WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**3695/19**
Applicant:	**Shane Robert Paul Croft**
Respondent:	**Jason Daniels**
Date of Determination:	**21 February 2020**
Citation:	**[2020] NSWWCC 50**

The Commission determines:

1. The applicant suffered a condition in his right heel consequent upon injury to the right great toe deemed to have occurred on 24 December 2015.

2. The surgery to amputate the applicant's right leg below the knee on 26 June 2017 was reasonably necessary as a result of injury to the right great toe deemed to have occurred on 24 December 2015.

3. The matter is remitted to the Registrar for referral to an Approved Medical Specialist for assessment of whole person impairment as a result of injury to the applicant's right lower extremity (right great toe) deemed to have occurred on 24 December 2015 and scarring.

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

   (a) Application to Resolve a Dispute and attachments;

   (b) Reply and attachments;

   (c) Application to Admit Late Documents dated 9 September 2019 and attachments;

   (d) Application to Admit Late Documents dated 23 October 2019 and attachments;

   (e) Application to Admit Late Documents dated 18 November 2019 and attachments;

   (f) this Certificate of Determination and Statement of Reasons.

5. The Registrar is requested to arrange for the examination of the applicant by an Approved Medical Specialist to take place in Coffs Harbour.

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

Brett Batchelor
Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OF BRETT BATCHELOR, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A MacLeod

Ann MacLeod
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Shane Robert Paul Croft (the applicant/Mr Croft) seeks lump sum compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act) as a result of injury to his right great toe deemed to have occurred on 21 December 2015 arising out of or in the course of his employment as a trolley collector with Jason Daniels (the respondent) at the Grafton Shopping World.

2. Mr Croft commenced his employment with the respondent on 27 March 2015. His work involved collecting shopping trolleys in the carpark area of, or around, the shopping centre and returning them to the various stores in the centre. This work required Mr Croft to be on his feet for hours on end, with a lot of heavy pushing and pulling duties manoeuvring lines of trolleys in the centre.

3. In 1997 the applicant had been diagnosed with insulin dependent diabetes. In 2009, he trod on a gumnut whilst walking to his car in socks, injuring his right heel. He was admitted to Nepean Hospital for three and half months and underwent surgery on his right heel on nine occasions for the infections he suffered at that time. Mr Croft was given a disability support pension in 2009.

4. On 23 and 24 October 2015 whilst engaged in his usual trolley collection duties, the applicant experienced pain in his right foot from rubbing inside his shoe. After he finished work on 24 October 2015, on removal of his shoe, he noticed that he had developed a large blister around the outer side of his right great toe. It had not been there two days previously.

5. The applicant attended Grafton Hospital on 24 October 2015 for treatment and was informed that his toe was infected. He remained in hospital until 30 October 2015 after which time he was discharged home. Due to the failure of his toe to heal, he consulted his general practitioner, Dr Bradshaw, and another doctor at the same surgery, Dr Rae.

6. Mr Croft returned to work with the respondent with his right great toe still painful. On 24 December 2015 the pain was so bad that he vomited and collapsed. He was admitted to Grafton Base Hospital on 25 December 2015 and moved to Lismore Base Hospital on 28 December 2015. On 30 December 2015 the applicant's right great toe was amputated. On 15 January 2016 he was transferred back to Grafton Base Hospital where he remained for treatment until 19 January 2016. On his release from hospital Mr Croft continued to receive treatment from his treating surgeon, Dr Deepak Williams and his general practitioner Dr Bradshaw.

7. The applicant says that after amputation of his right great toe he had a great deal of difficulty walking and balancing in his right foot, compared to how he was beforehand.

8. The applicant also continued to receive treatment on the site of his toe amputation and for his right heel from Lismore Base Hospital and Grafton Base Hospital. He continued to see the community nurses at the diabetic clinic for dressing changes.

9. On 5 April 2016 Employers Mutual NSW Limited (EML) issued to the applicant a notice under s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) containing a denial of liability for his claim for injury sustained to the right great toe.

10. The applicant underwent a skin graft on his right heel carried out by Dr Williams on 29 November 2016.

11. The applicant brought proceedings in the Commission, number 598/17, which were resolved at a telephone conference on 17 March 2017. Pursuant to Amended Certificate of Determination – Consent Orders dated 17 and 20 March 2017 (the 2017 Consent Orders) the respondent agreed to pay the applicant weekly benefits from 24 December 2015 to date and continuing pursuant to ss 36 and 37 of the 1987 Act and s 60 expenses incurred by the applicant "as a result of injury to the right great toe as a result on injury deemed to have occurred on 24.12.2015."[1]

12. The applicant continued to consult Dr Bradshaw throughout March, April, May and June 2017. On 8 June 2017, he was admitted to Lismore Base Hospital under the care of Dr Williams who advised him that his right foot was so bad that he could not save it. He had an MRI scan on 10 June 2017 and another on 19 June 2017. On 26 June 2017, Dr Williams amputated the applicant's right leg below the knee. Following the surgery Mr Croft continued to consult Dr Bradshaw on a regular basis. He had problems with the development of an ulcer at the end of his stump at the surgery site and with infection in the wound on the stump. He saw Dr Williams on 15 March 2018 for the ongoing problems with the infection in the stump and had developed a fistula.

13. On 9 January 2019, the applicant's solicitor forwarded a letter of claim to EML setting out a claim by the applicant for compensation pursuant to s 66 of the 1987 Act in respect of 30% whole person impairment (WPI) as a result of injury on 12 October 2015. A report of Dr A G Hopcroft dated 13 November 2018[2] was enclosed.

14. On 18 April 2019, EML issued a notice to the applicant under s 78 of the 1998 Act containing a denial of liability for the applicant's claim for lump sum compensation[3]. In disputing liability EML relied upon reports of Dr Chris Walls, occupational physician, dated 24 December 2018, 19 March 2019, 21 March 2019 and 15 April 2019. Based on the opinion of Dr Walls in his final report, that the right heel ulcer was the more likely culprit for the right below knee amputation, EML disputed that such amputation was consequential upon, or causally related to, the accepted injury to the right toe deemed to have occurred on 24 December 2015.

15. EML also disputed that the right below knee amputation surgery was reasonably necessary as a result of the injury deemed to have been received on 24 December 2015 within the meaning of s 60 of the 1987 Act.

16. The Application commencing the current proceedings was registered on 24 July 2019. Part 4 thereof contains the following injury description:

> "The worker developed a blister on his right great toe pushing trolleys for the Respondent. The blister became infected and consequentially his right great toe and then subsequently his right leg below the knee had to be amputated at Lismore Base Hospital."

