WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **1992/20**
Applicant: **Donna Morgan**
Respondent: **Royal Society for the Prevention of Cruelty to Animals**
Date of Determination: **7 July 2020**
Citation: **[2020] NSWWCC 224**

The Commission determines:

1. The applicant has a consequential condition affecting her right knee as a result of injury to her left knee on 15 May 2015.

The Commission orders:

1. The matter is remitted to the Registrar for referral to an Approved Medical Specialist (AMS) for assessment as follows:

    Date of injury: 15 May 2015

    Body parts: Left lower extremity (knee)
    Right lower extremity (knee) (consequential)

    Method: Whole Person Impairment.

2. The materials to be referred to the AMS are to include the Application to Resolve a Dispute and all attachments; the Reply and all attachments; and this Certificate of Determination and accompanying Statement of Reasons.

3. The referral is to be placed on the Medical Assessment Pending List.

4. The matter to be listed for further teleconference upon receipt of the Medical Assessment Certificate.

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

Rachel Homan
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 RACHEL HOMAN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Ms Donna Morgan (the applicant) was employed by the Royal Society for the Prevention of Cruelty to Animals (the respondent) as an inspector.

2. The applicant claims that in the course of her employment on 15 May 2015, she sustained an injury to her left leg when she was attempting to restrain a dog in a vehicle and the dog moved suddenly, causing her to strike her left knee against the vehicle.

3. The applicant additionally claims that as a result of the injury to her left leg she began to favour that leg causing a consequential condition at the right knee.

4. The respondent's insurer accepted liability for an injury to the applicant's left leg on 15 May 2015 but declined liability for an arthroscopic meniscectomy which was proposed by the applicant's surgeon, Dr Sherif M Rizkallah. That decision was notified to the applicant in a notice issued pursuant to former s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) on 17 August 2015 and maintained in further notices dated 6 October 2015 and 6 November 2015. The applicant underwent the arthroscopic meniscectomy nonetheless, funding it herself.

5. In a notice dated 28 February 2017, the insurer declined liability to pay benefits of weekly compensation and medical expenses in relation to the left knee injury.

6. On 16 October 2018, the applicant made a claim for lump sum compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act) in respect of permanent impairment of both of her knees resulting from the injury on 15 May 2015. On 22 March 2019, liability to pay the lump sum compensation and liability for the alleged consequential condition at the right knee were declined in a notice issued pursuant to s 78 of the 1998 Act.

7. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) lodged in the Commission on 9 April 2020. The applicant seeks lump sum compensation in respect of permanent impairment of both knees. The applicant also seeks compensation pursuant to s 60 of the 1987 Act for incurred expenses related to treatment of her knees including, further surgeries performed at her left knee by Dr Buddhika Balalla on 22 August 2017, 20 February 2018 and 6 March 2018.

ISSUES FOR DETERMINATION

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

    (a) Whether the applicant sustained a consequential condition affecting her right knee as a result of the injury to her left leg on 15 May 2015;

    (b) The degree of permanent impairment resulting from the injury on 15 May 2015; and

    (c) The applicant's entitlement to s 60 expenses as claimed.

PROCEDURE BEFORE THE COMMISSION

9. The parties appeared for conciliation conference and arbitration hearing by telephone on 15 June 2020. The applicant was represented by Mr Andrew Campbell of counsel, instructed by Ms Claudia Carro. The respondent was represented by Mr Graham Barter of counsel instructed by Ms Diane Pritchard.

10. During the conciliation conference, leave was granted to the applicant to correct an error at paragraph four of her written statement where reference was made to the right knee instead of the left knee.

11. 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

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

    (a) ARD and attached documents; and

    (b) Reply and attached documents.

13. Neither party applied to adduce oral evidence or cross-examine any witness.

Applicant's evidence

14. The applicant's evidence is set out in a written statement made by her on 18 March 2020.

15. The applicant said that when she was young she played lots of sport and injured her right knee. The applicant underwent a surgery to repair her anterior cruciate ligament when she was about 17 years old. Two further surgeries to repair the right anterior cruciate ligament were performed, the last of which occurred when the applicant was approximately 26 years of age. The applicant said she did not then have any major difficulties with her knee until the work injury.

16. The applicant commenced work with the respondent in or about 2004 as an inspector. The applicant passed a medical/fitness examination in order to gain employment and worked for many years without any problems to either knee.

17. Toward the end of her pregnancy with her last child in mid to late 2012, the applicant felt pain and discomfort in her left knee area. The applicant had put on a lot of weight with the pregnancy and her general practitioner referred her for scans to make sure that all was in order. The applicant returned to work after her maternity leave, undertaking her usual pre-injury duties in March 2013. The applicant said she had no difficulties undertaking those duties and had no pain in either her right or left knee until the work injury of 15 May 2015.

18. On 15 May 2015, the applicant was at the respondent's Yagoona office when two police officers came in and requested assistance with a dog that had broken its leg and was in the back of their van. The police van had two doors but only one side was open. The applicant leant in to attempt to manoeuvre the dog towards the door. The dog suddenly started to struggle and, while attempting to restrain him, the applicant twisted and hit her left knee on the back of the vehicle.

19. The applicant limped back to her desk and put an icepack on her knee. The applicant was in a lot of pain so left work early to see a general practitioner, Dr Trieu. Dr Trieu certified the applicant as fit for light duties to 19 May 2015. Dr Trieu also certified the applicant fit for limited fieldwork which she felt totally unable to do. Dr Trieu eventually referred the applicant for scans which showed a compression fracture. On or about June 2015, the applicant was referred to orthopaedic surgeon Dr Rizkallah.

20. The applicant said,

> "My left knee was very tender and very sore and I heavily relied on my right knee to get about. I would lean on my right leg to get up from a seated position, I would lean on it to try and pick up low lying items off the floor, to go upstairs and generally relied on it to steady myself. I started relying on my right leg almost immediately after my work injury. My left knee was very sore and clicking when moving."

21. In September 2015, the applicant consulted a new general practitioner, Dr Jerew as she had lost confidence in Dr Trieu. The applicant was referred for a further scan which also showed a tear. By this time, it had been many months since the injury and the applicant was still experiencing lots of pain in her left knee and developing pain in her right knee.

