WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

MATTER NO:	**6665/19**
APPLICANT:	**Michael Varcoe**
RESPONDENT:	**Macquarie Manufacturing Pty Ltd**
DATE OF DETERMINATION:	**24 February 2020**
CITATION:	**[2020] NSWWCC 51**

The Commission determines:

1. The applicant sustained an injury to his right ankle arising out of or in the course of his employment on 8 April 2008.

2. The applicant developed a consequential condition in his lumbar spine as a result of the injury sustained to his right ankle on 8 April 2008.

The Commission orders:

3. I remit this matter to the Registrar for referral to an Approved Medical Specialist pursuant to section 321 of the *Workplace Injury Management and Workers Compensation Act 1998* for assessment of the whole person impairment of the applicant's right lower extremity (ankle), scarring (TEMSKI) and lumbar spine due to injury sustained on 8 April 2008.

4. The documents to be reviewed by the Approved Medical Specialist are:

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

    (b) Reply and attached documents, excluding the report of Dr Bosanquet dated 8 September 2015, and

    (c) Application to Admit Late Documents received on 10 January 2020.

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

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 GLENN CAPEL, SENIOR ARBITRATOR, WORKERS COMPENSATION COMMISSION.

Ann Macleod
Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Michael Varcoe (the applicant) is 40 years old and was employed by Macquarie Manufacturing Pty Ltd (the respondent) as a boilermaker.

2. There is no dispute that the applicant injured his right ankle on 8 April 2008. Liability was accepted by Employers Mutual Ltd (the insurer) and payments of compensation were made for a number of hours that the applicant took off work between 18 April 2008 and 1 May 2008, when he was cleared to return to his pre-injury duties.

3. The applicant or his treating doctor sought approval for ankle surgery in 2010. On 27 October 2010, the insurer issued a notice pursuant to s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) disputing that it was liable for the payment of weekly compensation and medical expenses because he had recovered from his injury.

4. It seems that the applicant made a claim for weekly compensation, medical expenses and lump sum compensation in 2015 based on a report of Dr Bentivoglio dated 24 June 2015. The notice of claim and the report of Dr Bentivoglio are not in evidence.

5. The insurer determined the claim and issued a further notice on 13 November 2015, disputing that the need for the surgery, his impairment and his subsequent incapacity was caused or contributed to by the work injury on 8 April 2008. It cited ss 9, 9A, 33, 60 and s 66 of the *Workers Compensation Act 1987* (the 1987 Act).

6. On 30 July 2018, the applicant's solicitor served a notice of claim on the insurer with respect to weekly compensation, medical expenses and lump sum compensation pursuant to s 66 of the 1987 Act.

7. On 22 October 2018, the insurer issued a notice pursuant to s 74 of the 1998 Act, disputing that the applicant had suffered a consequential condition in his lumbar spine as a result of the incident on 8 April 2008. It alleged that the applicant had recovered from the effects of his right ankle injury and denied that he was entitled to receive weekly compensation or the payment of medical expenses. Finally, it disputed that the applicant had a work-related permanent impairment. It cited ss 33, 60 and 66 of the 1987 Act.

8. By an Application to Resolve a Dispute (the Application) registered in the Commission on 17 December 2019, and amended at the arbitration hearing, the applicant claims lump sum compensation in respect of his right lower extremity (ankle), scarring (TEMSKI) and a consequential condition in his lumbar spine due to injury sustained on 8 April 2008.

PROCEDURE BEFORE THE COMMISSION

9. 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.

ISSUES FOR DETERMINATION

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

    (a) whether the need for surgery on the applicant's right ankle resulted from his accepted right ankle injury on 8 April 2008;
    (b) whether the applicant developed a consequential condition in his lumbar spine as a result of the injury sustained to his right ankle on 8 April 2008, and

    (c) quantification of the applicant's entitlement to lump sum compensation – s 66 of the1987 Act.

11. The parties agreed that the applicant's claim should be referred to an Approved Medical Specialist (AMS), irrespective of the outcome 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) Application and attached documents;

    (b) Reply and attached documents, excluding the report of Dr Bosanquet dated 8 September 2015, and

    (c) Application to Admit Late Documents received on 10 January 2020.

Oral evidence

13. Neither party sought leave to adduce oral evidence or cross examine any witnesses.

REVIEW OF EVIDENCE

Applicant's statements

14. The applicant provided a statement on 19 July 2019. He indicated that he suffered an injury to his right ankle in March 1988. He was admitted to Tamworth Base Hospital where he remained in hospital for 10 days. He stated that he had not suffered any pain and restriction following this injury and had been able to play sport. He had worked in an abattoir and as a boilermaker after he left high school. He commenced employment with the respondent as a welder in 2005 or 2006.

15. The applicant stated that on 8 April 2008, as he was stepping off a trailer, he fell and landed on a nut or bolt. His right ankle rolled sharply inwards and he experienced severe pain. He saw a doctor, but he did not take any time off work. He saw Dr Warner and Dr Graham, and he had x-rays and physiotherapy.

16. The applicant stated that he was certified fit to return to work on or around 22 May 2008, but he continued to experience ankle pain when he walked or stood up for long periods of time. He was worried about losing his job, so he returned to work despite his pain.

17. The applicant stated that he had further diagnostic tests in late 2009. He consulted Dr Nicholson, who referred him for an MRI scan and recommended an ankle arthroscopy. The procedure was not undertaken as the insurer denied liability. He ceased work with the respondent on or around 19 May 2011.

18. The applicant stated that he commenced employment as a welder with Bosmac Pty Ltd around 19 May 2011. He experienced increasing pain in his right ankle, and he sought treatment from his general practitioner between 2011 and 2013 almost monthly. He had difficulty walking and standing due to his pain. He was prescribed pain medication and he was referred to Dr Wines. On 22 August 2013, Dr Scally provided him with a Centrelink certificate of unfitness, and he ceased working. On 2 September 2013, Dr Wines performed a right ankle fusion at Dubbo Base Hospital.

