WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **5021/20**
Applicant: **Shane Clarke**
Respondent: **Whiteley Corporation Pty Ltd**
Date of Determination: **23 December 2020**
Citation No: **[2020] NSWWCC 422**

The Commission determines:

1. Finding that the applicant did not suffer an injury to his right lower extremity (hip) on 23 February 2011.

2. Award for the respondent with respect to the claim for s 60 expenses for treatment to the applicant's right hip.

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

Catherine McDonald
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 CATHERINE McDONALD, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A MacLeod

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

STATEMENT OF REASONS

BACKGROUND

1. Shane Clarke suffered an accepted injury to his lumbar spine on 23 February 2011 whilst employed by Whiteley Corporation Pty ltd (Whiteley) when he bent to pick up an empty pallet from the floor. He was paid compensation, including permanent impairment compensation in respect of that injury.

2. Mr Clark claims that he also suffered an injury to his right hip in the same incident. He claims s 60 expenses in respect of a right hip arthroscopy and labral repair proposed by Dr D Dewar in 2016.

3. There is no dispute that surgery to Mr Clarke's right hip is appropriate – Whiteley disputes that his employment materially contributed to the need for that surgery.

PROCEDURE BEFORE THE COMMISSION

4. The matter was listed for conciliation conference and arbitration hearing by telephone on 26 November 2020. Mr Niven of counsel appeared for Mr Clarke and Mr Baker of counsel appeared for Whiteley.

5. At about the same time that these proceedings were filed, Whiteley sought a reconsideration of a Medical Assessment Certificate (MAC) dated 17 April 2018 in matter 1515/18. The parties agreed that the reconsideration should be dealt with at the conclusion of these proceedings because the outcome of these proceedings will determine that reconsideration.

6. 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

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

    (a) Application to Resolve a Dispute (ARD) and supporting documents;

    (b) Reply;

    (c) documents produced under direction by Dr Dewar;

    (d) Whiteley's Application to Admit Late Documents dated 20 November 2020, and

    (e) Mr Clarke's Application to Admit Late Documents dated 23 November 2020.

8. There was no oral evidence.

9. Mr Clarke prepared three statements. The first was dated 6 November 2013 and was prepared for proceedings in which Mr Clarke sought s 60 expenses for surgery to his lumbar spine. The statement did not mention any injury to his right hip.

10. The second statement was signed on 6 June 2019. Mr Clarke said that he did not remember the circumstances in which he made his first statement and that he did not receive legal advice. He said that the primary injury was to his back but that his right hip was also affected and he developed a limp. He did not begin investigations into the condition because his back took precedence. Mr Clarke said that he underwent injections in 2016 ordered by his general practitioner, Dr Salaria. He said that his right hip was getting worse.

11. Mr Clarke made two further statements on 18 September 2020. In the statement in the ARD he said:

> "While my back was the primary injury and caused me the most pain, my right hip was also affected. I started experiencing pain in my right hip immediately after the injury and developed a limp. However, I did not begin investigations into it as my back injury took precedence. I have seen the report of Professor Ghabrial dated 9 May 2013 and I agree that I saw Professor Ghabrial on that date and that the history he has recorded as to the onset of my symptoms is accurate. I particularly recall having pain in both my legs subsequent to the injury.
> …
> With regards to my previous statement dated 6 November 2013 I make the following comments;
>
> (a) I do not recall the particular circumstances which gave rise to me providing the statement to EML. To the best of my memory I believe the purpose of the statement was to gain approval for my first surgery.
> (b) I did not receive legal advice with regards to this statement.'
> (c) At the time of my termination I had no knowledge of the workers compensation system, hence I did as I was asked by my employer and insurer. I trusted and expected them to do the right thing."

12. A second statement dated 18 September 2020 appears in his Application to Admit Late Documents. He said that the first pain he noticed after the injury was in his low back which seemed to run into his right groin and down the inside and back of his right leg. He said that it was initially a niggle and he did not think too much about it in the context of the more severe pain in his back. He said his general practitioner at the time told him it was "all part of the back injury" and the slight pain in his groin never went away and has become worse.

13. Whiteley lodged a claim form on 3 March 2011, stating that the injury had been suffered and reported on 23 February 2011. Mr Clarke ceased work on 3 March 2011. The only injury identified is a back strain.

