Reference Determination Content

Example document — fictitious patient. A suggested draft determination prepared by the Veterans Health Centre from the matching example Diagnostic Assessment, to show how a DVA delegate could determine the claim. Names, dates, service details and clinicians are invented. It is not a decision of the Department of Veterans' Affairs.

Right Ankle - Instability, Plantar Perifasciitis and Talonavicular Ganglion Cyst

Evidence

The evidence that I have considered in making this decision includes:

- Formal Claim with supporting statements;
- A Statement of your Service from the Department of Defence;
- Copies of your Service Medical Records.
- A Diagnostic Assessment by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 28 May 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 28 May 2025;
- A role 2 consultation and X-ray report by the medical officer, Afghanistan, dated 14 May 2008;
- A psychiatric assessment by the consultant psychiatrist, dated 10 March 2009;
- A sports medicine consultation by the sports physician, dated 12 April 2010;
- An outpatient health record by the medical officer, Garrison health centre, dated 8 February 2012;
- An MRI lumbar spine and X-ray right ankle by the radiologist, dated 8 February 2012;
- A pre-deployment medical examination by the medical officer, dated 20 December 2012;
- A deployed clinic record by the medical officer, Solomon Islands, dated 5 March 2013;
- Stress radiographs by the radiologist, dated 14 August 2013;
- An orthopaedic consultation by the orthopaedic surgeon, dated 2 September 2013;
- A deployed health record by the medical officer, Middle East Area of Operations, dated 18 September 2016;
- An MRI and stress radiographs by the radiologist, dated 22 November 2016;
- An ultrasound report and sports medicine consultation by the sports physician, dated 14 June 2017;
- A discharge medical examination by the medical officer, dated 15 October 2019;
- A clinical assessment by the general practitioner, dated 28 May 2025.

Your service

I have identified that you have the following service:
Australian Defence Force service between :

3 February 2003 and 15 October 2019

Right Ankle - Instability, Plantar Perifasciitis and Talonavicular Ganglion Cyst

You have stated that your condition was caused by:

- *having physical trauma to the affected joint at the time of the clinical onset of joint instability*
- *having a dislocation or subluxation of the affected joint before the clinical onset of joint instability*
- *having a sprain of the affected joint before the clinical onset of joint instability*
- *having damage to a soft tissue structure as specified before the clinical onset of joint instability*
- *having a fracture or bony abnormality involving the articulating surfaces of the affected joint before the clinical onset of joint instability*
- *having a disease process as specified affecting the normal structural or functional relationship between the articulating surfaces of the affected joint at the time of the clinical onset of joint instability*
- *being pregnant within the six weeks before the clinical onset of joint instability*
- *for temporomandibular joint instability only, undertaking an activity or undergoing a medical procedure that involves wide opening of the mouth at the time of the clinical onset of joint instability*
- *for total hip prosthesis joint instability only, having lumbar spondylosis, lumbar intervertebral disc prolapse, lumbar spondylolisthesis, lumbar spinal stenosis or lumbar spinal fusion at the time of the clinical onset of joint instability*
- *for total hip joint prosthesis joint instability only, being obese at the time of the clinical onset of joint instability*
- *for tibiofemoral joint instability only, being severely obese at the time of the clinical onset of joint instability*
- *for total knee joint prosthesis joint instability only, having morbid obesity at the time of the clinical onset of joint instability*
- *for elbow joint instability only, having more than three local glucocorticoid injections for epicondylitis before the clinical onset of joint instability*

Diagnosis: Instability, Plantar Perifasciitis and Talonavicular Ganglion Cyst

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 28 May 2025, and is supported by an orthopaedic consultation by the orthopaedic surgeon, dated 2 September 2013.

I am satisfied this is the appropriate diagnosis.
In determining your claim for this condition, I have applied the SOP:

Statement of Principles concerning Joint Instability (Reasonable Hypothesis) (No. 57 of 2019)

which sets out the factors that can connect the condition with service.

I am satisfied that you have met the following factor:

- *having physical trauma to the affected joint at the time of the clinical onset of joint instability*
- *having a dislocation or subluxation of the affected joint before the clinical onset of joint instability*
- *having a sprain of the affected joint before the clinical onset of joint instability*
- *having damage to a soft tissue structure as specified before the clinical onset of joint instability*
- *having a fracture or bony abnormality involving the articulating surfaces of the affected joint before the clinical onset of joint instability*
- *having a disease process as specified affecting the normal structural or functional relationship between the articulating surfaces of the affected joint at the time of the clinical onset of joint instability*
- *being pregnant within the six weeks before the clinical onset of joint instability*
- *for temporomandibular joint instability only, undertaking an activity or undergoing a medical procedure that involves wide opening of the mouth at the time of the clinical onset of joint instability*
- *for total hip prosthesis joint instability only, having lumbar spondylosis, lumbar intervertebral disc prolapse, lumbar spondylolisthesis, lumbar spinal stenosis or lumbar spinal fusion at the time of the clinical onset of joint instability*
- *for total hip joint prosthesis joint instability only, being obese at the time of the clinical onset of joint instability*
- *for tibiofemoral joint instability only, being severely obese at the time of the clinical onset of joint instability*
- *for total knee joint prosthesis joint instability only, having morbid obesity at the time of the clinical onset of joint instability*
- *for elbow joint instability only, having more than three local glucocorticoid injections for epicondylitis before the clinical onset of joint instability*

I have noted your contention as to the cause of this condition. The available evidence indicates, I have noted your contention to the cause of your condition. Your service medical records indicate

that you presented to the health facility with lateral right ankle pain and swelling and a sensation of the ankle giving way, with repeated episodes of giving way on steps and uneven ground in the following weeks on 5 March 2013.

The diagnosis was confirmed by an orthopaedic surgeon on 2 September 2013 from a history of recurrent giving way, a positive anterior drawer test and talar tilt on examination, and stress radiographs on 14 August 2013 showing a talar tilt of 15 degrees and anterior talar translation of 12 millimetres. A Cumberland Ankle Instability Tool score of 14 of 30 confirmed functional instability.

This has then led to further investigations and the diagnosis of your condition of *Instability, Plantar Perifasciitis and Talonavicular Ganglion Cyst*. I have accepted your condition of *Instability, Plantar Perifasciitis and Talonavicular Ganglion Cyst*.

Having considered your service records and the available medical evidence, I am satisfied the SOP is met and that this condition is related to your wartime service.

I have therefore accepted that this condition is related to your service with effect from 5 March 2013.

Right Ankle - Instability, Plantar Perifasciitis and Talonavicular Ganglion Cyst (Worsening)

Evidence

The evidence that I have considered in making this decision includes:

- Formal Claim with supporting statements;
- A Statement of your Service from the Department of Defence;
- Copies of your Service Medical Records.
- A Diagnostic Assessment by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 28 May 2025;
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- Stress radiographs by the radiologist, dated 14 August 2013;
- An orthopaedic consultation by the orthopaedic surgeon, dated 2 September 2013;
- A deployed health record by the medical officer, Middle East Area of Operations, dated 18 September 2016;
- An MRI and stress radiographs by the radiologist, dated 22 November 2016;
- An ultrasound report and sports medicine consultation by the sports physician, dated 14 June 2017;
- A discharge medical examination by the medical officer, dated 15 October 2019;
- A clinical assessment by the general practitioner, dated 28 May 2025.

Your service

I have identified that you have the following service:
Australian Defence Force service between :

3 February 2003 and 15 October 2019

Right Ankle - Instability, Plantar Perifasciitis and Talonavicular Ganglion Cyst (Worsening)

You have stated that the worsening of your condition was caused by:

- *having physical trauma to the affected joint at the time of the clinical worsening of joint instability*
- *having damage to a soft tissue structure as specified before the clinical worsening of joint instability*
- *having a fracture or bony abnormality involving the articulating surfaces of the affected joint before the clinical worsening of joint instability*
- *having a disease process as specified affecting the normal structural or functional relationship between the articulating surfaces of the affected joint at the time of the clinical worsening of joint instability*
- *being pregnant within the six weeks before the clinical worsening of joint instability*
- *for temporomandibular joint instability only, undertaking an activity or undergoing a medical procedure that involves wide opening of the mouth at the time of the clinical worsening of joint instability*
- *for total hip prosthesis joint instability only, having lumbar spondylosis, lumbar intervertebral disc prolapse, lumbar spondylolisthesis, lumbar spinal stenosis or lumbar spinal fusion at the time of the clinical worsening of joint instability*
- *for total hip joint prosthesis joint instability only, being obese at the time of the clinical worsening of joint instability*
- *for tibiofemoral joint instability only, being severely obese at the time of the clinical worsening of joint instability*
- *for total knee joint prosthesis joint instability only, having morbid obesity at the time of the clinical worsening of joint instability*
- *for elbow joint instability only, having more than three local glucocorticoid injections for epicondylitis before the clinical worsening of joint instability*
- *inability to obtain appropriate clinical management for joint instability*

Diagnosis: Instability, Plantar Perifasciitis and Talonavicular Ganglion Cyst (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 28 May 2025, and is supported by an orthopaedic consultation by the orthopaedic surgeon, dated 2 September 2013.