19. The applicant stated that he was off work from 9 August 2013 to 28 February 2014. His right ankle was in a cast for three months and his employer would not allow him to return to work until he was fit for his pre-injury duties which were physically demanding. He had difficulty walking due to a restricted range of movement in the ankle and he walked with a limp. He was eventually cleared to return to work by Dr Scally on 19 February 2014. He ceased employment with Bosmac on 6 July 2014 because of the physical demands of his position as a welder.

20. The applicant stated that he commenced employment with SCT Logistics as a casual forklift driver on 7 July 2014 and he became a permanent part-time employee working 20 hours per week on 3 August 2015.

21. The applicant stated that he is working for less hours, but he finds the work as a forklift driver to be more manageable than welding. He walks with a limp and due to his altered gait, he has sought treatment from a chiropractor for his spine. He also relies heavily on pain relieving medication. He has restricted movement in his ankle, which places strain on his knees and hips. He also experiences pain and restriction of movement in his lower back.

22. The applicant stated that he is no longer able to perform any heavy lifting and he relies on other people at work to assist him with heavy lifting. He cannot stand for long periods due to the pain in his back and right ankle. He has difficulty with squatting, kneeling, walking up and down stairs, climbing and standing on ladders, heavy lifting, pushing and pulling activities, mowing, gardening and household maintenance.

Clinical notes of Tamworth Base Hospital

23. The notes of Tamworth Base Hospital show that the applicant was admitted to the hospital on 6 March 1988 and he was discharged on 16 March 1988. He was diagnosed with septic arthritis and was treated with antibiotics.

Diagnostic tests of the right ankle and lumbar spine

24. An x-ray of the right ankle dated 14 April 2008 showed no evidence of a bony injury.

25. An x-ray dated 30 October 2009 showed an irregularity in the talar dome which was consistent with a talar dome impression fracture and degenerative joint disease with degenerative cyst formation.

26. A CT scan dated 9 December 2009 showed an osteochondral talar dome injury with secondary osteoarthritis.

27. An MRI scan dated 29 December 2009 showed a large osteochondral lesion of the talar dome with extensive adjacent bone marrow oedema and degenerative ankle changes.

28. X-rays of the applicant's back and pelvis on 23 June 2011 and 19 November 2012 showed scoliosis and anterolisthesis of L5 on S1 and bilateral pars defect at L5.

29. An x-ray of the right ankle dated 6 August 2012 showed prominent osteoarthritis and articular cartilage loss, but there was no evidence of a bony defect or any loose bodies. A CT scan taken on the same date revealed similar pathology. There were small osteophytes and degenerate subchondral cysts, but there was no osteochondral defect or loose bodies.

30. A CT scan 1 July 2013 showed marked joint space narrowing, articular bony sclerosis and pseudo cyst formation. The radiologist was unsure whether this related to the previous osteomyelitis or an injury.

31. An ultrasound and x-rays taken on 8 January 2014 showed some fluid in the soft tissues anterior to the lateral malleolus, but there was no evidence of any tendon or ligamentous damage.

32. An ultrasound and x-rays taken on 15 September 2014 showed the fusion, but there was no other abnormality in the ankle.

33. X-rays taken on 17 May 2017 and 24 July 2017 confirmed the ankle joint fusion. There was no evidence of any acute bone or joint abnormality.

Clinical notes and reports of Dr Graham and Dr Scally

34. Dr Graham reported on 11 September 2009, 26 February 2010 and 27 April 2010. He noted that he initially saw the applicant on 18 April 2008 and by 22 May 2008, his ankle injury had settled. However, about one month later, the applicant's pain recurred and slowly increased over the next few months. He diagnosed a large lateral osteochondral lesion and noted that the applicant was waiting to undergo surgery. He stated that based on the history, the applicant's current condition appeared to be related to his work injury.

35. The handwritten notes of Dr Graham commence on 9 January 2008 and conclude on 4 November 2009. Unfortunately, the handwriting is illegible, so the notes are difficult to decipher and are of no assistance.

36. In a report dated 2 May 2008, a physiotherapist, Karen Burns, advised that the applicant attended on 21 April 2008 following an inversion injury to his right ankle at work two weeks earlier. He attended on three occasions for treatment and he made a good recovery. He had returned to his full duties with no problems.

37. The applicant was certified fit for suitable duties by Drs Warner and Graham from 18 April 2008 to 30 April 2008, when he was cleared to return to his pre-injury duties.

38. On 28 October 2009, Dr Graham noted that the applicant had suffered an exacerbation of his original right ankle injury and he certified him fit for suitable duties from 28 October 2009 to 12 November 2010.

Clinical notes of Parkes Chiropractic Centre

39. The clinical notes of Parkes Chiropractic Centre commence on 23 June 2011. These are difficult to read, but it seems that the applicant had treatment for L5/S1 spondylolisthesis on a regular basis until 7 June 2013. It appears that he had further treatment on his lower back on 18 December 2015 following a flare up that morning.

40. The applicant had x-rays of his back and pelvis on 23 June 2011 and 19 November 2012. These showed scoliosis and anterolisthesis of L5 on S1 and bilateral pars defect at L5.

Clinical notes and reports of Dr Scally

41. Dr Scally reported on 17 June 2015. He advised that he first saw the applicant on 22 August 2013. He provided the applicant with a Centrelink medical certificate in respect of his right ankle condition. He noted that the applicant had a fusion to address severe osteoarthritis as a result of a work injury in 2008 when he rolled his right ankle. This was on a background of having osteomyelitis when he was eight years old. He noted that the applicant's symptoms had relapsed and had persisted.

42. Dr Scally diagnosed osteoarthritis in the applicant's right ankle which required a fusion. The doctor considered that it was likely that the work injury in 2008 contributed to the ankle degeneration to a degree and there appeared to be a definitive temporal relationship between the applicant's ankle symptoms and the 2008 injury, as the applicant denied that he had experienced any ankle pain or dysfunction prior to the work injury.

