QUEENSLAND INDUSTRIAL RELATIONS COMMISSION

CITATION:	*Horne v Workers' Compensation Regulator* [2020] QIRC 135
PARTIES:	**Horne, Amanda** (Appellant) v **Workers' Compensation Regulator** (Respondent)
CASE NO:	WC/2018/210
PROCEEDING:	Appeal against decision of the Workers' Compensation Regulator
DELIVERED ON:	28 August 2020
HEARING DATES:	3 and 4 December 2019
DATES OF WRITTEN SUBMISSIONS:	Appellant's written submissions: 24 January 2020 Respondent's written submissions: 10 February 2020 Appellant's written submissions in reply: 14 February 2020
MEMBER:	Merrell DP
HEARD AT:	Townsville
ORDERS:	**1. The review decision of the Respondent dated 31 October 2018 is confirmed.** **2. The Appellant pays the Respondent's costs of the appeal.**
CATCHWORDS:	WORKERS' COMPENSATION - APPEAL AGAINST DECISION OF WORKERS' COMPENSATION REGULATOR - worker employed as a custodial correctional officer - worker suffered injury to right foot and lower

	back - whether worker suffered a secondary injury to right knee caused by altered gait due to injury to right foot
LEGISLATION:	*Workers' Compensation and Rehabilitation Act 2003* (Qld), s 32
CASES:	*Avis v WorkCover Queensland* [2000] QIC 67; (2000) 165 QGIG 788
	Church v Workers' Compensation Regulator [2015] ICQ 031
	Kavanagh v Commonwealth [1960] HCA 25; (1960) CLR 547
	Newberry v Suncorp Metway Insurance Ltd [2006] QCA 48; (2006) 1 Qd.R 519
	Rossmuller AND Q-COMP (C/2009/36) http://www.qirc.qld.gov.au
	Seltsam Pty Ltd v McGuiness [2000] NSWCA 29; (2000) 49 NSWLR 262
APPEARANCES:	Mr A. Collins instructed by Mr J. Windridge of Rapid Legal Solutions for the Appellant.
	Ms L. Willson, directly instructed by Ms K. Bednarek of the Respondent.

Reasons for Decision

Introduction

[1] Ms Amanda Lee Horne was employed by the State of Queensland through Queensland Corrective Services ('QCS') as a Custodial Correctional Officer ('CCO') at the Townsville Correctional Centre (the 'TCC').

[2] It is agreed between the parties, that on 26 April 2015, at about 8.45 pm, when working at the TCC, Ms Horne suffered a personal injury, which was accepted by WorkCover Queensland as an injury within the meaning of the *Workers' Compensation and Rehabilitation Act 2003* ('the Act'), namely:

- a musculo-ligamentous injury to her right ankle with plantar fasciitis; and

- an aggravation of an age-related degeneration at L5/S1[1] (which Ms Horne, later in her submissions, refers to as the 'the second accepted injury').[2]

[3] On 1 November 2017, Ms Horne filed a Notice of Claim for Damages which included an un-assessed right knee injury. By decision dated 25 June 2018, WorkCover Queensland rejected Ms Horne's right knee injury claim. Ms Horne subsequently sought a review of the WorkCover decision by the Workers' Compensation Regulator. By review decision dated 31 October 2018, the Regulator also rejected Ms Horne's right knee injury claim.

[4] Ms Horne appeals against the review decision. In her appeal, Ms Horne contends that:

- as a consequence of the accepted injuries to her right foot and lower back, she continues to suffer the symptoms of:
  - a limp;
  - lower back pain;
  - pain in the right foot and ankle;
  - deformity/curling of the toes on her right foot;
  - restricted movement of the right ankle and toes; and
  - an altered gait; and

- over time, the symptoms, in particular the limp, have caused her to favour her right side, causing her right knee to give way at times and have led to the development of a right knee injury.[3]

[5] The Regulator contends that Ms Horne's right knee injury:

- is not secondary to any other injury she may have sustained to her right ankle or foot; and

- as a result, Ms Horne's employment is not a significant contributing factor to any condition that she may have in her right knee.[4]

[6] In summary, Ms Horne's case is that her right knee injury is as a consequence of her altered gait pattern; and her altered gait pattern was directly referable to the incident on 26 April 2015.[5]

[7] The Regulator's case, in summary, is that:

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[1] Ms Horne's Statement of Facts and Contentions filed on 5 March 2019 ('Ms Horne's contentions'), Attachment 'A', para. 4 and the Regulator's Statement of Facts and Contentions filed on 15 April 2019 ('the Regulator's contentions'), para. 4. Ms Horne submitted that a complicating feature of the appeal '… is the fact that two injuries have been accepted by WorkCover, and that there is a concurrence of opinion that one of the accepted injuries i.e. plantar fasciitis may be a misdiagnosis.': Ms Horne's written submissions filed on 24 January 2020 ('Ms Horne's submissions'), para. 2.7.
[2] Ms Horne's contentions, para. 4 and the Regulator's contentions, para. 6.
[3] Ms Horne's contentions, Attachment 'A', paras. 5 and 6.
[4] The Regulator's contentions, page 2/2.
[5] Ms Horne's submissions, para. 2.10.

- Ms Horne did not suffer a right knee injury, or if she did, the cause of the injury is unrelated to work or the incident which occurred on 26 April 2015; and
- if Ms Horne did suffer a knee injury arising out of her employment, then her employment was not a significant contributing factor to that knee injury because if that the injury occurred because of an altered gait pattern, the altered gait pattern was a result of a controlled and deliberate gait that Ms Horne adopted, not as a result of the incident on 26 April 2015, but for some other reason.[6]

[8] The questions to determine are:

- did Ms Horne sustain an injury to her right knee in the way she has described, namely, secondary to the right foot and lower back injuries that arose out of or in the course of her employment? and

- if Ms Horne did have a right knee injury in the way she has described, did that injury arise out of her employment as a CCO at the TCC? and

- if so, was her employment as a CCO at the TCC a significant contributing factor to that injury?

[9] In my view, Ms Horne did not sustain an injury to her right knee in the way she has described, namely, secondary to the right foot and lower back injuries that arose out of or in the course of her employment and, as a consequence, Ms Horne does not have a right knee injury that arose out of her employment as a CCO at the TCC.

[10] My reasons follow.

The relevant legal principles

[11] An injury which arises out of employment occurs where there is a causal connection between the employment and the injury.[7] There must be some causal or consequential relationship between the worker's employment and the injury.[8]

[12] The requirement that the employment is a significant contributing factor to the injury requires that the exigencies of the employment must contribute in some significant way to the occurrence of the injury.[9]

[13] An appeal of this type, pursuant to ch 13, pt 3 of the Act, is a hearing *de novo*.[10] The onus is on Ms Horne to prove, on the balance of probabilities, that she has an injury within the meaning of the Act.[11]

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[6] The Regulator's written submissions filed on 10 February 2020 ('the Regulator's submissions'), para. 6.
[7] *Kavanagh v Commonwealth* [1960] HCA 25; (1960) CLR 547, 558-559 (Fullagar J).
[8] *Avis v WorkCover Queensland* [2000] QIC 67; (2000) 165 QGIG 788, 788 (Hall P).
[9] *Newberry v Suncorp Metway Insurance Ltd* [2006] QCA 48; (2006) 1 Qd.R 519, [27] (Keane JA, de Jersey CJ at [1] and Muir J at [49] agreeing).
[10] *Church v Workers' Compensation Regulator* [2015] ICQ 031, [27] (Martin J, President).
[11] *Rossmuller AND Q-COMP (C/2009/36)* http://www.qirc.qld.gov.au, [2] (Hall P).

[14] The common law test of balance of probabilities is not satisfied by evidence which fails to do more than just establish possibility.[12] In *Seltsam Pty Ltd v McGuiness* (*'Seltsam'*), Spigelman CJ relevantly stated:

> 79 Evidence of possibility, including expert evidence of possibility expressed in opinion form and evidence of possibility from epidemiological research or other statistical indicators, is admissible and must be weighed in the balance with other factors, when determining whether or not, on the balance of probabilities, an inference of causation in a specific case could or should be drawn. Where, however, the whole of the evidence does not rise above the level of possibility, either alone or cumulatively, such an inference is not open to be drawn.

Did Ms Horne sustain an injury to her right knee in the way she has described, namely, secondary to the right foot and lower back injuries that arose out of or in the course of her employment?

Ms Horne's employment with QCS

[15] Ms Horne's unchallenged evidence was that:

- upon her application for employment with QCS, she successfully underwent a number of assessments including a circuit activity, physical fitness test;[13]
- she successfully completed all assessments and commenced employment as a CCO on a full-time basis in 2012;[14] and
- she performed all CCO duties, inside the women's farm and in the women's section of the TCC.[15]

The events of 26 April 2015

[16] On 26 April 2015, Ms Horne commenced work at about 7.00 pm and had performed a headcount at the women's farm when, at about 9.00 pm, she was directed to walk the 300-400m back to the main centre to conduct a headcount there.[16]

[17] Ms Horne stated that while she was walking back to the main centre of the TCC, she was in a gully when she saw, from behind a fence, a sow pig and some piglets.[17]

[18] Ms Horne's evidence then was that:

- she went over to the fence to where the pigs were;
- a boar then charged and hit the fence;
- she screamed, stumbled backwards into a gutter and fell on her backside;

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[12] *Seltsam Pty Ltd v McGuiness* [2000] NSWCA 29; (2000) 49 NSWLR 262, [80] (Spigelman CJ) ('*Seltsman*').
[13] T 1-12, l 1 to T-13, l 36.
[14] T 1-11, ll 15-16 and T 1-14, ll 11-12.
[15] T 1-14, ll 19-20.
[16] T 1-14, l 33 to T 1-15, l 1.
[17] T 1-15, ll 7-12.