22. Dr Rizkallah recommended surgery by way of arthroscopy to the applicant's left knee. The insurer declined the claim for treatment but paid for other treatment such as medication and physiotherapy. As the applicant was in enormous pain, she decided to accept Dr Rizkallah's advice and proceed with the surgery. The surgery took place on 17 December 2015 and was paid for by the applicant with some costs recovered through private insurance. The applicant was off work for about four weeks then returned to suitable duties.

23. The applicant was not happy with the surgery results. In or about October 2016, she was referred by Dr Jerew to Dr Boundy. Dr Boundy performed injections but the treatment was not successful. The insurer paid for some of Dr Boundy's treatment, including a leg brace which the applicant wore at work as recommended by Dr Boundy.

24. In about June 2017, the applicant ceased employment with the respondent and commenced lighter, mainly office work for NSW Police as an unsworn investigator.

25. In July 2017, Dr Boundy referred the applicant for a further MRI. On seeing the results, the applicant was referred to another orthopaedic surgeon, Dr Balalla. Dr Balalla performed surgery to the applicant's left knee on 22 August 2017. Dr Balalla performed further surgery to the left knee on 20 February 2018 to remove plates and screws. A further procedure was performed on 6 March 2018 to aspirate the wound and flush it out. All of these procedures were partially covered by the applicant's private insurance.

26. The applicant returned to employment with the respondent in January 2018 as a position which could accommodate her physical limitations became available.

27. The applicant was experiencing discomfort in her right knee. The applicant complained to her doctors about the right knee pain and was referred to Dr Balalla and for a scan in or about June 2019. Dr Balalla recommended injections to the applicant's right knee which were performed in or about July 2019. Dr Balalla had indicated to the applicant that surgery to repair a tear at her right knee may be required. The applicant was unwilling to risk any further surgeries to her knees.

Radiological evidence

28. The report of an MRI of the left knee performed on 5 December 2012 noted a history of a painful knee giving way. The report found:

> "Main finding is anteriorly where there is some focal Grade lll/IV full thickness chondral loss within the medial patellar facet extending approximately 16mm x 14mm. Some minor high signal within the superior aspect of Hoffa's fat. Some mainly low, minor (Grade I/II) chondral change within the apex of the trochlear groove in its mid-third. Some low grade chondral change also demonstrated in the junction mid to posterior aspect of the MFC and within the postero-central aspect of the lateral tibial plateau. No focal chondral defect or flap. No evidence of meniscal tear. A small joint effusion and a small popliteal cyst."

29. An MRI of the left knee performed on 29 May 2015 noted a clinical history of left knee injury, joint instability and ongoing pain." The report said the MRI revealed:

> "Subcortical trabecular compression fracturing at the anterolateral tibial plateau with surrounding marrow oedema. This may be the result of abnormal loading due to meniscal dysfunction; there is chronic meniscal scarring and free margin fraying throughout the lateral compartment. There is further scarring and free margin fraying of the medial meniscus. Prominent patellofemoral degenerative changes seen on background dysplasia. Mild synovitis and effusion."

30. A left knee x-ray performed on 10 July 2015 indicated that the trabecular compression fracture shown on the MRI study of 29 May 2015 was not appreciated on the plain film x-ray. There was minimal knee joint effusion and mild degenerative disease involving the medial compartment and patellofemoral joint.

31. An MRI of the left knee performed on 17 September 2015 showed:

> "Horizontal cleavage tear mid body medial meniscus breaching tibial articular surface. Grade 2 chondral wear of medial femorotibial compartment. No acute fracture of the lateral tibial plateau. Full-thickness chondral loss posterior weightbearing lateral tibial plateau. Grade 2-3 chondral wear of patellofemoral compartment."

32. An ultrasound of the applicant's right knee performed on 23 November 2016 indicated a small non-specific suprapatellar bursal effusion, probably physiological and a Baker's cyst. No other significant abnormality was noted.

33. An MRI of the applicant's right knee performed on 28 June 2019 revealed:

> "Chronic horizontal cleavage tear of the posterior horn of the medial meniscus with a small amount of truncation of the inner free edge of the posterior horn and posterior root attachment of the medial meniscus. There is grade IV chondromalacia patellae in the medial trochlea and medial patella with early OA. The ACL reparative graft is intact."

Dr Rizkallah

34. A letter from orthopaedic surgeon, Dr Rizkallah, to the insurer, dated 15 June 2015 reported that the applicant had injured her left knee on 15 May 2015. The applicant described a direct trauma with a twisting movement to the knee. The applicant had been in pain since the injury with swelling and intermittent clicking.

35. Dr Rizkallah recorded:

> "Clinical examination demonstrates an obvious limp. She has tenderness over the lateral tibial plateau and both joint lines. The McMurray's manoeuvre for the menisci is equivocal. The knee is clinically stable and has good range of movement with pain at the extreme of flexion. Her MRI scan demonstrates bone bruising involving the lateral tibial plateau with 2 small tears involving both menisci.
>
> I discussed with Donna the nature of her injuries and recommended commencing physiotherapy. I shall review her again after 4 weeks and if not better she may require arthroscopic meniscectomy."

36. In a report dated 9 July 2015, Dr Rizkallah indicated that the applicant's left knee was still troubling her with pain, clicking and intermittent catching. The applicant wished to proceed with a left knee arthroscopic meniscectomy.

37. In a further report dated 7 October 2015, Dr Rizkallah indicated that an MRI scan performed on 17 September 2015 demonstrated a tear involving the medial meniscus consistent with the work injury. The applicant was experiencing ongoing significant symptoms and developing significant apprehension and depression in relation to the injury. Dr Rizkallah requested urgent approval for a left knee arthroscopic meniscectomy and debridement.

Dr Jerew

38. The applicant's general practitioner, Dr Firas Jerew, provided a medical certificate dated 22 September 2015 which stated:

> "Ms Donna Morgan had injury to her left knee in May 2015. Her most recent MRI (Sept 15) confirms healing of the fracture. However most of her symptoms are coming from chondral defects and meniscal tears. These type of injuries are unlikely to improve by themselves and it may accelerate wear and tear of the rest of her knee tricompartmental function. She will benefit from arthroscopic washout and debridement if the surgeon suggest them too. She is likely to experience pain and restrictions of her daily functions. Her pain is likely to get worse if she stand for long, walk for long, kneel and running or jogging. These restrictions may even get worse over the next few years due to anticipated accelerated degenerative changes."