Medical evidence

14. Because the issue in dispute concerns the time at which complaints were made, I have considered the medical evidence in substantially chronological order. It is important to remember when reviewing that evidence that Mr Clarke alleges that he suffered an injury to his right hip on 11 February 2011. Despite some of the correspondence summarised below, he did not allege that he suffered a consequential condition in his right hip as a result of the accepted back injury.

15. There are no clinical notes from Mr Clarke's general practitioners in the file.

16. The first medical report in the file was prepared for Whiteley by Dr E Price on 9 March 2011. Dr Price recorded that Mr Clarke had continued to work after reporting the incident and suffered back pain after travelling to Melbourne over the weekend. Dr Price noted that Mr Clarke had seen his general practitioner, Dr Ballantyne and undergone physiotherapy. Dr Price noted that Mr Clarke walked without a limp. He diagnosed a left para-lumbar muscle strain adjacent to L4/5 and considered Mr Clarke fit for selected duties.

17. Dr Price reported again on 25 May 2011 to consider Mr Clarke's fitness for selected duties. He set out the current status, noting that Mr Clarke reported constant pain in his back at the L4 level. He suffered stiffness in the morning and after sitting but had no pain in his right leg except after prolonged sitting when it radiated to his leg and he had occasional pins and needles in his right foot.

18. There are no reports or notes from Dr Ballantyne from the time of the injury.

19. Dr Ballantyne referred Mr Clarke to Dr R Kuru, orthopaedic surgeon, who reported on 17 June 2011. He recorded that Mr Clarke suffered sharp pain in his back which radiated toward his buttock with occasional numbness in his right foot. He noted that Trendelenburg's test was normal and straight leg raising was equal. Hip range of motion was non-irritable. He considered that x-rays were normal and recommended an MRI scan. Dr Kuru diagnosed non-specific back pain.

20. The MRI scan was carried out on 28 June 2011 and was reported as showing L3/4 and L4/5 disc degeneration with a small bulge at L4/5 causing minor impression on the thecal sac.

21. Dr Kuru saw Mr Clarke on a number of other occasions in late 2011. He said that Mr Clarke's spine was stable and that he could be active within the tolerance of his symptoms. Dr Kuru considered that the imaging findings were degenerative and pre-existing.

22. On 7 September 2011, Mr Clarke saw Dr S Potter, rheumatologist, for Whiteley's insurer as an injury management consultant. He said he had discussed the matter with Dr Ballantyne who had agreed that Mr Clarke suffered a simple back strain. He noted that Mr Clarke's gait pattern was normal as were his lower limbs.

23. Intercurrently, Mr Clarke saw Dr S Tame, a specialist in pain medicine, and the first consultation took place on 13 September 2011. Dr Tame saw Mr Clarke in respect of chronic low back pain, which he said was probably related to disc desiccation at L3/4. He did not set out any history of the incident but noted that Mr Clarke was undergoing rehabilitation and was working on suitable duties.

24. On 9 November 2011, Dr R Pillemer, orthopaedic surgeon, provided a report to Whiteley's insurer. He recorded the history that when Mr Clarke lifted the pallet on 23 February, he felt a "bang" in his low back with severe pain and had suffered ongoing back pain since that time. Mr Clarke said that he had radiation down both legs to his knees but those symptoms had settled by May 2011. Mr Clarke told Dr Pillemer that he had improved since the injury. Dr Pillemer diagnosed a "mechanical problem" at L3/4 and particularly at L4/5 where there was some internal disc disruption and minor bulging.

25. The only report from Dr Ballantyne, Mr Clarke's original general practitioner is dated 30 November 2011 and addressed to Whiteley's insurer. Dr Ballantyne said that Mr Clarke was still working and had been asked to attend the examination with Dr Pillemer at short notice which required him to drive in morning traffic. The examination resulted in a "predictable" exacerbation of back pain but was conducted appropriately. Dr Ballantyne said that Mr Clarke's deteriorating mental state was of "more significance" and that he had suffered depression as a result of his back injury. Dr Ballantyne considered that Mr Clarke was unable to perform his selected duties because of mental health issues which he described as an acute mental health crisis.

26. Dr Ballantyne hoped that Mr Clarke's back injury would resolve and that he would return to normal life and full duties. He said;

> "Unfortunately the physical back injury Is likely to be a long term injury and have a chronic pain aspect which will also be long term, with the risk of intermittent exacerbation. To this extent the mental health aspects of his Injury need to be carefully managed and considered in all aspects of management of his health."

27. Dr Ballantyne stressed that excessive car travel was not appropriate for Mr Clarke's back injury. The report is detailed and refers to Mr Clarke's injury as his back injury.