- her right foot became wedged in the gutter and she could not move her right foot; and

- her right foot hurt and became swollen to the point where she could not get her foot back into her work boot.[18]

The events after April 2015

[19] Ms Horne received medical treatment for the injuries to her right ankle and lower back which included undergoing X-Rays and MRIs and, commencing in 2016, physiotherapy.[19]

Ms Horne's altered gait

[20] Ms Horne stated that she began to have trouble with her right knee due to the way she was walking. Ms Horne said that she noticed the toes on her right foot started to claw after about 12 months from the events of 26 April 2015.[20]

[21] In this regard, Ms Horne's evidence was that:

- she had a bad lean when she walked and had a changed gait;

- a knee brace was prescribed to straighten her leg;

- her knees went, specifically her right knee, and she would drop to the floor;

- when she walked, her right knee would give way such that she fell at home once when walking down the back steps and on another occasion when stepping into the shower;[21] and

- the problems with her right knee started when she was still seeing her physiotherapist, Ms Jane Wilkinson.[22]

[22] In cross-examination, Ms Horne stated that:

- she first noticed her right toes clawing in about late 2016;[23]

- she first had knee pain in the first year after the injury or just after;[24]

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[18] T 1-15, l 13 to T 1-18, l 9.
[19] T 1-19, l 12 to T 1-22, l 2.
[20] T 1-18, ll 30-37.
[21] T 1-22, ll 7-45.
[22] T 1-23, ll 6-9. Exhibit 14 includes the clinical notes from Ms Horne's physiotherapist which shows Ms Horne first consulted Ms Wilkinson on 20 June 2016.
[23] T 1-33, ll 19-35.
[24] T 1-33, l 45 to T 1-34, l 2.

- she started to walk with a lean about six months after the injury to her lower back and right foot;[25]

- both her left and right knee gave way, but that it started with her right knee;[26] and

- notwithstanding the falls she had suffered, she had improved in the way that she walked since 2016.[27]

Falls and assistive devices

[23] Exhibit 14 contained the clinical notes from Ms Wilkinson. The notes recorded, amongst other matters, that:

- on 26 June 2016, Ms Horne reported falls twice a week and that she had crutches and a walking stick, but was reluctant to use them due to social stigma and was advised to use crutches or a walking stick to prevent further falls;[28]

- on 7 July 2016, she felt as though her right ankle and knee seized up;[29]

- on 18 July 2016, she was fitted with a knee brace;[30]

- on 15 August 2016, she reported that on 21 July 2016 she had a big fall when her left knee gave way;[31]

- on 14 November 2016, gait retraining was provided and Ms Horne was able to twice walk 5 metres without a stick;[32] and

- on 13 February 2017, Ms Horne reported she had been managing well with a single stick and no knee brace.[33]

[24] Ms Horne stated that she started constantly using a walking stick when her knee started to give way more.[34] In re-examination, Ms Horne stated that she was using a walking stick before 23 February 2016.[35]

Driving

[25] Ms Horne has five children, three of whom, in 2015, were of school-age.[36] Ms Horne's evidence was that:

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[25] T 1-34, ll 34-40.
[26] T 1-35, ll 20-29.
[27] T 1-36, ll 7-12.
[28] Exhibit 14, pages 2 and 3 of 14.
[29] Exhibit 14, page 5 of 14.
[30] Exhibit 14, page 7 of 14.
[31] Exhibit 14, page 9 of 14.
[32] Exhibit 14, page 13 of 14.
[33] Exhibit 14, page 4 of 14.
[34] T 1-23, ll 29-30.
[35] T 2-6, l 35 to T 2-7, l 40.
[36] T 1-28, ll 9-14.

- in 2016, her physiotherapist told her that she could not drive and that she only accepted that advice for a '… little while';[37]

- she drove because she wanted a life and that she did not drive the children when she was heavily medicated;[38] and

- she would drive her children to and from school using her left foot to engage the accelerator and brake on the automatic vehicles she drove.[39]

[26] The note of a surgery consultation Ms Horne had on 23 February 2016 with Dr Prashanta Mitra, General Practitioner, records that Ms Horne stated that she had to use a walking stick to walk even a few metres and that she '… can not drive because she can not feel the pedal.'[40]

[27] In cross-examination, it was suggested to Ms Horne that it was not true to say that she rarely drove, to which Ms Horne stated that she only drove for about 40 minutes to get her children to and from school.[41] Ms Horne admitted however that she did drive in 2016 but not every day.[42] Ms Horne stated that her mother and her father-in-law did most of the driving when her husband, a fly in, fly out worker, was away.[43]

Work around Ms Horne's home

[28] Ms Horne described a 'good day' in 2017 as being able to 'hang out four pieces of clothing' and walking to her neighbour across the road without falling;[44] and that a 'bad day,' was taking more medication than she should just to get through the day.[45]

Other matters

[29] Ms Horne concluded her evidence-in-chief by stating that:

- her present right knee pain was a '9' on a '1 to 10' scale;[46]

- sitting too long and sometimes standing too long aggravated her right knee pain;[47]

- prior to the fall on 26 April 2015, her right knee was fully functional and that she had no problems with her right knee prior to that time;[48]

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[37] T 1-29, ll 3-5.
[38] T 1-29, ll 33-47.
[39] T 1-29, ll 12-25.
[40] Exhibit 13.
[41] T 1-77, ll 14-22.
[42] T 1-77, ll 24-28.
[43] T 1-78, ll 8-12.
[44] T 1-23, ll 21-24.
[45] T 1-23, ll 38-39.
[46] T 1-30, ll 20-21.
[47] T 1-30, ll 25-27.
[48] T 1-30, ll 31-32.

- her April 2015 fall changed the way she walked because she was walking too much on her left side;[49] and

- a knee brace did not help her and she still had difficulty walking in terms of the way she steps out her gait.[50]

The surveillance evidence

[30] Exhibits 2, 3 and 4 were reports by Verifact Pty Ltd of surveillance conducted of Ms Horne.[51] These reports were mainly based upon video surveillance undertaken on 9, 10 and 11 May 2017 (Exhibit 6), on 17 May 2017 (Exhibit 7), on 4 October 2017 (Exhibit 8) and on 13 January 2018 (Exhibit 9). All these exhibits were tendered by the Regulator.

Exhibit 6

[31] The footage of 9 May 2017 shows Ms Horne, unassisted, getting out of the front, passenger side seat of a parked blue Toyota SUV. Another female and a male also get out of the vehicle and are with Ms Horne for most of the time she is depicted in the video.

[32] Ms Horne is wearing thongs on her feet and has a walking stick in her left hand. No knee brace is visible.

[33] Ms Horne then, with a limp, walks down a footpath stopping momentarily, starting again, and then stopping momentarily again. Ms Horne then walks to a building bearing the sign 'Alliance Rehabilitation'. When she is walking, Ms Horne's right foot is flat on the ground. At about the time she is walking towards the building, but before she walks up a ramp to the door, it can be seen that Ms Horne's right big toe is clawed.

[34] The same video then shows Ms Horne walking out of that building and walking on the footpath back to the vehicle, with the walking stick in her left hand. Ms Horne is walking with a limp, but her right foot is flat on the ground when she is walking. The video then depicts Ms Horne, unassisted, getting back into the passenger side front seat of the parked SUV.

[35] The footage of 10 May 2017:

- depicts vision from a vehicle following the same blue Toyota SUV along a number of streets;

- then depicts Ms Horne walking into a residence, without a walking stick, with a mobile phone held in her left hand to her left ear;

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[49] T 1-30, ll 34-37.
[50] T 1-30, ll 41-46.
[51] Exhibits 2 and 3 were prepared on the instructions of WorkCover Queensland. Exhibit 4 was prepared on the instructions of Crown Law.

- then depicts the parked blue Toyota SUV, with Ms Horne getting into the driver's seat and reversing the vehicle out of the driveway; and when the vehicle then moves forward, Ms Horne appears to be talking on the mobile phone with the phone held in her left hand to her left ear, and she was steering the vehicle with her right hand; and

- further depicts the blue Toyota SUV pulling up at a residence, with Ms Horne, wearing thongs on her feet, getting out of the driver's seat, without the use of a walking stick or visible knee brace, where her right foot is placed flat on the ground when she alights from the vehicle, and then walking towards the residence but with a limp.

[36] The footage of 11 May 2017:

- depicts Ms Horne getting into the same blue Toyota SUV outside of a residence;

- Ms Horne walking to the driver's side door without the use of a walking stick, getting into the driver's seat of the vehicle and then reversing the vehicle out of the driveway; and

- about an hour later, the vehicle is depicted pulling up outside of the residence, Ms Horne gets out of the driver's side of the vehicle without a walking stick, walks with a limp, and then opens a gate and enters the yard of the residence.

Exhibit 7

[37] The footage of 17 May 2017 shows Ms Horne, using a walking stick in her left hand, getting into the driver's seat of a black SUV.

Exhibit 3 and Exhibit 8

[38] Exhibit 3, being the unchallenged Verifact written report of the surveillance of Ms Horne on 4 October 2017, dated 16 October 2017, relevantly stated:

- at 1.42 pm, Ms Horne was observed by an agent, in the vicinity of her given address, walking to a black Ford F250 utility bearing a Queensland registration plate;[52]

- Ms Horne did not have a walking stick and was talking on her phone;[53]

- Ms Horne then boarded the driver's position of the black Ford F250 utility;[54]

- mobile surveillance was initiated and a white Suzuki Vitara bearing a Queensland registration plate,[55] which was parked at the front of the residence with a different

[52] Exhibit 3, page 4. The identifying letters and numbers are set out in the report.
[53] Ibid.
[54] Ibid.
[55] The identifying letters and numbers are set out in the report.

female sitting in the driver's position, followed Ms Horne in the black Ford F250 utility;[56]

- Ms Horne then parked in Albury Street, Pimlico which was around the corner from Ms Horne's later medical appointment at 62 Park Street, Pimlico;[57]

- Ms Horne alighted from the black Ford F250 utility and then boarded the passenger position of the white Suzuki Vitara;[58] and

- the white Suzuki Vitara then parked in a disabled park opposite 62 Park Street, Pimlico.[59]

[39] Exhibit 8, being the footage of 4 October 2017, relevantly depicts:

- between 13:42:48 and 13:42:50, on the footpath in front of a residence, Ms Horne walking toward a black dual cab utility, which was parked in the driveway of the residence, without a walking stick;

- between 13:43:16 and 14:43:38, a black dual cab utility, with Ms Horne in the driver's seat, talking on a mobile phone, with her left hand holding the mobile phone to her left ear and her right hand on the steering wheel;

- between 13:43:39 and 14:43:47, Ms Horne then reversing the black dual cab utility, out of the driveway, still talking on the mobile phone which was being held in her left hand to her left ear, and steering the vehicle with her right hand;

- between 14:04:01 and 14:05:16, a white Suzuki SUV, with the same registration plate as set out in the report, with Ms Horne getting out of the front passenger side seat with a walking stick in her left hand, without any visible knee brace and walking onto the adjacent footpath; Ms Horne is then joined by another female who was driving the white Suzuki SUV and they begin to walk towards a building;[60] and Ms Horne, when she is walking towards the building, is clearly walking on the lateral aspect of her right foot and is walking with a limp; and

- between 14:11:33 and 14:12:42, Ms Horne and the other female then walking out of the same building, Ms Horne has the walking stick in her left hand, is walking with a limp and then she and the other female person walk across the street.