43. Dr Scally reported that the applicant had been employed on a casual basis with SCT Logistics since July 2014 and he was fit for his full duties in that employment. He stated that the applicant should not work for more than 40 hours per week or in occupations that involved prolonged standing or walking. The doctor stated that the recent onset of right knee pain was likely secondary or compensatory to his right ankle condition and fusion.

44. In his report dated 23 March 2017, Dr Scally indicated that the applicant had suffered a precipitation and ongoing aggravation of mechanical low back and lumbar spine pain since his right ankle injury in 2008 as a result of transference of biomechanical strain to his lumbar spine caused by the reduced range of motion of the applicant's right ankle, particularly since the fusion. He had been treated with chiropractic and massage therapy, as well as acupuncture.

45. The clinical notes of Dr Scally commence on 22 August 2013 and conclude on 9 September 2015. The consultations largely concerned the pre and post-surgery condition of the applicant's right ankle. There were complaints of right ankle pain throughout 2014 and in early 2015.

46. At the consultation on 8 May 2015, the doctor recorded that the applicant had injured his left ankle at work on 4 May 2015. The applicant complained about his left ankle at subsequent consultations and there was no mention of any right ankle symptoms until 13 August 2015.

47. A physiotherapist Jeff McClurg reported on 23 December 2013. He noted that the applicant had been attending for treatment following the right ankle fusion. The applicant complained of pain extending from the lateral side of the ankle over the dorsum to the great right toe, which Mr McClurg considered was consistent with lateral impingement caused by the aversion of the calcaneus. This had resulted in a limp.

Reports of Dr Nicholson

48. Dr Nicholson, a specialist foot and ankle orthopaedic surgeon, reported on 9 December 2009 and 10 February 2010. He reported that the applicant had suffered an inversion injury to his right ankle in 2008 which was initially diagnosed as a mild sprain. He was treated by a physiotherapist and wore an ankle brace. He had significant pain in his right ankle which was brought on by weight bearing.

49. Dr Nicholson referred the applicant for an MRI scan and the doctor reported that this showed a large lateral osteochondral defect on the talus. He recommended an arthroscopic debridement of the osteochondral lesion to allow the bone and fibro cartilage to regenerate over the lesion.

50. In a report to the insurer dated 10 February 2010, Dr Nicholson stated that the applicant had informed him that he had no problems with his right ankle prior to his work injury. His ankle pain did not resolve and had worsened.

51. Dr Nicholson advised that a talar dome injury could be asymptomatic or relatively asymptomatic for a period of time, and it can progress and increase in size with time. He explained that an osteochondral injury was a differential diagnosis for ongoing pain following what was initially diagnosed as an ankle sprain. He noted that the x-ray report dated 30 October 2009 showed an irregularity of the articular surface of the talar dome.

52. Dr Nicholson stated that the MRI and CT scans did not show significant degeneration of the ankle, but secondary degeneration related to the osteochondral lesion, which was consistent with an osteochondral injury. The proposed arthroscopic procedure was considered to be the most successful method of relieving symptoms.

53. Finally, in his two reports dated 25 May 2010, Dr Nicholson took issue with the opinion of Dr Smith. He noted that the applicant was completely asymptomatic until his ankle injury in April 2008. He explained that the applicant had a history of a right ankle infection as a child, but this was managed surgically and resolved completely. He did not require an extended course of antibiotic therapy and he had no further problems until his work injury and this was entirely consistent with the radiological findings.

54. Dr Nicholson agreed that the MRI scan showed degenerative changes in the ankle mortice, but it also showed a large isolated osteochondral lesion of the talar dome with extensive adjacent bone marrow oedema indicating a relatively acute process.

55. Dr Nicholson conceded that he had not viewed the x-rays that were taken on 14 August 2008, but noted that these were reported to show no evidence of any bony injuries. The doctor observed that Dr Smith felt that the cystic changes in the talus and distal tibia pre-dated 2008, but if this was the case, he would have expected that they would have been reported on in the initial x-rays.

56. Dr Nicholson noted that the applicant was still troubled by ankle pain and that he had not recovered from his work injury. He stated that even if there were pre-existing radiological features as a result of the childhood surgery, the applicant was able to function and work in complete comfort until his work injury. He concluded that the applicant's current condition was related to his injury on 8 April 2008, and this was entirely consistent with the clinical and radiological findings.

Clinical notes of Dubbo Base Hospital

57. The clinical notes of Dubbo Base Hospital confirm that the applicant was admitted for a right ankle arthrodesis which was performed by Dr Wines on 2 September 2013. He was discharged the following day.

Clinical notes of Dr Wines

58. The clinical notes of Dr Wines consist of a series of reports from 29 September 2015 to 1 August 2017. They only deal with the applicant's left ankle injury and surgery. The only reference to the applicant's right ankle was in the report dated 9 May 2017, when the applicant complained of right sided aching and occasional sharp pain. The applicant stated that his symptoms fluctuated and tended to be exacerbated by prolonged weight bearing activity. The doctor reported that the applicant had an antalgic gait.

59. In his report dated 1 August 2017, Dr Wines noted that the applicant mild subtalar pain in his right hindfoot and he only had a barely perceptible limp. There was mild irritability in the subtalar joint and the doctor stated that the applicant's pain was secondary to his right subtalar osteoarthritis.

Reports of Dr Patrick

60. Dr Patrick reported on 11 January 2018. He recorded that the applicant suffered injury when he landed heavily and awkwardly on his right ankle which rolled right over. He sought treatment and had minimal time off work and he performed light duties for nearly two months. The doctor noted that the applicant had ongoing right ankle pain and this deteriorated. In 2009, he consulted Dr Graham for treatment of his continuous right ankle pain. He ceased work with the respondent, and he obtained work elsewhere.