28. A further letter from Dr Ballantyne deals with arrangements for a case conference.

29. On 20 April 2012 Dr Tame reported to both the insurer and Dr Ballantyne. He told the insurer that he was not confident that Mr Clarke would progress past his current suitable duties. He proposed to consider whether his back pain could be reduced with facet joint treatments. His report to Dr Ballantyne was longer and described treatment and proposals in respect of discogenic low back pain.

30. On 21 May 2012 Dr Tame again wrote to the insurer providing detail about proposed medial branch block testing which in respect of back pain so that radiofrequency neurotomy could be considered. Dr Tame told Dr Ballantyne that approval had been granted on 15 June 2012.

31. On 13 July 2012 Dr Tame said that there was no easy fix for Mr Clarke's pain because he did not have facet joint pain. He said that the insurer's plan to return him to pre-injury duties was not realistic.

32. Dr Tame did not record any reference to a right hip injury or right hip pain in any of his reports.

33. Dr Brummit wrote to Whiteley's insurer on 12 November 2012. She said that Mr Clarke was totally unfit for work as a result of mechanical back pain and depression caused by stress from chronic pain.

34. Mr Clarke was referred to Ms J Miller, physiotherapist, for a work conditioning assessment which was carried out on 5 December 2012. Ms Miller noted that the location of Mr Clarke's injury was the lower back.

35. On 18 January 2013, Mr Clarke saw Dr P Sharp at the request of Whiteley's insurer. He recorded that Mr Clarke suffered lower back pain in the incident on 23 February 2011 and that he suffered further low back pain when bending to unhook a garden hose at home in about September 2011 which increased after a fall at home in February 2012. Dr Sharp noted that Mr Clarke complained of constant low back pain which was either a dull ache or sharp, stinging, burning pain which radiated to both buttocks. At times he had pins and needles or numbness down the back of his left leg. On examination, he noted that Mr Clarke's sacroiliac joints appeared normal.

Treatment by Dr Ghabrial

36. Mr Clarke's new general practitioner, Dr Brummit, referred him to Dr YAE Ghabrial, orthopaedic surgeon, who reported on 9 May 2013. Dr Ghabrial recorded that the injury resulted in lower back pain and bilateral sciatica. He set out his findings on examination and referred Mr Clarke for an MRI scan. He noted that Mr Clarke walked with a list to the right. On 24 June 2013, Dr Ghabrial said that the MRI scan showed an annular tear at L4/5 with a small disc protrusion. He noted that Dr Tame had provided five injections but that conservative treatment had been exhausted. Dr Ghabrial proposed right L4/5 discectomy with the aim of relieving nerve root compression and helping leg pain.

37. Dr Ghabrial responded to the insurer's questions about surgery on 29 July 2013 and responded to a series of reports by Dr P Sharp. Dr Ghabrial said that Mr Clarke had right L5 sensory changes, Grade IV weakness of the EHL (which I understand to mean extensor hallicus longus muscle on the outside of the lower leg) and positive tension signs in the right leg. Dr Ghabrial confirmed his recommendation for surgery.

38. Dr Sharp re-examined Mr Clarke and reported to the insurer on 23 August 2013. The complaints he recorded were consistent with those in January 2013 though Mr Clarke now complained of pain radiating down both legs. Again, Dr Sharp noted that Mr Clarke's sacro-iliac joints appeared normal and he noted that movements of Mr Clarke's hips were normal.

39. On 25 June 2014, Dr Ghabrial noted that Mr Clarke's EHL was almost back to normal. Dr Ghabrial referred Mr Clarke for a dynamic MRI.

40. The next report from Dr Ghabrial is dated 27 January 2015 and confirms that he performed a right L4/5 partial laminectomy on that day. The disc was found to be moderately prolapsed and adherent to the right L5 nerve root in the lateral recess. Dr Ghabrial reviewed Mr Clarke on 30 April 2015. He noted that an MRI scan showed some fluid in the paravertebral muscles consistent with surgery and recommended aspiration, which was carried out.

41. On 4 June 2015, Dr Ghabrial noted that Mr Clarke had residual symptoms in his back and right leg and that he remained under the care of Dr Tame. There are no further reports from Dr Tame in the file.

42. Mr Clarke saw Dr Kuru again on 29 July 2015. Dr Kuru noted that surgery had been undertaken for back and leg symptoms though Dr Kuru confirmed that Mr Clarke had not complained to him of significant leg symptoms.

