WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **3610/19**
Applicant: **Allen Simpson**
Respondent: **Ausgrid**
Date of Determination: **19 September 2019**
Citation: **[2019] NSWWCC 307**

The Commission determines:

1. That the applicant has not established that the medical condition in his lumbar spine results from the accepted injury to his left knee on 20 March 2015.
2. Proceedings dismissed.

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 Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Allen Simpson (Mr Simpson) was employed by the respondent, Ausgrid (the respondent) as a cable joiner. The respondent was self-insured at the relevant time.

2. In the course of his employment duties on 20 March 2015, Mr Simpson was climbing out of a manhole when his left foot gave way and he twisted his left knee causing injury to the left knee.

3. In an Application to Resolve a Dispute (the application) lodged in the Workers Compensation Commission (the Commission) on 17 July 2019, Mr Simpson claimed lump sum compensation in respect the injury to the left lower extremity on 20 March 2015 and in respect of a consequential injury to the lumbar spine.

4. The respondent issued a section 78 Notice dated 20 September 2018. The respondent disputed that the applicant had suffered a frank injury or consequential condition in his lumbar spine and that he had passed the threshold to bring a claim in respect of his left lower extremity pursuant to s 66 of the 1987 Act.

ISSUES FOR DETERMINATION

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

    (a) Whether Mr Simpson sustained a consequential condition to his cervical spine as a result of the injury to the left knee on 20 March 2015.

PROCEDURE BEFORE THE COMMISSION

6. The parties attended a conciliation conference and arbitration 12 September 2019. The applicant was represented by Mr Morgan, who was instructed by Mr Taouk of Law Partners Personal Injury Lawyers. The respondent was represented by Mr Saul, who was instructed by Sparke Helmore Lawyers. 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

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

    (a) The Application and attached documents, and

    (b) Reply and attached documents.

8. There was no application by either party to adduce oral evidence.

FINDINGS AND REASONS

Evidence of Mr Simpson

9. In a statement dated 17 October 2018, Mr Simpson said that he was employed by the respondent as a labourer in 1988 and became a cable joiner in 2008. He said that on 20 March 2015, whilst in the course of his duties, he sustained an injury to his left knee. He wrote: "My left knee injury altered my gait, causing me to walk with a limp that led to the development of pain in my lower back."

10. Mr Simpson stated that he continued to work after the accident despite pain and swelling in the left knee. He said that he attended his general practitioner, Dr Quach, on 25 March 2015 because the left knee pain was not improving and the knee had started giving way when he walked. Dr Quach referred Mr Simpson for scans and he began physiotherapy.

11. On 30 March 2015, Mr Simpson had an MRI on the left knee and was referred to Dr Ke Huang, Orthopaedic Surgeon. Mr Simpson attended Dr Huang on 9 April 2015 and was advised to continue with physiotherapy and avoid excessive bending or squatting. Mr Simpson thought that he had about a month off work and then returned to pre-injury duties, as there were no light duties available.

12. Mr Simpson stated that on 10 May 2016, he suffered an aggravation to his left knee whilst at work, which caused increased pain and constant clicking and locking. He said that he started to rely heavily on his right knee for support and soon began to feel pain in the right knee and increased strain in his lower back. Dr Quach referred him to Dr Bijoy Thomas, Orthopaedic Surgeon, for a second opinion.

13. Mr Simpson wrote: "Due to my altered gait I began to experience back pain, which at the time was both in the hip and back. I visited Dr Quach on 11 September 2015 and complained of the pain in my right hip and buttocks area when walking."

14. On 8 June 2016, Mr Simpson underwent an arthroscopy of the left knee. He said that he returned to work on light duties in late July 2016 but his left and right knee discomfort was ongoing. He said that his left knee often became locked and he would need to shake it to get it moving again. He said he would compensate by limping and relying on his right knee.

15. Mr Simpson wrote: "I often felt that walking with an altered gait was increasingly straining my lower back, although it was necessary in order to minimise the pressure on my knees."

16. Mr Simpson was made redundant on 21 December 2017.

17. Mr Simpson wrote:

> "While I had experienced lower back pain since my accident in 2015, it became increasingly painful at the beginning of 2018 and I was noticing it more than ever. In order to investigate, I underwent a CT scan of my lower back on 19 April 2018 which showed stenosis and disc osteophytes."

18. Mr Simpson listed his ongoing disabilities and said that he walked with a small limp and had constant pain in his lower back especially in the morning.