17. Part 5.6 of the Application sets out the claim for lump sum compensation in respect of the right lower extremity and scarring, based on a deemed date of injury of 24 December 2015.

18. Part 3 of the Reply dated 14 August 2019 contains a confirmation of matters in dispute as per dispute notice(s) attached to the Application.

[1] Application to Resolve a Dispute (the Application) p 41.
[2] Application p 42.
[3] Application p 43.

ISSUES FOR DETERMINATION

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

    (a) Was the amputation of the applicant's right leg below the knee on 26 June 2017 consequent upon, or causally related to, the accepted injury which the applicant sustained to his right great toe, deemed to have occurred on 24 December 2015?

    (b) Was the right below knee amputation surgery reasonably necessary as a result of the accepted injury which the applicant sustained to his right great toe, deemed to have occurred on 24 December 2015?

PROCEDURE BEFORE THE COMMISSION

20. The parties attended a conciliation conference/arbitration hearing in Coffs Harbour on 18 September 2019. Mr M Inglis of counsel appeared for the applicant instructed by Mr W Langler. The applicant was present. Mr A Combe of counsel appeared for the respondent. The matter was stood over part-heard for further arbitration hearing on 13 December 2019, which unfortunately did not proceed because of transport difficulty I experienced in reaching the Coffs Harbour venue. Accordingly on 16 December 2019 a direction was issued to the parties to lodge and serve by 7 February 2020 further written submissions addressing:

    (a) matters raised by Arbitrator Batchelor in email sent to the legal representatives of the parties on 16 December 2019, and

    (b) any further authorities on which they wish to rely in support of their submissions.

    Relevant matters in the email referred to in (a) above will be referred to hereunder.

21. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

EVIDENCE

Documentary evidence

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

    (a) the Application and attached documents;

    (b) Reply and attached documents;

    (c) Application to Admit Late Documents dated 9 September 2019 lodged by the respondent with various clinical record extracts of Grafton Base Hospital attached (the Grafton Base Hospital records);

    (d) Application to Admit Late Documents dated 23 October 2019 lodged by the applicant, the attachments to which commence with letter to Dr C Walls dated 12 December 2018 (AALD 23.10.19);

(e) Application to Admit Late Documents dated 18 November 2019 lodged by the respondent, the attachments to which commence with CV of Dr Chris Walls (AALD 18.11.19);

(f) Transcript of arbitration hearing on 18 September 2019 (T);

(g) Written Outline of Applicant's Submissions dated 25 November 2019 (applicant's submissions);

(h) Applicant's Chronology;

(i) Respondent's Outline of Submissions to be supplemented orally, undated (respondent's submissions), with Respondent's Chronology attached (respondent's chronology);

(j) Applicant's Supplementary Submissions dated 6 February 2020 (applicant's supplementary submissions), and

(k) Respondent's Submissions in Reply to Direction for Submissions dated 16 December 2019, dated 7 February 2019 (respondent's supplementary submissions).

Oral evidence

23. There was no application to adduce oral evidence or to cross-examine the applicant.

SUBMISSIONS

Page References

24. Page references in this Statement of Reasons are to the page numbers in the Commission's electronic files.

Applicant

25. In the Background to the applicant's submissions, the applicant refers to the matters summarised above at [2]-[7]. It is noted that as a result of the 2017 Consent Orders the following matters can no longer be in issue by virtue of the estoppel created by that award:

(a) that the applicant suffered an injury to his right great toe in the course of his employment with the respondent (s 4 1987 Act);

(b) that such employment was a substantial contributing factor to injury, and

(c) that as a result of injury to the right great toe, it was amputated due to osteomyelitis.

26. The applicant relies upon the medical reports of Dr P Tomlinson dated 31 May 2016[4] and Dr A G Hopcroft dated 28 April 2016[5], 13 November 2018 (x2)[6], 20 December 2018[7] and 13 May 2019[8].

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[4] Application p 52.
[5] Application p 56.
[6] Application pp 73 and 76.
[7] Application p 78.
[8] Application p 80.

27. Dr Tomlinson's report was commissioned at the request of the insurer and addresses issues in respect of the injury to the right great toe and amputation thereof. The applicant emphasises that Dr Tomlinson notes that following the amputation **the wound** (emphasis added) was completely healed by the end March 2016. He also notes the doctor's opinion that, if he was not a diabetic, it is more probable than not that the original wound to the right great toe would have healed. The fact that it did not heal and that he continued to have problems with infections and osteomyelitis in the foot requiring amputation is also associated with his diabetic vascular disease. The applicant notes Dr Tomlinson's belief that the right toe amputation is substantially related to his work rather that his diabetic peripheral vascular disease.

28. The applicant refers to Dr Hopcroft's qualifications as a general surgeon specialising in orthopaedics and notes that he is a lecturer in orthopaedics and general surgery at the University of Newcastle. The applicant submits that Dr Hopcroft is eminently qualified to provide a medico-legal opinion in relation to the issue of osteomyelitis and has had the advantage of considering all of the relevant clinical, general practitioner and hospital records regarding his past treatment as well as other extensive medical records that have been provided to him to assist in forming his opinion.

29. The applicant refers in detail to the findings of Dr Hopcroft at the time of his initial examination, and again in 2018 when he prepared the report dated 13 November 2018. He relies on the ultimate conclusion of Dr Hopcroft and his belief that the amputation of the right leg below the knee was a direct result of the injury suffered to the right great toe complicated by his diabetic status. That is to say, had it not been for the blistering injury to the right great toe, it is unlikely that Mr Croft would have lost his right leg below the knee.

30. The applicant refers to the comments of Dr Hopcroft in his report dated 13 May 2019 on the opinions expressed by Dr Walls in his reports dated 19 March 2019 and 15 April 2019.

31. In respect of the respondent's medical evidence regarding causation, the applicant notes that the notwithstanding respondent's complaint that there is no evidence from a vascular surgeon lodged on his behalf, Dr Tomlinson is a vascular surgeon and general surgeon. He examined the applicant at the request of the respondent in relation to the right great toe. The respondent chose not to have the applicant re-examined by Dr Tomlinson but instead substituted Dr Chris Walls, an occupational physician.

32. The applicant notes that in his reports dated 24 December 2018 and 19 March 2019, Dr Walls expressed the opinion that, as far as he could determine, the right below knee amputation was consequential upon the right great toe blister that became infected. This opinion did not change in the later report dated 21 March 2019. However, it did change in Dr Walls' report dated 15 April 2019. The reason for this change, according to the applicant, is apparent from the reading of the letter from the respondent's solicitor dated 12 April 2019[9] to Dr Walls which selectively highlights part of the clinical history and invited him to change his opinion. The applicant submits that Dr Walls' opinion that "*It may be that the toe blister was a secondary event from that infection/ulcer or a 'de novo' injury*"[10] cannot be historically or clinically correct based on the body of medical evidence before the Commission and the effect of the 2017 Consent Orders.