Dr Boundy

39. Sports Medicine Specialist, Dr Kevin Boundy prepared a report for Dr Jerew, on 26 October 2016.

40. Dr Boundy took a history of injury as follows:

> "Donna told me she was retrieving a dog from the back of a police car. She went to grab the dog by the scruff of its neck but it shook itself free. She fell to her left striking the lateral aspect of her left tibia on the tailgate of the police car and was immediately aware of severe pain in the left knee."

41. With regard to the right knee, Dr Boundy recorded:

> "Donna says that her right knee is fine. Despite having had the right ACL repaired three times she has no pain in this knee. The pain in her left knee is localised to the medial aspect of the knee and extends across the anterior joint line beneath the patella."

42. Dr Boundy's examination on that occasion revealed:

> "On examination of the right knee Donna had a stable knee with a full range of movement. The knee was ligamentously stable and the ACL was performing well, with Donna having a negative pivot shift test. There was no tenderness around the joint line and McMurray's test for meniscal irritation was negative. Clarke's test for patellofemoral irritation was strongly positive.
>
> Examination of the left knee showed that Donna was unable to fully extend the knee due to pain. When a valgus force was applied to the medial collateral ligament Donna almost convulsed with the severity of the pain she experienced."

43. Dr Boundy made the following diagnosis:

> "Donna has injured her knee at work when she has been levered over the tailgate of a police vehicle while trying to restrain an animal. The direct blow to the outside of her leg has left her with bruising in the lateral tibial plateau. As her weight has been levered over edge of the car she has strained her medial collateral ligament. This last injury has gone unnoticed until her present GP ordered an injection of cortisone into the area."

44. Dr Boundy prepared a further report for the applicant's solicitors on 27 June 2017.

45. Dr Boundy gave a history that immediately following the injury the applicant's general practitioner requested an MRI which revealed oedema in the lateral tibial plateau. A follow-up MRI was ordered three months later to investigate why the applicant still had pain. That MRI showed resolution of the oedema but significant strain of the deep fibres of the medial collateral ligament and the suspensory ligaments of the medial meniscus. As the applicant was troubled by severe pain, her orthopaedic surgeon offered to perform an arthroscopy.

46. The applicant's pain was so bad she was unable to sleep through the night without waking whenever she moved. Eager for some pain relief, the applicant paid for the procedure herself. Following the surgery and a period of rest, the applicant's knee pain settled considerably but as soon as she returned to work pain about the medial aspect of the left knee flared again. The applicant's general practitioner ordered an injection of cortisone about the MCL which the applicant said relieved all of her pain for about two months.

47. With regard to the arthroscopic surgery, Dr Boundy said:

> "From the above it would appear that Ms Morgan was dragged to her left and had her left knee levered over the back tailgate of a police car. This resulted in a direct blow to the lateral tibia, and a significant strain to the MCL and associated structures. The orthopaedic surgeon who reviewed her case felt that she might benefit from arthroscopy even though there was really no clear indication for the procedure. Ms Morgan acquiesced and had the operation believing it would help relieve her pain. It did not. A third MRI of the knee performed after her surgery showed that she had significant loss of articular cartilage through the medial compartment of the knee compared to her previous MRIs."

48. Dr Boundy was asked whether the surgery to the applicant's left knee had been reasonably necessary at the time and responded:

> "Looking specifically at whether or not the surgery that Ms Morgan had was reasonably necessary at the time, I would like to point out that Ms Morgan had been living with severe pain that interrupted her sleep and interfered with her ability to work for 4 months before she proceeded to surgery.
> …

> At the time that she had the surgery "exploratory" arthroscopies were still considered reasonable practice, at least by some orthopaedic surgeons. Given the general knowledge of the community at the time about knee arthroscopies there was no reason for Ms Morgan to doubt the surgeon could help her. I am sure it was his intention to do the best he could for her.
>
> In the time since Ms Morgan has had her surgery community attitudes have changed. We are now aware that most arthroscopic surgery provides little long-term benefit to the patient above a placebo.
>
> Having worked in orthopaedic operating theatres for 30 years I can also say that Ms Morgan probably had her knee injured by well-meaning orthopaedic surgeon who was looking for a cause of her severe pain. He probably saw a roughened patch of articular cartilage, and, in trying to smooth her articular surfaces, debrided healthy cartilage from the medial aspect of her knee.
>
> For many years orthopaedic surgeons thought that they were helping patients when they saw a small divot with a sharp edge in the articular cartilage. They would smooth out the surrounding area making a very large crater with a smooth surface. It has now been documented in independent medical journals that arthroscopic surgery where tissue is removed can accelerate the onset and progression of osteoarthritis rather than preventing it.
>
> Although it is easy in hindsight to be critical of the surgeon, at the time that Ms Morgan had her surgery it was a reasonably accepted form of treatment in orthopaedic circles."

49. Dr Boundy provided a detailed opinion as to the treatment he proposed for the applicant.

Dr Balalla

50. Orthopaedic surgeon Dr Buddhika Balalla, prepared a report for Dr Boundy on 17 August 2017.

51. Dr Balalla recorded a history of the applicant striking the lateral aspect of her left knee on an object while wrestling with a dog. The applicant experienced a sudden and severe pain which did not improve over a period of months. The applicant underwent arthroscopy by Dr Rizkallah which unfortunately did not improve the applicant's symptoms.

52. Dr Balalla's examination revealed:

> "On examination, Donna has a slightly varus posture to her left knee. She has an antalgic gait and limited range of movement from 5 to 90•. There is a moderate effusion. Her ligaments are functioning normally and she is able to walk unaided."

53. Dr Balalla provided an opinion as follows:

> "Donna is 41-year-old lady with premature medial compartment arthritic change due to previous trauma and a subsequent meniscectomy. The pain is now quite severe and affecting her quality of life. She has failed non-surgical management, and as such I have recommended that she consider a high tibial osteotomy. An osteotomy to shift the weightbearing line to the lateral compartment should alleviate her pain significantly."

