Krogseter v Territory Insurance Office Board [2004] NTSC 49

PARTIES:	KROGSETER, CAROL E
	v
	TERRITORY INSURANCE OFFICE BOARD
TITLE OF TRIBUNAL:	MOTOR ACCIDENTS (COMPENSATION) APPEAL TRIBUNAL
JURISDICTION:	CIVIL
FILE NO:	M5 of 2002 (20215012)
DELIVERED:	17 SEPTEMBER 2004
HEARING DATES:	23, 24, 25 AUGUST 2004
JUDGMENT OF:	ANGEL J

REPRESENTATION:

Counsel:

Applicant:	Self–represented
Respondent:	Ms Judith Kelly instructed by Ms T Ling

Solicitors:

Applicant:	–
Respondent:	Cridlands

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Ang200406
IN THE MOTOR ACCIDENTS
(COMPENSATION) APPEAL
TRIBUNAL AT DARWIN

Krogseter v Territory Insurance Office Board [2004] NTSC 49
No. M5 of 2002 (20215012)

BETWEEN:

CAROL E KROGSETER
Applicant

AND:

TERRITORY INSURANCE OFFICE BOARD
Respondent

CORAM: ANGEL J

REASONS FOR JUDGMENT

(Delivered 17 September 2004)

[1] This is an application under sections 17 and 18 of the Motor Accidents (Compensation) Act for compensation for permanent impairment and payment of medical and rehabilitation expenses in respect of injuries claimed to have resulted from a motor vehicle accident. The relevant issue to be determined is whether the applicant's current health circumstances are related to an accident in which she was involved on 15 March 1991.

[2] The applicant, who was self represented, has lived in the Northern Territory for many years. On 15 March 1991 she was in Queensland. She had travelled to Sydney for medical reasons and was driving back to Darwin. The vehicle was a Northern Territory registered Toyota Lite Ace van. She

was some 70 kilometres outside Cloncurry. She was wearing a seatbelt, but failed in time to see a cow coming onto the highway. The vehicle struck the cow at some 60 – 80 kilometres per hour. The applicant was 42 years old at the time of the accident. She suffered injuries and on 22 April 1991 applied to the respondent for benefits under the Act.

[3] The respondent commenced paying medical and rehabilitation expenses to the applicant pursuant to s 18 of the Act.

[4] On 9 March 1998, the Designated Person under the Act determined that:

1. The applicant was a person who at the time of the occurrence qualified as a resident of the Northern Territory as defined within section 4 of the Act.

2. The applicant's then current dental condition was not related to the 15 March 1991 accident.

3. No benefits for dental treatment pursuant to section 18 of the Act were payable to the applicant.

[5] By letter dated 19 August 1999, the respondent indicated to the applicant that the only then current medical problems related to her accident were certain left knee injuries (including a left proximal tibia fracture).

[6] On 3 June 2002, the Designated Person under the Act determined that:

1. The applicant was entitled to reasonable reimbursement of medical expenses in accordance with section 18 of the Act.

2. On the basis of medical evidence to hand, the applicant was not entitled to costs associated with the bilateral heel pad syndrome, including the provision of podiatry and heel cup treatment, as this condition is not related to any injury sustained in the occurrence.

3. Pursuant to section 17, the Act provided for payment of compensation to a person who is assessed as suffering a permanent disability, or loss, of no less than 5% of the whole person.

4. Based on the same medical evidence, the applicant had not suffered any permanent impairment of the whole person as the result of injuries sustained in the occurrence and therefore was not entitled to compensation under section 17.

5. The Determination provided for the applicant's full and final entitlement to compensation under section 17 of the Act for injuries sustained in the occurrence.

6. In addition, the applicant was not entitled to further medical, hospital or rehabilitation benefits under section 18 of the Act,

as the applicant's then current conditions were not related to the occurrence.

[7] On 3 September 2002, the respondent upheld the determination of the Designated Person dated 3 June 2002. The applicant referred the determination of the Board to the Motor Accidents (Compensation) Appeal Tribunal pursuant to section 29 of the Act for a hearing de novo. The Particulars of the Reference recited paragraphs 2, 4 and 6 of the determination. The applicant seeks to establish that her current conditions are related to the occurrence and that:

(a) the applicant is entitled to costs associated with the bilateral heel pad syndrome;

(b) the applicant is entitled to compensation for permanent impairment of the whole person.