61. Dr Patrick reported that the applicant was referred to Dr Nicholson in 2010. He ceased work with the respondent, and he obtained employment with Bosmac where he remained for two to three years. The applicant had increasing difficulty carrying out underground work in the mines and he was reliant on pain killers. He eventually had a right ankle joint fusion by Dr Wines. He was off work for six months and then secured employment with SCT Logistics.

62. Dr Patrick noted that the applicant suffered a prior injury to his right ankle when he was eight years old. A precautionary plaster was applied at Tamworth Base Hospital and the ankle was incised and drained due to septic arthritis and/or osteomyelitis. The applicant was treated with antibiotics and he recovered from this injury. He actively participated in sports and he had not experienced any issues prior to the work incident.

63. Dr Patrick also recorded a history of low back pain in 2000. He had a CT scan on 7 July 2000 which showed spondylolisthesis due to bilateral pars defects, but there was no evidence of a protrusion. His back symptoms settled, and he had no problems until after the work injury and ankle surgery. The doctor commented that “it appears likely that his recurrence of significant lumbar spinal symptoms is as a consequence of altered gait over a considerable period of time, subsequent to his work injury of 8 April 2008”.

64. Dr Patrick noted that the applicant injured an inversion injury to his left ankle in early May 2015. He had an ultrasound on 17 June 2015, followed by an MRI scan and injection.

65. The applicant complained of pain over the whole of the right ankle, and there had been improvement in the pain levels subsequent to the fusion. He could not squat as before and he continued to take analgesic medication unlike the strong opioids of Endone and Tramadol that he took before and after the fusion.

66. Dr Patrick reported that the applicant was currently working part-time for three nights a week as a forklift driver. He experienced some right knee discomfort from time to time, but there had been a significant recurrence of low back pain which was present prior to his left ankle injury. The applicant attributed this to his altered gait since the work injury. The doctor observed a minimally antalgic gait on examination.

67. Dr Patrick stated that the workplace injury rendered the applicant’s right ankle markedly symptomatic and on balance of probabilities, the need for the right ankle fusion performed by Dr Wines on 2 September 2013 was a direct consequence of the workplace injury on 8 April 2008, with a possible contribution of one fifth caused by his childhood right ankle problem. His employment was a substantial contributing factor to his injury.

68. Dr Patrick noted that an x-ray taken after the 2008 incident showed no evidence of a bony injury and he expected that the radiologist would have commented if there was any other major pathology. The doctor rejected the views of Dr Smith, who was qualified by the insurer.

69. Dr Patrick considered that the applicant’s lumbar spinal condition represented a significant flare-up of the pre-existing spondylolisthesis which had been dormant for many years, and his limping was putting undue strain onto his low back since his work injury on 8 April 2008.

70. Dr Patrick stated that the applicant was unfit for his pre-injury duties as a boilermaker and he had a permanent partial work incapacity, such that he was unable to carry out physical work involving prolonged standing, significant squatting and kneeling, stairs or ladder work, and heavy lifting and carrying due to his low back and right ankle conditions.

71. Dr Patrick assessed 4% whole person impairment of the lumbar spine, 15% whole person impairment of the right lower extremity (ankle) and 1% whole person impairment for scarring (TEMSKI), for a total of 19% whole person impairment, due to injury sustained on 8 April 2008.

Application for employment with Bosmac Pty Ltd

72. In his application for employment with Bosmac Pty Ltd, the applicant admitted that he had suffered previous problems with his right ankle as a child, but he did not disclose the injury that he sustained to his right ankle in April 2008.

Report of Dr Kafataris

73. Dr Kafataris provided a file review report on 17 February 2010. Noting that the applicant was able to return to his pre-injury duties six weeks after sustaining a relatively minor ankle injury and was able to continue working for nearly 18 months, he questioned how the need for surgery related to his work injury. The doctor noted the diagnostic findings and he thought that it was more likely that the significant degeneration and osteochondral lesion had developed over a period of years. He stated that the appearances in original x-rays taken shortly after the incident would be a critical factor.

Reports of Dr Smith

74. Dr Smith reported on 18 March 2010 and 5 May 2010. He recorded details of the applicant's ankle injury and noted that he returned to work on light duties for less than a month before he resumed his normal work. The applicant told the doctor that between 22 May 2008 and 28 October 2009 he was not too bad and only had some niggling discomfort. His symptoms then increased in severity, so he returned to see Dr Graham. He had subsequently developed constant pain in his ankle. The applicant indicated that when he was eight years old, he had surgery to drain some pus from his ankle and it then became asymptomatic.

75. Dr Smith noted that the x-rays dated 14 August 2008 were reported to show no bony injury, whilst a CT and x-rays taken on 9 December 2009 revealed gross arthritic changes, an irregular surface of the talar dome and cystic changes on the talar side. Similar changes were shown in an MRI scan dated 29 December 2009.

76. Dr Smith stated that it was impossible for the applicant to have developed the marked arthritic changes in the right ankle as a result of the accident 8 April 2008, because he had only suffered an inversion sprain. He considered that the arthritis was a consequence of septic arthritis that he suffered as a child. The cystic changes were also longstanding and pre-dated the work incident. The doctor stated that the applicant would be better served if he had an arthrodesis to address the longstanding changes resulting from his septic arthritis, but this was not related to his work injury.

77. Dr Smith stated that the applicant had recovered from his ankle sprain and his employment was not a substantial contributing factor to his current condition. He stated that he was fit for work.

78. Dr Smith agreed that the applicant did not have any symptoms from his arthritic ankle prior to the incident in April 2008, but then stated that “because of the underlying arthritic change that long pre-dates 2008 the exacerbation hasn't resolved”. He stated that the changes pre-dated the incident and the comment in the x-ray report dated 14 August 2008 that there was “no bony injury” did not exclude the presence of arthritic changes in the actual x-rays which were not available for review.