54. Operation records indicate that Dr Balalla performed a left knee arthroscopy and high tibial osteotomy with bone grafting on 22 August 2017; a left knee arthroscopy and removal of plate on 20 February 2018; and drainage of a left knee haematoma on 6 March 2018.

Dr Conrad

55. The applicant relies on a medicolegal report prepared by general surgeon, Dr Peter Conrad, dated 2 October 2018.

56. Dr Conrad took a history of the work injury on 15 May 2015 including the surgery by Dr Rizkallah on 17 December 2015. The applicant underwent an injection of hypertonic glucose in the left knee on three occasions and an injection of platelet rich plasma. The applicant had a knee brace fitted. Eventually the applicant was referred to a further orthopaedic surgeon, Dr Balalla who performed three further operations on the left knee.

57. The applicant gave a history to Dr Conrad that due to her irregular gait she developed pain and stiffness in the right knee which had been injured previously and for which she had had three operations of ligamentous reconstruction in her 20s. The applicant reported a good result from the surgeries apart from some temporary left knee pain in 2012 for which she had an MRI scan.

58. The applicant reported pain and stiffness in both knees and difficulty standing, walking and going up or down stairs. The applicant was unable to squat, kneel or run.

59. Dr Conrad considered the ultrasound and MRI scan of the left knee performed in December 2012 in addition to investigations of the left knee performed following the May 2015 injury.

60. Dr Conrad gave an opinion as follows:

> "This lady was involved in an accident on 15 May 2015, whilst working as an RSPCA Inspector. Ms Morgan sustained an injury to her left knee, which consisted of meniscal tears, chondral damage to the knee and a compression fracture involving the anterolateral tibial plateau.
>
> Whilst Ms Morgan did have a previous minor injury to the left knee in 2012, on the available evidence she made a complete recovery from the 2012 accident and the injury of 15 May 2015 is solely responsible for the ongoing problems with her left knee.
>
> For the 2015 accident, Ms Morgan had four operations and has been left with considerable pain and restriction of movement and progressive osteoarthritis in the left knee. In addition, due to irregular gait, she has reinjured her right knee for which she had three operations in her 20's for ligamentous injuries. The right knee now has progressive arthritis setting in."

61. Dr Conrad made an assessment of 11% whole person impairment (WPI) to the left and right knees including scarring at the left knee.

Associate Professor Miniter

62. The respondent relies on a series of medicolegal reports prepared by orthopaedic surgeon, Associate Professor Paul Miniter. Dr Miniter's first report, dated 24 July 2015, took a history of the applicant striking the anterior and lateral aspect of her left knee against the police vehicle.

63. Dr Miniter reported that an x-ray performed soon after the injury was within normal limits but a subsequent MRI scan, which Dr Miniter had seen, demonstrated marked bone bruising throughout the proximal anterolateral tibia. Dr Miniter described the bone bruising as "impressive and extensive" but there were no other features on the x-ray or MRI scan to suggest major injury to the knee.

64. Dr Miniter noted that the applicant's right knee had previously been reconstructed on two occasions. The latest procedure had rendered the knee stable. The applicant had full range of motion but did experience discomfort with extended exercise.

65. Dr Miniter gave the opinion that the applicant had suffered an injury to the left knee in the nature of a bone contusion to the proximal aspect of the tibia which would resolve completely with the passage of time. Dr Miniter said this would take another two or three months. Dr Miniter said surgery was contraindicated and saw no reason at all to consider arthroscopic surgery. The applicant's pain was related to the bone oedema and contusion which were the result of the work injury.

66. Dr Miniter provided a second report on 3 November 2015. On this occasion, Dr Miniter said the horizontal tear of the medial meniscus was not a matter that required surgical treatment. Dr Miniter described this as a "silent and serendipitous finding that bears no relationship to her current presentation."

67. Regardless of the findings on the new MRI scan, Dr Miniter expressed the view the applicant was not a candidate for arthroscopy for many reasons. Dr Miniter said the matter should be brought to a close. If the oedema in the proximal tibia had passed then it was safe to assume the applicant had returned to normal function.

68. In a third report dated 18 February 2019, Dr Miniter noted that the applicant had proceeded to arthroscopic surgery under the care of Dr Rizkallah and commented:

> "Unfortunately, as I was trying to say in my previous report, this is not in the patient's interest and in a setting such as this of longstanding slow degeneration of the knee with clear findings of osteoarthritic change on the MRI scan and with no symptoms arising from the knee joint proper, it is inappropriate to have proceeded to arthroscopic surgery in most circumstances."

69. Dr Miniter noted that since the osteotomy by Dr Balalla, the applicant had been dramatically better and the applicant was happy with the outcome from that surgery. Dr Miniter noted symptoms of medial compartment osteoarthritic change developing in the right knee which had been subject to surgical treatment in the past.

70. Dr Miniter gave the opinion:

> "The diagnosis of the matter is one of osteoarthritic change affecting both knees. This is constitutional in nature and, as I mentioned in my previous report, the serious injury to the proximal tibia on the left hand side was one that had been associated with tibial bone bruising and not with disruption to the knee itself. After careful consideration, I still find it difficult to associate the osteoarthritic disease in the left knee with the contusion to the proximal tibia. As I mentioned earlier, it is likely that the arthroscopic surgery performed by Dr Rizkallah was instrumental in the deterioration of the knee. This is an unfortunate circumstance and I made reference to this in my previous report.
>
> As far as I could determine, the work-related matter of this issue, that is of contusion of the proximal tibia has entirely resolved."

71. Dr Miniter noted that Dr Conrad was a general surgeon with no experience in surgery of the knee. Dr Miniter said he did not believe the disease of the right knee had been the result of the left knee, commenting that medial compartment osteoarthritic disease was very common in women of the applicant's age group who were overweight.

72. In a fourth report dated 7 March 2019, Dr Miniter noted that he had been able to review the applicant's radiological imaging. Dr Miniter reiterated his previous view:

> "I do not believe that medial meniscectomy was indicated in this case and that there was no evidence on the original MRI report to suggest that the knee itself had been injured. The injury had without doubt occurred to the proximal tibia. She gave an excellent history in association with this and the proximal oedema had resolved on the subsequent MRI scan. In my opinion, the MRI scan did not suggest that there had been an injury to the knee proper, as mentioned above."