Medical Reports

Medico-legal Reports

19. In a report dated 26 June 2018, Dr Min Fee Lai, consultant plastic surgeon, noted that Mr Simpson injured his left knee and lower back on 20 March 2015. Dr Lai reported that six months after the left knee injury, Mr Simpson had to place an increased load on his right knee and started to have pain in the right knee. Dr Lai wrote: "Meanwhile, the original back injury also started to cause more pain, although not to the same extent as that of his left knee. He attributes this to the altered gait from the injury."

20. Dr Lai noted that Mr Simpson had intermittent periods of time off work but returned to light duties and later to normal duties for two months before taking redundancy.

21. Under "Current Status" Dr Lai noted that Mr Simpson still had an altered gait that "he attributes to aggravating the injury to his lower back". He noted that Mr Simpson still complained of back pain and described the pain as constant, with occasional radiation of pain into his buttocks and thighs.

22. Under "Physical Examination" Dr Lai reported that Mr Simpson walked into the room with an antalgic gait. Examination of the lumbar spine revealed it to be midline with a normal lordosis. There was tenderness to palpation on the lower left lumbar spine with underlying guarding. He could forward flex his back with the fingertips reaching 15 cm below the lower patellar border. Lateral flexion was even with both left and right fingertips reaching the upper edge of the patella. Lateral rotation was uneven with rotation to the left side being half the range of the right side. Straight leg raising was 50' bilaterally. No lower limb muscle wasting was present nor was there any muscle weakness of the lower limbs detected. The sensation to pinprick to both lower limbs was present and normal. His knee, medial hamstring and ankle reflexes were all present and even.

23. Dr Lai expressed the opinion that Mr Simpson had a lumbar spine injury with foraminal stenosis, aggravated by altered gait. He assessed 7% whole person impairment of the lumbar spine.

24. In a report dated 18 September 2018, Associate Professor Paul Miniter, consultant orthopaedic surgeon, noted that Mr Simpson was involved in an incident at work in March 2015 and after attending his GP was referred to Dr Huang. He noted that an arthroscopic procedure was carried out in June 2016 by Dr Thomas, which had been a failure.

25. Under "Current Symptoms", Associate Professor Miniter noted that Mr Simpson had discomfort in the left knee and an inability to extend the knee. There were also complaints about lower back pain. Mr Simpson described being blown out of a hole as part of his work several years ago but could not recall the precise time. Mr Simpson said that he had some discomfort at the time, spent a night in Mona Vale Hospital but did not have any further treatment and returned to work over a three-day period.

26. On examination, Associate Professor Miniter noted that Mr Simpson had bilateral quadriceps muscle wasting. Associate Professor Miniter wrote:

> "Discomfort in his lower back is diffuse. There are no specific areas of maximum pain and there are certainly no features of neurological impairment. His legs extend fully and the straight leg raising manoeuvre and femoral nerve stretch test were negative. His reflexes are uniformly depressed but there are no features of neurological involvement."

27. Associate Professor Miniter reviewed the investigations and stated that there was clear evidence of longstanding pathology affecting the left knee and the lower back.

28. Associate Professor Miniter expressed the opinion that the permanent impairment did not relate to the workplace. He wrote:

> "Even though there may have been a period of aggravation following the injury as described to me in March 2015, there is no doubt that this has settled and there are no features on investigation immediately after the episode to suggest a significant injury. From this point of view, one would have to sheet home the impairment assessment to his constitutional disease.
>
> I do not believe evidence of impairment of the lumbar spine exists relating to the workplace as well. The same comments are made in relation to the cervical spine."

Reports of Treating Doctors

29. In a report dated 14 September 2015, Dr Connolly, radiologist, noted that an ultrasound of the right hip had been performed. He made findings of gluteal tendinosis with trochanteric bursitis. A right trochanteric bursa injection was performed.

30. Dr Ke Huang, treating orthopaedic specialist, in a report dated 9 April 2015, noted that Mr Simpson had developed left anterior knee pain two weeks ago when he was getting out of a deep hole. Dr Huang wrote: "On examination today, Allen is walking with a normal gait. There is no significant effusion of the left knee. Patellofemoral joint is mildly irritable. There is no significant crepitus medial and lateral joint lines are not tender. Ligaments are intact."