[8] The applicant's case was essentially that she currently suffers various health conditions, specifically as regards the bilateral heel pad syndrome and more generally as establishing permanent impairment of the whole person. These conditions, she claims, are related to the accident, or in so far as they may have existed before the accident, they have been exacerbated by it. In either or both cases, they have not yet stabilised and are properly, she says, the subject of payment by the respondent under ss 17 and 18 of the Act.

[9] Sections 17 and 18 of the Act provide relevantly:

17. Compensation for loss of limb or other permanent impairment

(1) In addition to any other benefit payable under this Act, a resident of the Territory –

(a) who suffers permanent impairment in or as a result of an accident that occurred in the Territory or in or from a Territory motor vehicle;

(b) who survives that accident for a period of 3 months; and

(c) whose permanent impairment is assessed by the Board at a percentage of the whole person equal to not less than 5%,

shall, subject to subsection (2), be paid compensation equal to that assessed percentage of the prescribed amount.

…

18. Medical and rehabilitation expenses

(1) Subject to subsections (2A) and (3) and sections 18A and 18B, there is payable to or on behalf of a person entitled to a benefit under this Act in respect of an injury received by him in or as a result of an accident all the expenses reasonably incurred by him or on his behalf for the provision of the treatment required by him in respect of that injury other than –

(a) accommodation and treatment as a public patient in a public hospital;

(b) accommodation as a private patient in a public hospital; or

(c) single room accommodation in a private hospital,

in the Territory.

(2) In subsection (1) "treatment" means –

(a) medical, surgical or dental treatment or nursing or other care provided to the person referred to in that subsection;

(b) training, education or care required for the rehabilitation of that person; and

> (c) the conveyance of that person to any place for the purpose of his receiving any treatment referred to in this subsection or to a hospital.
>
> …

Injuries arising from the accident

[10] In the accident, the front of the vehicle was stove in, the dashboard collapsed upon the applicant's knees, and she was trapped inside the vehicle for some hours, before she was found and freed by a road gang. She was initially taken to Cloncurry Hospital. In a letter of 6 July 1999, Dr Chetty, Medical Superintendent at the Cloncurry Hospital, indicated that when the ambulance brought the applicant in:

> "Injuries consisted of bruises to the right knee and right lower leg, trauma, minor abrasions to the left shoulder and upper arm, bruising and soft tissue damage on the dorsum of the left hand. There was no history of loss of consciousness or head injury.
>
> Examination was unremarkable except for the above findings. Xray of the right knee suggested fracture of the tibial plateau and the patient was transferred to Mt Isa Base Hospital for further management".

[11] The applicant was transferred to Mt Isa Hospital the following day. Dr Natkunam, Director of Surgery at Mount Isa Hospital, in a letter of 26 July 1991 records "a fracture of the upper end of the left tibia with mild haemarthrosis of the left knee joint". In a letter dated 4 January 1993, Dr J Hayllar, Acting Medical Superintendent at Mt Isa Base Hospital, described the transfer letter dated 16 March 1991, transferring the applicant

from Cloncurry Hospital, as recording that "[s]he was not thought to have lost consciousness. Abrasions were noted to her left arm, right knee and left knee". He adds "[t]here is no record of swelling and cuts to head and no record of ejection through windscreen. There may well have been a laceration to the upper arm, a fragment of glass was apparently removed by the patient from her left upper arm on 24 March 1991. There is no record of severe bruising to hands, feet and body. There is no record of the patient losing consciousness or suffering convulsions" (although I note that the applicant now believes that she did lose consciousness). The applicant was managed in traction for four days and then mobilized on crutches, prior to being discharged home on 25 March 1991.

[12] The applicant travelled back to Darwin by bus, but was admitted to the Royal Darwin Hospital on 29 March 1990 complaining of increased pain and swelling over her left tibia, left hip pain, and glass in her left arm. An above knee 3M cast was applied and she was to remain non-weight bearing with crutches. The Hospital's records show that glass fragments were still present in her left upper arm, but all pieces could not be removed as they could not be located. She was discharged on 4 April 1991.