79. In his report dated 8 June 2010, Dr Smith advised that he had seen a CD of an x-ray which demonstrated osteoarthritis of the ankle and no bony injury. He advised that arthritis was readily apparent. He considered that the arthritic changes were due to the previous infective illness. The doctor believed that this arthritic condition was aggravated on 8 April 2008, but the applicant had recovered, and he did not have any symptoms again until around October 2009.

80. In his final report dated 14 September 2018, Dr Smith noted that since his previous examination, the applicant had undergone surgery on his right ankle, and he was working as a forklift driver. The doctor referred to the various diagnostic tests and the reports of a number of doctors, including those of Dr Patrick. The applicant told the doctor that he had experienced low back pain since 2009 from time to time and he had seen a chiropractor on a regular basis, but over the last several years, he had not had any treatment and had put up with his pain.

81. Dr Smith diagnosed constitutional spondylolisthesis at L5-S1 as well as degenerative disease. He believed that the infection in the right ankle and surgery when the applicant was eight years old led to the development of osteoarthritis in his right ankle and this condition would have eventually become symptomatic. The condition had worsened, and he had surgery.

82. Dr Smith considered that the applicant suffered an aggravation of the arthritis in the incident at work on 8 April 2008, but this aggravation had resolved after a day or two, a week or two to three months at the very most. He stated that once the condition was rendered symptomatic, the applicant would continue to have aggravations from time to time with a variety of different activities. He stated that if the applicant did not have the osteoarthritis of the right ankle, then the work injury on 8 April 2008 would not have caused any problems.

83. Dr Smith stated that there was no relationship between the right ankle osteoarthritis and treatment and the lumbar degenerative disease and the spondylolisthesis at L5-S1. There was also no relationship between his right ankle osteoarthritis and his back condition because lumbar degenerative disease affected 100% of the population and becomes symptomatic in 100% of the population with the passage of time. There was no relationship between the applicant’s gait and his low back pain. The incidence of low back pain was 100% of the population who limp for whatever reason, and 100% of the population who did not limp.

84. Dr Smith stated that the applicant was fit for fulltime work, including his pre-injury duties as a boilermaker, but he would have difficulty working on uneven ground and should avoid excessively heavy and repetitive bending and lifting activities. He assessed 15% whole person impairment, but this was due to any work injury.

APPLICANT'S SUBMISSIONS

85. The applicant's counsel, Mr Barter, submits that in his statement, the applicant described his past ankle problem, but he recovered, and it had not interfered with his activities or ability to work. He ceased work with the respondent in May 2011, but he continued to have on-going problems. He eventually stopped work due to right ankle pain in August 2013. There was no history of any aggravating injury before he had the fusion on 2 September 2013.

86. Mr Barter submits that the applicant indicated that he continually walked with a limp and he experienced low back pain. He required chiropractic treatment and medication.

87. Mr Barter submits that Dr Nicholson took issue with the opinion of Dr Smith and identified a flaw in his reasoning. The evidence of Drs Nicholson, Wines and Patrick should be preferred to that of Dr Smith. The applicant provided a consistent history and common-sense dictated that the need for surgery resulted from the ankle injury sustained on 8 April 2008. Further, the antalgic gait led to the onset of low back symptoms according to Drs Scally and Patrick.

88. In reply, Mr Barter submits that Dr Wines operated on the applicant's right ankle. This was recommended and considered appropriate by Dr Nicholson. According to Dr Nicholson, the need for surgery was due to the injury sustained on 8 April 2008. Dr Scally confirmed that the applicant had a reduced range of back movement, especially since his right ankle surgery suggesting a causal connection.

RESPONDENT'S SUBMISSIONS

89. The respondent's counsel, Mr Halligan, submits that the applicant was able to obtain employment with Bosmac Pty Ltd in 2011 and in his application for employment, he only identified a prior condition of a build-up of fluid in his right ankle when he was a child. Therefore, this was uppermost in the applicant's mind.

90. Mr Halligan submits that there was only a record of osteoarthritis and there was no mention of the work incident when the applicant was admitted to Dubbo Base Hospital for surgery in September 2013. There was no medical evidence from Dr Wines regarding the applicant's right ankle and the relevance of the 1988 injury.

91. Mr Halligan submits that Dr Wines' reports concentrated on the applicant's left ankle injury in 2015. The reports show that the applicant had pain and swelling in his left ankle and he had surgery. If the applicant had consequential back pain, there was no reason why it only related to his right ankle, given the difficulties that he had experienced in his left ankle since 2015. This was not addressed by Dr Patrick.

92. Mr Halligan submits that the evidence of Dr Patrick suggests that the applicant's complaints result from the antalgic gait rather than the defect. Dr Scally indicated that the 2008 injury likely contributed to the applicant's ankle condition.

93. Mr Halligan submits that Dr Patrick referred to the ultrasound taken in 2015, but he gave no details of the aftermath and the attendance of Dr Wines. The applicant had a history of low back pain and there was sufficient pathology to cause symptoms.

94. Mr Halligan submits that there is no evidence from Dr Wines regarding the applicant's right ankle and the need for surgery, which was not paid for by the insurer. There was a natural progression following the aggravation and the applicant was certified for his pre-injury duties in April 2008.

95. Mr Halligan submits that the applicant ceased work with the respondent in 2011, and immediately found employment. According to Dr Wines, the applicant had problems with his left ankle, so the low back symptoms may have resulted from the injuries to each ankle.

REASONS

Did the need for surgery on the applicant's right ankle result from the injury sustained on 8 April 2008?