31. Dr Huang in a report dated 9 November 2015, noted that Mr Simpson had reported improvements in the left knee symptoms overall but there was still intermittent anterior knee pain, particularly with squatting and walking on stairs. On examination, there was mild patellofemoral crepitus but without significant irritation and mild anterior lateral joint line pain. Range of motion was from 0 to 120 degrees without irritation. Dr Huang noted that Mr Simpson had Grade IV osteoarthritic changes in the left knee and at the moment, the best approach was non-operative management with symptomatic control. He noted that if the pain deteriorated further, the next option would be a total knee replacement.

32. In a referral to Dr Thomas dated 12 May 2016, Dr Quach, general practitioner, noted that Mr Simpson had persistent left knee pain with "locking up and giving way" and this was a "work related injury since last year".

33. In a report dated 18 May 2016, Dr Bijoy Thomas, treating orthopaedic surgeon, noted that the main symptoms were pain as well as locking of the knee. He wrote: "He states that he has to shake his leg off to unlock the knee and moving again which he finds hard when he working in confined spaces [sic]".

34. In a report dated 25 May 2016, Dr Thomas noted that the MRI scan showed a tear of the medial meniscus along with fraying of the lateral meniscus, and degenerative changes in the medial compartment. Dr Thomas advised Mr Simpson that given the fact he has mechanical symptoms such as a painful click and locking of the knee which were interfering with his work and lifestyle, he would benefit from an arthroscopy to deal with the meniscal tear.

35. In a report dated 20 June 2016, Dr Thomas noted that Mr Simpson underwent arthroscopy on 8 June 2016. On examination there was a well healed surgical scar from where the sutures were removed. The knee joint had a range of motion from l0°- almost full flexion. He advised Mr Simpson to continue with physiotherapy.

36. In a report dated 19 September 2016, Dr Thomas noted that Mr Simpson said he had occasional bad days with pain in the anterior aspect of the knee. He did not give any mechanical symptoms. On examination the knee joint had a mild effusion and a range of motion from 0-110° of flexion. He noted that there was significant weakness of the quadriceps musculature present and instructed the physiotherapist to work with Mr Simpson to strengthen his quadriceps muscle especially the vastus medialis and offloading the patellofemoral joint.

37. In a report dated 20 June 2017, Associate Professor Justin Roe, treating orthopaedic surgeon, noted that Mr Simpson had fallen over climbing out of a hole about 18 months ago. Conservative management failed and then Dr Thomas performed an arthroscopy in June 2016. Mr Simpson reported that he has improved but was certainly not back to normal. On examination, there was some tenderness in the patella-femoral joint and x-rays clearly show patella-femoral compartment degenerative changes. Mr Simpson had some early medial compartment changes too. Associate Professor Roe advised Mr Simpson to manage his symptoms conservatively.

38. In a report of a CT scan of the lumbar spine dated 19 April 2018, Dr Kapoor, radiologist noted that there was foraminal stenoses most marked on the right at L4-5 and bilaterally at L5-S1, and disc osteophytes present at these levels. Dr Kapoor commented that from a diagnostic and therapeutic prospective, this was amenable to follow-up guided steroid injections for symptomatic relief if clinically indicated.

39. In Dr Quach's clinical notes, the entries included the following:

    (a) 3 February 2012 – Dr Quach – "mid back strain - R sided spine clear, nil tender legs neurovasc and walking well – pain free at rest - sharp pain with movements trunk... rest, physic, nsaids - review *2/7".*

    (b) 8 July 2015 – Dr Quach – "talk to physic wc review - knee still stiff, sore on *off* with exertion walking is ok."

    (c) 13 August 2015 – Dr Quach – "Actions: Prescription added: COLGOUT T ABLET 500mcg q.i.d. 2 tablets stat and 1 tablet 6 hourly until Gout pains better or until develop diarrhea…ACUTE GOUT L KNEE...INFLAMMED".

    (d) 11 September 2015 – Dr Quach – Diagnostic Imaging requested: X-ray- Hip (R), X-ray- Pelvis, X-ray- Femur (R) - PERSISTENT PAIN R HIP AREA 2/52 - pain minimal at rest sharp pain r lower hip, buttock area with walking - nil swelling noted- mild tenderness."

    (e) 12 September 2015 – Dr Quach – "ultrasound r hip ...cortisone injection if indicated - trochanteric bursitis?"

    (f) 22 September 2015 – Dr Quach – "Trochanteric Bursitis Tendonitis- gluteus physio - still sore walking ok".

    (g) 25 September 2015 – Ms Kobryn, Dietician – "Patient struggling recently with tendonitis and trochanteric bursitis. Seeing physiotherapist- reports adhering to their recommendations."