Exhibit 9

[40] The footage of 13 January 2018:

- first, depicts:

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[56] Exhibit 3, page 4.
[57] Exhibit 3, page 5.
[58] Exhibit 3, page 5.
[59] Exhibit 3, page 5.
[60] Identified by the surveillance investigator as the Mater Hospital: Exhibit 3, page 5.

- Ms Horne and another female leaving what appears to be commercial premises[61] and walking towards a blue Toyota SUV;

- Ms Horne wearing thongs on her feet and as she walks towards the vehicle, she uses a walking stick in her left hand and when she walks her right foot appears to be flat on the ground; and

- Ms Horne getting into the driver's seat of the vehicle which then reverses out and drives off;

- secondly, depicts:

  - the blue Toyota SUV parked out the front of the commercial premises, Ms Horne alighting from the driver's seat of the parked vehicle, another female also alighting from the front passenger seat and them both walking towards a store;[62] and

  - Ms Horne walking with a stick in her left hand;

- thirdly, depicts:

  - Ms Horne and the other female in the Harvey Norman store looking at computers;

  - Ms Horne with a backpack slung over her right shoulder, is holding a parcel by its handle in her right hand and holding onto the walking stick with her left hand; and

  - Ms Horne, who is wearing thongs on her feet, momentarily letting go of the walking stick with her left hand and using her left hand, slinging the left hand strap of the backpack over her left shoulder so that the backpack is resting on her back;

- fourthly, depicts:

  - Ms Horne and the other female both standing and, after a conversation with a salesperson, walking up and down the area where the computers are displayed;

  - Ms Horne and the other female engaging in further conversations with the salesperson and when Ms Horne was stationary, her right foot was placed flat on the floor; and

  - at times,[63] Ms Horne places all of her weight onto her right leg;

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[61] Identified as a JB Hi-Fi store in Exhibit 4, page 8.
[62] Identified as a Harvey Norman store in Exhibit 4, page 10.
[63] Exhibit 9, 10:41:41-10:41:51 and 10:43:14-10:43:44.

- fifthly, depicts Ms Horne walking in the area, where the computers are displayed, having further conversations with the salesperson, when she is then joined by the other female and, at those points, the video depicts Ms Horne with her right foot flat on the ground although at the point where it appears the sale has been made, Ms Horne's right toe appears to be clawed;[64] and

- sixthly, depicts:

  – Ms Horne and the female person walking out of the store where Ms Horne has the walking stick in her left hand and is walking with a slight limp;

  – the other female carrying a large box and Ms Horne carrying a plastic bag over her right shoulder; and

  – the two of them approaching the blue Toyota SUV, where Ms Horne opens the tailgate door, the packages are placed in the back of the SUV and Ms Horne then walks around and gets into the front passenger side of the vehicle.

[41] Exhibit 9, depicts that, apart from when Ms Horne was in the vehicle, she was standing for the entire time.

The expert evidence

Dr Mitra

[42] In his note of the surgery consultation Dr Mitra had with Ms Horne on 23 February 2016, he notes that Ms Horne:

> is walking with gross limp putting her all [sic] weight on left leg . her right foot is grossly inverted some wound on the dorsum.
> neurological examination shows that she has complete loss of pain , touching and pressure sensation right lower limb starting from the lateral thigh down to the toes
> The toes are turned inwards , deformed.'[65]

Dr Bruce Low, Orthopaedic Surgeon

[43] Dr Low was called by Ms Horne. Dr Low examined Ms Horne on 7 September 2016. In his first report of the same date, Dr Low opined that:

- Ms Horne suffered a soft tissue injury as a result of her fall at the TCC on 26 April 2015;[66]

- the diagnosis from the ultrasound and x-ray was plantar fasciitis, that Ms Horne was given orthotics and time to settle, but the foot swelled and became painful, that it took three months before she could get back to work, however she only

[64] Exhibit 9, 10:53:54.
[65] Exhibit 13.
[66] Exhibit 11, page 11.

lasted half a day; and that after that, she developed knee, hip, low back and right shoulder pain and became non-ambulatory and housebound;[67]

- Ms Horne required a brace on her right knee and a cane to ambulate and spent most of her time indoors;[68] and

- Ms Horne could not shop, drive or cook, could not watch her children play sport and could not do any physical exercise and was in constant pain.[69]

[44] Dr Low opined that Ms Horne had a 30% whole person impairment.[70]

[45] For the purposes of making his supplementary report dated 14 August 2018, Dr Low reviewed the surveillance footage taken by Verifact of 13 January 2018 (Exhibit 9, being the video surveillance of Ms Horne at the Harvey Norman store).[71] Dr Low stated that he believed the surveillance video he saw did not agree with his earlier assessment that he had made of Ms Horne where he found she could hardly move her right hip and right knee at all.[72] In his supplementary report, Dr Low stated that, in his opinion, Ms Horne had a 7% whole person impairment.[73]

[46] In his evidence-in-chief, Dr Low stated that he had the report of Dr Helen Land, Musculoskeletal Physiotherapist, dated 17 November 2019 and that he agreed with Dr Land's comments about gait patterns and weight pressure on the lateral part of the right knee.[74]

[47] In cross-examination, Dr Low stated where, in this first report:

- he referred to Ms Horne's domestic circumstances and the restrictions in her domestic circumstances, that information came directly from other medical reports or from Ms Horne;[75] and

- he referred to Ms Horne's current symptoms, that information came from her and he agreed that he did not diagnose Ms Horne with having any injury to her knee.[76]

[48] In re-examination, Dr Low stated that he did not physically re-examine Ms Horne for the purposes of completing his second report.[77]

Dr Allan Cook, Specialist Orthopaedic Consultant

[49] Dr Cook was called by Ms Horne. Dr Cook examined Ms Horne on 26 June 2018 and on 6 March 2019. Two reports were tendered through Dr Cook, being his first report

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[67] Exhibit 11, page 11.
[68] Exhibit 11, page 11.
[69] Exhibit 11, page 12.
[70] Exhibit 11, page 12.
[71] Exhibit 12, first page.
[72] Exhibit 12, second page.
[73] Exhibit 12, second page.
[74] T 1-80, ll 27-32.
[75] T 1-81, ll 31-41.
[76] T 1-83, ll 7-10.
[77] T 1-83, ll 25-26.

dated 18 September 2018 (Exhibit 15) and his second report dated 9 March 2019 (Exhibit 16).

Dr Cook's first report

[50] In his first report, Dr Cook opined that:

- Ms Horne was favouring her right side causing her to limp, and because her right knee was giving way at times, that resulted in a number of falls which altered her gait over a period of some months;[78] and

- the changes to Ms Horne's right foot and toes, right ankle and lower leg '… are now becoming irreversible and if there is no improvement with the treatment outlined above then consideration should be given to her undergoing either a below knee or even an above knee amputation of her right leg.'[79]

[51] Dr Cook stated that in respect of the three CD discs and report of the video surveillance he received, he could only view the activity on 17 May 2017 (Exhibit 7) and 4 October 2017 (Exhibit 8) and that he could not open the CD of the activity on 13 January 2018. Dr Cook felt that 'some of the surveillance' may have been of someone else and that the surveillance did not change his views or opinions.[80]

Dr Cook's second report

[52] Dr Cook stated, in his second report, that Ms Horne reported to him on 6 March 2019:

- that since the last time she saw him (Dr Cook) on 26 June 2018, she felt her right leg, foot and ankle had become gradually worse;[81] and

- that in relation to her right knee, she continued to have constant aches and pains in that joint in the front and on both sides of it, though she did have some good days when those pains were less but did have bad days when the aches and pains were so bad that she could hardly get out of bed without help; [82] and

- on a good day, she could be up and about and mobile to a degree provided that was not for longer periods of time or longer distances and that, on an average week, she has 3 to 4 bad days and the rest of the days of the week she has better days.[83]

[53] Dr Cook further reported that:

- Ms Horne was noted to be mobile with one walking stick in her left hand with an obvious right side limp;[84]

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[78] Exhibit 15, page 13.
[79] Exhibit 15, page 16.
[80] Exhibit 15, page 15.
[81] Exhibit 16, page 2.
[82] Exhibit 16, page 3.
[83] Ibid.
[84] Exhibit 16, page 4.

- Ms Horne was noted to weight bear and walk on the lateral side of her right foot, and that even when standing she was unable to make the foot go flat or plantigrade so that all the medial aspect of her right midfoot and forefoot was off the floor;[85]

- his examination of the right knee joint showed no obvious swelling, deformity or discolouration and that the area over and around her right knee joint was warm but there was no detectable effusion in the right knee joint;[86] and

- he strongly recommended that Ms Horne undergo an MRI scan of her right knee joint as it may be orthopaedically appropriate to recommend an arthroscopic examination of the joint and to deal with any injuries or pathology found that may be causing or contributing to the right side knee pain and what is restricting or limiting the movement of the joint.[87]

[54] Dr Cook's oral evidence-in-chief included:

- that there was nothing that alerted him to inconsistencies between what Ms Horne reported to him, compared to what was contained in the medical reports provided to him;[88]

- in reference to page 9 of his first report, Ms Horne was requested to bring the right foot and ankle up towards the neutral position but she was unable to achieve that so he then used his hands to attempt a passive range of motion but that he was totally unable to bring her foot and ankle anywhere close to the neutral position, which indicated that her joints had a very limited range of motion;[89] and

- that although Ms Horne stated that she had no knee pain from the time of the injury in April 2015, that may not have been accurate. This was because, in Dr Cook's opinion, she may have actually suffered a soft tissue injury to the knee joint because of the way that she fell and that the analgesic medication she received after the injury may have masked any pain in the knee joint.[90]

[55] Dr Cook, in his oral evidence-in-chief, was also taken to Dr Land's report (Exhibit 10). In this regard, Dr Cook:

- stated that Dr Land's description of Ms Horne's gait pattern displaying no plantar flexion and minimal hip flexion action, was consistent with his examination of Ms Horne;[91]

- stated that Dr Land's opinion, that Ms Horne's abnormal right foot posture resulting from the tonic dystonia resulted in Ms Horne's weight being taken on