96. Whether the need for reasonably necessary treatment resulted from an injury is a question of causation and must be determined based on the facts in each case. The accepted view regarding causation was discussed in *Kooragang Cement Pty Ltd v Bates*[1] where Kirby J stated:

> "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."[2]

97. It is accepted that a condition can have multiple causes, but the applicant must establish that the injury materially contributed to the need for surgery. This was confirmed by Deputy President Roche in *Murphy v Allity Management Services Pty Ltd*[3], where he stated:

> "Moreover, even if the fall at Coles contributed to the need for surgery, that would not necessarily defeat Ms Murphy's claim. That is because a condition can have multiple causes (*Migge v Wormald Bros Industries Ltd* (1973) 47 ALJR 236; *Pyrmont Publishing Co Pty Ltd v Peters* (1972) 46 WCR 27; *Cluff v Dorahy Bros (Wholesale) Pty Ltd* (1979) 53 WCR 167; *ACQ Pty Ltd v Cook* [2009] HCA 28 at [25] and [27]; [2009] HCA 28; 237 CLR 656). The work injury does not have to be the only, or even a substantial, cause of the need for the relevant treatment before the cost of that treatment is recoverable under s 60 of the 1987 Act.
>
> Ms Murphy only has to establish, applying the commonsense test of causation (*Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796), that the treatment is reasonably necessary 'as a result of' the injury (see *Taxis Combined Services (Victoria) Pty Ltd v Schokman* [2014] NSWWCCPD 18 at [40] – [55]). That is, she has to establish that the injury materially contributed to the need for the surgery (see the discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716)."[4]

98. According to the applicant, he recovered from the injury that he sustained to his right ankle in 1988 and he had no problems until his injury on 8 April 2008. It is true that he had minimal time off work and he did not seek treatment after the incident, but the applicant indicated in his statement that he had continued to experience ankle pain when he walked or stood up for long periods. He had concerns about job security, and he remained at work despite his pain. This evidence has not been challenged.

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[1] (1994) 35 NSWLR 452; 10 NSWCCR 796 (*Kooragang*).
[2] *Kooragang* [463].
[3] [2015] NSWWCCPD 49 (*Murphy*).
[4] *Murphy*, [57] to [58].

99. The need for surgery was first identified in 2009 when the applicant was still working for the respondent. The insurer declined to pay for an arthroscopy at that stage. Whilst the applicant was working for Bosmac Pty Ltd, he experienced increasing pain in his right ankle. There is no evidence to suggest that the applicant suffered a subsequent injury to his right ankle at this employer or elsewhere. Eventually he had a fusion on 2 September 2013.

100. There is no dispute that the applicant suffered an injury and had an infection in his ankle in 1988, but there is no medical evidence to suggest that the applicant had any problems before the work incident. The x-ray report dated 14 April 2008 only referred to the absence of a bony injury, whilst the x-ray dated 30 October 2009 showed the talar dome irregularity and degenerative changes.

101. According to Dr Graham, the applicant had a large lateral osteochondral lesion which he attributed to the applicant's work injury. Although he cleared the applicant to return to his pre-injury duties in April 2008, he reported that the applicant's pain recurred and slowly increased over the following months. This is not consistent with the assertion by Dr Smith that the applicant had recovered from his work injury.

102. Whilst Dr Graham noted that the applicant had suffered an exacerbation of his original right ankle injury in late 2009, the evidence does not suggest that the applicant had completely recovered from the effects of his work injury, even allowing for the fact that he was certified fit for work. Therefore, whilst Dr Graham did not comment on the need for surgery, he stated that there was a causal connection between the work incident and the applicant's ankle condition.

103. Dr Scally saw the applicant shortly before his right ankle fusion. The doctor reported that the applicant's symptoms had relapsed and had persisted. He stated that the surgery was undertaken to treat the severe osteoarthritis and there was a likely contribution from the work injury in 2008. The doctor was aware of the history of osteomyelitis and noted that the applicant had no symptoms before the incident. Therefore, Dr Scally accepted a causal nexus between the applicant's injury and the need for surgery.

104. Dr Nicholson recorded a consistent history and noted that the applicant had recovered from the effects of his 1988 injury, he had ceased treatment, and he was asymptomatic at the time of the work incident. His pain had not resolved following the work injury, and it had worsened. He recommended an arthroscopy to address the osteochondral defect on the talus, but this was not authorised by the insurer. The doctor stated that the applicant had not recovered from his work injury.

105. Dr Nicholson provided a logical explanation regarding the genesis of a talar dome injury, which could be asymptomatic or relatively asymptomatic for a period of time, before progressing and increasing. He indicated that the MRI and CT scans did not show significant degeneration, and the degeneration that was present was secondary to the injury and osteochondral lesion.

106. Dr Nicholson conceded that he had not viewed the x-rays taken on 14 August 2008, but he stated that the radiologist would have reported the presence of degenerative changes if they were present, and even if there were such changes, the applicant was able to function normally before the work injury. Therefore, Dr Nicholson supported the contention that the applicant suffered an osteochondral lesion, and this led to secondary degenerative changes.

107. The notes of the Dubbo Base Hospital and the reports of Dr Wines are of little assistance, given their focus was on the applicant's left ankle injury. The history noted by Dr Wines in May 2017 of right-sided aching, occasional sharp pain and an antalgic gait would not be consistent with a recovery from a right ankle injury. In August 2017, the applicant still had pain and a slight limp.

108. Dr Patrick recorded a consistent history of a recovery from the childhood injury and the circumstances of the work incident. He noted that the applicant had ongoing and deteriorating right ankle pain before he had surgery. There had been some improvement after the operation, but the applicant still had an antalgic gait and he experienced right knee discomfort at times.

109. According to Dr Patrick, the work injury caused symptoms and gave rise to the need for surgery, but he accepted that it was possible that the childhood injury may have contributed. Like Dr Nicholson, he stated that the radiologist would have mentioned the presence of any degenerative changes at the time of the first x-rays if these were observed on the films. Therefore, Dr Patrick seems to support the proposition of a contribution from the work injury and a lesser contribution from the childhood injury.

110. In my view, little flows from the applicant's denial of having any past problems with his right ankle when he applied for work with Bosmac Pty Ltd. Whilst he did not explain why he had not disclosed his work injury to his new employer, the applicant's prospects of obtaining employment would most likely have been enhanced by this omission.