    (h) 18 April 2018 – Dr Quach "Diagnostic Imaging requested: CT - spine – lumbar – recurrent low back pain."

Reports of Physiotherapists

40. In a report dated 19 October 2015, Ms Chick, physiotherapist, noted that Mr Simpson had received 16 physiotherapy treatments between 10 April 2015 and 9 October 2015. She reported that on final assessment Mr Simpson reported some aggravation of the left knee pain due to walking heavily on the left side secondary to right hip bursitis. She reported that there was some tightness in the left ITB and hamstring muscles on examination.

41. Ms Chang, physiotherapist, in a report dated 8 May 2015, noted that Mr Simpson reported of "giving way" of the knee particularly with fatigue after prolonged walking.

42. Mr Attia, physiotherapist, in a report dated 11 June 2016, noted that Mr Simpson presented for physiotherapy post left knee arthroscopy. Mr Simpson reported that the pain was beginning to settle down with intermittent aches present.

43. In a report dated 20 September 2016, Mr Attia noted that treatment had involved soft tissue work quadriceps and hamstrings strengthening, ROM exercises and education on ICE and heat therapy. Mr Simpson reported that he was currently at approximately 50% of his full functional capacity as he continued to experience discomfort when performing repetitive squatting, climbing and prolonged walking.

44. In a report dated 4 October 2016, Mr Attia noted that Mr Simpson reported that he was at approximately 50% of his full functional capacity as he continues to experience discomfort when performing repetitive squatting, climbing and prolonged walking. He recommended hydrotherapy.

45. In a report dated 5 January 2017, Mr Hua, physiotherapist, noted that on final examination Mr Simpson reported feeling much better, and he attended hydrotherapy regularly which assisted his mobility. Mr Hua noted that the active range of movement was full with knee flexion and extension. Mr Simpson felt an increase in soreness towards the end of the working day. Manual muscle testing of the quadriceps and hamstrings produced "5/5 bilaterally" and he was able to squat and lunge with 10 repetitions without issue.

46. In a report dated 5 June 2019, Mr Brian Tran, physiotherapist, noted that Mr Simpson first consulted him on the 18 October 2018 regarding neck pain, lower back pain, and left knee pain. Mr Tran reported that in first consultation, the neck pain was the most important region to be assessed and treated, and this was managed first. Mr Tran noted that on 1 November 2018 Mr Simpson saw him regarding his lower back pain. Mr Tran wrote:

> "Mr Allen Simpson reports his lower back pain started approximately 3 years ago, which he feels is related to his ongoing left knee pain following a work-related injury. The pain is mostly located centrally but can radiate into his left buttock with occasional paraesthesia. The lower back pain he experiences can fluctuate from a 0/10 at best, to a 7/10 at worst on a VAS/NRS, and is usually aggravated in the mornings, bending a lot, and relieved by rest and analgesic medications. I note some recent CT scans show the presence of L4/5 foramina! stenosis {worse on the right), mild canal and bilateral moderate foramina! stenosis at L5/S1, and the presence of disc osteophytes at L4/5/S1 also. He has had no treatment to date prior to me seeing him for his lower back pain. I saw him for a total of 3 treatment sessions for his lower back pain."

47. On physical examination, Mr Tran reported that Mr Simpson exhibited a larger BMI, generalised stiffness in his lumbar spinal joints, and poor activation, strength, and endurance of his lower limb muscles, most notably on the left side of his body compared to his right side. He did not show any neurological signs of radiculopathy.

48. Mr Tran made a diagnosis of chronic non-specific lower back pain. He commented that symptoms may be related to irritation of the L4/5/S1 nerve roots, especially from the presence of the L4/5/S1 disc osteophytes and reduced central canal and inter-foramina! space, but this was difficult to confirm clinically.

49. In answer to the question "*In your opinion.* was *the incident of 20 March 2015 the main contributing factor to our client's bilateral knee and lumbar spine injuries? Please provide your reasoning.",* Mr Tran wrote:

> "In my opinion, it is plausible that the initial incident on 20 March 2015 to his left knee contributed to the right knee pain and lower back pain. This can commonly be from the altered gait due to knee pain/reduced range of motion, and the compensatory movement patterns that result. This can lead to muscle inhibition of his quadriceps and gluteal muscles, which in turn lead *to* a relatively greater demand on his hamstrings and lumbar muscles, which are common responses following lower leg injuries causing altered gait. There are many contributing factors to lower back pain, but since Mr Allen Simpson did not report any similar lower back pain prior to this, and the back pain got worse following the incident, the bilateral knee may well be a large contributing factor to the current lower back pain complaint."