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[85] Ibid.
[86] Ibid.
[87] Exhibit 16, page 5.
[88] T 2-18, ll 25-26.
[89] T 2-21, ll 35-44.
[90] T 2-23, ll 20-29.
[91] T 2-20, ll 16-20.

the lateral aspect of her right foot and whole lower limb corresponded with what he reported when he examined Ms Horne, as set out on page 8 of his first report (Exhibit 15);[92]

- agreed with Dr Land's opinion that Ms Horne's right knee remained extended with a varus force observed during the mid-stance phase;[93]

- agreed with Dr Land's opinion that Ms Horne's rigid foot posture through the stance phase would lead to the ground reaction forces being transferred up the lower limb chain, placing increased force on the lateral aspect above the knee and hip;[94] and because Ms Horne's weight was on the outside of her (right) foot, it altered the dynamic, to the extent that the weight was transmitted to the outside of the ankle and outside of the leg rather than being evenly distributed on both sides;[95]

- agreed with Dr Land's opinion that it was reasonable to deduce that Ms Horne had been weight bearing on the lateral aspect of a rigid, dystonic right lower limb as described in the medical reports since she sustained the injury in April 2015;[96]

- agreed with Dr Land's opinion that the repeated loading was resulting in excessive pressure on an area not designed to absorb the extra load with increasing pain to be expected in those structures over time and, in this regard, stated that meant the whole normal dynamics of walking, propulsion and weight bearing are significantly altered through the whole limb from the foot up the leg and through the knee into the hip and lower back;[97]

- agreed with Dr Land's opinion - that Ms Horne's lateral right knee pain was consistent with nociceptive pain emanating from the lateral soft tissue structures of the right knee which were absorbing increased ground reaction forces during each phase of gait - because Ms Horne had said that her knee had given way for no obvious reasons, that she had falls which itself suggested a problem within her knee joint and that he could not distinguish whether that was from an abnormal gait or whether that was from an injury she suffered to her knee in April 2015;[98]

- agreed with Dr Land's opinion that Ms Horne's tonic right lower limb dystonia has resulted in an abnormal right lower limb posture during the stance phase of gait, placing increased loading through the lateral aspect of the knee likely to cause increased pain in that area over time, and, in this regard, Dr Cook stated that the knee was like a hinge and that pressure in the knee overloads the knee;[99] and

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[92] T 2-20, l 29 to T 2-21, l 9.
[93] T 2-22, ll 1-4.
[94] T 2-22, ll 6-12.
[95] T 2-22, ll 14-19.
[96] T 2-22, ll 21-29.
[97] T 2-22, ll 33-42.
[98] T 2-23, l 40 to T 2-23, l 18.
[99] T 2-24, l 33 to T 2-25, l 29.

- agreed with Dr Land's opinion that Ms Horne's tonic right lower limb dystonia has resulted in an abnormal right lower limb posture during the stance phase of gait, placing increased loading through the lateral aspect of the entire right lower limb.[100]

[56] In cross-examination, Dr Cook stated that when he first saw Ms Horne on 26 June 2018, he did not identify any injury to her right knee[101] and that he did not attribute any right knee pain Ms Horne had to her altered gait.[102]

[57] In re-examination, Dr Cook referred to the parts of his first report (Exhibit 15) where he recorded Ms Horne complaining of pain in her right knee, namely, in the first paragraph on page 6, the last paragraph on page 6 and the last paragraph on page 9.[103]

Dr Helen Land, Musculoskeletal Physiotherapist

[58] Dr Land was called by Ms Horne. Dr Land is not a medical practitioner but has a PhD in the clinical study of shoulders.[104] Dr Land examined Ms Horne on 15 November 2019.[105]

[59] In her report, Dr Land stated that she conducted a gait assessment, active and passive movement assessment, isometric muscle testing and palpation assessment of Ms Horne.[106]

[60] In respect of the active and passive movement assessment, Dr Land reported that:

- Ms Horne's '… right hindfoot was fixed in inversion with the lateral four toes fixed in a clawed position and the remainder of the foot inverted'; and

- Ms Horne's right knee '… had very limited active or passive movement, resting at 55 degrees of flexion', and that the left knee was within normal range, which Dr Land stated was consistent with other reports including those of Dr Low dated 7 September 2016 and Dr Cook dated 18 September 2018.[107]

[61] Under the heading of 'Opinion', Dr Land stated that:

- Ms Horne's gait pattern displayed no plantar flexion and minimal hip flexion action;

- instead, the abnormal right foot posture resulting from the tonic dystonia results in her weight being taken on the lateral aspect of the right foot and whole lower limb;

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[100] T 2-25, ll 31-41.
[101] T 2-27, ll 38-39.
[102] T 2-28, ll 37-38.
[103] T 2-30, ll 18-43.
[104] T 1-62, l 9.
[105] Exhibit 10, first page.
[106] Exhibit 10, second and third pages.
[107] Exhibit 10, second page.

- the right knee remained extended with a varus force observed during mid-stance phase;

- the rigid foot posture through stance phase '… will lead to the ground reaction forces being transferred up the lower limb chain, placing increased force on the lateral aspect of both the knee and the hip'; and

- Ms Horne's injury was sustained four years and seven months ago, that each medical report provided to her (Dr Land) detailed either 'limping', 'antalgic gait' or that Ms Horne was observed to walk on the lateral aspect of foot and that some of those reports were prepared three years ago.[108]

[62] Under the same heading, Dr Land then opined:

> It is reasonable to deduce Ms Horne has been weight bearing on the lateral aspect of a rigid, dystonic right lower limb for this time. This repeated loading is resulting in excessive pressure on an area not designed to absorb this extra load, with increasing pain expected in these structures over time.[109]

[63] In her oral evidence-in-chief, Dr Land said:

- that when she stated Ms Horne's right hindfoot was fixed in inversion with the lateral four toes fixed in a clawed position and the remainder of the foot inverted, this meant the sole of the foot was visible on the inside, the heel bone was turned in at a 45 degree angle and that the toes looked like a claw;[110]

- that she examined all of Ms Horne's joints, including the right knee, and found that the right knee had a limited range of motion, that there was a small active end of range which was very limited, that there was no passive give in any of the ligament tests, that there was 'very much' a lot of stiffness, that the patella was mobile and that she could not get a contraction of the hamstrings;[111]

- when she refers in her report to 'gait', she is referring to how a person walks; and

- normally, a person walks with equal weight transference by heel to arch and pushing off on the big toe in equal step length, but that Ms Horne had a limp of quite a distinct pattern and that her weight was lying on the outside part of her right foot and there was more time on her left leg than the right.[112]

[64] Dr Land was asked how Ms Horne presented with her right foot. The transcript records:

> All right. Now, even though there was some unusual aspects about the way in which Mr [sic] Horne presented with the foot, I take it the foot wasn't sort of cast in bronze and it's stuck in that one position; is that right?---No. And I've been around for a long time, and that foot has been stuck like that for a long time. So it was concrete-like. It was solid. I applied – I'm fairly

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[108] Exhibit 10, third page.
[109] Exhibit 10, third page.
[110] T 1-64, ll 6-19.
[111] T 1-65, ll 11-16.
[112] T 1-67, ll 3-35.

> strong. I do go to the gym pretty regularly, and there was no way on this earth I could move it. And to the credit of Ms Horne, she was biting her tongue and letting me do it, but there was definitely no movement.[113]

[65] Dr Land concluded her evidence-in-chief by stating that:

- she assessed Ms Horne four years and seven months from the date of her injury, all the reports reported Ms Horne limping from April 2015 and therefore by the time she saw Ms Horne (on 15 November 2019) her pain would have increased due to the structures in her right knee continuing to get loaded;[114] and

- Ms Horne had an injury to her right foot, she had been limping since the time of the injury and therefore her knee pain can be linked to that injury.[115]

[66] In cross-examination, Dr Land agreed that when she examined Ms Horne, she could see the sole of Ms Horne's right foot and that she could not get that to change, which meant that on the day of her assessment she could not get Ms Horne to stand flat on the ground.[116] Dr Land further stated that:

- she had not seen the surveillance footage of Ms Horne and that she had not seen the MRIs of Ms Horne's right knee, but '… those sort of pathological changes do not have to equate to pain anyway.';[117]

- she denied, in giving her opinion, that she relied on Ms Horne's reporting of knee pain to her and others, stating that she (Dr Land) had:

  > been here for 34 years. So I don't just base it on someone telling me they're in pain. I'm wise to when people are in pain and when they're not. I more base it on what I physically observed in her gait;[118] and

- she agreed that she did not see any swelling in Ms Horne's right knee but disagreed with the proposition that she could not say Ms Horne had a physical injury to her right knee because, in her opinion, Ms Horne had a soft tissue overuse injury to her right knee and '… there's no changes on scans with any of those injuries.'[119]

Dr Leigh Atkinson, Neurosurgeon and Pain Medicine Physician

[67] Dr Atkinson was called by the Regulator. Dr Atkinson assessed Ms Horne, for WorkCover Queensland, on 11 May 2016. According to his written report, the injuries for which Ms Horne was assessed included:

- a musculoligamentous injury to the right foot;

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[113] T 1-64, ll 34-40.
[114] T 1-68, ll 17-31.
[115] T 1-69, ll 27-30.
[116] T 1-71, ll 1-16.
[117] T 1-71, ll 23-30.
[118] T 1-72, ll 19-24.
[119] T 1-72, ll 26-38.

- plantar fasciitis;
- possible complex regional pain syndrome ('CRPS') type 1; and
- a lumbar spine injury.[120]

[68] Dr Atkinson's findings in his clinical examination included that Ms Horne:

- walked initially with a stooped lumbar spine and an atypical gait with her foot inverted inwards and her toes clawed on the right side;[121]
- had restriction in the range of movements of her cervical spine with no associated symptoms, flexion was reduced to 30 degrees (normal is to 50 degrees) and rotation was to 40 degrees (normal is to 85 degrees);[122]
- was unable to walk on her heels, though she could walk on her toes;[123]
- had no wasting of the muscles of the calves on measurement, with both measuring 40 cm in circumference at a point 25 cm above the ankle, and her reflexes were uniformly normal in the lower limbs;[124] and
- had straight leg raising to 20 degrees on the right and to 40 degrees on the left.[125]

[69] In his evidence-in-chief, Dr Atkinson stated:

- he conducted a full examination of Ms Horne in respect of her trunk hips, knees, ankles and toes;[126]
- when in his report he stated that Ms Horne was unable to walk on her heels, that was her left and right heels;[127]
- Ms Horne could stand on both toes, but with fear of collapsing in that she could not take the weight of her body on her toes when he asked her to press down;[128] and
- when he reported, on page 4, that Ms Horne '… could stand on her toes' that meant she did it on medication.[129]

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[120] Exhibit 5, page 11.
[121] Exhibit 5, page 11.
[122] Exhibit 5, page 11.
[123] Exhibit 5, page 11.
[124] Exhibit 5, page 12.
[125] Exhibit 5, page 12.
[126] T 1-48, ll 18-21.
[127] T 1-48, ll 23-24.
[128] T 1-48, ll 26-29.
[129] T 1-48, ll 34-39.