[13] The x-rays and other medical records contemporaneous with the accident have also been the subject of extensive scrutiny and interpretation by various medical specialists. In a report of 14 February 2002, Dr Peter Stevenson concluded that the accident "seems to have caused extensive soft tissue bruising [and] a fractured left tibial plateau with some involvement of

the joint". Dr David Millons in a report of 23 June 2003 provided the following more detailed assessment:

> "Definitive injuries sustained included a fracture of the upper end of the left tibia. There may well have been some bruising across the pelvis and in the groins where the steering wheel came down on her. She may well have sustained some minor foot injuries and perhaps some injury to the right knee. She does not appear to have done herself any major damage to her neck or back in the accident or indeed made any complaint of shoulder problems at the time.
>
> …
>
> The only injuries sustained in the motor vehicle accident appear to have been to the upper left tibia, perhaps the knees, perhaps the feet and perhaps some soft tissue bruising to the pelvis."

Current medical and health status

[14] An overview of the applicant's current physical condition can be gained from the results of an assessment carried out by a physiotherapist, Kylie Johnson-Leek, at the Arafura Physiotherapy & Sports Injury Clinic in April 2003, conducted at the applicant's request "to assist in ascertaining if there is a link between Mrs Krogseter's current physical problems and injuries sustained in the M.V.A. …". Prior to the assessment, the applicant related to Ms Johnson-Leek the following complaints: pain in right inguinal/groin region, spreading during the day to her lower abdominal area, inability to walk without lace-up trainers (with heel cups) on due to foot and heel pain, inability to walk fully upright or for long distances, neck pain and headaches, pain in sciatic distribution of both legs but predominantly the right, low back pain, pain in the region of the symhysis pubis, bilateral knee

pain, the right hip "giving way". The assessment provides a detailed account of her range of movement, finding some aspects normal and others variously limited. The assessment concluded: "In my opinion, Mrs Krogseter's current musculoskeletal status is that of generalised wear and tear, compounded by a 1.5 cm leg length discrepancy …. In my experience, I would say that Mrs Krogseter's degree of debility is poorer than would be expected in a person of similar gender, age, build and activity levels". It is clear from this report that the applicant suffers a higher than average degree of debility, although I note that the report does not establish if or to what extent this is the result of the accident.

[15] The applicant tendered records of the Royal Darwin Hospital relating to various complaints, including rashes on her arms, in the years since the accident. The applicant also pointed to a bone scan in November 2002 which "shows evidence of cervical and lower right lumbar facet joint arthritis. There is evidence of right hip, left knee and right subtalar joint arthritis".

[16] In his report of 23 June 2003, Dr Millons records the applicant as maintaining "considerable ongoing problems" - some aching across both hips; aching in the left knee; her left shin aches a lot; her left leg is getting worse as time passes; she gets pain in both feet and has done since the accident; there is aching across the region of her symphysis pubis; some (not too severe) pain going up her back; she has lost feeling from her waist down to her feet; there is pain in her neck; she gets pain in her jaw; her hearing is

somewhat reduced since the accident; and she has been having some problems with her left shoulder.

[17] On examination, Dr Millons found no spasm or tilt of the cervical spine; some slight tenderness down both sides of the neck; flexion and extension of the neck are of good range; rotation to left and right is two thirds normal range; lateral flexion one half normal range (movements being restricted by stiffness and pain); a full range of painless movements at the right shoulder; right elbow, wrist and hand are normal to examination; some tenderness anteriorly at the left shoulder; left shoulder exhibits a full range of movements with a complaint of pain at the extreme of elevation and internal rotation; no painful arc is crossed as the left arm is raised and lowered; left elbow, wrist and hand are normal to examination; hollow grip with her left hand, being unable to close the hand over the examining fingers – yet able to make a normal fist; no abnormal neurological signs in either upper limb; right leg seems 1.5 cm shorter than the left; no frank spasm of the lumbar musculature; some tenderness at the lumbrosacral level; moderate tenderness over the symphysis pubis and in the groins; flexion brings her fingertips to mid shin at which point she complains of a feeling of stress in her lower back, her back unwinds well in achieving that position, extension is painful at the extreme; good range of lateral flexion to left and right; straight leg raising is to 80 degrees on both sides with a complaint of some discomfort across the hips but not in the back or down either limb; sciatic stretch tests are negative; tone, power and sensation through both lower limbs appear