50. Mr Tran expressed the opinion that the subsequent development of right knee pain and lower back pain due to an increased load on these areas from an altered gait and compensatory movement patterns is also possible and common.

51. In answer to the question "*Are our client's bilateral knee and lumbar spine complaints as a result of the workplace incident which occurred on the 20 March 2015? If so. please provide your reasoning."* He wrote:

> "Again, it is plausible that the workplace incident lead to an altered gait and increased amount of load on the right knee and lumbar spine. This in turn may have contributed to the ongoing right knee and lumbar spine pain. I note that the initial incident occurred in 2015, and he still experiences left knee pain now with reduced ROM and reduced strength. These ongoing impairments may be why Mr Allen Simpson has these ongoing symptoms."

52. In the clinical notes of Mr Tran, the following entries were made:

    (a) 18 October 2018 – "History - Body Chart (1) Neck, central, can travel down the left arm, started over past yr, VAS now 4/10, bad day 6/10, - Trauma 5+ yrs ago, trauma landed on neck,
    (2) LBP. cdentrla, tingling left side buttocks doens spread [sic], VAS now 4/10 bad day 4/10 (3) Left knee, workers camp. last few yrs,". I noted that examination and treatment was focused on the cervical spine.

    (b) 25 October 2018 – "Law partners- Nathan Tarvook History: Subjective:
    - Been driving a lot, family member unwell
    - Asking about lower back, wants report? advised need to speak to lawyer first …" (Examination and treatment was focused on the cervical spine).

    (c) 1 November 2018 – "Neck been OK – Hips been a bit stiff – Lower back pain sore, would like that assessed today… LBP, reportedly started after knee pain, feels related, VAS now 5/10, bad day 7110, good day 0/10 - Current History: 3 yrs ago,- Past History: has prev LBP, bending over a lot, usually goes away with rest… Prev Rx: no treatment to date

- Prev Inv: CT formianal sntepsi wors [sic] on right, disc osteophytes, mild canal and bilateral moderate foramina! Stenosis…- Management:
- Treat for suspected chronic non-specific low back pain, likely related to recurrent strains/sprains on top of poor underlying physical conditioning of back/glute muscles."
-Advice/education: regarding prognosis, natural history, reassurance, need to keep active…"

(d) 8 November 2018 – "Lower backpain, has been doing ex's, minimal change".

(e) 17 November 2018 –LBP treatment today. "Management: -Treat for suspected chronic non-specific low back pain, likely related to recurrent strains/sprains on top of poor underlying physical conditioning of back/glute muscles - Advice/education: regarding prognosis, natural history, reassurance, need to keep active - STM's: lumbar es, quad lumb, gluteals, iliopsoas,
-Manual therapy: PAIVMS 3 x 20 sec reps L4/5/S1, PPIVMS 3 x 20 sec sets lat flex right (open left) *II* no symptoms - Exercises: Spinal mobility: McKenzie REIL prone, supine rotations
- Strengthen glutes: glute bridge dual leg with post pelvic tilt, sidelying hip abds, - Loading: add KB deadlifts 6kgs, goblet squats, standing rotations."

(f) 29 November 2018 – - Back been onoff - Neck bit sore, asking for DNT - Management:
-Treat for suspected acute non-specific neck pain, largely muscular and facet mediated (facet syndrome) - STW: levator scapulae, upper traps, rhomboids, SCM, sub occipitals,
- Mobs: cervical spine, thor spine, scap, ribs [sic]" .

Injury to the lumbar spine

53. Mr Simpson has framed his case in relation to the lumbar spine as a consequential condition and not a frank injury.

54. The issue to be determined is whether Mr Simpson sustained a consequential condition to his lumbar spine, which resulted from the injury to the left knee on 20 March 2015. The respondent argued that the applicant had the onus of proof in this matter and had failed to establish the causal chain connecting any symptoms or condition in the lumbar spine to the injury at work to the left knee on 20 March 2015. In particular, the respondent argued that there was insufficient evidence of the injury to the left knee resulting in an altered gait and I could not be satisfied that there was a causal connection between any condition in the lumbar spine and the injury to the left knee on 20 March 2015.

55. The applicant submitted that he had sustained a consequential injury to the lumbar spine as a result of an altered gait, which placed a strain on the lumbar spine and aggravated the pre-existing degenerate condition in the lumbar spine.