[70] Dr Atkinson stated that he did not remember Ms Horne mentioning her right knee and that he did not diagnose an injury to her right knee because she did not report any specific abnormalities of the knee.[130]

[71] In cross-examination, Dr Atkinson agreed that Ms Horne had pain down her right lower limb but no source had been located as to what caused that pain[131] and that Ms Horne could have had plantar fasciitis.[132]

Mr Mark Scalia, Occupational Therapist

[72] Mr Scalia was called by Ms Horne. Mr Scalia conducted an assessment of Ms Horne on 27 December 2016. In his report, Mr Scalia stated:

> Prior to the accident, Ms Horne enjoyed exercising and actively playing with her children. She reported that she would swim/run and exercise daily. She describes being very active prior to the injury and enjoyed it taking her kids to athletics, assist [sic] with coaching, riding bicycles, horse riding and fishing. She no longer engages in her previous leisure activities because of right foot, right knee and low back pain, fatigue, reduced functional tolerances and loss of motivation. She has become more reclusive and declines social outings or invitations from friends. She now has an inactive lifestyle where she does not move from her couch. She has suffered a loss of quality of life.[133]

[73] In cross-examination, Mr Scalia was taken to paragraph 10 of his report where he identified the post injury support and future care requirements for Ms Horne, in particular, the paragraph where he set out the recommended ongoing care for Ms Horne in respect of meal preparation, domestic cleaning and prompting and emotional/social support. It was suggested to Mr Scalia that he formed the view that, having regard to those recommendations he made, Ms Horne was significantly disabled. Mr Scalia agreed and said those recommendations were also based upon the medical information provided to him, in particular, the medical report of Dr Low in which Dr Low stated that Ms Horne had a whole person impairment of 30%.[134]

[74] It was put to Mr Scalia that, if Ms Horne could drive distances at least a couple of times a week, could shop and could stand for 20 minutes, he would need to review the recommendations he made. Mr Scalia agreed, on the basis that there was an improvement in her condition.[135]

Dr James Price, Consultant Orthopaedic Surgeon

[75] Dr Price was called by the Regulator. Dr Price had prepared reports on Ms Horne dated 19 December 2016 (Exhibit 18), 31 March 2017 (Exhibit 19), 21 June 2017 (Exhibit 20) and 11 October 2017 (Exhibit 21).

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[130] T 1-49, ll 1-9.
[131] T 1-50, ll 6-13.
[132] T 1-51, ll 6-9.
[133] Exhibit 17, page 11.
[134] T 2-35, ll 28-35.
[135] T 2-36, ll 1-7.

[76] In his evidence-in-chief, Dr Price stated, in respect of his examination of Ms Horne in late 2016, he had no notes of her complaining of pain in her right knee but that, from memory, he did not ask her about pain in her right knee.[136]

[77] Dr Price was provided with the Verifact surveillance report dated 25 May 2017 (Exhibit 2) and the video surveillance contained in Exhibits 6 and 7 for the purpose of making his 21 June 2017 report. In respect of that material, Dr Price opined:

> It would certainly seem that the atypical gait and the atypical position the foot is being held when I examined her are not a permanent problem. She was walking on a completely plantigrade foot with her toes out straight in one section of the surveillance video when she was walking without a stick. Therefore, this position is obviously voluntary and is not a fixed deformity. I do not know whether she has any underlying psychological issues that have caused her to do this or whether she was doing it deliberately.[137]

[78] In his oral evidence-in-chief, Dr Price stated that a plantigrade foot is where the foot is able to be put flat from the ground without any inversion or aversion so that the sole of foot is directly on the ground. Dr Price stated that Ms Horne's toes were extended so they were flat on the ground rather than being flexed or scrunched up, which was different to the position of her foot when he examined her for his report in December 2016, where her foot was held in the fixed inverted and plantigrade position and could not be moved out of that position.[138]

[79] In cross-examination, Dr Price conceded that he never examined Ms Horne in respect of her knee and that his report dated 11 October 2017 (Exhibit 21) was about his assessment of Ms Horne's permanent impairment about her ankle injury.[139]

[80] Dr Price stated that he had not seen Dr Land's report about Ms Horne and that insofar as Ms Horne's right knee was concerned, he could not take the matter very far because he did not examine her knee and that he only examined her ankle.[140]

[81] It was suggested to Dr Price that Ms Horne's foot and ankle may have become worse over time. Dr Price said that her soft tissue injury had not resolved and that she may have neuropathic pain.[141]

Dr Robin 'Sid' O'Toole, Occupational & Environmental Physician

[82] Dr O'Toole was called by the Regulator. Dr O'Toole examined Ms Horne on 9 May 2017 at the request of WorkCover which led to his first report dated 15 May 2017 (Exhibit 23). WorkCover subsequently provided Dr O'Toole with the video surveillance as contained in Exhibits 6 and 7 which led to Dr O'Toole's supplementary report dated 9 June 2017 (Exhibit 24).

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[136] T 2-41, ll 9-14.
[137] Exhibit 20, page 4 of 6.
[138] T 2-41, ll 34-44.
[139] T 2-46, l 19 to T 2-47, l 12.
[140] T 2-49, ll 28-39.
[141] T 2-50, ll 10-14.

[83] In his first report, Dr O'Toole reported that Ms Horne walked with a normal gait and demonstrated an unimpeded ability to walk on both her heels and toes.[142] In his oral evidence-in-chief, Dr O'Toole stated that:

- he obtained that information by undertaking a lumbar spine assessment which involves assessing the patient's gait, which is done by viewing the patient in three stages:
  - first, as they walk into and leave the consultation room;
  - secondly, asking the patient to stand and walk backwards and forwards the length of the consultation room; and
  - then by the patient walking on their toes for a number of steps and their heels for a number of steps;[143]
- he assessed Ms Horne by watching her ambulate and looking at how both her legs functioned;[144] and
- when looking at the neurological component of a neurovascular examination he would be able to notice any clawing of the toes, however he did not notice any clawing of Ms Horne's toes.[145]

[84] In his supplementary report, Dr O'Toole stated that when he examined Ms Horne on 9 May 2017, she could not perform a straight leg raise test at all with either leg, despite being able to sit on the bed with her hips and knees bent, stand, sit, walk and stand up from a seated position, which, in his opinion, demonstrated sufficient strength to be able to perform a straight leg raise test.[146]

[85] In cross-examination, Dr O'Toole:

- stated that his examination of Ms Horne would have taken 10-15 minutes;[147]
- agreed that Ms Horne was distressed when he examined her;[148] and
- agreed that he was not asked to provide any opinion about Ms Horne's knee;[149]

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[142] Exhibit 23, fourth page.
[143] T 2-53, l 43 to T 2-54, l 5.
[144] T 2-54, ll 11-17.
[145] T 2-54, ll 19-26.
[146] Exhibit 24, third page.
[147] T 2-56, ll 35-37.
[148] T 2-58, ll 33-35.
[149] T 2-58, ll 37-38.

Ms Horne's submissions

[86] Ms Horne submits that she suffered a soft tissue injury to her right knee as a consequence of her altered gait pattern which is directly referable to the workplace injury she sustained on 26 April 2015.[150]

[87] Ms Horne's contention was that, as a consequence of the accepted injuries to her right foot and lower back, she continued to suffer the symptoms of a limp, lower back pain, pain in the right foot and ankle, deformity/curling of the toes on her right foot, restricted movement of the right ankle and toes and an altered gait; and that over time, those symptoms, in particular the limp, have caused her to favour her right side causing her right knee to give way at times and have led to the development of a right knee injury.[151]

[88] Ms Horne's general submission is that the workplace injury she suffered on 26 April 2015 resulted in an altered gait pattern; and that the altered gait pattern had a consequential connection with a soft tissue injury to her right knee.[152]

What does Ms Horne submit caused her altered gait pattern?

[89] Ms Horne submitted[153] that Dr Atkinson considered that she developed an aggravation of the age-related degenerative changes in her lumbar spine at L5/S1, that the changes were secondary and related to her abnormal gait[154] and that Dr Atkinson concluded that the physical findings he made could not be explained by any organic neurological injury.[155]

[90] What does Ms Horne submit caused or had a causal connection with her abnormal or altered gait? In her submissions, Ms Horne points to Dr Low's opinion, as expressed in his report dated 7 September 2016, that while Ms Horne's original injury, as sustained on 26 April 2015, should have settled very quickly, it did not and that Ms Horne developed secondary knee, hip, back and right shoulder problems as a result of her altered gait pattern because she could not walk normally on the right foot and ankle.[156]

[91] Ms Horne's case, that the pain in her right knee had a causal connection with her altered gait, was developed by her significant reliance on the evidence of Dr Low, Dr Cook and Dr Land, namely, that her altered gait was as a result of right lower limb tonic dystonia. This is made clear because Ms Horne submitted that:

- Dr Atkinson, Dr Price and Dr O'Toole were not asked to consider Dr Land's report;[157]

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[150] Ms Horne's submissions, para. 2.3.
[151] Ms Horne's contentions, Attachment A, paras. 5 and 6.
[152] Ms Horne's submissions, para. 2.10.
[153] Ms Horne submissions, paras. 10.2 and 10.3.
[154] Exhibit 5, page 15.
[155] Ms Horne's submissions, para. 10.5 (referring to Exhibit 5, page 15).
[156] Exhibit 11, page 10, para. 1.
[157] Ms Horne's submissions, para. 10.9.