normal; knee jerks are present, ankle jerks are absent; reasonable range of movements at both hips with a complaint of pain at the extremes; mild degree of bilateral genu valgum; no effusion into the left knee joint or any deformity there, no localised tenderness, patellar friction test is negative on both knees, left knee exhibits a range of movements from 0 degrees to 120 degrees accompanied by some mild crepitus and some pain at the extremes; left knee seems stable; no effusion into the right knee joint, no particular tenderness around the right knee; right knee exhibits a range of movements from 0 degrees to 125 degrees accompanied by some mild crepitus; right knee seems stable, both ankles are normal to examination; mild degree of flat feet; some tenderness underneath the heel pads; reasonable range of movements through the feet. Dr Millons notes that the applicant has been given heel cups for the discomfort she feels around the heels.

[18] Dr Millons' conclusions following his examination of the applicant were:

> "The fracture of the left tibia has gone on to union in good position. Clinically there does not appear to be much untoward going on at the left knee. … There may be some underlying constitutionally based attritional change in the knee.
>
> She states that she hurt her right knee in the accident. That knee seems in reasonably good order clinically now.
>
> … She does have a mild degree of flat feet …. I would not have thought that was of any great significance. The discomfort that she feels around the heels … does not really relate to the motor vehicle accident.

> … Her hips exhibit a good range of movements and I do not believe there has been any specific hip injury as a result of the motor vehicle accident.
>
> She … has recently been diagnosed as having a pubic symphysitis for which she is on medication.
>
> …
>
> She does have some mild constitutionally based attritional changes in the lower back. Symptoms there seem to be coming from the normal activities of daily living ….
>
> …
>
> She does not have any particular problems with her neck or hand."

[19] Dr Millons notes the applicant's recent diagnosis of symphysis pubis. This is an important aspect of the applicant's case which she argues supports her principal contention that the injuries she sustained in the accident have never been properly diagnosed and treated.

Pre-existing conditions

[20] The applicant put her case before the Tribunal principally on the footing of coincidence, that is, given that she had been healthy before the accident, what but the accident could explain her current medical condition. She referred the Tribunal to an x-ray report by Dr R W Morgan dated 2 November 1989 indicating of her thoracic spine that "Vertebral bodies, their appendages and discs, all have a normal appearance". She described climbing Kings Canyon at Christmas 1990 as evidence of her being physically healthy at that time. The applicant also pointed to statements provided by family and friends, in particular her daughter Narelle and

Herbert Williams who has known her since 1976, suggesting that her physical capabilities have deteriorated since the accident.

[21] While asserting that she was physically healthy immediately prior to the accident, the applicant concedes certain pre-existing conditions but asserts that even in respect of those they have been exacerbated by the accident.

[22] In her application of 22 April 1991 to the respondent for benefits, the applicant describes her pre-existing medical condition as encompassing whiplash to the neck from a car accident in 1978, a metal screw in her right shoulder, and a broken T4 or T5 in her back diagnosed in 1990. Consistent with this description:

(i) Mr Stephen Baddeley, an orthopaedic surgeon, in his report of 8 June 1993 stated that on 5 August 1983 he had performed a right Bristow procedure upon the applicant and a screw was placed in her right shoulder, after finding "all the signs and symptoms of recurrent anterior dislocation" of that shoulder. He also noted in his report of 1 June 1999 that the applicant gave a history of left knee pain which had been with her since approximately 18 years of age.

(ii) Dr David Welch, who acted as the applicant's general practitioner from 1986 until 1992, in a letter of 24 March 2003 indicated that after the applicant suffered a back pain in November 1989, a CT scan showed an "old fracture of the transverse process of T5". Dr Millons in his report of 23 June 2003, interpreting the report of the CT scan,

concluded it showed a "healing undisplaced fracture of the left transverse process of T5, but not a fracture of the T5 vertebral body".