56. In *Kooragang Cement Pty Ltd v Bates*[1] (*Kooragang*), Kirby P stated [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."

[1] (1994) 35 NSWLR 452

57. Further, his Honour stated [at 463–464]:

> "The result of the cases is that each case where causation is in issue in a workers' compensation claim, must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from' is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a common sense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation. In each case, the question whether the incapacity or death 'results from' the impugned work injury (or in the event of a disease, the relevant aggravation of the disease), is a question of fact to be determined on the basis of the evidence, including, where applicable, expert opinions. Applying the second principle which Hart and Honoré identify, a point will sometimes be reached where the link in the chain of causation becomes so attenuated that, for legal purposes, it will be held that the causative connection has been snapped. This may be explained in terms of the happening of a novus actus. Or it may be explained in terms of want of sufficient connection. But in each case, the judge deciding the matter, will do well to return, as McHugh JA advised, to the statutory formula and to ask the question whether the disputed incapacity or death 'resulted from' the work injury which is impugned."

58. The High Court in *Comcare v Martin*[2] (*Martin*) considered the extent to which one can rely on a "common sense approach".

59. In *Martin* the High Court stated 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." (Footnotes omitted)

60. In Martin the High Court referenced its decision in *Allianz Australia Insurance Ltd v GSF Australia Pty Ltd* [3], wherein it was stated:

> "[96] Santow JA also emphasised that this question of causality was not at large or to be answered by "common sense" alone; rather, the starting point is to identify the purpose to which the question is directed. Those propositions should be accepted. The following may be added.
>
> [97] First, in March v Stramare (E&MH) Pty Ltd, McHugh J doubted whether there is any consistent 'common sense notion of what constitutes a "cause"', and added:

[2] (1994) 35 NSWLR 452
[3] [2005] HCA 26; (2005) 221 CLR 568 at 596-597 [96]- [97]

> ‘Indeed, I suspect that what common sense would not see as a cause in a non- litigious context will frequently be seen as a cause, according to common sense notions, in a litigious context. This is particularly so in many cases where expert evidence is called to explain a connexion between an act or omission and the occurrence of damage. In these cases, the educative effect of the expert evidence makes an appeal to common sense notions of causation largely meaningless or produces findings concerning causation which would often not be made by an ordinary person uninstructed by the expert evidence.’"

61. However, as I understand it, Kirby P in *Kooragang* when referring to applying “common sense” was not suggesting it be applied “at large” or that issues were to be determined or answered by "common sense" alone, and instead was referring to the need for a careful analysis of the evidence.

62. Wood DP in *Arquero v Shannons Anti Corrosion Engineers Pty Ltd* [2019] NSWWCCPD 3 (*Arquero*) stated at [157-158]:

> “At arbitration, Shannons submitted that Mr Arquero’s evidence fell short of providing details of what he was doing that placed greater strain on the left knee. The submission ignores the evidence in Mr Arquero’s first statement that he had difficulty doing housework, walking long distances, using stairs and took longer to do the gardening.
>
> It is a common-sense proposition that a person who is not immobilised, and attempts to carry out everyday activities despite his right knee difficulties, would be walking and otherwise using his lower limbs as a matter of course.
>
> Also during the arbitration, Shannons referred to and relied upon the decision in *Moriarty-Baes*, and submitted that particular paragraphs of that decision establish what evidence is required to satisfy the causal connection. In *Moriarty-Baes,* the worker suffered a left wrist injury, then subsequently complained of right shoulder symptoms. She alleged the right shoulder was a further injury, or in the alternative a condition consequent upon the left wrist injury. In relation to the alleged overuse of the right shoulder because of the left wrist injury, Ms Moriarty-Baes’ statement was effectively silent. The Arbitrator found that the absence of any evidence as to what the worker was doing was fatal to her case, and that finding was confirmed on appeal.”[10]

63. The respondent submitted that the applicant had the onus of proving the consequential condition in the lumbar spine and that I could not be satisfied on the evidence that the applicant had developed a condition in the lumbar spine as a consequence of the injury to the left knee on 20 March 2015. The respondent relied on the opinion of Associate Professor Miniter.

64. The applicant submitted that there was sufficient evidence for me to make a finding of secondary injury to the lumbar spine and relied on the opinions of Dr Lai and Mr Tran.