- Dr Low and Dr Cook agreed with Dr Land's report and in particular, Dr Cook found that Dr Land's findings were consistent with his own;[158]

- in those circumstances, there is no logical reason to reject Dr Land's opinion that '… the lateral right knee pain is consistent with noicicptive [sic] pain emanating from the lateral soft tissue structures of the right knee which are now absorbing increase ground reaction forces during each phase of gait';[159]

- Dr Land's opinion that she displayed lower limb tonic dystonia was not seriously challenged.[160]

[92] Ms Horne also submitted that:

- the Regulator's proposition, that because there is no identifiable physical injury which caused the pain to her right side, including her knee, and that as a consequence there is in fact no injury '… flies in the face of Dr Atkinson's approach to the injury which he identified as being "…secondary and related to her abnormal gait;" '[161]

- as far as Dr Price and Dr O'Toole were concerned, the weight of evidence is against them because neither of them examined Ms Horne's right knee;[162] and

- insofar as Dr Land's evidence is that Ms Horne suffers from an unidentified soft tissue injury in the vicinity of the right knee, Dr Price adopted the same methodology to identify that Ms Horne suffered a soft tissue injury to her right ankle and Dr Price did not rely upon any imaging investigation to reach that diagnosis.[163]

[93] Ms Horne submitted that, it followed therefore, that there was no evidence to rebut the proposition that she had suffered an injury to her right knee.[164]

[94] In terms of a causal link between any right knee injury suffered by Ms Horne and her employment, Ms Horne submitted that the 'second accepted injury, clearly satisfied these requirements.'[165] Ms Horne submitted that her abnormal gait has been accepted as a factor causing the second accepted injury, namely, an aggravation of age-related degeneration at L5/S1.[166] Assuming that to be so, on Ms Horne's case, her abnormal gait existed prior to the aggravation of the degenerative change in her lumbar spine and her abnormal gait had a causal connection with the aggravation of that degenerative change in her lumbar spine.

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[158] Ms Horne's submissions, para. 10.10.
[159] Ms Horne's submissions, para. 10.11.
[160] Ms Horne's submissions, para. 10.12.
[161] Ms Horne's submissions, para. 10.7
[162] Ms Horne's submissions, para. 10.8.
[163] Ms Horne's submissions, paras. 10.13 and 10.14.
[164] Ms Horne's submissions, para. 10.15.
[165] Ms Horne's submissions, para. 10.18.
[166] Ms Horne's submissions, para. 10.23, 2), ii.

[95] Ms Horne submitted that the Regulator's proposition that because there is no identifiable physical injury which caused the pain to her right side, including her knee, and that as a consequence there is in fact no injury, was directly inconsistent with Dr Atkinson's approach to the 'injury' which he identified as being secondary and related to her abnormal gait.[167] However, that part of Dr Atkinson's report concerned the accepted aggravation injury to Ms Horne's lumbar spine, not to an injury to her right knee.

[96] Ms Horne then went on to submit that Dr Cook and Dr Land agreed that the limp, which was recognised from a very early stage after the injury to Ms Horne's ankle, was central to the causation of the knee injury.[168]

[97] Ms Horne then submitted that:

- there are numerous proven facts which support the inference of the existence of an injury including:
  - the facts and circumstances surrounding the incident on 26 April 2015;
  - her course of medical treatment;
  - the slow degeneration of the condition of her right foot and right limb; and
  - the inversion of her right foot and the clawing of her toes on the right foot;
- an inference of the existence of a soft tissue injury to her right knee can safely be drawn on the proven facts including:
  - that she developed a limp soon after the incident on 26 April 2015;
  - that the abnormal gait has been accepted as a factor causing the second accepted injury;
  - the clubbing of her toes on her right foot; and
  - the physiotherapy notes (Exhibit 14); and
- a causal link to the employment can be safely drawn by the above-mentioned proven facts.[169]

[167] Ms Horne's submissions, paras. 10.6 and 10.7.
[168] Ms Horne's submissions, para. 10.21.
[169] Ms Horne's submissions, para. 10.23.

The Regulator's submissions

[98] The Regulator submitted that:

- the basis of the argument that Ms Horne has suffered an injury (to her right knee) involves the acceptance that she walked abnormally due to the accepted work-related injury to her right foot which resulted in a right knee injury;[170]

- given the inconsistent reporting and video surveillance, it is open to the Commission to make a finding that Ms Horne did not always walk with an abnormal gait and that this was not a feature of any injury from the incident on 26 April 2015;[171]

- on the authority of *Seltsam*,[172] the common law test of the balance of probabilities is not satisfied by evidence which fails to do more than establish the possibility;[173]

- the circumstances of the original incident and the course of Ms Horne's medical treatment does not give rise to an inference of injury regarding the right knee, and specifically:

  – Ms Horne did not notice any pain in her knee for '… at least months' after the incident, has had no medical treatment for a knee injury and has not had any investigation regarding her right knee;[174]

  – there is no objective medical evidence of a slow degenerative condition of her right foot and limb and there is no organic basis for these features;[175]

  – the inversion of the right foot and the clawing of the toes as an involuntary position has been challenged by the opinions of Dr Price and Dr O'Toole and therefore those matters are not a proven fact;[176]

  – an abnormal gait could be a factor for a soft injury however, there are no objective facts to support that Ms Horne has a soft tissue injury and that without objective facts of injury, the proposition that the gait has caused the injury is merely conjecture;[177] and

  – there is no objective medical evidence to support that the inversion of the right foot and/or the clawing of the toes was due to an accepted work-related injury;[178]

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[170] The Regulator's submissions filed on 10 February 2020 ('the Regulator's submissions'), para. 77.
[171] The Regulator's submissions, para. 79.
[172] *Seltsam* (n 12), [80] (Spigelman CJ).
[173] The Regulator's submissions, para. 80.
[174] The Regulator's submissions, para. 82(a).
[175] The Regulator's submissions, para. 82(b).
[176] The Regulator's submissions, para. 82(c).
[177] The Regulator's submissions, para. 82(d).
[178] The Regulator's submissions, para. 82(e).

- on the basis of the primary facts, it is not reasonable for the Commission to draw a secondary fact, namely that Ms Horne suffered a right knee injury at all;[179] and

- consideration must also be given to the inconsistency of symptoms, identified in the surveillance and the reporting of symptoms to medical professionals, and that it is open to the Commission to conclude, that for some reason, including dishonesty, Ms Horne sought to embellish, overstate and present to have catastrophic outcomes as a result of a foot injury on 26 April 2015.[180]

Does Ms Horne have right lower limb symptoms and a gait pattern consistent with that as she presented to Dr Low, Dr Cook and Dr Land?

[99] Given the evidence and submission by the parties, a material issue is whether Ms Horne suffered from right lower limb symptoms and a gait pattern consistent with that as she presented to Dr Low, Dr Cook and Dr Land.

[100] There are inconsistencies between the presentation of Ms Horne's right lower limb and her gait to Dr Low, Dr Cook and Dr Land, and the surveillance report dated 16 October 2017 and the depiction of Ms Horne in the video surveillance.

[101] Dr Land explained what she meant in her report when she referred to Ms Horne displaying 'tonic right lower limb dystonia.' Dr Land stated that in her report, she defined 'dystonia' as a '… state of abnormal muscle tone resulting in muscle spasm and abnormal posture'[181] and stated that 'tonic' meant constant.[182]

[102] In respect of Ms Horne's presentation to her, Dr Land seemed to state that Ms Horne's muscles were always in that state of spasm, that Ms Horne was keeping her knee largely extended, the hip was largely turned in and that there was increased muscle tension throughout that area.[183]

[103] In cross-examination, it was put to Dr Land that the tonic right lower limb dystonia was Ms Horne's clawed toes. Dr Land disputed that and stated that tonic right lower limb dystonia:

> affects the entire lower limb. It's not just clawed toes. That is totally false. So basically, the whole posture of the extended leg, turned in hip, lateral - the inverted foot, the whole thing means she only has that service on which she can put her load.[184]

[104] Dr Land's opinion, in summary, was:

- that Ms Horne had a permanent deformity in that her right hindfoot was fixed in inversion with the lateral four toes fixed in a clawed position and the remainder of the foot inverted, and her (Dr Land's) finding was consistent with the written reports of Dr Atkinson dated 13 May 2016, A & I Physiotherapy dated 20 June 2016, Dr Low dated 7 September 2016, Dr Price dated

[179] The Regulator's submissions, para. 85.
[180] The Regulator's submissions, para. 86.
[181] T 1-66, ll 24-25.
[182] T 1-66, l 40.
[183] T 1-66, ll 42-45
[184] T 1-70, ll 14-19.

19 December 2016, Mr Scalia dated 25 January 2017 and Dr Cook dated 18 September 2018;[185] and

- that abnormal right foot posture, resulting from the tonic dystonia, resulted in Ms Horne's weight being taken on the lateral aspect of the right foot and the whole lower limb, placing increased force of the lateral aspect of both the knee and the hip.[186]

[105] Ms Horne submitted that:

- critical to the process of drawing the inferences, which are essential to her proving her case on the balance of probabilities, is that there is no other inference which can be drawn on those established facts;[187] and

- there is no alternative inference to be drawn upon the proven facts and that the video surveillance evidence contained in Exhibits 6, 7, 8 and 9 would not be sufficient to supplant the primary finding of the existence of an injury to her right knee.[188]

[106] In my view, the surveillance evidence is material having regard to Ms Horne's reliance on Dr Land's opinion, her reliance on the significant agreement by Dr Cook with Dr Land's opinion[189] and her reliance on Dr Low's agreement with Dr Land's comments about gait patterns and weight pressure on the lateral part of the right knee.[190]

[107] Dr Low examined Ms Horne on 7 September 2016. In his report of the same date, Dr Low opined that:

- Ms Horne required a brace on the right knee and a cane to ambulate and that she spent most of her time indoors;

- she could not shop or drive or cook, watch her children play sport, could not do any physical exercise and that she was in constant pain;

- his examination revealed that her right leg was extremely difficult to examine, she had a flexed hip, flexed knee and a plantar flexed, inverted right foot that was extremely difficult to examine as she resisted any attempt to move the knee, hip, foot or ankle, and that there were some sensory changes in a glove and stocking manner in the right leg;

- her gait was with one cane and a brace on her right knee; and

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[185] Exhibit 10, second page, fourth paragraph.
[186] Exhibit 10, third page, fourth paragraph.
[187] Ms Horne's submissions, para. 10.24.
[188] Ms Horne submissions, paras. 10.27, 10.28 and 10.29.
[189] T 2-19, l 33 to T 2-20, l 35 and T 2-21, l 45 to T 2-27, l 9.
[190] T 1-80, ll 30-33.