33. The respondent submits that the best that Dr Walls can do is to speculate when he says that he cannot determine which injury (if either) led to the cascade of infection and hypoischaemia resulting in Mr Croft's amputation. His subsequently expressed opinion that it was the right heel ulcer, which from the applicant's description was obviously infected and of longstanding, was the more likely culprit cannot be accepted. This is because in his previous reports Dr Walls was in no doubt that it was the osteomyelitis resulting from amputation of the right toe that was responsible for the below knee amputation.

[9] AALD 23.10.19 pp 18-20.
[10] Reply p 506.

34. The applicant submits that the medical evidence tendered on his behalf, notably that of Dr Hopcroft, is more persuasive because:

    (a) Dr Hopcroft has had the beneficial experience of reporting on his condition since April 2016, prior to the right leg below knee amputation;

    (b) Dr Hopcroft has extensive relevant experience as is demonstrated by his curriculum vitae in general and orthopaedic surgery;

    (c) Osteomyelitis is a bone related infection and is well within the sphere of orthopaedic surgery, and

    (d) Dr Hopcroft not only examined all the relevant clinical records but has taken extensive and accurate histories.

35. The applicant submits that Dr Walls is an occupational physician with no apparent experience in the matters in respect of the applicant's condition, and in his early reports he supported the causal connection between the right great toe injury and the right below knee amputation. He only departs from this in an equivocal and speculative way following receipt of a letter from the respondent's solicitor setting out selective excerpts of clinical history which supports the respondent's case. This is made clear by Dr Hopcroft's in his report dated 13 May 2019.

36. The applicant submits that he has discharged the onus of establishing that his subsequent right below the knee amputation is consequential upon or causally related to his accepted right great toe injury, and that should be an award in his favour. The matter should be referred to an Approved Medical Specialist (AMS) for assessment of WPI.

Respondent

37. The respondent refers to the undisputed history of the applicant's amputation of his right great toe on 30 December 2015 as a result of injury to that toe, a blister, arising out of or occurring in the course of his employment. The respondent notes that, due to long term Diabetes Mellitus (Type 1 diabetes), this blister led to osteomyelitis of the right great toe.

38. The respondent notes that the applicant must establish that on a commonsense basis there is an unbroken causal chain connecting the injury to the right big toe and amputation of the right leg below the knee, that is, that the latter "results" from the injury.

39. The respondent refers to a number of authorities to support this submission, commencing with *Kooragang Cement Pty Ltd v Bates*[11] (*Kooragang v Bates*).

40. The respondent notes that the applicant has a longstanding history of a right heel ulcer related to his longstanding diabetes, which was diagnosed in 1997. The right heel ulcer originated on 13 September 2009 after he stepped on a gumnut causing hospitalisation and nine lots of surgery, noting that the heel ulcer "effectively never healed", according to the applicant's evidence in his statement dated 17 January 2017[12], history given to Dr Hopcroft on 28 April 2016[13], clinical note of Dr Bradshaw dated 14 September 2016[14] and report of Dr Bradshaw 21 [sic, 27] January 2015[15].

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[11] (1994) 35 NSWLR 452 at 463F – 464C.
[12] Application p 13.
[13] Application p 56.
[14] Application p 329.
[15] Reply p 150.

41. The respondent then refers in detail to the applicant's treatment from after the date of amputation of the right big toe on 30 December 2015, with reference to the clinical records of Dr Williams, the treating vascular surgeon, Dr Bradshaw, the treating general practitioner, Grafton Base Hospital and reports on radiological investigations. Reference is also made to the examination of the applicant by Dr Hopcroft on 28 April 2016.

42. The respondent notes in particular that:

    (a) Dr Williams [sic, Dr Bradshaw] recorded in a clinical note on 25 February 2016[16] that the right heel was smelly with "no progress with healing since last seen";

    (b) on 29 February 2016 an x-ray of the right foot showed no osteomyelitis and Dr Bradshaw reported that there was no sign of infection in the right toe[17], and

    (c) on 17 March 2016 Dr Williams reported that the right toe was "healed completely"[18].

43. The respondent notes that the applicant continued to receive treatment for his unhealed right heel ulcer from Dr Williams and Dr Bradshaw throughout 2016 and 2017[19] and that on 8 May 2017 the applicant consulted Dr Bradshaw for the right heel and was informed that there was no osteomyelitis[20].

44. The respondent submits that the clinical picture changed dramatically for the worse in June 2017 in respect of the right heel ulcer. In a consultation with Dr Williams on 19 June 2017, the applicant was advised that MRI results revealed extensive osteomyelitis and fractures in the calcaneum which were not there previously[21]. Below knee amputation (BKA) is recorded as being discussed. In a consultation with Dr Bradshaw the following day the need for amputation was discussed[22].

45. The respondent noted that surgery took place on 26 June 2017, with Dr Williams assisting Dr Cameron Law. Further reference is made to the applicant's treatment following surgery.

46. The respondent submits that Dr Hopcroft's opinion cannot be accepted as having any weight as his conclusion in his report dated 13 November 2018 that "it was almost certain that the infection had invaded the patient's right calcaneus which broke down and shattered, and also began to discharge in June 2017" is not substantiated by the treatment history in 2016 and 2017 which was solely for the right heel. Neither is it substantiated by any radiological evidence of progressive osteomyelitis spreading from the big toe amputation site in 2016 and 2017. The respondent notes that the applicant has not adduced that MRI scan referred to in the clinical note of Dr Williams dated 19 June 2017 and there is no evidence that this MRI scan was provided to Dr Hopcroft. The respondent submits that there is no evidence that Dr Hopcroft had regard to the radiological examinations from 23 June 2016 to 27 February 2017 which showed no osteomyelitis of the right foot or of the calcaneum, or the surgery report of the amputation. That showed that the need for surgery as being the osteomyelitis of the calcaneum and a fracture of the calcaneum itself. The respondent also submits that there is no evidence that Dr Hopcroft had regard to the progress noted of 23 and 24 June 2017, 12 July 2017 and 17 August 2017 that record that the below knee amputation was due to the non-healing ulcer of the right heel which was in turn due to stepping on a gumnut in 2009 and not work related.