[23] I also note that in his report, Dr Millons reviewed x-rays of the pelvis and hips taken 10 May 1988, from which he concluded "[t]here appears to be some mild irregularity of the symphysis pubis". Dr Stevenson in his report of 14 February 2002 noted that he found a 1989 x-ray of the right knee suggesting "so presumably she had been having some pain, probably from patellofemoral discomfort in that knee two years prior to the accident".

[24] In May 1990, the applicant applied for a Commonwealth invalid pension, on the basis that a back injury rendered her unable to work. She was at that time in receipt of Commonwealth Sickness Benefits, granted in December 1989. Her medical history was detailed by a Commonwealth Medical Officer, Dr Boyce, on 12 June 1990 as part of that application. Dr Boyce records the applicant as suffering backache, abdominal pain and chronic anxiety. Dr Boyce concludes: "Very anxious personality, preoccupied with bodily symptoms". Notwithstanding this application for an invalid pension some months prior to the accident, the applicant stated that her condition had been improving in the months following, as evidenced by her having climbed Kings Canyon that Christmas.

[25] I note that a review of the rejection of her claim was successful on 11 April 1991, finding her to be 85% incapacitated at least 50% of this incapacity

being due to medical factors. Although the outcome of the review post-dates the applicant's accident, it is clear from reading the review that it is based on information pre-dating the accident, although the reviewer notes having had contact with Mt Isa Hospital where the applicant is noted to be currently an in-patient, with a fractured leg.

[26] Outpatient records of the Department of Health on 11 April 1986 records a complaint of recurrent ear and throat irritations. In a letter dated 1 November 1995, Brian McMillan, Registrar Oral and Maxillofacial Surgery, states that the applicant in describing pain on the right side of her face below her left cheek, "reports that this pain has been present for at least 15 years … ". Katherine Edyvane, Surgical Registrar, in a letter dated 21 September 1995 describes the applicant as having "had longstanding nausea for the last 20 years, and multiple other somatic complaints for which she has been extensively investigated". Dr Edyvane refers to her having "been seen many times by the Gynaecologists at The Royal Darwin Hospital over the last 20 years. … and has had extensive investigations for longstanding pelvic pain". Dr K C Lee, Senior Dermatologist, in a letter dated 18 July 1990 states "her rash, which she now points to mainly on her forearms, upper arms and back has been present since February 1990 …". The applicant argued that the rashes on her arms which she has experienced both prior to and since the accident result from broken bones, but this is not established in the evidence before the Tribunal.

Permanent disability related to the accident

[27] Counsel for the respondent pointed to the broad consistency between many of the applicant's health complaints prior to the accident and currently. The applicant argued that in so far as various of her current health complaint may reflect complaints she had prior to the accident, these have in any event been exacerbated by the accident.

[28] Dr Chong Wah, the applicant's treating general practitioner, gave evidence on her behalf. However, he had not seen her until a year after the accident and had not been able to examine her to assess the immediate injuries she had sustained. In a report of 12 April 1999, he noted:

> "From the extracts of the reports above the only injuries that [were] verified [were] the left knee haemarthrosis and the left tibial fracture. It is acceptable that she also had bruising to her hands, neck, hips, right knee, shoulders and both hands. There is also possible dental damage …".

Dr Chong Wah concluded in that report:

> "It is possible that at least some of her problems may be the results of the accident. … she has degenerative problems and the incident may have aggravated some pre-existing condition".

[29] In oral evidence before the Tribunal, Dr Chong Wah concluded that while a motor vehicle accident may accelerate existing health conditions, he was "not in a position to know one way or another" what of the applicant's complaints related to the accident.

[30] Oral evidence was also given on the applicant's behalf by a psychologist, Dianne Knox, who had provided a psychological report for the applicant on 11 December 2003. In that report, Ms Knox noted that the applicant "is firmly of the view that the injuries she sustained in this accident have not been adequately diagnosed and treated, and that she is suffering greatly both physically and psychologically as a consequence". However, in that report and in her oral evidence, Ms Knox also indicated that "[w]hether [the applicant's] symptoms are medically related or causally linked to the MVA is within the expertise of medical professionals and beyond the scope of this report" and her area of expertise. To the contrary, although (as indicated in her report) the applicant has "no psychotic or delusional features to her presentation", she concluded in her oral evidence that there is a psychological component to the applicant's injuries and a pre-occupation with her condition. In addressing the question whether this pre-occupation could itself be said to have arisen from or been exacerbated by the accident, counsel for the respondent pointed to the assessment by the Commonwealth Medical Officer, Dr Boyce, on 12 June 1990 that even prior to the accident the applicant was "preoccupied with bodily symptoms".

