and second toes. MRI done on 10 October 2018 showed “no evidence of a disc protrusion or neural compression, multi-level disc desiccation, no canal stenosis”. She has been referred for neurology review and NCS to investigate further.
>
> Vicki reports ongoing back pain from mid to low back, with left leg pain. The back pain is worse than the leg pain. She denies issues with bladder and bowel. She tried multiple medications in the past, including Panadeine Forte, OxyContin and venlafaxine, which did not help her pain. Tramadol helped but only on high dose. She had physio years ago, which helped her back and leg pain. She never tried Lyrica.
>
> Vicki unfortunately fell backwards into pool in June 2018 and sustained right plateau fracture. She underwent ORIF right tibial plateau and bone graft on 22 June 2018."

20. The proposed operation referred to by Dr Sui was a microdiscectomy at the hands of Dr Allan, suggested to the applicant in 2009 and referred to in her statement from paragraph 7. In his report to the applicant’s then treating general practitioner dated 27 January 2009, Dr Allan noted the applicant’s fall in 2007 and said:

> “Since that time she has had back and leg pain, particularly left leg pain. She has been reviewed by Tom Taylor and Stephen Ruff. She has had ongoing physiotherapy which has helped at some stages. She has not been able to attend hydrotherapy as her pool is apparently not suitable for this. I would probably advise, if hydrotherapy is to be performed, that this be performed in the context of a supervised session, however.
>
> Her current symptoms are of pain in her lower back which radiates to her left leg, as well as a numb, dead feeling on the top of her left leg. For the last six weeks there has been decreased feeling in her toes in particular. She has not had any epidural injections or nerve root blocks.
>
> Her neurological examination reveals that there is no limitation of straight leg raising on the right but on the left-hand side straight leg raising is limited with pain reproduced at approximately 30°. She is very antalgic with movements around her left ankle with reproduction of her pain but when I am able to break through the resistance, I do not feel that there is any significant weakness of her left leg with 4+/5 power being demonstrated around the ankle…
>
> I discussed with her the treatment options going forward from here. As she has already had a year of conservative therapy, she has essentially failed this treatment. The other options to consider therefore are a selective nerve root block or a lumbar microdiscectomy. I described both of these in detail to her. I explained the nature of a selective nerve root block. Unfortunately, I suspect the effect of this may be short-lived but it would be very reasonable to try this initially.
>
> The other option to consider would be a lumbar microdiscectomy and I spent some time describing this to her. I indicated this is essentially a keyhole operation.

Unfortunately, with long-lived pain such as this, the success rate would be lower and may be in the order of 80 - 85%.

I explained the risks of surgery including neurological injury such as nerve root injury, as well as risks of other more severe neurovascular injuries such as those that might cause paraplegia or sphincter dysfunction.

Mrs Wilson plans to consider her options and will contact my office in due course if she wishes me to seek approval from her workers' compensation insurer for her to undergo either a nerve root block or indeed surgery."

21. In April 2019, Dr Sui reported the applicant complained of low back pain and continued suffering of numbness, foot drop and a burning pain in her left foot. In other words, the applicant still had radicular symptoms in 2019 consistent with those noted by Dr Allan a decade earlier.

22. Mr Baker for the respondent took the Commission to numerous entries in the clinical notes produced by the Health Service. In my view, those records are as one would expect, namely from time to time the applicant would visit the Health Service and make complaints concerning her back and/or her left leg; and on other occasions she would visit concerning different health issues. The fact she did not complain about her back and leg symptoms every time she visited her general practitioner is utterly unremarkable, as is the fact that from time to time she did so.

23. References to the applicant's lower back and/or left leg symptoms are recorded in the clinical records of the Health Service on at least the following occasions:

    (a) 12 December 2007;
    (b) 19 March 2008;
    (c) 15 May 2008;
    (d) 12 March 2009;
    (e) 19 January 2009;
    (f) 11 November 2009;
    (g) 17 November 2009;
    (h) 15 December 2009;
    (i) 3 February 2010;
    (j) 13 May 2010;
    (k) 7 June 2010;
    (l) 28 November 2011;
    (m) 4 August 2011;
    (n) 5 August 2014;
    (o) 12 October 2015;
    (p) 4 April 2016;
    (q) 28 February 2017;
    (r) 30 August 2017.