Dr Drummond

73. Orthopaedic surgeon, Dr Robert Drummond provided a medicolegal report to the insurer dated 17 January 2017.

74. Dr Drummond described the injury of 15 May 2015 as the applicant bumping "her left knee on the van impacting on the lateral side of the knee joint resulting in intense pain with difficulty standing."

75. Dr Drummond noted that the MRI performed on 29 May 2015 diagnosed subcortical trabecular compression fracturing at the anterior lateral tibial plateau with surrounding marrow oedema.

76. Dr Drummond noted that Dr Rizkallah performed arthroscopic partial medial and lateral meniscectomy with chondroplasty on 17 December 2015. Following the surgery there was minimal improvement particularly at the medial joint.

77. Dr Drummond noted that there had been left knee pain in 2012 and the MRI performed on 5 December 2012 showed Grade III/IV full thickness chondral loss on the medial patellar facet and Grade II chondral changes in the apex of the trochlear groove at its mid third. Low-grade chondral change shown at the medial femoral condyle and lateral tibial plateau. Treatment at the time was an exercise program and the applicant felt the symptoms settled so that she returned to work without restriction.

78. Dr Drummond noted the history of surgery to the right knee. The applicant reported that she avoided kneeling because of a feeling of stiffness of the right knee.

79. Dr Drummond expressed the opinion:

> "The history of trauma at work on 15 May 2015 is compatible with direct contusion of the left knee producing the MRI changes described with trabecular fractures and extensive marrow oedema.
>
> The symptom episode has been confused by some symptoms due to developing osteoarthritis in the left knee.
>
> It is evident that osteoarthritis has commenced with symptoms in 2012 with articular cartilage changes demonstrated on the MRI and confirmed by the arthroscopy findings with fraying of the articular surfaces and menisci on the colour photographs.
>
> It is reasonable to suggest that the effect of the incident from May 2015 ceased with comfort following arthroscopy and intra-articular injection of hydrocortisone.
>
> The gradual return of pain in the left knee with gym exercises reflects the underlying changes of osteoarthritis and general degenerative changes within the left knee joint.

> The treatment undertaken by Dr Kevin Boundy with prolotherapy and platelet rich plasma is treatment aimed at osteoarthritic change in the knee joint.
> …
> The current symptoms are attributable to the disease process of degeneration, osteoarthritis of the left knee joint."

Applicant's submissions

80. Mr Campbell referred me to the MRI performed following the left knee injury on 29 May 2015. Mr Campbell noted that the applicant was referred to Dr Rizkallah who took a history of direct trauma with a twisting movement to the knee.

81. Dr Rizkallah initially recommended that the applicant wait to see whether her symptoms settled down. When the symptoms did not settle down an x-ray was performed which showed the compression fracture had resolved. Follow-up MRI of the joint showed medial meniscus tear. Dr Rizkallah considered that the tear involving the medial meniscus was consistent with the applicant's work-related injury and significant symptoms. A left knee arthroscopic meniscectomy and debridement were performed. Mr Campbell submitted that that surgery was reasonably necessary as a result of the injury to the left knee on 15 May 2015.

82. Mr Campbell submitted that Dr Boundy had taken a good history and described the mechanism of injury, delving into detail which others had not. Dr Boundy gave the opinion that there was a direct blow to the lateral tibia and a significant strain to the MCL and associated structures in the incident on 15 May 2015.

83. Mr Campbell submitted that there was not just a blow to the tibial portion of the knee but also a twisting injury. The nature of the injury had been misconstrued by Dr Miniter. Mr Campbell noted that Dr Rizkallah had also described a twisting mechanism of injury. Mr Campbell submitted that Dr Boundy's report indicated that the surgery performed by Dr Rizkallah was reasonable. The applicant's symptoms had not settled down by the time of the surgery as predicted by Dr Miniter.

84. Mr Campbell referred me to Dr Conrad's report and noted the opinion expressed in that report was consistent with the treating medical evidence.

85. Mr Campbell noted that Dr Miniter took a history of striking but no twisting. Dr Miniter concentrated on the bone bruising revealed on the initial MRI scan. Dr Miniter considered there was just a bone contusion which would resolve with the passage of time. Dr Miniter did not consider any internal disruption to the knee and did not express support for the arthroscopic surgery, which was then not approved.

86. Mr Campbell noted that Dr Rizkallah's recommendation for surgery was made only after the second MRI was performed. Dr Miniter had recommended against surgery because of his view that there was only a bone bruise which should have resolved. Despite Dr Miniter's views, Mr Campbell submitted that it was reasonably necessary that the surgery be performed on the treating specialist's advice. Dr Miniter did not seem to have considered the full mechanics of the injury. Mr Campbell submitted that I would prefer the opinions given by Dr Boundy who thought the surgery was reasonable at the time, having regard to the actual history of the injury.

87. Mr Campbell submitted that the applicant experienced significant problems after the surgery. The applicant underwent three subsequent surgeries performed by Dr Balalla. Dr Balalla's tibial osteotomy appeared to have improved the applicant's situation, however, during this period the applicant noted the onset of symptoms in her right knee. Mr Campbell referred to the ultrasound of the applicant's right knee performed on 23 November 2016 after she had been seen by Dr Boundy.

88. Mr Campbell noted that the dispute notice issued in February 2017 was issued in reliance on the opinion given by Dr Drummond who said there was no ongoing injury in the left knee but purely degenerative changes. Mr Campbell noted, however, that contrary to Dr Drummond's opinion the applicant's evidence was of continuing pain in her left knee and now right knee. The applicant had significant ongoing disabilities at the left knee causing reliance on the right joint.

89. Dr Conrad had no difficulty accepting a consequential condition in the right knee due to altered gait which was more likely than not related to the left knee injury.

90. Mr Campbell submitted that the applicant had previously undergone surgery to the right knee but was symptom-free until the onset of left knee problems. Mr Campbell submitted that the applicant's right knee may not have been completely structurally sound and she may have been predisposed to the onset of symptomology at the right knee. There was, however, a clear relationship between the onset of symptomology in the right knee in the left knee injury.