[31] Dr John Burvill provided a psychiatric report on 9 August 1993. He found her to be "an unreliable historian who has difficulty in separating emotions and bodily feelings which could possibly relate to an accident in 1991, or to have been present before that, or to be more likely related now, as are her feelings of tiredness, to being in yet another crisis". However, he concluded

of the applicant that she was "without evidence of any major psychiatric or organic mental disorder" and he did "not consider that she needs any form of psychiatric treatment". Mr Baddeley in his report of 8 June 1993 also concluded: "I believe that this lady has a very significant psychiatric element to her problems. I believe it is impossible to separate any organic problem from the non-organic problems. … Whilst it is not possible to say how many or how much of her numerous problems are truly organic, I believe that the organic element is relatively minimal".

[32] Dr Millons in his report of 23 June 2003 observed that the applicant "does appear to be besotted by her complaints and seems to be blaming everything that is wrong with her on the motor vehicle accident, which is clearly not right". The applicant pointed to the observation by Dr Millons in his report upon x-rays taken 15 August 2002 that the irregularity of the symphysis "is a little more prominent than on the earlier x-rays". The applicant's contention is that while Dr Millons interpreted x-rays even prior to the accident as showing some irregularity of the symphysis pubis, this condition has been exacerbated by the accident. While acknowledging that he is not competent to comment on the particular gynaecological problems which the applicant blames on the accident, Dr Millons concluded that:

> "The only injuries sustained in the motor vehicle accident appear to have been to the upper left tibia, perhaps the knees, perhaps the feet and perhaps some soft tissue bruising to the pelvis. Orthopaedically she seems to have made a reasonably good recovery from those various injuries.
>
> …

> Her condition does seem to be quite stable, she having apparently made a good recovery from the injuries sustained in the accident. I can really find no convincing evidence that there is any whole person impairment as a direct result of the effects of the motor vehicle accident on 15.3.91".

[33] This is consistent with the views of Dr Stevenson. In his report of 14 February 2002, Dr Stevenson concluded that "I can identify no incapacity now in consequence of the accident. She appears to have made a substantial recovery. She has mild genu valgum and is quite obese, so probably has some disposition to osteoarthritis of the knees anyhow. As the fracture did involve the joint surface, she would have a somewhat increased risk of osteoarthritis in the left knee, but I could not really find any convincing signs there today that this has progressed". He added: "I could not identify any permanent consequences of the accident. On clinical grounds she seems to have made a good recovery from the fracture without osteoarthritis. I cannot identify any other permanent consequence of her widespread soft tissue injuries. One would suppose that in the very long term, she is somewhat more prone to develop osteoarthritis in the left knee than in the right, but at the moment there is no evidence of such impairment". Dr Stevenson reiterated in a report of 3 April 2002 that he "could identify no permanent impairment as a consequence of the accident. She appeared to have made an excellent recovery from the fracture without the development of osteoarthritis. Soft tissue injuries per se heal without permanent sequelae. There is no permanent impairment".

[34] At trial, the applicant put to Dr Stevenson various documentation which had not been available to him at the time of his earlier assessment, in particular the bone scan in November 2002 which "shows evidence of cervical and lower right lumbar facet joint arthritis. There is evidence of right hip, left knee and right subtalar joint arthritis". I note that there is reference throughout the bone scan report to various degenerative changes, to the cervical spine, right hip joint and the medial tibiofemoral joint compartment of the left knee with further minor degenerative changes in the subtalar joints bilaterally. Having considered this material, Dr Stevenson concluded that it did not support any change to his earlier conclusions. He also observed that the applicant's symphysis pubis issues would not cause the abdominal pain she reports; nor did he know of any case in which the symphysis pubis had parted because of trauma.