    The reference to those entries is not exhaustive. Moreover, after the incident where the applicant suffered her right knee fracture in 2018, she continued to attend upon the Health Service, including but not limited to entries on 9 October 2019 and 8 January 2020 in which she still complained of problems with her left leg which she connected to her original lumbar spine injury.

24. Dr Doig, IME for the applicant, referred to the lower back injury in 2007 and attributed the subsequent injury to her right knee to the foot drop and radiculopathy caused by the initial injury. He noted the applicant had been prescribed Tramadol from 2007 to 2018 for her pain. In my opinion, the clinical records support that conclusion.

25. The clinical records also reveal the applicant had suffered some falls and problems with her left leg and foot between the injury in 2007 and the fall in June 2018. For example, she had a fall on 24 November 2015 and hit her left thigh. She saw a doctor afterwards.
On 21 January 2016, she also reported injury to her left foot. The respondent submitted the genesis of the loss of feeling in the applicant's left leg and foot was one or more of those falls. For the following reasons, I reject that submission.

26. Firstly, Dr Allan reported loss of sensation in the left leg as long ago as 2007, and decreased feeling in the applicant's toes at that time. That evidence is unequivocal and uncontested. It demonstrates problems with loss of sensation in the applicant's left leg and foot as long ago as January 2009. The suggestion that those symptoms are a comparatively recent phenomenon brought about by falls in or about 2017 and 2018 flies in the face of that evidence and cannot be accepted on the face of the evidence of a treating neurosurgeon's report from nearly a decade earlier.

27. On 28 February 2017, the applicant reported a fall with "left S1 area numb". Mr Baker submitted this may be the point at which the applicant's left foot became numb, however, there are multiple complaints of altered sensation in the applicant's left foot and leg before that fall, stretching as far back as the report of Dr Allan in 2009. Moreover, the entry which states "says left foot is numb" is not, in my view, suggestive that the numbness to the left foot began when the applicant suffered her fall in February 2017. This is particularly the case when the records reveal longstanding problems with the applicant's left leg and foot. Those records are consistent with the applicant's own statement, which indicates a long history of lower back and left leg symptoms. In my opinion, that history cannot realistically be challenged in the face of over a decade's worth of intermittent and persistent complaints concerning the applicant's lumbar spine and left foot/leg.

28. At a visit to the Health Service on 30 August 2017, the following history found at page 43 of the AALD was taken:

    (a) "Back pain – injury incident 2007;
    (b) Lower back pain since incident
    (c) Intermittent, sharp, 8-9/10 pain radiating down to lateral thigh and toe;
    (d) Sometimes feel weakness or feel numbness of lower leg;
    (e) Aggravated by sitting too long, sitting to stand and not responding to PCM on long-term tramadol;
    (f) she does not drive but drives only in the area;
    (g) No urine or bowel incontinence or saddle anaesthesia;
    (h) No family history of osteoporosis;
    (i) On examination:
        i) not pale, afebrile in severe pain;
        ii) back – gait limping, unable to do toe walking, heel walking;
        iii) deformities plus (lacking normal lumbar curvature?), no swelling, no redness
    (j) Palpation – spinal process L2-5 and S1, facet joints tender and painful, tenderness more over L4-S1;
    (k) ROM – severely restricted;
    (l) SLR – could not get to the bed due to the pain;
    (m) Lower limb NS examination;
        i) look – wasting +;
        ii) feel – unable to check;
        iii) movement – power tone as it is too painful.
        iv) dorsi flexion okay, plantarflexion impaired, aversion impaired;
    (n) Sensations – numb sensation patches, L5, S1 (dermatomes);
    (o) Reflex – knee L3-4, normal. Ankle reduced in left side.
    (p) Plan:
        i) letter to Centrelink;
        ii) CT scan;
        iii) continue pain management;

iv) nerve conduction test;
v) neurosurgery referral;
vi) pain specialist."