[16] Application p 351.
[17] Application p 351 and p 65.
[18] Application p 607.
[19] See respondent's submissions at [8]-[10] and respondent's chronology.
[20] Clinical note Application p 320.
[21] Medical Progress Notes of Dr Williams - Reply p 1865.
[22] Reply p 733.

47. The respondent submits that Dr Hopcroft's opinion on causation in his report dated 13 November 2016 is a bare *ipse dixit* which is not proved by application of his knowledge or specialised experience to observed facts and cannot be tested nor independently appraised and is merely an oracular pronouncement, citing *Davie v Lord Provost, Magistrates and Councillors of the City of Edinburgh*[23].

48. The respondent submits that in contrast to Dr Hopcroft, Dr Walls has considered the clinical records and formed an opinion that the most likely cause of the right below knee amputation was the right heel ulcer which predated the applicant's employment with the respondent. Dr Walls' report should be accepted as providing, at very least, a plausible alternative explanation for the osteomyelitis of the right calcaneum that led to the amputation.

49. The respondent finally notes that if any attack is made on Dr Walls' and qualifications and expertise to opine on surgical or orthopaedic matters, it is to be noted that the applicant's solicitors objected to an examination by a different doctor and insisted that their client be re-examined by Dr Walls[24].

Matters raised by the Arbitrator and the parties' response.

50. In the email dated 16 December 2019 that I caused to be sent to the legal representatives of the parties (referred to in [20(a)] above), reference was made at [1]-[4] to the submissions of the parties in respect of the evidence of Dr Tomlinson, Dr Hopcroft and Dr Walls. Certain matters raised for the consideration of the parties were set out at [A]-[H]. Included in those at [G] was a reference to the supplementary report of Dr Walls dated 21 March 2019 in which he refers to an article by Carey on "Risk of Infection in Type 1 and Type 2 Diabetes Compared With the General Population…". At [H] in the email I noted that Dr Walls appears to use the article by Carey as a basis for the statement in his report dated 15 April 2019 that "On reviewing the documentation again, I cannot be dogmatic but would view the pre-existing and deep heel ulcer a more likely candidate."

51. The queries I raised with the parties are set out at [I]-[J] in the email as follows:

> "I. Do the parties have any comment on:
>
> (i) the use by Dr Walls of the article by Carey as a basis for assessment of permanent impairment of the applicant's right lower leg in his report dated 21 March 2019, and as a basis for the opinion expressed in hie [sic, his] report dated 15 April 2019?
>
> (ii) the expertise of Dr Walls, having regard to his qualifications and his use of the article by Carey, to make comment on or give an opinion on the causation for the below right knee amputation that the applicant underwent on 26 June 2017?
>
> J. Dr Hopcroft in his report dated 13 May 2019 refers to the opinion of Dr Walls in his report dated 24 December 2018 and the supplementary reports of 19 March, 21 March and 15 April 2019 (Application to Resolve a Dispute p 80). He refers to 'a gigantic leap' that Dr Walls makes in expressing the opinion that the applicant's heel ulcer was the cause of his right toe blister, where in fact, according to Dr Hopcroft, it was quite obviously due to the rubbing of his shoes when walking up and down ramps pushing trolleys. Dr Walls in fact states that "it may even be that the toe blister was a secondary event from that infection/ulcer or a 'de novo' injury." (Reply p 705). What is the Commission to make of this proposition of Dr Walls?"

[23] 1953 SC 34 at 39-40.
[24] AALD 18.11.19 p 16.

Applicant's supplementary submissions

52. The applicant notes that the fact that he suffered from diabetes pre accident is not in issue. He has always been at risk of contracting an infection due to his underlying diabetic condition just as many other workers are subject to greater risk due to pre-existing conditions, for example, degenerative change.

53. Dr Walls' calculations are speculative and beyond his expertise. Hence other than confirming the predisposition to infection they are of no probative value.

54. There is no dispute that the applicant contracted osteomyelitis, which is a blood born infection, as a result of injury to the right toe.

55. Dr Hopcroft provided compelling reasons as to why it should be accepted that there is a direct causal connection between the original infection which developed into osteomyelitis which ascended to the heel and resulted in subsequent amputation.

56. It is significant that despite the irrefutable evidence that the applicant had suffered from an ulcerated heel for many years, there had never been a diagnosis and/or evidence of osteomyelitis prior to the toe injury and subsequent infection.

57. The opinion of Dr Walls that "*it may be that the toe blister was a secondary event from that infection/ulcer or a 'de novo' injury*" (emphasis in original) is not only speculative but totally lacking factual and diagnostic foundation. In these circumstances the opinions of Dr Walls can be comfortably rejected by the Commission.

Respondent's supplementary submissions

58. In respect of item [I] in the email dated 16 December 2019 the respondent submits that the article by Carey is a scientific article reflecting the risk of bone and joint infections for diabetics. There is no dispute that the applicant suffers from pre-existing diabetes of a longstanding nature. This pre-existed both the injury to the large toe and the amputation of the leg below the knee. It was therefore appropriate for a deduction to be applied by the doctor (Dr Walls) pursuant to s 323 of the 1998 Act on the basis that the diabetes was a "pre-existing condition or abnormality."

59. The reliance upon the article by Carey is appropriate as it is directed to the specific condition or abnormality suffered by the applicant.

60. As to the appropriateness of the expertise of Dr Walls, given his qualifications, to make comment on causation, the respondent notes that Dr Walls is an occupational physician but is still a qualified medical practitioner. He is entitled to form an opinion as to the progression of diabetes in circumstances where his qualifications and basis for his opinion are based not only his experience as a medical practitioner, but also his research into the incidents of risk based on an analysis of the diabetic condition. The respondent submits that Dr Walls' qualifications as an occupational physician are suitable to comment upon the issue of causation, and he is in no better or worse position than Dr Hopcroft as an orthopaedic specialist who has no background or experience in the treatment of diabetes. The respondent notes that Dr Hopcroft provided an opinion in circumstances where the treating surgeon, Dr Williams, was a vascular surgeon. Therefore the qualification of Dr Walls has as much weight as that of Dr Hopcroft.

61. With respect to item [J] in the email dated 16 December 2019, the respondent respectfully submits that the statement by Dr Walls that the toe blister was a secondary event from that infection/ulcer may be disregarded, as it is contrary to the accepted injury that was the basis of the original report of Dr Tomlinson dated 31 May 2016, noting that Dr Tomlinson is a vascular surgeon.

62. The respondent submits that the toe blister was clearly a “de novo” injury in the sense that it was as a result of the blister on the lateral aspect of the right toe which became infected, leading to osteomyelitis. That is consistent with the opinion of Dr Hopcroft in his initial report dated 28 April 2016.