[35] Another point of contention during the trial was the presence of pain in the applicant's left shoulder. The applicant contended that this pain has been present since the accident. She referred to Royal Darwin Hospital records of 3 April 1991 noting that glass fragments were still present in her left upper arm. An ultrasound conducted at Mr Baddeley's request on 26 May 1999 revealed mild sub-acromial bursitis in the applicant's left shoulder. However, in a letter dated 1 June 1999 Mr Baddeley referred to 7 occasions the applicant had seen him since the accident without referring to this pain. In particular he noted that on seeing her on 20 April 1993 she had identified 15 distinct problems. He had previously outlined these in a letter of 8 June

1993, in which he also indicated that the applicant related all of these problems to the accident, either directly or as aggravating pre-existing conditions:

1. right knee pain;
2. pain in the right wrist;
3. left thumb pain;
4. neck pain, present prior to 1991 but made worse by the accident of 1991;
5. increasing headache;
6. interscapular back pain, which she related to an old T5 vertebral fracture;
7. left second toe did not sit properly in her shoe;
8. right ankle pain on walking;
9. right calf pain;
10. left knee pain;
11. right hip pain;
12. low back pain;
13. aggravation of right shoulder pain;
14. a “funny” feeling around the inner end of the right clavicle;
15. a sore throat, which has been worse since the 1991 accident.

[36] In his letter of 1 June 1999, Mr Baddeley agreed that the applicant has a left supraspinatus impingement problem. However, noting that he could find no x-rays performed of her left shoulder since the accident and her lack of previous reference to the problem, he concluded that he was "fairly certain in my own mind that there is no significant chance that this lady sustained an injury to her left shoulder in the motor vehicle accident of 1991". While conceding in oral evidence before the Tribunal that Royal Darwin Hospital records of 3 April 1991 showed glass fragments present in her left upper arm, Mr Baddeley did not resile from his earlier conclusion. He added that if glass had been present just under the skin after the accident, it would not precipitate bursitis of the shoulder.

Heel pad syndrome

[37] The applicant pointed to the fact that the respondent had initially made payments in respect of this condition. Counsel for the respondent stated that these had ceased after Mr Baddeley's report of 15 October 2001. In that report, Mr Baddeley noted that although he had seen the applicant on many occasions with regard to problems with her motor vehicle accident, he had first been seen by her about her heel pad problem on 16 August 2001. The applicant pointed to documents demonstrating that this had been a matter of concern to her well prior to Mr Baddeley's report and challenged his conclusion that he "can see no obvious relationship between the motor vehicle accident and her present symptoms". However, in reiterating his conclusions in oral evidence before the Tribunal, Mr Baddeley stated that it

was highly unlikely that a person would suffer heel pad syndrome as a result of a motor vehicle accident. He noted the syndrome often arose in middle-aged, overweight women.

[38] Mr Baddelely emphasised in his oral evidence in answer to specific questioning by the applicant that he has never considered that the applicant has lied about any of her complaints and that there has been nothing judgmental in his reports. Rather, he said, he has at all times been trying to help her. He and the other members of the medical community whose evidence is before me have clearly been attempting to assist the applicant in the treatment of her complaints. That their findings are in at least some respects inconsistent with her own self-assessments does not in any way suggest she has lied about those complaints. I accept that the applicant genuinely believes the matters about which she gave evidence. However, it is also clear from the united force of the extensive medical evidence that her current health complaints are not, or are at least unlikely to be, the result of the motor vehicle accident, either intrinsically or as an exacerbated pre-existing condition. The applicant has failed to discharge her onus of proof.

[39] In accordance with the above reasons, I am not satisfied that the applicant has received a permanent impairment in or as a result of the accident. The applicant is not therefore entitled to a benefit under s 17http://www.austlii.edu.au/cgi-bin/disp.pl/au/cases/nt/NTSC/1998/100.html?query=motor+accidents+and+compensation+and+section+17 - disp14#disp14 of the Act. I am also not

satisfied that the applicant's bilateral heel pad syndrome has resulted from the accident for the purposes of s 18 of the Act. Accordingly, I make determinations in those terms.

_____