65. There is no dispute that the applicant sustained an injury to his left knee on 20 March 2015. Following that injury, Mr Simpson continued working for a period of about 2-3 weeks with some difficulty and was then off work for four weeks and then returned to work on light duties. He underwent an arthroscopy in June 2016 and returned to work on light duties and then normal duties before he was made redundant on 21 December 2017.

66. Mr Simpson stated that after the injury to the left knee on 20 March 2015, due to his altered gait, he began to experience back pain, which at the time was both in the hip and back. He consulted Dr Quach on 11 September 2015 and said that he complained of the pain in his right hip and buttocks area when walking.

67. After the arthroscopy of the left knee on 8 June 2016, Mr Simpson returned to work on light duties in late July 2016 but said his left and right knee discomfort was ongoing and his left knee often became locked and he would need to shake it to get it moving again. He said he would compensate by limping and relying on his right knee. He said that he often felt that walking with an altered gait was increasingly straining his lower back.

68. Mr Simpson stated that while he had experienced lower back pain since the accident in 2015, it became increasingly painful at the beginning of 2018 and he underwent a CT scan of the lower back on 19 April 2018 which showed stenosis and disc osteophytes.

69. I accept that Mr Simpson attended Dr Quach on 11 September 2015 and complained about pain in his hip and buttocks. However, although Mr Simpson, in his statement dated 17 October 2018, said that he had pain in both the hip and back, there is no record of a complaint of low back pain being made during the consultation with Dr Quach.

70. In his clinical notes dated 11 September 2015, Dr Quach reported that Mr Simpson had persistent pain in the right hip area for two weeks and "sharp pain r lower hip, buttock area with walking – nil swelling noted – mild tenderness". Dr Quach referred Mr Simpson for x-rays of the right hip, pelvis, and right femur. In his clinical notes dated 12 September 2015, Dr Quach wrote: "ultrasound r hip ...cortisone injection if indicated - trochanteric bursitis?". The diagnosis of trochanteric bursitis was confirmed in the clinical notes dated 22 September 2015 when Dr Quach wrote: "Trochanteric Bursitis Tendonitis- gluteus physio - still sore walking ok". On 25 September 2015, Ms Kobryn (a dietician in Dr Quach's practice) noted: "Patient struggling recently with tendonitis and trochanteric bursitis. Seeing physiotherapist- reports adhering to their recommendations."

71. On 14 September 2015, Dr Connolly, radiologist, noted that an ultrasound of the right hip had been performed. He made findings of gluteal tendinosis with trochanteric bursitis. A right trochanteric bursa injection was performed.

72. On 19 October 2015, Ms Chick stated that on final assessment Mr Simpson reported some aggravation of the left knee pain due to walking heavily on the left side secondary to right hip bursitis.

73. I am satisfied that no complaint of back pain was made to Dr Quach in September 2015 and the problems that Mr Simpson experienced in the buttock area were more likely than not related to the trochanteric bursitis which was treated. It was also significant in my view that Dr Quach in his note dated 22 September 2017 reported that Mr Simpson was walking "OK".

74. There was no reference to any complaint of back pain or symptoms in the lumbar spine in any of the reports or clinical notes and records of treating doctors and physiotherapists until 18 April 2018, that is, over three years after the injury to the right knee on 20 March 2015. There is also no reference to an altered gait in any of the reports or clinical notes and records of treating doctors and physiotherapists. Although Mr Tran refers to altered gait being a cause of symptoms in the low back, he does so on a theoretical basis and, despite treating Mr Simpson on a number of occasions, made no findings or observations of an altered gait.

75. The only doctor who observed an altered gait was Dr Lai, who examined Mr Simpson on one occasion on 26 June 2018. Dr Lai was of the opinion that Mr Simpson had sustained the following injuries: "Left torn medial meniscus. Right knee consequential injury with increased load. Lumbar spine injury with foraminal stenosis aggravated by altered gait".

76. Dr Huang, in a report dated 9 April 2015, noted that on examination Mr Simpson was walking with a normal gait. Neither Dr Thomas, nor Associate Professor Roe, in their various reports made any comment about gait. In short, none of the treating orthopaedic specialists or the GP, Dr Quach, made any observations about altered gait or reported any complaint about altered gait.

77. Mr Simpson was treated by a number of physiotherapists, Ms Chick, Ms Chang, Mr Attia, Mr Hua and Mr Tran. As noted above, Mr Tran referred to altered gait as being a cause of symptoms in the low back, but appeared to do so on a theoretical basis and made no actual findings or observations of altered gait. None of the other physiotherapists reported any complaints about gait or made any observations of altered gait.