Respondent's submissions

91. Mr Barter submitted that the ongoing disabilities and need for medical treatment at the left knee resulted from degenerative changes rather than the injury on 15 May 2015. Mr Barter submitted that the degenerative changes of the left knee were apparent from as early as December 2012, referring me to the MRI performed at that time.

92. Mr Barter noted that it was the applicant's evidence that she played a lot of sport in her youth and damaged her right knee. Mr Barter submitted that if the applicant had played a lot of sport in her youth causing damage to her right knee, it was likely that the applicant also suffered left knee damage.

93. Mr Barter noted that the dispute notices made reference to an initial notice of injury submitted on the applicant's behalf on 19 May 2015 which described injury to the left knee as follows:

> "Leaning into police van to remove dog, pressure on knee. Made crack sound."

94. Mr Barter submitted that this history was more consistent with the history provided to Dr Miniter and Dr Drummond. No twisting injury to the knee was recorded. The first reference to any history of twisting the left knee could be found in Dr Rizkallah's reports.

95. Mr Barter noted that Dr Miniter referred to the MRI images and found significant bruising. Dr Miniter noted the meniscal lesion and said it was constitutional and consistent with the 2012 MRI. Dr Miniter considered the degenerative pathology was separate and distinct from the damage done on 15 May 2015.

96. Mr Barter submitted that it was clear that the problems the applicant experienced from September 2015 onwards were the result of chondral defects and meniscal tears because the fracture was confirmed to have healed. Mr Barter submitted that Dr Miniter was kept well abreast of developments in the applicant's case and found her symptoms consistent with the pathology shown on the 2012 MRI.

97. Mr Barter submitted that Dr Boundy had come to a different conclusion but did not have all of the evidence available to Dr Miniter. Mr Barter noted that Dr Boundy did not take a history of twisting and said it was unclear which MRIs he had. Dr Boundy did not appear to have the 2012 the MRI which recorded a history of a painful left knee giving way. Mr Barter submitted that Dr Boundy had formed a view as to what happened in the mechanism of injury that was not consistent with the history given elsewhere.

98. Mr Barter noted that Dr Miniter had expressed the view that the surgery performed by Dr Rizkallah should not have taken place. The surgery was opposed from the beginning and repeated requests from Dr Rizkallah for approval for surgery were denied. Dr Miniter had expressed the view that the surgery was not to address the pathology from the injury but rather the degenerative changes. Mr Barter submitted that it followed that the effects of that surgery on the applicant's knees did not result from the injury on 15 May 2015.

99. Mr Barter referred me to the authority in *Kooragang Cement Pty Ltd v Bates*[1]. Mr Barter said it had not been established that the complaints of pain in the applicant's right knee resulted from the injury to her left knee in 2015. Mr Barter submitted that there was little to no evidence of any extra loading or strain as a result of the bruising at the tibial plateau. Mr Barter submitted that there was insufficient evidence to say that the condition at the applicant's right knee resulted from the left knee. There was a background of significant structural damage which had been addressed by surgery in the past. The applicant's statement as originally expressed suggested possible further problems in the right knee in the course of her second pregnancy.

100. Mr Barter submitted that pursuant to s 59A a two year time limit on entitlements to medical expenses under s 60 remained in place. The applicant had not received weekly benefits and there was no assessment by an Approved Medical Specialist (AMS) exceeding 10% WPI. As a result, the applicant was precluded by s 59A from claiming expenses beyond 15 May 2017.

Applicant's submissions in reply

101. Mr Campbell noted that the applicant had given evidence of right knee loading in her written statement. The applicant referred to relying heavily on her right knee to get about, leaning on her right leg to get up from a seated position and when picking up items from the floor, going upstairs or steadying herself. The applicant said this occurred almost immediately after the work injury. Mr Campbell said the applicant had described various stresses and strains on her right leg as result of her left knee problems.

102. Mr Campbell noted that Dr Miniter had said there was no doubt that there was an injury to the proximal tibia in May 2015 which had resolved. Mr Campbell said Dr Miniter provided no explanation for why the symptoms had not resolved when the bruising went away. There were no previous symptoms reported in the applicant's left knee apart from a transient problem in 2012 during the applicant's pregnancy until the injurious event. The accident on 15 May 2015 was significant and placed significant stress on the knee joint. Despite the bruising resolving, the applicant experienced ongoing symptoms and it was reasonable for the applicant to accept the offer of surgery provided by Dr Rizkallah.

103. Mr Campbell submitted that there was at least an aggravation of the degenerative changes in the left knee. Mr Campbell submitted that Dr Boundy looked at the matter very carefully and had no problem accepting that the applicant's MCL was traumatised in the accident on 15 May 2015. There was a significant strain to the MCL and associated structures.

104. Mr Campbell conceded that the applicant's entitlement to compensation for treatment after two years including Dr Balalla's surgeries was contingent on an AMS assessment of greater than 10% WPI.

[1] (1994) 10 NSWCCR 796.

FINDINGS AND REASONS

Consequential condition

105. Section 9 of the 1987 Act provides that a worker who has received an "injury" shall receive compensation from the worker's employer. The term "injury" is defined in s 4 of the 1987 Act as follows:

> **"4 Definition of 'injury'**
>
> In this Act:
> **injury:**
>
> (a) means personal injury arising out of or in the course of employment,
>
> (b) includes a disease injury, which means:
>
> (i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and
>
> (ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, and
>
> (c) does not include (except in the case of a worker employed in or about a mine) a dust disease, as defined by the *Workers' Compensation (Dust Diseases) Act 1942*, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined."

106. It has been accepted by the respondent that the applicant sustained an "injury" pursuant to s 4(a) of the 1987 Act to her left knee on 15 May 2015. There is, however, a dispute as to the nature of that injury. It is necessary for me to determine the nature of the injury on 15 May 2015 in order to consider whether there is a condition at the applicant's right knee which results from the injury to the left knee.

107. It is not necessary for the applicant to establish that the condition at her right knee is itself an 'injury' pursuant to s 4 of the 1987 Act. Deputy President Roche in *Moon v Conmah*[2] observed at [45]-[46]:

> "It is therefore not necessary for Mr Moon to establish that he suffered an 'injury' to his left shoulder within the meaning of that term in section 4 of the 1987 Act. All he has to establish is that the symptoms and restrictions in his left shoulder have resulted from his right shoulder injury. Therefore, to the extent that the Arbitrator and Dr Huntsdale approached the matter on the basis that Mr Moon had to establish that he sustained an 'injury' to his left shoulder in the course of his employment with Conmah they asked the wrong question."