In my opinion, that entry is strongly supportive of the applicant reporting a longstanding history of left leg and foot symptoms aggravated by certain activities. It is just one example of over ten years' worth of evidence which confirms the applicant had left leg and foot problems after the 2007 injury.

29. An entry on 14 September 2017 referred to a pre-consultation examination and noted "severe chronic back pain in the lower back for the past three weeks. Sharp pain and pulling 10/10 pain going down the lower leg." There can be no suggestion that the chronic back pain referred to in that entry had only been present for three weeks. Rather, given the earlier entry on 30 August 2017, it is apparent that the severity of the applicant's long-standing back pain had increased over the three weeks leading up to 14 September 2017.

30. In March 2018, the applicant again attended the Health Service and complained of numbness in her left big toe. She provided a history of the back and nerve injury, with multiple recent falls.

31. Mr Baker submitted the applicant's issues with her left leg including numbness and lack of feeling were caused by these falls. I reject that submission for the reasons already stated, and note the entry referring to recent falls is equally suggestive of the applicant's difficulty with her left leg playing a causative part in them.

32. The history of left leg problems associated with the lumbar spine injury persuades me not to accept Mr Baker's submission and to prefer the version set out in the applicant's statement, namely that she had a long history of left leg and foot problems, including weakness and numbness following the injury in 2007. That finding is supported by the reports of treating specialists Dr Allan and Dr Sui, which are in turn consistent with the views of Dr Doig, the applicant's IME as to the nature of the applicant's lumbar spine and left leg problems.

33. As late as 31 May 2018, the applicant attended her general practitioner seeking pain relief for her chronic back pain. On 6 June 2018, she reported her symptoms were feeling better. Then, after the June 2018 accident in which her right knee was fractured, the applicant continued to complain of low back pain and left foot numbness.

34. I note Dr Bentivoglio, IME for the respondent in these proceedings saw the applicant at the request of her then solicitors in 2009. The fact he had previously assessed the applicant for her solicitors was drawn to his attention by the respondent's attorneys. I find it somewhat unusual that Dr Bentivoglio considered it appropriate to accept a brief to provide an opinion from the solicitors for a party to this dispute having done so for the other party a decade ago. Nonetheless, no objection was taken to the admission of his reports and they must be examined at face value.

35. Notwithstanding Dr Bentivoglio's views regarding the applicant's symptoms, I find she has suffered persistent radicular problems in her lower back and left leg since the 2007 injury. Dr Bentivoglio adopts, in my opinion, almost an advocate's enthusiasm in describing the applicant's claim of a two-year history of low back pain and foot drop as "amazing". Yet, a perusal of the clinical record demonstrates these complaints were present over many years, and thereby repudiates Dr Bentivoglio's disavowal of her symptoms. Moreover, the clinical records disclose, contrary to Dr Bentivoglio's view, that the applicant did see her doctors and had investigations carried out relating to her back and leg problems, including radiological scans in 2017.

36. By contrast, Dr Doig, IME for the applicant clearly sets out a causal link between the 2007 injury and the fall in 2018. At page 28 of the Application, he says in answer to a question as to which body parts have been impaired as a result of the 2007 injury:

> "The lower back was primarily injured in the incident of 11 December 2007. There was a subsequent injury to the right knee as a result of a foot drop arising from the lower back injury with associated radiculopathy. This resulted in a displaced, comminuted, lateral tibial plateau fracture requiring operative intervention."

37. At page 25 of the Application, Dr Doig set out a history of the 2018 fall consistent with that provided in the applicant's statement. He noted:

> "Ms Wilson informed me that she sustained an injury to her lower back on 11 December 2007 work at Target Retail Group within customer services. She describes simply stepping back in a fitting room and twisting, resulting in a fall as she lost balance. She had immediate back discomfort and problems continuing to work…
>
> Unfortunately, Ms Wilson's condition failed to improve, and she developed left lower limb symptoms which worsened with time, including the development of a foot drop.
>
> An MRI scan on 18 March 2008 shows moderately sized, intervertebral disc protrusion at the left L5/S1 level on a background of minor degenerative change. This was confirmed on an MRI scan in January 2009. Ms Wilson saw a neurosurgeon and an epidural steroid injection was organised in May 2009 which helped with her left leg symptoms for a short period of time. Operative intervention has not been undertaken.
>
> As a result of the ongoing weakness affecting the left foot, Ms Wilson fell into a swimming pool on 20 June 2018 when a hose accidentally wrapped around her left foot which she was unaware of. She was taken to the Dubbo Base Hospital where imaging revealed a displaced, depressed fracture of the lateral tibial plateau requiring operative intervention two days later. This was followed by routine, postoperative rehabilitation with initial non-weightbearing and physiotherapy."