63. The respondent relies on the authority of a Commission decision, *Vargha Mahdavi-Aghdam v Imad’s Locksmith and Shoe Repair Pty Ltd*[25] at [63]-[66] for a summary of the relevant case law with respect to consequential conditions and causation. It is confirmed in that decision at [67] that the Commission must be satisfied on the balance of probabilities by using a commonsense approach that a consequential condition relates to an original injury.

64. The respondent submits that the onus of proof remains undischarged with respect to the applicant’s claim that the right below-knee amputation was due to the original right toe amputation.

FINDINGS AND REASONS

The expert evidence

65. The applicant relied upon the first report of Dr Hopcroft dated 28 April 2016 in support of the earlier proceedings number 598/17 referred to in [11] above. The doctor examined the applicant on 28 April 2016 and reported on examination the amputation of the right great toe. He noted in respect of the right foot:

> “He has a full range of movement of his right ankle and the rest of the toes of his right foot, but he has a deep penetrating ulcer on the ventral aspect of the middle of his right heel 1cm in diameter, and through the full cutaneous layers.”

In his Diagnosis Opinion and Prognosis the doctor said that:

> “Being a brittle diabetic with peripheral neuropathy, that problem went on to become grossly septic, with x-ray confirmation of osteomyelitis affecting the proximal phalanx.”

66. Dr Hopcroft then referred to the consultation with the vascular surgeon in Lismore and the progress to amputation of the right great toe. Then said:

> “However, as a result of the ongoing deterioration in his peripheral vascular supply from his very longstanding diabetes and in spite of his endovascular treatment of arterial stenoses, an injury to his right heel, suffered in 2009, persists, and this patient is at extreme risk of ultimately requiring right below-knee amputation as the diabetic complications in his foot progress.”

67. Dr Hopcroft expressed the opinion that the applicant’s employment was the substantial contributing factor to his injury, causing severe aggravation of underlying diabetic changes that led to protracted sepsis and the requirement of the amputation described. He also said that future treatment will be for the longstanding diabetic problems, but that the applicant should be wearing a carefully fitted diabetic pressure boot which will maximally offset the possibility of pressure sores developing and further irreversible sepsis. An assessment of WPI was then provided.

68. Dr Tomlinson, vascular and general surgeon, saw the applicant on 31 May 2016 and reported to EML that day. The doctor noted that the applicant was a diabetic with diabetic peripheral vascular disease. He said that the injury received to his right great toe leading to amputation had been caused by his employment and the forces applied to his foot in that employment when pushing trolleys up car park ramps. That led to an injury of the right great toe which caused ulceration and had not healed because of continuing trauma at work and

[25] [2019] NSWWCC 371.

also because of his peripheral vascular disease. Dr Tomlinson went on to say that if Mr Croft had an injury of such a nature and was not a diabetic, there would have been a chance more probable than not that the wound would have healed. The fact that it did not heal, and he continued to have problems with infection and osteomyelitis in the foot requiring amputation, was also associated with his diabetic peripheral vascular disease. Dr Tomlinson expressed the belief that employment was the most substantial contributing factor to the injury, but that however the diabetic peripheral vascular disease was also a contributing factor. The doctor said that (the injury) was an aggravation of an existing problem.

69. Dr Deepak Williams, the treating vascular surgeon, provided a report to the applicant's solicitors dated 13 July 2016[26]. He noted that on admission to Lismore Base Hospital on 29 December 2015 investigations revealed that the applicant had osteomyelitis in the distal phalanx of the right great toe, therefore treated with antibiotics and underwent an operation for amputation of the right great toe on 30 December 2015. Dr Williams said in the report:

> "When I first examined Mr Croft on the 29 December 2015, he had a heavily infected right big toe and a chronic ulcer on the plantar aspect of his right heel. This ulcer was about 1 cm wide and about 5mm deep. This was chronic in nature. At that stage there was no history given that all this was due to an injury, as the nature of his problem was chronic."

70. Dr Williams stressed the need in the long term the need of the applicant to have special shoes to spread the weight of his body across the whole foot rather than just on the heel. He also needed continuous monitoring done to ensure that the blood supply to his foot was always good, and the foot needed to be checked every day to make sure that Mr Croft had not injured himself without realising it.

71. It is relevant to also note at this stage that Dr Williams had seen the applicant on 17 March 2016 for review in his rooms[27]. He noted that the right big toe wound had "healed completely and the wound on the right heel is coming along nicely." The doctor reassured the applicant and arranged for another review in two months. The applicant in submissions draws attention to the wound having healed completely. The respondent in submissions and in its chronology stated that Dr Williams found that the right toe was healed completely.

72. Dr Hopcroft provided two reports dated 13 November 2018 following examination of Mr Croft on that day. Prior to the date of examination, the applicant's solicitor wrote to Dr Hopcroft on 18 October 2018, 26 October 2018 and 8 November 2018[28]. Extensive medical records were forwarded with the letter dated 18 October 2018, including those of Dr Bradshaw, report of Dr Williams dated 13 July 2016 (referred to above at [69]), clinical notes of Queen Street Clinic (Dr Bradshaw's notes), clinical notes of Lismore Base Hospital and of Grafton Base Hospital. On 26 October 2016 the medical records of Dr Williams were forwarded to Dr Hopcroft. On 8 November 2018 a Certificate of Capacity of Dr Bradshaw dated 6 November 2018 and medical records of Dr Allison Duchow (who had treated the applicant in the past for multiple abscesses and to control his diabetes) were forwarded.

73. In the principal report dated 13 November 2018, Dr Hopcroft noted under "**Ongoing Medical History**" that with the applicant having a significant pressure sore over his right heel from his previous injury he continued under the care of the vascular surgeon, Dr Deepak Williams in Lismore Base Hospital. He was taken to theatre on 20 February 2917 where he had debridement of the ulcer of his right heel which led to ongoing dressings including use of a VAC pump. Dr Hopcroft then said:

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[26] Reply p 10.
[27] Application p 607.
[28] AALD 23.10.19 pp 21-26.

"Although the wound healed over it was almost certain that the infection had invaded the patient's right calcaneus which broke down and shattered, and also began to discharge, in June 2017.

That led to the patient requiring a right below-knee amputation which was undertaken by Dr Williams in Lismore Base Hospital on 26 June 2017."

74. Under "**Diagnosis Opinion and Prognosis**" Dr Hopcroft said:

"This patient's original injury that occurred during the course of his work on 24 October 2015, which involved blistering of his right great toe, has progressed enormously and drastically due his brittle diabetic status, leading to his undergoing a right below-knee amputation."