- the best way to give her impairment would be to refer to lower limb impairment due to gait derangement and that he awarded her 30% whole person impairment.[191]

[108] Dr Cook in his report dated 18 September 2018, following his first examination of Ms Horne on 26 June 2018, noted that Ms Horne stated she continued to have pain in the whole of her right foot and ankle which also extended up to her right knee and recently pain up as far as the right hip, buttock and right side pelvis.[192] Dr Cook also reported:

> Further examination of the right lower limb revealed fixed plantar flexion of approximately 30 degrees in relation to her right ankle and also inversion position of her right foot plus marked varus of the foot giving the appearance that the right foot rolled over onto the lateral or outside rays of the foot with the foot turned inwards. During this examination the writer attempted to bring the right foot and ankle up towards the neutral position but was unable to achieve this. It was noted that all the toes of the right foot have fixed flexion deformities at the level of the proximal interphalangeal joints in the order of 70 to 80 degrees consistent with hammer toe deformities but there was also minimal movement in metatarsophalangeal joints of the right foot. Attempts at obtaining some movement in these joints resulted in report of greatly increased pain.[193]

[109] In his oral evidence-in-chief, Dr Cook was asked, insofar as Ms Horne's knee was concerned, about the significance of her gait. Dr Cook answered:

> Her – her gait is so poor that she obviously cannot walk normally. She cannot get her foot plantigrade on the ground for an even weight distribution, and because she can only weight bear through the outside raise of her right foot alters the dynamics right through the whole of the foot, ankle, leg right up to the hip and lower back, and because the foot is in a degree of plantar flexion means that she either has to swing her leg out in a circular fashion or try to flex her knee more so that the foot clears the ground because if she doesn't do that, she's just going to constantly trip herself up because her toes – or the toes of her shoe or whatever she's got on will catch on the ground.[194]

[110] Both before and after the dates of the surveillance of Ms Horne (conducted on 9, 10, 11, 17 May 2017, on 4 October 2017 and on 13 January 2018):

- Dr Low and Dr Cook reported that Ms Horne was in significant pain;

- Dr Low reported that Ms Horne had a plantar flexed, inverted right foot that was extremely difficult to examine as she resisted any attempt to move the knee, hip, foot or ankle;

- Dr Cook reported that the inversion of a right foot, plus a marked varus of the foot, giving the appearance that the right foot rolled over onto the lateral side or outside rays of the foot with the foot turned inward, was so pronounced that he was unable to move the foot and ankle upwards towards the neutral position; and following his second examination again noted Ms Horne's right foot toes were in

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[191] Exhibit 11, pages 11-12.
[192] Exhibit 15, page 6.
[193] Exhibit 15, page 9, second paragraph.
[194] T 2-26, ll 29-39.

fixed flexion deformities, an inverted immobile right foot and again, loss of movement in the right ankle; and

- Dr Low reported a deranged gait and Dr Cook reported that Ms Horne's gait was so poor that she could not walk normally and could not get her foot plantigrade on the ground for an even weight distribution.

[111] However, in Exhibit 6, in respect of the depiction of Ms Horne on 9 and 10 May 2017, Ms Horne was walking with her right foot flat on the ground.

[112] True, part of the footage of 4 October 2017, which depicts Ms Horne alighting from the white Suzuki SUV, walking into the Mater Hospital and then walking across a road, certainly shows her walking on the lateral aspect of her right foot. However, the report of the surveillance agent was that Ms Horne was walking towards a black Ford F250 Utility truck (approximately 20 minutes before she alighted from the white Suzuki SUV, walking into the Mater Hospital) and that she was not walking with a walking stick.[195] Although very brief, that is what I saw in Exhibit 8 between approximately 13:42:48 and 13:42:50.

[113] Three months later, on 13 January 2018, Ms Horne was depicted:

- standing;

- to the extent she was seen walking, was walking with her right foot flat on the ground; and

- on occasions, was putting her body weight on her right leg.

[114] Dr Price examined Ms Horne on 9 December 2016. Dr Price stated that Ms Horne walked into his room with a very atypical gait, that she was holding her foot in an equinovarus position and walking on the lateral side with clawed toes, that he could not correct the varus deformity of the hindfoot, but that he could eventually stretch out the toes and correct the claw deformity of the toes so that it was not a fixed deformity.[196]

[115] Dr Price was then provided with the video surveillance contained in Exhibits 6 and 7 for the purposes of making his report dated 21 June 2017. After viewing that video footage, Dr Price opined that the atypical gait and atypical position Ms Horne's foot was being held in when he examined her on 9 December 2016 were not a permanent problem, in that she was walking on a completely plantigrade foot with her toes out straight in one section of the surveillance video when she was walking without a stick. Dr Price concluded that the position was obviously voluntary and not a fixed deformity.[197]

[116] Dr Low, for the purposes of his report dated 14 August 2018, viewed the surveillance video of Ms Horne taken on 13 January 2018 (Exhibit 9).[198] Dr Low stated that:

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[195] Exhibit 3, page 4.
[196] Exhibit 18, page 5 of 7.
[197] Exhibit 20, page 4 of 6
[198] Exhibit 12, first page, second paragraph.

- in the video, he saw Ms Horne walking fairly normally with a stick in her left hand and that she did not appear to be distressed;[199]

- while he could not get a good view of her right foot, she seemed to adopt a variable supinated inverted right foot posture with a slight limp and a crutch in her left hand, and noted that he had seen her standing upright leaning on her right leg;[200]

- from a distance, he could see the right hindfoot was in slight varus, the forefoot was slightly adducted, that it was not as severe and that it certainly varies enormously in how severe she adopted with the right foot; however it did not seem to be distressing to her and that she walked fairly normally;[201]

- he saw Ms Horne getting in and out of the car and loading and unloading, that she was getting in and out of the car in a normal fashion and that she could stand without recourse to using a stick in her left hand at all; and

- in fact, she lent on her right leg on more than one occasion.[202]

[117] Dr O'Toole did not notice any clawing of Ms Horne's right toes when he examined her on 9 May 2017 and opined that because Ms Horne could sit on the bed with her hips and knees bent, stand, sit, walk and stand up from a seated position, she had sufficient strength to be able to perform a straight leg raise, even though she could not perform a straight leg raise test at all with either leg.

[118] Dr Land examined Ms Horne on 15 November 2019, approximately 10 months after the date of the surveillance contained in Exhibit 9. Dr Land reported that:

- Ms Horne's gait pattern displayed no plantar flexion and minimal hip flexion;[203]

- Ms Horne's right foot had been stuck in the position for a long time and was '… concrete-like';[204]

- Ms Horne's injury was sustained four years and seven months ago, each medical report provided to her Land detailed either 'limping', 'antalgic gait' or 'observed to walk on the lateral aspect of foot' and it was reasonable to deduce that Ms Horne had been weight-bearing on the lateral aspect of a rigid, dystonic right lower limb for some time;[205]

- the tonic right lower limb dystonia resulted in an abnormal right lower limb posture during the stance phase of gait, placing increased loading through the lateral aspect of the entire right lower limb; and that the tonic muscular spasm

[199] Exhibit 12, first page.
[200] Exhibit 12, first page.
[201] Exhibit 12, first page.
[202] Exhibit 12, first page.
[203] Exhibit 10, third page.
[204] T 1-64, ll 34-40.
[205] Exhibit 10, third page.

resulted in the right leg remaining internally rotated and extended throughout the gait cycle;[206] and

- Ms Horne's tonic right lower limb dystonia, resulted in an abnormal right lower limb posture during the stance phase of gait, placing increased loading through the lateral aspect of the knee, which was likely to cause increasing pain in that area over time.[207]

[119] Dr Land did not view the video surveillance of Ms Horne.

[120] The video surveillance of 9, 10, 11 and 17 May 2017 and 13 January 2018 (apart from 4 October 2017 when Ms Horne was seen alighting from a white Suzuki SUV with another female, walking into the Mater Hospital and then walking across a road) depicts Ms Horne walking, with a slight limp, but with her right foot flat on the ground. Whilst she walks with a slight limp, there does not appear to be any significant discomfort or significant pain suffered by Ms Horne. Ms Horne does not have a pronounced altered gait.

[121] Ms Horne could drive the children depicted in the video surveillance in May 2017, and she could get in and out of the vehicles depicted with ease over the period of time of the surveillance videos.

[122] Certainly, in respect of the video surveillance when Ms Horne was in the Harvey Norman store, she stood for a reasonably significant period of time, namely, between 10:34:56 and 10:54:15 as shown in Exhibit 9. Between 10:41:41 and 10:41:51, Ms Horne is shown putting all of her weight on her right leg and, it appears, little weight being taken by the cane she is holding in her left hand. Between 10:43:14 and 10:43:44, Ms Horne is shown again putting her weight on her right leg. When Ms Horne is depicted standing in, walking into, within and outside of the Harvey Norman store, her right foot is flat on the ground.

[123] In cross-examination, it was put to Ms Horne that she could walk without a walking stick, she could stand for an excess of 20 minutes and that the reality was that she could probably go back to work but that she did not want to go back to work. Ms Horne stated she could walk a short distance, with a limp, without a walking stick, that she would like to be able to walk for over 100m but she could not stand for longer than 20 minutes and that she did want to go back to work.[208]

[124] It was further put to Ms Horne that her knees did not give way at all, which Ms Horne denied;[209] and it was put to Ms Horne that she did not have a knee injury at all, to which Ms Horne responded: 'No, it's just painful.[210] Ms Horne denied that the reason she had a cane was because she wanted people to think that she was severely hurt.[211]

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[206] Exhibit 10, fourth page.
[207] Exhibit 10, fourth page.
[208] T 1-86, ll 20-35.
[209] T 1-86, l 37.
[210] T 1-86, l 39.
[211] T 1-87, ll 1-3.

[125] For the reasons referred to above in paragraph [91] of these reasons for decision, Ms Horne's case relies heavily on the evidence of Dr Low, Dr Cook and Dr Land. Having regard to Exhibit 3, and the video surveillance, I am not satisfied that Ms Horne's right lower limb is affected to the extent as she presented to Dr Low, Dr Cook and Dr Land.

[126] In my view, the extent to which Ms Horne stated she was in pain, had difficulty performing the ordinary activities of life such as domestic duties and driving, and the extent to which Ms Horne had a right lower limb abnormality and an altered gait as she presented to Dr Low, Dr Cook and Dr Land, is significantly inconsistent with the unchallenged observations of her by the surveillance agent on 4 October 2017 contained in Exhibit 3 and with the video surveillance. For these reasons, I am not persuaded that Ms Horne is in pain and that her right lower limb is affected to the extent as she presented to those medical practitioners.