38. Mr Baker submitted the applicant's claim that she had no other injuries which affected her left leg is incorrect, given her problems in 2013 and 2014 in relation to left ankle oedema and the problem of “restless leg” all her life.

39. An oedema, even one serious enough to warrant attendance at a doctor, is not in my view determinative or suggestive of causing symptoms such as foot drop or numbness in the left leg and ankle. Were that the case, I would expect medical opinion to indicate that is the case. No one does. Absent such evidence, I reject the submission that left ankle oedema in 2013 was the cause of the applicant’s left leg and foot problems. Plainly, an examination of the evidence reveals they were present well before that time.

40. Additionally, the condition of “restless leg” with which the applicant has been diagnosed has not, on my reading of all the clinical material and indeed Dr Bentivoglio’s report, ever been considered causative of her left leg numbness and weakness. Rather, to the extent the medical evidence discusses the cause of the applicant's left leg problem, it draws a link between the lumbar spine injury and the development of left leg radicular symptoms.

41. Taking into account all of the entries by the Health Service, treating specialists and the qualified medical evidence together with the applicant's statement, I have no difficulty in finding she suffered symptoms including but not limited to numbness, weakness and foot drop in her left leg and foot as a result of the lumbar spine injury suffered on 11 December 2007. The evidence also discloses those symptoms persisted up to the fall in June 2018 in which she fractured her right knee.

42. I also accept the applicant's version of events, namely that the pool hose wrapped around her left foot and, because she had sensory loss in that foot brought about by the 2007 injury, she was unaware of the presence of the hose, which in turn caused her to trip and fall, fracturing her right knee.

43. The applicant's evidence as to the cause of the fall into the swimming pool in June 2018 is uncontested by any lay evidence, and I accept it. Dr Bentivoglio expresses some doubt as to the alleged mechanism of the fall, however, his comments in relation to it amount to a bare assertion that the forces at play in the alleged fall are unlikely to have caused the fracture. I reject that opinion. The applicant's version of events regarding the fall in 2018 has always been consistent to every medical practitioner she has consulted since it took place.

44. Mr Baker submitted Dr Bentivoglio's history of a two-year onset of foot drop and left leg symptomology is consistent with those symptoms being brought about by an incident in 2017 where the applicant tripped on a phone cord. In my opinion, that submission ignores over 10 years' history of low back and left leg/ foot symptoms, and the preponderance of the medical evidence instead establishes the applicant's left leg symptoms have been present for much longer than just the timeframe submitted by Mr Baker.

45. In this matter, having regard to the medical evidence relied upon by the parties together with the lay evidence contained in the applicant's statement, I am satisfied that the right knee fracture was caused by her lumbar spine injury in 2007 in that the applicant was unable to feel the pool hose which had wrapped around her left foot, causing her to fall and suffer the fracture to the right knee.

46. In so finding, I have had regard to the opinions of each of Dr Doig and Dr Bentivoglio. I have also read the report of Dr Davies, former IME for the respondent and considered the clinical notes. Having done so, I am satisfied the evidence establishes the applicant had ongoing issues with her left leg and foot as a result of her lumbar spine injury, including weakness, numbness and loss of feeling. Having accepted her version of events, I find the evidence establishes that she was unaware of the presence of the pool hose touching her left foot owing to the symptoms caused by the original 2007 injury, which in turn led to her fall and right knee fracture in June 2018.

47. This being so, both the lumbar spine injury and the right lower extremity injury will be referred to an AMS for determination of the applicant's degree of permanent impairment.

SUMMARY

48. Summary of the above reasons, the Commission makes the findings and orders as set out on page 1 of the certificate of determination.