I am satisfied this is the appropriate diagnosis.
In determining your claim for this condition, I have applied the SOP:

Statement of Principles concerning Joint Instability (Reasonable Hypothesis) (No. 57 of 2019)

which sets out the factors that can connect the condition with service.

I am satisfied that you have met the following factor:

- *having physical trauma to the affected joint at the time of the clinical worsening of joint instability*
- *having damage to a soft tissue structure as specified before the clinical worsening of joint instability*
- *having a fracture or bony abnormality involving the articulating surfaces of the affected joint before the clinical worsening of joint instability*
- *having a disease process as specified affecting the normal structural or functional relationship between the articulating surfaces of the affected joint at the time of the clinical worsening of joint instability*
- *being pregnant within the six weeks before the clinical worsening of joint instability*
- *for temporomandibular joint instability only, undertaking an activity or undergoing a medical procedure that involves wide opening of the mouth at the time of the clinical worsening of joint instability*
- *for total hip prosthesis joint instability only, having lumbar spondylosis, lumbar intervertebral disc prolapse, lumbar spondylolisthesis, lumbar spinal stenosis or lumbar spinal fusion at the time of the clinical worsening of joint instability*
- *for total hip joint prosthesis joint instability only, being obese at the time of the clinical worsening of joint instability*
- *for tibiofemoral joint instability only, being severely obese at the time of the clinical worsening of joint instability*
- *for total knee joint prosthesis joint instability only, having morbid obesity at the time of the clinical worsening of joint instability*
- *for elbow joint instability only, having more than three local glucocorticoid injections for epicondylitis before the clinical worsening of joint instability*
- *inability to obtain appropriate clinical management for joint instability*

I have noted your contention as to the cause of this condition. The available evidence indicates, I have noted your contention to the cause of your condition. Your service medical records indicate that you presented to the health facility with lateral right ankle pain and swelling and a sensation of the ankle giving way, with repeated episodes of giving way on steps and uneven ground in the following weeks on 5 March 2013.

The diagnosis was confirmed by an orthopaedic surgeon on 2 September 2013 from a history of recurrent giving way, a positive anterior drawer test and talar tilt on examination, and stress radiographs on 14 August 2013 showing a talar tilt of 15 degrees and anterior talar translation of 12 millimetres. A Cumberland Ankle Instability Tool score of 14 of 30 confirmed functional instability.

After the condition arose, it was worsened during your service. On warlike service in the Middle East on 18 September 2016 you missed a step and inverted your right ankle again. The ligament

tears sustained on warlike service in Afghanistan in 2008 persisted, with an absent anterior talofibular ligament and a complete calcaneofibular ligament tear on MRI in 2016, before the worsening. The talar dome fracture sustained on warlike service in Afghanistan in 2008 had become an unstable osteochondral lesion with subchondral cysts before the worsening on warlike service in the Middle East in 2016. The post-traumatic osteoarthritis arising from the Afghanistan injury was moderate on MRI in November 2016 and present at the time of the worsening on warlike service on 18 September 2016. You conceived on about 25 August 2016 during your warlike deployment to the Middle East, with the pregnancy confirmed on 22 September 2016. At the moment of the fall on warlike service on 18 September 2016 you were vomiting with early pregnancy nausea, an activity involving wide opening of the mouth, at the time of the worsening. The lumbar spondylosis arising from load carriage, including on warlike service in Afghanistan, was present at the time of the worsening on warlike service in the Middle East in 2016. Your BMI was 42.3 at the worsening on warlike service in 2016, the result of antipsychotic medication for posttraumatic stress disorder arising from warlike service. With a BMI of 42.3 you were severely obese at the time of the worsening on warlike service in the Middle East on 18 September 2016. With a BMI of 42.3 you had morbid obesity at the time of the worsening on warlike service on 18 September 2016, caused by treatment of posttraumatic stress disorder arising from warlike service. By the worsening on 18 September 2016 you had received six local glucocorticoid injections for right lateral epicondylitis, the four given from 2010 to 2012 and two more on 10 June 2014 and 22 March 2015. On warlike service in Afghanistan in 2008 your subluxation, ligament tears and talar dome fracture received no orthopaedic opinion, MRI or arthroscopy, and you returned to dismounted duties after three weeks.

This has then led to further investigations and the diagnosis of your condition of *Instability, Plantar Perifasciitis and Talonavicular Ganglion Cyst (Worsening)*. I have accepted your condition of *Instability, Plantar Perifasciitis and Talonavicular Ganglion Cyst (Worsening)*.

Having considered your service records and the available medical evidence, I am satisfied the SOP is met and that the worsening of this condition is related to your wartime service.

I have therefore accepted that the worsening of this condition is related to your service with effect from 18 September 2016.

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