108. A common sense evaluation of the causal chain is required. The legal test of causation is that discussed by the Court of Appeal in *Kooragang Cement Pty Ltd v Bates*[3], where Kirby P said (at 461) (Sheller and Powell JJA agreeing):

> "From the earliest days of compensation legislation, it has been recognised that causation is not always direct and immediate…

[2] [2009] NSWWCCPD 134.
[3] (1994) 10 NSWCCR 796 at [810].

> 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."

109. His Honour said 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."

110. There is no dispute that the incident on 15 May 2015 caused the applicant to sustain an injury in the nature of bone contusion or trabecular fractures to the tibial plateau with surrounding bone marrow oedema. Where the parties differ is on the question of whether the incident also caused internal disruption to the knee joint.

111. The medical opinions relied on by the applicant consistently indicate that the injurious event did impact the knee joint. Dr Rizkallah took a history of a direct trauma with twisting movement to the knee. Dr Rizkallah said the applicant had tears involving the medial meniscus which were consistent with the work injury.

112. Dr Boundy described a direct blow as well as the applicant's weight being levered over the edge of the police van, which he considered caused a strain to the medial collateral ligament and associated structures.

113. Dr Jerew did not describe the mechanism of injury in his medical certificate but did describe the injury as involving the fracture as well as symptoms coming from chondral defects and meniscal tears.

114. Dr Balalla described the injury as involving the striking of the knee. By the time Dr Balalla saw the applicant, the fracture and oedema had healed and the applicant had undergone arthroscopy by Dr Rizkallah. Dr Balalla's opinion was that the applicant had premature medial compartment arthritic change due to the previous trauma but also the subsequent meniscectomy by Dr Rizkallah.

115. Dr Conrad described the injury as consisting of a compression fracture as well as meniscal tears and chondral damage to the knee.

116. The medicolegal experts qualified by the respondent both considered that only the bone contusion and fracture and marrow oedema had resulted from the work injury. Dr Miniter took a history of the applicant striking the knee. Whilst Dr Miniter accepted that there was a horizontal tear of the medial meniscus, he described this as a "silent and serendipitous finding" that bore no relationship to the applicant's presentation. Dr Miniter considered the applicant had long-standing osteoarthritic disease in the knee.

117. Dr Drummond described the injury as involving the applicant bumping her left knee on the police van. Dr Drummond considered this trauma to be compatible with contusion producing the fractures and extensive marrow oedema. Dr Drummond considered that this symptom episode had been confused with symptoms due to developing osteoarthritis in the knee which had commenced with symptoms in 2012. Dr Drummond considered the applicant's current symptoms were attributable to the disease process of degeneration.

118. The applicant's own description of the injurious event in her written statement involved twisting and hitting her left knee as she leant into the police vehicle in an attempt to manoeuvre the dog towards the door. In this regard, the applicant's evidence is most akin to the history recorded by Dr Rizkallah around a month after the event. A twisting mechanism was not, however, recorded in the initial notice of injury which described pressure on the knee and a cracking sound.

119. It is not ultimately necessary for me to reach a concluded view as to the precise mechanism of injury. What is necessary to determine is the effect, if any, of the injury on the applicant's knee joint. After considering the medical evidence on both sides, I am satisfied that the injurious event did cause the applicant to experience significant and persisting symptoms in the left knee joint in addition to the bone contusion, fracture and marrow oedema at the tibial plateau.

120. It is clear that the applicant had pre-existing degenerative changes in the left knee joint. This was demonstrated in the 2012 MRI report. The applicant's evidence, however, is that the flare of symptoms in 2012 coincided with weight gain during her pregnancy and later resolved, allowing the applicant to return to full duties at the conclusion of her maternity leave. There is no evidence of the applicant receiving any further treatment of the knee, being referred for investigation, complaining of symptoms or suffering any incapacity at the left knee for more than two years after returning to work.

121. Following the injurious event on 15 May 2015, the applicant experienced an immediate onset of significant pain and swelling. The applicant also described intermittent clicking and catching. The knee symptoms persisted even after the x-ray on 10 July 2015 and MRI on 17 September 2015 showed that the compression fracture or contusion and oedema described in the 29 May 2015 MRI had resolved. Dr Miniter's opinion that this pathology would resolve within two or three months was therefore correct. Dr Miniter has not, however, explained why the applicant continued to experience significant symptoms at the knee after the contusion and oedema had resolved. It is notable that the applicant was not re-examined by Dr Miniter at the time of his second report on 3 November 2015.

122. Dr Drummond recorded that the left knee symptoms the applicant experienced in 2012 settled so that the applicant was able to work without restriction. Dr Drummond then described a gradual return of pain in the left knee with gym exercise which he attributed solely to the degenerative disease process. This explanation for the applicant's presentation is, however, at odds with the history given to Dr Drummond of an immediate onset of intense pain with the injurious event, which persisted after the surgery by Dr Rizkallah.

123. In my assessment, both Dr Miniter's and Dr Drummond's opinions are rendered less persuasive due to their failure to engage sufficiently with the applicant's reported experience of symptoms which was reflected in the contemporaneous medical evidence. For this reason, I prefer the opinions given by the applicant's treating doctors and Dr Conrad as to the nature and effects of the injury on 15 May 2015.

124. It is in this context that the applicant came to the surgery performed by Dr Rizkallah. Dr Rizkallah did not immediately offer the surgery. His initial advice was that the applicant should commence physiotherapy and return for review in four weeks. The surgery was performed only after the MRI on 17 September 2015 revealed a tear at the medial meniscus and the applicant continued to experience significant symptoms causing distress despite the fracture and oedema having healed. The applicant's general practitioner at the time, Dr Jerew, was supportive of the surgery in his certificate dated 22 September 2015.

125. Dr Miniter's opinion that the surgery was contraindicated must be viewed in the context of his particular opinion as to the limited nature of the work injury and his view that the knee joint was not injured or producing any symptoms. Although Dr Miniter also said that the applicant was not a good candidate for arthroscopy for several reasons, those reasons were not articulated.