Dr Hopcroft then dealt with the applicant's fitness to return to work. He then said:

"I believe his employment has been the substantial contributing factor to his alleged injury and current significant and compromised musculo-skeletal status.

I believe the amputation of his right leg below the knee was a direct result of the injury suffered to his right great toe complicated by his diabetic status. That is to say, had it not been for the blistering injury to his right great toe he is unlikely to have lost his right leg below the knee."

75. In a supplementary report dated 13 November 2018, Dr Hopcroft gave an assessment of WPI of 30%. On 10 December 2018, the applicant's solicitor wrote to Dr Hopcroft raising queries in respect of the assessment of WPI, to which Dr Hopcroft responded on 20 December 2018.

76. The applicant was seen by Dr Walls on one occasion only, 13 December 2018. Dr Walls provided an "**INJURY MANAGEMENT CONSULTATION REPORT**" following the examination, dated 24 December 2018[29]. In that report the doctor notes that the documents reviewed included, relevantly:

(a) Surgical report of Dr Duchow dated 27 October 2015;

(b) Grafton Base Hospital copy of discharge and other hospital notes dated 25 December 2015;

(c) General practice records of Dr Bradshaw dated 20 April 2016;

(d) Lismore Base Hospital records dated 21 April 2016, and

(e) Report of Dr Tomlinson dated 31 May 2016.

77. Dr Walls discussed the matter with Dr Bradshaw on 18 December 2018. As a result of the review the doctor concluded that:

(a) Mr Croft had a right below knee amputation arising from an injury at work;

(b) he had severe underlying Diabetes Mellitus with multiple complications, and he had minimal work capacity because if the need for renal dialysis at that time;

(c) he was unable to tolerate the prosthetic leg, meaning that he was wheelchair bound, and

[29] Reply p 687.

(d) until the prosthetic leg was tolerable there was no work capacity.

78. On 18 March 2019, the solicitor for the respondent wrote to Dr Walls urgently requesting a supplementary report[30]. Extensive documentation was included therewith. The respondent's solicitor notes that the applicant had refused to attend a further examination for the purposes of his current claim for lump sum compensation and accordingly the doctor was requested to provide an updated opinion on causation and assessment of impairment of the right leg and scarring based on his previous examination.

79. The reason for the refusal of the applicant to attend again on Dr Walls is found in the email from the applicant's solicitor to the respondent's solicitor dated 25 January 2019[31], namely:

    (a) the applicant underwent an IME assessment for EML with Dr Walls on 13 December 2018 and his report had not been provided to the applicant. Dr Walls was accredited to assess permanent impairment, and it was thought that it [sic] should adequately address any issues regarding the claim;

    (b) the applicant's solicitor noted that cl 7.6 of the SIRA Workers Compensation Guidelines, which commenced on 1 January 2019, provided that subsequent IMEs must be with the same IME, and it had been less than six months since the last IME, and

    (c) the applicant was not fit to travel to Sydney for an assessment because of his condition.

80. In his supplementary report dated 19 March 2019 Dr Walls reviewed an extensive list of documentation including the clinical records of Queen Street Clinic and of Lismore Base Hospital. In answer to a specific question:

> "**But for the work related injury to the right big toe sustained on 24 December 2015 (deemed), do you consider that the worker would have required a below knee amputation of the right leg? Do you consider that the below knee amputation of the right leg is consequential to the right toe injury sustained on 24 December 2015? Please provide reasons for your answer.**"
> (emphasis in original)

Dr Walls said:

> "As far as I can determine the Right Below Knee amputation was consequential upon the Right Great Toe blister that became infected.
>
> It is common for Diabetics to have prolonged healing/recovery from trivial leg wounds and not uncommon for these trivial wounds to become infected.
>
> If no such wound had occurred the more common clinical pathway would be slowly worsening peripheral ischaemia leading to amputation because the dependent tissues were non-viable because of the lack of oxygenated blood supply.
>
> I am unaware of such suffers spontaneously developing de novo lower leg or foot osteomyelitis (in the absence of some trauma) although I would not exclude that possibility.

[30] AALD 23.10.19 p 7.
[31] AALD 18.11.19 p 16.

Nevertheless, that would be a diagnosis of exclusion and where trauma was evident, even trivial trauma most reasonable medical commentators would attribute the subsequent infection to that trauma."

81. Dr Walls gave an assessment of WPI in that report of 30%.

82. A further supplementary report was requested from Dr Walls by the solicitor for the respondent which was supplied on 21 March 2019. This was in respect of Dr Walls' assessment of WPI of 30% and what deduction should be made for any pre-existing injury or impairment. In this report Dr Walls referred to the article by Carey, referred to above at [51]. With the assistance of material contained in that article, Dr Walls calculated that the deduction that should be made from his assessment of WPI of 30% for pre-existing injury or pre-existing condition should be 95%. His reference in the report to Carey's article is as follows (omitting footnotes):

> "An article by Carey gives an Incident Rate Ratio (IRR) for Insulin using Diabetics of 22.34 (95% Confidence Interval 12.12 - 41.20) for *'Bone and Joint infections'* (Table 2), that is the incidence rate (number of new cases) amongst Insulin using Diabetics is 22 times greater than in a matched population (for age, sex etc) who do not have Insulin requiring Diabetes.
>
> Converting those figures to an Attributable Risk requires developing a Risk Ratio and I have used the raw figures from Carey's article (Table 2, page 517) of 5.75 (exposed rate) and 0.3 (unexposed rate) developing a Relative Risk of 19 (rounded).
>
> Attributable Risk is then calculated *(RR - 1/RR)* giving the Attributable Risk as 95% and I have used this as the contribution from the pre-existing condition in Mr Croft's case."

In respect of the deduction from his assessment, Dr Walls said:

> "I have supplied the calculations above to develop an Attributable Risk.
>
> This suggests that 95% of the risk of "bone infection" which I have equated to 'osteomyelitis' is attributable to the pre-existing Diabetes Mellitus requiring the use of Insulin."

83. Dr Walls' updated assessment of WPI after deduction for any pre-existing injury or impairment was 3%. It is to be noted that Dr Walls in giving this report had not changed his opinion that the right below knee amputation was consequential upon the right great toe blister that became infected.

84. The solicitor for the respondent requested a further supplementary report from Dr Walls on 12 April 2019[32]. Attention of Dr Walls was drawn to the report of Dr Williams dated 17 March 2013 (referred to above at [71]) and the clinical notes of Queen Street Clinic (which were previously provided to the doctor in letter dated 18 March 2019). Thereafter attention was drawn to 14 "relevant entries" in the report and clinical notes. In light of those records pertaining to the progression of the applicant's prior right heel injury, Dr Walls was asked to confirm the basis of his opinion that the right below knee amputation was consequential to the right toe injury sustained on 24 December 2015 (deemed). In the alternative, Dr Walls was asked if he considered that the right below knee amputation was consequential to the non-work related right heel injury sustained in 2009. Reasons for such opinion were requested.