111. Little weight can be given to the report of Dr Kafataris because he did not examine the applicant. It is unclear what documents he had in his possession and he was also hampered by the absence of the initial x-rays.

112. The respondent relies primarily of the views of Dr Smith. Dr Smith recorded a history that the applicant had no symptoms prior to his work injury and that he had experienced niggling discomfort that increased in intensity. This description seems to mirror what Dr Nicholson said about the nature of osteochondral lesions.

113. Dr Smith stated that it was not possible for the applicant to have developed marked arthritic changes in his ankle as a result of an ankle sprain, but he felt that these changes were aggravated. This conclusion would be somewhat similar to the opinion of Dr Patrick.

114. Dr Smith did not comment on the presence of a talar dome lesion, which he merely described as an irregularity. He maintained that the degenerative changes were gross and longstanding, but this seems to be the doctor's own interpretation, which is inconsistent with the interpretations provided by the specialist radiologists and Dr Nicholson.

115. The radiologists who performed the scans in December 2009 did not describe the degenerative changes as severe. Further, Dr Nicholson advised that the MRI and CT scans did not show significant degeneration, but merely secondary degeneration related to the osteochondral lesion.

116. Dr Smith's opinion that the aggravation had resolved is at odds with the applicant's evidence and the history and the opinions recorded in the reports of the other doctors. The doctor advised against an arthroscopy and he recommended an arthrodesis, a procedure which was ultimately performed by Dr Wines.

117. Dr Smith stated that once the ankle became symptomatic, the applicant would continue to suffer aggravations from time to time. However, if that was the case that the applicant had recovered from a minor ankle sprain, one would have expected the applicant to become asymptomatic as he had been before the incident. According to the evidence of the applicant and Dr Graham, any respite from his symptoms was short-lived. Therefore, I am not satisfied that the applicant has recovered from the effects of his work injury.

118. Although I do am not obliged to determine whether the surgery was reasonably necessary as a result of the work injury, the evidence in support of that contention is compelling.

119. Drs Graham, Scally and Nicholson saw the applicant on a regular basis unlike Dr Smith, who only examined the applicant in 2010 and 2018. I am also mindful that Dr Nicholson is a specialist foot and ankle orthopaedic surgeon and his views, and those of the treating doctors, should be preferred to those of Dr Smith, whose views were clouded by his conclusion that the applicant had recovered from his injury, and yet he even agreed that the fusion was appropriate to treat the applicant's ankle condition.

120. I am satisfied, when applying the common-sense test of causation in *Kooragang*, the weight of evidence from Drs Graham, Scally, Nicholson and Patrick supports the applicant's case that his injury in 2008 materially contributed to the need for the right ankle fusion that was performed by Dr Wines in 2013.The medical evidence supported the need for the operation to address the effects of the applicant's work injury.

Did the applicant develop a consequential condition in his lumbar spine?

121. I do not need to find that the applicant sustained a further injury or developed pathology in a case involving a consequential condition. This is again a question of causation and the common-sense evaluation of the causal chain discussed in *Kooragang.*

122. The principles to be applied in cases involving consequential conditions were discussed in *Kumar v Royal Comfort Bedding Ltd*[5], where Deputy President Roche stated:

> "By asking if Mr Kumar has suffered a s 4 injury to his right shoulder, the Arbitrator erred in his approach and asked the wrong question. This error affected his approach to the medical evidence and his conclusion. Mr Kumar's claim was always, as the respondent has conceded on appeal, that the right shoulder condition, and the need for surgery, resulted from the accepted back injury. It was not necessary for him to prove that he suffered a s 4 injury to his right shoulder."[6], and
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> "…Of more significance is that Dr Wallace's opinion that Mr Kumar's activities after the back surgery would not be consistent with the cause of 'significant right shoulder pathology' failed to address the correct issue. It is not necessary for Mr Kumar to establish that he has significant pathology in his shoulder, only that the proposed surgery is reasonably necessary as a result of the injury on 19 March 2009. Dr Wallace's opinion may well be relevant to the ultimate question of whether the shoulder surgery is reasonably necessary, but it does not determine the question of whether the right shoulder condition has resulted from the back injury."[7]

123. The Deputy President continued:

> "While Mr Kumar's evidence is less than ideal and the general preparation of his case by his solicitors has been sloppy, his evidence of experiencing a lot of pain in his right shoulder having to lift himself after his back surgery is unchallenged and not implausible. His symptoms were sufficient for him to seek medical treatment. Dr Di Mascio and Dr Ireland were satisfied that an aggravation had occurred in the manner alleged by Mr Kumar. In these circumstances and given that Dr Wallace did not address the proper question, the compelling conclusion is that Mr Kumar's right shoulder symptoms in June 2010 resulted from his accepted back injury."[8]

[5] [2012] NSWWCCPD 8 (*Kumar*).
[6] *Kumar*, [35].
[7] *Kumar*, [55].
[8] *Kumar*, [59].

124. This was also confirmed by Deputy President Snell in *Trustees of the Roman Catholic Church for the Diocese of Parramatta v Brennan*[9], where he considered the principles discussed in *Kumar* and *Bouchmouni v Bakhos Matta t/as Western Red Services*[10]*.* He stated:

> "The above do not suggest any need that a finding of a consequential condition necessarily involves the identification of pathology. It is sufficient to find (if the evidence supports it) a condition that results from an employment injury. I accept the respondent's submission that it is sufficient to find a consequential condition, pathology need not necessarily be identified. In *Kumar,* the relevant finding was based on the existence of symptoms."[11]

125. It is true that there is a lack of complaints regarding the applicant's back condition in the clinical notes. However, the Court of Appeal in decisions such as *Davis v Council of the City of Wagga Wagga*[12], *Nominal Defendant v Clancy*[13], *King v Collins* [2007] NSWCA 122 and *Mastronardi v State of New* South *Wales*[14] has cautioned against placing too much weight on the clinical notes of treating doctors, given their primary concern was treatment. In the Court's view, the notes rarely, if ever, represented a complete record of the exchange between a busy doctor and the patient. These decisions have been cited with approval by Deputy President Roche in the Commission in *Winter v NSW Police Force*[15]*.*

126. The applicant's statement is largely unhelpful regarding the nature and onset of his back symptoms. He advised that he had difficulty walking due to a restricted range of movement in the ankle and he walked with a limp after his surgery. He has pain and restriction in his lower back which he attributes to his altered gait, and he consulted a chiropractor for treatment. He is unable to stand for long periods due to the pain in his back and right ankle.