126. In hindsight, the surgery was not a success and appears to have resulted in an acceleration of the degenerative changes in the knee joint. I accept, however, noting the detailed analysis of Dr Boundy, that the surgery performed by Dr Rizkallah was reasonably necessary at the time it was performed. Dr Boundy has explained that the applicant had been living with severe pain which interrupted her sleep for four months before proceeding to surgery. The surgery was a reasonably accepted form of treatment in orthopaedic circles at the time. The applicant's treating surgeon and general practitioner were both supportive of the procedure. In these circumstances, I accept that it was reasonable for the applicant to accept her doctor's advice despite the insurer's refusal to pay for the surgery.

127. The evidence indicates and I accept that following Dr Rizkallah's surgery the applicant's pain settled temporarily with rest but flared again once the applicant returned to work. Dr Drummond's view that it was "reasonable to suggest that the effect of the incident from May 2015 ceased with comfort following arthroscopy and intra-articular injection of hydrocortisone" is simply not reflected in the evidence from the applicant's treating doctors. The applicant's symptoms appear to have persisted and deteriorated, despite Dr Boundy's treatment, until she came to further surgery by Dr Balalla in August 2017 and early 2018.

128. Although I accept Dr Drummond's observation that the treatment offered by Dr Boundy and Dr Balalla was aimed at osteoarthritic change in the knee joint, I find that the treatment was reasonably necessary as a result of the injury on 15 May 2015. I accept Dr Balalla's and Dr Conrad's opinions that the osteoarthritic changes were aggravated and accelerated by both the injurious event on 15 May 2015 and the surgery performed by Dr Rizkallah which followed.

129. Having made these findings as to the nature and effects of the injury to the applicant's left knee, it is necessary to consider whether there is a condition at the applicant's right knee which results from the left knee injury.

130. It is undisputed that there was significant pre-existing pathology at the applicant's right knee, which had been treated with multiple surgeries, the last of which was performed when the applicant was approximately 26 years of age.

131. There is, however, nothing in the material to cause me to doubt the applicant's evidence that she did not have any real difficulties with the right knee from that time until the work injury to her left knee. The applicant passed a physical examination before commencing employment with the respondent in 2004 and performed her duties without difficulty until the work injury. There is no evidence of any further complaint, investigation or treatment of the right knee until after the injury to the left knee. In his first report, Dr Miniter took a history that the right knee was stable following the earlier surgeries and had full range of movement although the applicant did experience some discomfort with extended exercise.

132. The applicant has given evidence that almost immediately after the left knee injury she began to rely on her right knee to get about. The applicant would lean on her right leg to get up from a seated position, pick up items off the floor and go upstairs and generally relied on it to steady herself. The applicant's evidence is consistent with the evidence of ongoing significant symptoms at the left knee, causally related to the work injury, apart from brief periods whilst the applicant rested after Dr Rizkallah's surgery and following an injection of cortisone.

133. Dr Rizkallah recorded that the applicant had an "obvious limp" in his report dated 15 June 2015. In October 2016, Dr Boundy reported that the applicant's right knee was at that stage "fine". The applicant had no pain, full range of movement and the knee was ligamentously stable although Clarke's test for patellofemoral irritation was strongly positive. In November 2016, the applicant was referred for an ultrasound of the right knee. In January 2017, the applicant told Dr Drummond that she avoided kneeling because of a feeling of stiffness at the right knee. In August 2017, Dr Balalla reported that the applicant had an antalgic gait, limited range of movement and was in severe pain at her left knee. By the time of Dr Conrad's examination in October 2018, the applicant had pain and stiffness at the right knee. An MRI performed in June 2019 revealed significant degenerative pathology although the ACL reparative graft remained intact.

134. Dr Conrad has given the opinion, consistent with the applicant's evidence and the contemporaneous medical evidence that due to irregular gait, she had "reinjured" her right knee.

135. Dr Miniter, on the other hand, has expressed the view that the osteoarthritic disease of the right knee was not the result of the left knee, commenting that medial compartment osteoarthritic disease was very common in women of the applicant's age group who were overweight. Dr Miniter has not, however, considered whether the disease was rendered symptomatic or at least whether the applicant's symptoms at the right knee may have been rendered more intense because of the antalgic gait and reliance on the right leg to protect her injured left knee. In the absence of any express consideration of these questions by Dr Miniter, I prefer the opinion of Dr Conrad.

136. I am satisfied that the applicant has a consequential condition affecting her right knee as a result of the injury to her left knee on 15 May 2015.

137. In view of these findings, and on the evidence before me, I consider it appropriate to remit the matter to the Registrar for referral to an AMS to assess the degree of permanent impairment at the left lower extremity (knee) and right lower extremity (knee) as a result of the injury on 15 May 2015.

138. The materials to be referred to the AMS will include the ARD and all attachments, the Reply and all attachments and this Certificate of Determination and Statement of Reasons.

139. In view of the protocols currently in place in response to the COVID-19 pandemic, the referral should be placed on the Medical Assessment Pending List as a physical examination will be required.

140. It is not appropriate to make any orders dealing with the claim for s 60 expenses at this time as the extent of the applicant's entitlement to compensation pursuant to s 59A, will be determined by the AMS assessment of the degree of permanent impairment. The matter will be listed for further teleconference to deal with that part of the claim upon receipt of the Medical Assessment Certificate unless the parties file consent orders in the intervening period.

SUMMARY

141. The Commission determines:

    (a) The applicant has a consequential condition affecting her right knee as a result of the injury to her left knee on 15 May 2015.

142. The Commission orders:

    (a) The matter is remitted to the Registrar for referral to an AMS for assessment as follows:

Date of injury:	15 May 2015
Body parts:	Left lower extremity (knee) Right lower extremity (knee) (consequential)
Method:	Whole Person Impairment.

    (b) The materials to be referred to the AMS are to include the ARD and all attachments; the Reply and all attachments; and this Certificate of Determination and accompanying Statement of Reasons.

    (c) The referral is to be placed on the Medical Assessment Pending List.

    (d) The matter to be listed for further teleconference upon receipt of the Medical Assessment Certificate.