[32] AALD 23.10.19 p 18.

85. In his report dated 15 April 2019, Dr Walls outlined the sequence of events as he understood them. He said:

   (a) there was a previous history of right heel injury/ulcer after standing on a gumnut which led to ulceration at the site and multiple surgeries in the past;

   (b) the earliest record that he could find in the General Practice records was a discussion of the right heel on 1 May 2015, and the condition waxed and waned but did not resolve;

   (c) Mr Croft developed a blister in the right great toe at work on 12 October 2015, which became infected;

   (d) he subsequently developed osteomyelitis of am ascending nature and ultimately, coupled with his peripheral vascular disease, led to the amputation;

   (e) unless there is microbiological evidence linking one of the ulcers to the osteomyelitis (that is one infective agent cultured from both from one ulcer and the osteomyelitis but not the other ulcer) then it is difficult to be dogmatic about which injury (if either) led to the ascending infection;

   (f) he would accept that the heel ulcer, which was described as deep and had been present for some time, was the prime candidate to seed any infection, and

   (g) it may even be that the toe blister was a secondary event from either that infection/ulcer or a “de novo” injury.

86. Dr Walls’ opinion was expressed as follows:

   (a) he presumed that there was no direct microbiological marker linking one ulcer to the ascending infection;

   (b) on reviewing the information he could not determine which injury (if either) led to cascade of infection and hypoischaemia resulting in Mr Croft’s amputation;

   (c) he was of the opinion that the right heel ulcer which from Dr Bradshaw’s description was obviously infected and of longstanding was the more likely culprit;

   (d) the toe ulcer remained a possibility, but this could not be proven, and

   (e) as his assessment of contribution states all of this was on the background of a severely unwell person greatly at risk from trivial trauma or a spontaneous occurrence.

87. In his last report dated 13 May 2019, Dr Hopcroft reviewed Dr Walls’ reports. He agreed with the opinion of Dr Walls in his report dated 19 March 2019 that in a person without diabetes mellitus and peripheral neuropathy vascular disease it would be much more likely than not that this blister would have healed without sequelae. He said however that the contention fails to qualify the additional fact that once a joint under a blister becomes infected, chronic sepsis in any synovial joint can prove extremely refractory to treatment. He then goes on to comment on the fact that the applicant had diabetes mellitus and peripheral neuropathy did not preclude him from holding a position of trolley collection and retrieval, and had it not been for the development of that blister the applicant’s employment would not have been interrupted.

88. Dr Hopcroft agrees with Dr Walls' opinion that as far as he could determine the below knee right amputation was consequential upon the right great toe blister that became infected.

89. Dr Hopcroft notes Dr Walls' comment that he could not determine which injury (if either) led to the cascade of infection and hyperischaemia [sic, hypoischaemia] resulting in Mr Croft's amputation and says that Dr Walls:

> "…then makes a gigantic leap of being of the opinion that the patient's heel ulcer was the cause of his right toe blister, where in fact it was quite obviously due to the rubbing of his shoes when walking up and down ramps pushing trolleys. Had he not been doing that work he would not have developed that blister."

Dr Hopcroft agrees with the last comment pf Dr Walls that the assessment of contribution is on the background of a severely unwell person. Dr Hopcroft says that, notwithstanding Mr Croft's general medical condition he was able to be employed as a trolley collector, and that:

> "It was not until the treatment of a simple great toe ulcer was delayed for one week that that infection broke into the metatarsophalangeal joint, which led to the necessity for amputation of the right great toe, and the history of his deteriorating and difficult gait thereafter led to the acceleration of the effects of ischaemia into his leg and descending infection, both of which led to his requirement of below knee amputation."[33]

It may be that Dr Hopcroft meant to refer to ascending infection in this report (as did Dr Walls). The oversight, if it was one, does not detract from the meaning Dr Hopcroft conveys. Dr Walls assumes an ascending infection in his report dated 15 April 2019 (see [86(a) above).

90. To be fair to Dr Walls, he says that the toe blister "*may even be*" secondary to the right heel ulcer. However that is clearly not correct as submitted by the applicant and conceded by the respondent. The toe blister was caused by the applicant's employment.

91. I do however have difficulty in accepting the opinion of Dr Walls, as in his report of 15 April 2019, he says that he cannot determine which injury (if either) led to the cascade of infection and hypoischaemia resulting in the amputation, then expresses the opinion that the right heel ulcer is the more likely culprit. The justification he gives for this is that the right heel ulcer was infected and of longstanding. In view of his earlier expressed opinion on causation of the need for the amputation of the right leg below the knee, and his contrary view expressed in the latest report after his attention had been drawn to medical records to which he had previous had access in preparing his earlier report dated 19 March 2019, I think that the doctor is speculating as to the likely cause.

92. The applicant submits that despite the irrefutable evidence that the applicant had suffered from an ulcerated heel for many years, there had never been a diagnosis and/or evidence of osteomyelitis prior to the toe injury and subsequent infection. That is correct. The first evidence of osteomyelitis appears in the x-ray dated 26 December 2018[34], with no evidence shown on an earlier x-ray dated 24 October 2015[35]. The respondent submits that there is no evidence of osteomyelitis in other bones originating from the big tor amputation site. That may be because the doctors treating Mr Croft at the time were focussing on the right big toe injury.

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[33] Application p 81.
[34] Application p 156.
[35] Reply p 58.

93. The respondent submits that Dr Hopcroft in his report dated 28 April 2016, stated that the big toe amputation had gone on to sound healing. There is no doubt that the wound had gone on to sound healing. Dr Hopcroft concedes this in his report dated 13 November 2018 but says that it was almost certain that the infection invaded the applicant's right calcaneus which broke down and shattered, and also began to discharge in June 2017. The respondent submits that this report is a bare *ipsi dixit*. I do not agree. I think that Dr Hopcroft's qualifications as a general surgeon specialising in orthopaedics, and his lectureship in those disciplines at the University of Newcastle, qualify him to give an opinion on the applicant's condition and the inflammatory disease of osteomyelitis from which he was suffering. Dr Hopcroft was provided with extensive relevant medical records, clinical notes and reports on which to base his opinion, including the medical records of Dr Williams (see [72] above). He does not need to refer to all of the material in his report, provided the evidence as a whole provides a sound basis for the opinion expressed in the report.