127. It would seem that the applicant had treatment from his chiropractor. Maree Lawryk, from 23 June 2011 to 7 June 2013 and again on 18 December 2015. The chiropractor referred him for x-rays in 2011 and 2012 that showed scoliosis and anterolisthesis of L5 on S1 and bilateral pars defect at L5.

128. Dr Scally addressed the question of a consequential condition in his report dated 23 March 2017. The doctor stated that as a result of the reduced range of movement in the applicant's right ankle following his injury in 2008 and surgery in 2013, he had placed strain on his lumbar spine, and this had resulted in a precipitation and ongoing aggravation of low back pain. He did not suggest that the consequential pain had resulted from the left ankle injury in 2015. The applicant had required chiropractic treatment, massage therapy and acupuncture for his back symptoms. Such a history is not recorded elsewhere.

129. The hospital notes and the reports of Drs Nicholson, Wines and Kafataris do not make any reference to back complaints, so they are of no assistance. The clinical notes and reports of Dr Wines from 2013 would certainly have been of assistance, but they were not in evidence. It is surprising that neither party adduced this relevant material.

130. Mr Halligan submits that the applicant's low back pain might also be related to his left ankle injury. Whilst that might well be a possible explanation for the applicant's back pain, there is no medical evidence to support such a submission.

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[9] [2016] NSWWCCPD 23 (*Brennan*).
[10] [2013] NSWWCCPD 4 (*Bouchmouni*).
[11] *Brennan*, [169].
[12] [2004] NSWCA 34.
[13] [2007] NSWCA 349.
[14] [2009] NSWCA 270.
[15] [2010] NSWWCCPD 12, [183].

131. According to Dr Patrick, the applicant had a CT scan on 7 July 2000 which showed spondylolisthesis due to bilateral pars defects. This scan report is not in evidence, but the findings seem to mirror the pathology shown in the x-rays taken in 2011 and 2012. Dr Patrick stated that it was likely that the recurrence of the applicant's lumbar symptoms, which had been dormant for many years, was caused by his altered gait since his work injury.

132. I have already expressed my concerns about the opinion of Dr Smith and his conclusion that the applicant had recovered from his ankle injury within a short period of the incident. The doctor did not record a history of any back symptoms when he examined the applicant in 2010, but that is not surprising, given that the first time that the applicant sought treatment for his back pain after the incident was in June 2011.

133. When Dr Smith re-examined the applicant in September 2018, the applicant told him that he he had experienced low back pain since 2009 and he had seen a chiropractor on a regular basis, but he had put up with his symptoms more recently. Such a history is not recorded elsewhere.

134. Dr Smith attributed the applicant's back symptoms to constitutional spondylolisthesis and degenerative disease, but he claimed that there was no relationship between the right ankle osteoarthritis and treatment and the degenerative disease and the spondylolisthesis. Further, there was no relationship between the applicant's gait and his low back pain. The reasons for this conclusion were not provided, other than a comment about the incidence of low back pain in the general population, without citing any scientific evidence to support his position. This also means little weight can be given to the doctor's opinion regarding the consequential condition.

135. The fact that the applicant had prior back symptoms and treatment in 2000 is irrelevant, as there is no requirement to identify any pathology, only symptoms. All that needs to be established is that a condition results from a work injury. This was confirmed in *Kumar* and *Brennan.*

136. The applicant bears the onus of proof to show that his low back symptoms have resulted from the accepted right ankle injury. He relies primarily on the views of Drs Scally and Patrick. The respondent has no persuasive medical opinion to challenge this evidence.

137. When one reviews the evidence as a whole, the applicant has support for a consequential condition in his lower back. I am satisfied that the right ankle injury materially contributed to the applicant's back symptoms, consistent with the principles discussed in *Murphy* and *Secretary, Department of Family and Community Services v Colleen Jones by Executor of her Estate Carol Hewston*[16]*.*

138. Therefore, applying the common sense causal chain in accordance with *Kooragang*, and in the absence of any evidence to the contrary, I am satisfied on the balance of probabilities that the applicant has discharged the onus of establishing that he developed a consequential condition in his lower back as a result of the accepted injury to his right ankle.

Quantification of whole person impairment

139. I will remit this matter to the Registrar for referral to an AMS pursuant to s 321 of the 1998 Act for assessment of the whole person impairment of the applicant's right lower extremity (ankle), scarring (TEMSKI) and lumbar spine due to injury sustained on 8 April 2008.

[16] [2016] NSWWCCPD 63.

FINDINGS

140. The applicant sustained an injury to his right ankle arising out of or in the course of his employment on 8 April 2008.

141. The applicant developed a consequential condition in his lumbar spine as a result of the injury sustained to his right ankle on 8 April 2008.

142. I remit this matter to the Registrar for referral to an Approved Medical Specialist pursuant to s 321 of the 1998 Act for assessment of the whole person impairment of the applicant's right lower extremity (ankle), scarring (TEMSKI) and lumbar spine due to injury sustained on 8 April 2008.

143. The documents to be reviewed by the Approved Medical Specialist are:

    (a) Application and attached documents;

    (b) Reply and attached documents, excluding the report of Dr Bosanquet dated 8 September 2015, and

    (c) Application to Admit Late Documents received on 10 January 2020.