Is there a permanent deformity of Ms Horne's right foot?

[127] Dr Land and Dr Cook's opinions were that the deformity to Ms Horne's right foot was fixed. On Ms Horne's case, her right lower limb tonic dystonia resulted in a permanent inversion of her right foot, which caused her altered gait, which in turn placed the excessive pressure on her right knee.

[128] In cross-examination, Dr Land's evidence was that it would surprise her if Ms Horne could get her right foot flat in that, given she saw Ms Horne in the last couple of months, she did not think Ms Horne could get her right foot flat any more.[212] Dr Cook agreed, in cross-examination, that his opinion about Ms Horne was based on the assumption that Ms Horne walked on the lateral part of her foot which caused pain to her right knee.[213] Dr Cook also agreed that if Ms Horne could put her foot flat on the ground, the forces on her right knee would not be so damaging.[214]

[129] I do not accept, as a fact, that Ms Horne's right foot was permanently inverted to the extent she presented to Dr Low Dr Cook and Dr Land.

[130] In my view, what was first observed by the investigator on 4 October 2017, as set out in Exhibit 3 and the depiction of Ms Horne in the video surveillance contained in Exhibits 6, 7, 8 (other than the video of Ms Horne alighting from the white Suzuki SUV on 4 October 2017) and 9 is inconsistent with Ms Horne's foot being permanently fixed in the way she presented to those medical practitioners.

[131] Furthermore, the depiction of Ms Horne, as she alighted from the passenger seat of the white Suzuki SUV on 4 October 2017, before she attended the Mater Hospital, was inconsistent with the surveillance report and video of her depicted approximately 20 minutes before that time of her walking without a walking stick and driving a black dual cab utility.

Ms Horne's explanations of the depictions of her in the video surveillance

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[212] T 1-71, ll 18-21.
[213] T 2-29, ll 23-24.
[214] T 2-29, ll 26-30.

[132] Ms Horne submits that the video evidence would not be sufficient to supplant the primary finding of the existence of an injury to the right knee. In this regard, Ms Horne points to the explanations she gave under cross-examination about the facts and circumstances of the surveillance.[215]

[133] In cross-examination, Ms Horne stated that she had been driving since 2016[216] but did not drive every day[217] and that she started driving so that she could feel like a human and that she was doing something '… not just a vegetable staying inside or not doing much. The more I get to do and the more I can practice and the more I can get out and do stuff, the better I feel as a human.'[218]

[134] Exhibit 7 shows Ms Horne, on 17 May 2017, using a walking stick in her left hand and getting to the driver's seat of a black SUV. The footage of 4 October 2017 shows Ms Horne in the driver seat of a black dual cab utility and then reversing out of the driveway, steering the vehicle with her right hand. The footage of 11 May 2017, in Exhibit 6, shows Ms Horne being able to get in and get out of the driver's side of a blue Toyota SUV with little difficulty.

[135] Ms Horne agreed that she had seen the videos and agreed that, in respect of Exhibit 9, she was in the shop for over 20 minutes.[219] Ms Horne stated however that she was standing still, going from weight to weight and shifting from foot to foot.[220] It was put to Ms Horne that when she was shifting from foot to foot, it was flat foot to flat foot. Ms Horne stated that her foot was still clawed, that it was still on the side and that she could not drive when she left the shop because she had been standing for too long and walking for too long.[221]

[136] Ms Horne agreed that she saw the video footage where she was walking without her walking stick.[222] Ms Horne stated that:

- she could walk short distances but she was still leaning;[223] and
- she could put her foot flat on the floor if she was standing but if she was to walk, that was where she had problems and that she starts to lean.[224]

[137] Ms Horne's explanation about the video footage where she was walking, without her walking stick, and standing is inconsistent with:

- what I viewed in Exhibit 6, being the footage of 10 May 2017 and 11 May 2017;

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[215] Ms Horne's submissions, para. 10.29.
[216] T 1-77, l 44.
[217] T 1-77, ll 24-28.
[218] T 1-77, ll 30-33.
[219] T 1-78, ll 31-34.
[220] T 1-78, ll 33-36.
[221] T 1-78, ll 38-40.
[222] T 1-78, ll 45-46.
[223] T 1-78, ll 46-47.
[224] T 1-79, ll 9-11.

- the surveillance agent's report of the observation of Ms Horne in the vicinity of her residence on 4 October 2017 as set out in Exhibit 3, page 4;

- what I viewed in the first part of Exhibit 8 prior to Ms Horne attending the Mater Hospital; and

- what I viewed in Exhibit 9, being the footage of 13 January 2018.

[138] Having regard to the video footage, I am not convinced that Ms Horne's explanations are plausible.

The effects of painkilling medication

[139] Ms Horne submitted that it was noteworthy that Dr Low, in his evidence, described the effect of medication on a person suffering chronic pain and that Dr Atkinson indicated the only reason he could see why Ms Horne was able to perform one of the tasks he required her to do was because she was on medication.[225] The suggestion appears to be that Ms Horne's depiction in the videos with her right foot flat on the ground, standing, walking and getting in and out of vehicles with relative ease, was atypical and brought about by the effects of medication.

[140] Dr Low was asked, insofar as any medications which Ms Horne might have received, what was the general effect of painkillers on a lower limb injury. Dr Low stated it would take all of the person's pain away so the person could function for a brief period of time, and that opioids or neuropathic agents were extremely effective but also had extreme side effects such as cognitive decline, and drowsiness so that '… they take away the pain that she normally would have and you feel normal. So - but they have severe side effects. Obviously you don't want to go and take opioids and neuropathic drugs unless there's a severe need to take these sort of drugs.'[226]

[141] Ms Horne's evidence was that the clawing of her toes developed 12 months after her injury at the TCC[227] and that the problems with her knee started after she was seeing her physiotherapist, Ms Wilkinson.[228] Ms Horne first saw Ms Wilkinson on 20 June 2016.[229]

[142] On 15 September 2015, Ms Horne was prescribed Targin, a painkiller, for the pain in her foot[230] and between February to May 2016 she was prescribed Panadeine Forte, Lyrica and Pregabalin.[231]

[143] The video surveillance contained in Exhibits 6 and 7 was taken in May 2017. Ms Horne was examined by Dr O'Toole on 9 May 2017 and reported that the pain

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[225] Ms Horne's submissions, paras. 10.30 and 10.31.
[226] T 1-80, ll 34-43.
[227] T 1-18, ll 36-37.
[228] T 1-23, ll 6-9.
[229] Exhibit 14.
[230] T 1-25, ll 11-22.
[231] T 1-26, l 4 to T 1-27, l 5.

medication she was on was Amitriptyline 50 mg at night, Panadeine Forte two tablets, four times daily, Lyrica 150 mg twice daily and Mirtazapine.[232]

[144] The video surveillance contained in Exhibit 8 was taken in early October 2017. Dr Price examined Ms Horne on 4 October 2017 and noted Ms Horne continued to take the medications of Lyrica, Panadeine Forte, tramadol, amitriptyline and Mersyndol.[233]

[145] When cross-examined about the video of her in the Harvey Norman store on 13 January 2018, it was suggested to Ms Horne that she must have been having a good day. Ms Horne's response was that '… With a few medications, yes. Probably six to eight Panadeine Forte plus my Lyrica and whatever else I was on.'[234]

[146] However, there was no specific medical evidence that the taking of Panadeine Forte, Lyrica or any other painkiller would have the effect of temporarily easing any abnormality of Ms Horne's right lower limb to the extent depicted in the surveillance.

[147] Certainly, when Dr Low was asked to review the surveillance footage of 13 January 2018, he did not attribute the manner in which he viewed Ms Horne standing and ambulating to any painkilling medication that Ms Horne may have been taking.[235]

[148] Furthermore, there was no medical evidence that her gait pattern was of such a nature that it would be severe on some days and ease on other days, thereby allowing her to stand and ambulate with little difficulty.

[149] I am not persuaded that Ms Horne has suffered a soft tissue injury to her right knee on the basis she submits, namely, right lower limb tonic dystonia altering her gait pattern which placed excessive pressure on her right knee. This is because I am not persuaded that her pain, her affected right lower limb, the deformity of her right foot and her altered gait was to the extent as Ms Horne presented in the examinations conducted of her by Dr Low, Dr Cook, and Dr Land.

If Ms Horne sustained a right knee injury in the way she has described, did that injury arise out of her employment as a CCO at the TCC?

[150] For the reasons given in paragraphs [99] to [149] of these reasons for decision, I am not persuaded that:

- Ms Horne sustained a right knee injury in the way that she has described, namely, secondary to the right foot and lower back injuries that arose out of or in the course of her employment;

- Ms Horne has a right knee injury as a consequence of an altered gait pattern where the altered gait pattern is directly referable to the work incident on 26 April 2015; and

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[232] Exhibit 23, third page, third paragraph.
[233] Exhibit 21, page 2 of 4.
[234] T 1-78, ll 42-43.
[235] Exhibit 12.

- Ms Horne has a right knee injury that has a causal connection with her employment as a CCO at the TCC.

Conclusion

[151] The principal question was whether, as a result of the right ankle and lower back injuries Ms Horne suffered at the TCC on 26 April 2015, she developed tonic right lower limb dystonia causing her to walk on the lateral aspect of her right foot which, in turn, caused Ms Horne to alter her gait pattern which, in turn, significantly increased the pressure on her right knee causing a soft tissue injury to her right knee.

[152] For the reasons I have given, the evidence does not rise above the possibility that such a causal chain of events occurred. Central to my conclusion is my factual finding that the pain Ms Horne suggests she experienced, the effect on her right lower limb and the consequential alteration of her gait is not as she presented to Dr Low, Dr Cook and Dr Land. The evidence upon which I come to this conclusion is the Verifact report dated 16 October 2017, the video surveillance, the later evidence of Dr Low and the evidence of Dr Price and Dr O'Toole.

[153] Further, there was no clear medical evidence which suggested Ms Horne's taking of any painkillers that she was prescribed would have the effect of permitting her to ambulate as depicted in the video surveillance.

[154] For the reasons I have given above, it is my view that Ms Horne has not suffered a right knee injury within the meaning of s 32 of the Act.

[155] The review decision of the Regulator of 31 October 2018 is confirmed.

Orders

[156] I make the following orders:

1. **The review decision of the Respondent dated 31 October 2018 is confirmed.**

2. **The Appellant pays the Respondent's costs of the appeal.**