94. As submitted by the respondent and noted in both the applicant's and respondent's chronology, the applicant was having considerable difficulty with his right heel in 2016, and 2017 leading up to the surgery to amputate the right leg below the knee on 26 June 2017.

95. The respondent refers in submissions to a dramatic, sudden and substantial pathological change of the calcaneum with extensive osteomyelitis and a fracture disclosed in am MRI on about 19 June 2017 as reported by Dr Williams to the applicant, which was not there previously. The respondent points to the lapse of 18 months after the toe removal surgery, and 15 months after Dr Williams reported in March 2016 that the toe amputation site had healed completely. The wound had healed completely, but Dr Hopcroft says that once a joint under a blister becomes infected, chronic sepsis in any synovial joint can prove extremely refractory to treatment.

96. The respondent notes the lack of a report from Dr Williams as the treating vascular surgeon. That may have been helpful, but the Commission must decide on the evidence before it. It is evident from Dr Bradshaw's post-surgery clinical notes of 21 July 2017 and 1 August 2017[36] that Dr Bradshaw was unsure as to the reason for the amputation and was working to sort out if it was related to the forefoot infection or heel infection.

97. The respondent did seek to tender at the arbitration hearing in Coffs Harbour on 18 September 2019 reports of an x-ray of the right foot dated 8 June 2017, an MRI of the right foot dated 9 June 2019 and an MRI of the right foot dated 19 June 2019. These were said to be "…within the purview of Lismore Base Hospital". This tender was vigorously opposed by the applicant[37], as it was the first time that the respondent had signalled its intention to rely on the reports, they had not been seen by Drs Hopcroft or Wall, had not been attached to the s 78 notice or attached to the Reply. Dr Hopcroft did not have the opportunity to comment on the reports, and therefore the applicant submitted that he would be prejudiced in the presentation of his case. After extensive argument, the tender was rejected. Nevertheless the respondent relies on the reference to the result of the MRI scan referred to in Dr Williams Medical Progress Note dated 19 June 2017 and Dr Bradshaw's clinical note of 20 June 2017 which are in evidence.

98. The Commission is therefore left with the expert evidence on causation expressed by Dr Walls and Dr Hopcroft, neither of whom had an opportunity to comment upon the material sought to be tendered by the respondent on 18 September 2019.

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[36] Application pp 319 and 318.
[37] T p 2.25 – p 6.30.

99. In *South Western Sydney Area Health Service v Edmonds*[38] McColl JA (Giles JA and Tobias JA agreeing) made comment upon evidence in proceedings before the Commission. She held at [129]-[130]:

> "129 Where the rules of evidence do not apply, in order to find error of law based on absence of evidence there must be an absence of material, whether strictly admissible according to the rules of evidence or not*: Smith & Anor v Collings Homes Pty Ltd & Anor* [2004] NSWCA 75 at [32] per Mason P (Handley JA and Campbell J agreeing)
>
> 130 In *Hevi Lift (PNG) Ltd v Etherington* at [84] I said (Mason P and Beazley JA agreeing) that '[a] court should not act upon an expert opinion the basis for which is not explained by the witness expressing it'. In so saying, I referred with approval (inter alia) to Heydon JA's analysis of the admissibility of expert evidence in *Makita (Australia) Pty Limited v Sprowles* (at [59] – [82]). In that case (at [59]) Heydon JA cited with apparent approval Lord President Cooper's statement in *Davie v The Lord Provost, Magistrates and Councillors of the City of* Edinburgh (1953) SC 34 at 39-40 that:
>
>> '... the bare *ipse dixit* of a scientist, however eminent, upon the issue in controversy, will normally carry little weight, for it cannot be tested by cross-examination nor independently appraised, and the parties have invoked the decision of a judicial tribunal and not an oracular pronouncement by an expert.'"

100. For the reasons outlined in [91] above, I do not accept the opinion of Dr Walls on causation of the applicant's below knee right leg amputation expressed in his report dated 15 April 2019. However, I find that Dr Hopcroft did have sufficient evidence before him on which to base his opinion on causation and that he did explain the basis of his opinion in his reports of 13 November 2018 and 13 May 2019.

101. The report dated 13 May 2019 refers to the applicant's difficult and deteriorating gait as part of the reason for the acceleration of the effects of ischaemia into the applicant's leg and descending infection. This is corroborated by what the applicant says in his statements. Dr Hopcroft also noted that once a joint under a blister becomes infected, chronic sepsis in any synovial joint can prove extremely refractory to treatment

102. Assessed on a common sense basis as outlined in *Kooragang v Bates,* I think that there is sufficient evidence which I have summarised herein to show a causal link between the undisputed injury to the applicant's right toe, deemed to have occurred on 24 December 2015, and the condition in the applicant's right heel which led to the amputation of his right leg below the knee on 26 June 2017.

103. There will accordingly be an award in favour of the applicant that the condition in his right heel giving rise to the need for amputation of the right leg below the knee on 26 June 2017 was consequent upon injury to the right great toe, deemed to have occurred on 24 December 2015.

104. Although EML, in its s 78 notice dated 18 April 2019, put in issue the reasonable necessity for the below right knee amputation as a result of injury deemed to have occurred on 24 December 2105, no submissions were put to the Commission to suggest that, in the event of a finding in favour of the applicant on the principal issue, the surgery carried out on 26 June 2017 was not reasonably necessary as a result of the condition in the right heel.

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[38] [2007] NSWCA 16.

105. There will also be a finding that the surgery carried out on 26 June 2017 was reasonably necessary as a result of the injury to the right great toe, deemed to have occurred on 24 December 2015.

SUMMARY

106. The applicant suffered a condition in his right heel consequent upon injury to the right great toe deemed to have occurred on 24 December 2015.

107. The surgery to amputate the applicant's right leg below the knee on 26 June 2017 was reasonably necessary as a result of the condition in the applicant's right heel.

108. The matter is remitted to the Registrar for referral to an AMS for assessment of WPI as a result of injury to the applicant's right great toe deemed to have occurred on 24 December 2015 and scarring.

109. The documents to be referred to the AMS are:

    (a) the Application and attachments;

    (b) Reply and attachments;

    (c) Application to Admit Late Documents dated 9 September 2019 and attachments;

    (d) Application to Admit Late Documents dated 23 October 2019 and attachments'

    (e) Application to Admit Late Documents dated 18 November 2019 and attachments, and

    (f) this Certificate of Determination and Statement of Reasons.

110. The Registrar is requested to arrange for the examination of the applicant by an AMS to take place in Coffs Harbour.