78. While I accept that there was evidence that Mr Simpson's left knee locked up and gave way, this did not amount, in my view, to there being an alteration in gait such as to cause symptoms in the lumbar spine. Similarly, the presence of bilateral quadriceps muscle wasting (found by Associate Professor Miniter) did not amount to a change in gait.

79. Only Dr Lai and Associate Professor Miniter addressed the question of whether Mr Simpson's low back pain results from the injury to his left knee. Dr Lai accepted that there was a causal relationship and expressed the view that the foraminal stenosis was aggravated by altered gait. Associate Professor Miniter did not find any ongoing impairment in the lumbar spine as a result of Mr Simpson's left knee injury. He found evidence of longstanding pathology affecting the left knee and the lower back and expressed the opinion that the permanent impairment did not relate to the workplace, but to the longstanding constitutional condition.

80. Mr Simpson expressed the opinion in his statement that "My left knee injury altered my gait, causing me to walk with a limp that led to the development of pain in my lower back." He expressed this opinion to Dr Lai and Mr Tran. The opinion is of little, if any, weight in the circumstances of this case. The rules of evidence do not apply in the Commission and so the prohibition on the reception of opinion evidence at common law or under the *Evidence Act (NSW) 1995* does not apply. While it is true that it is not always necessary to adduce medical evidence to establish injury or causation in cases under the workers compensation legislation, the opinion of the worker on a causation issue will rarely be logical and probative as required by the Rules and, more importantly, it will rarely be persuasive.

81. There was no reference in the medical records to low back pain until 18 April 2018. There was no reference to a limp and altered gait until Dr Lai's report of 26 June 2018. It is important to bear in mind the instruction of the Court of Appeal, that care must be taken, with clinical records: *Mason v Demasi* [2009] NSWCA 227(31July 2009). However, in circumstances where there is no sworn evidence and the injury relied upon occurred some years ago, they can provide a useful basis for scrutinizing written evidence.

82. There are complaints in the medical records of problems with the left knee following the injury on 20 March 2015. There was no reference to back pain until 18 April 2018. The evidence, in my view, suggests that the back pain of which Mr Simpson now complains really developed in 2018 and not at the earlier time as he stated. He did not report back pain until 18 April 2018 and there were no investigations of the lumbar spine undertaken until 19 April 2018.

83. The only references to actual altered gait in the evidence are those made by Dr Lai and by Mr Simpson. There was no reference in any of the medical reports of treating orthopaedic specialist to altered gait. There was no reference in any of the reports of treating physiotherapist to altered gait. There was a reference in the clinical notes of Dr Quach on 8 July 2015 to "walking is ok." Dr Huang, in his report dated 9 April 2015, noted Mr Simpson was walking with a normal gait.

84. In the context of the clinical records, I have some problems accepting the opinion of Dr Lai. His finding that Mr Simpson walked with an antalgic gait was not a finding made by any other doctor, including the general practitioner, Dr Quach, who saw Mr Simpson regularly and took, in my view, quite detailed notes.

85. The clinical record does not support the theory that Mr Simpson had pain and disability in his left knee as a result of the injury on 20 March 2105 that caused him to walk with an altered gait. The evidence does not permit a finding that Mr Simpson had back pain before April 2018. When back pain did commence and was reported to Dr Quach, the entries in the notes did not associate it with altered gait.

86. In the present case, there was a distinct lack of evidence that Mr Simpson was either limping, or had altered his gait as a consequence of the left knee injury.

87. These matters do raise some concern about the reliability of Mr Simpson's written evidence. These concerns could be dismissed if there was some evidence from a treating doctor or physiotherapist supporting Mr Simpson's case. There was no report from Dr Quach. This is unfortunate in a case such as this, when the issue is the causal nexus between an injury and a consequential medical condition which occurs some years later, in that evidence from the worker's general practitioner may be critical to the outcome of the matter.

88. After considering the evidence tendered in this case, I am not persuaded that the medical condition in Mr Simpson's lumbar spine results from the accepted injury to the left knee on 20 March 2015. In my view, the applicant has failed to discharge the onus upon him to establish that he sustained a consequential injury to his lumbar spine as a result of the injury to his left knee.

89. As the assessed impairment in respect of the left lower extremity does not exceed the threshold for permanent impairment compensation, the matter cannot be remitted to the Registrar for referral to an Approved Medical Specialist. Therefore, the proceedings are dismissed.