Referral to Dr Salaria

43. In December 2015, Dr Brummit referred Mr Clarke to another orthopaedic surgeon, Dr H Salaria. He recorded that Mr Clarke had suffered pain radiating to his legs since the original injury and that he had not worked since the injury. He noted other symptoms of which Mr Clarke complained and queried if he suffered Lerriche's [sic - Leriche] syndrome due to arterial atherosclerosis. Dr Salaria ordered a whole body bone scan to look for a source of pain from the facet joints and other bony lesions. Dr Salaria ordered vascular studies for both legs to rule out atherosclerosis.

44. The bone scan report is dated 11 January 2016 and notes the clinical history of chronic back pain. The report said "somewhat prominent uptake is seen at the superior acetabular margin of the right hip" and noted degenerative change at the right acromio-clavicular joint. There was unremarkable tracer distribution in the lumbar spine.

45. Dr Salaria reviewed Mr Clarke on 9 February 2016 and said:

> "He is walking with a stick and is limping on the right side. The bone scan didn't show any stress fracture or active arthritis in the spine but shows some increased uptake in the right acetabulum. He does have right buttock pain and occasional groin pain and limp. He has difficulty getting in and out of the car and putting on shoes which is generally related to hip pathology."

46. Dr Salaria ordered a diagnostic hip intra articular injection which he said would provide information about the role of hip joint pathology in Mr Clarke's symptoms. X-rays did not disclosed significant osteoarthritis.

47. The vascular ultrasound was carried out on 7 March 2016. The clinical history recorded was:

> "Bilateral leg pain. Smoker. Patient describes pain in both thighs and buttocks, more significantly in the right leg. Constant, no worse when walking. Occasional pins and needles in feet. History of back problems following work injury."

48. On 9 March 2016, Dr Salaria reviewed Mr Clarke and ordered a CT arthrogram and MRI. The MRI scan dated 29 March 2016 was reported as showing chondromalacia of the superior acetabular cartilage associated with a likely small superior labral tear. The report read:

> "There is chondromalacia with irregularity/delamination of the superior acetabular cartilage and early osteophytosis. This associated with an undersurface tear of the anterior superior labrum which is usually seen with chondromalacia and early osteoarthrosis."

49. Dr Salaria reviewed Mr Clarke on 6 April 2016 when he was limping less. He said that the MRI showed cartilage changes and a superior labral tear suggestive of early arthrosis.

50. On 1 July 2016, Dr Brummit wrote to Whiteley's insurer "in response to Dr Salaria's letter" and said that Mr Clarke had been admitted to a mental health unit as a result of depression. She said:

> "As regards to his back pain, he has recurrent flares In the severity of his pain, which also trigger a drop in his mood. He still has an antalgic gait and struggles with sitting for any length of time. He continues with numbness down his right leg. The majority of his pain is related to his lower back, not his hip."

51. On 5 July 2016, Dr Salaria observed that Mr Clarke had an obviously antalgic gait. Mr Clarke had been admitted to hospital for an exacerbation of depression which was also related to pain. He noted that internal hip rotation produced pain and that both hips were a little stiff.

52. Dr Ghabrial reported to Mr Clarke' solicitors on 13 July 2016 after examining him on that day. Mr Clarke told him that he had continuing symptoms in his lower back and right leg and had been limping. Dr Ghabrial summarised Mr Clarke's treatment and recent investigations and set out his findings on examination. Dr Ghabrial said that Mr Clarke had suffered an injury to his low back in 2011 and said that employment was the main contributing factor to "the present clinical features, disabilities and impairment." He considered that Mr Clarke's condition was stable for an assessment of permanent impairment and assessed 13% WPI in respect of DRE Lumbar Category III, adding 3% for radiculopathy persisting after surgery and 1% for scarring, resulting in a total assessment of 17%.

53. On 13 September 2016, Dr Salaria said that Mr Clarke's right groin pain and stiffness was getting progressively worse. He organised a repeat injection.

Referral to Dr Dewar

54. On 19 October 2016, Dr Salaria noted that the injection had provided only short term relief and said that Mr Clarke's symptoms were now affecting him enough to consider total hip replacement, "despite his youngish age". However, after ordering further x-rays, Dr Salaria told Dr Brummit on 25 October 2016 that the early arthrosis changes were mild and not significant enough for hip replacement. He referred Mr Clarke to Dr D Dewar for hip arthroscopy. Dr Salaria's referral is dated 25 October 2016. He said:

> "I would appreciate it if you could see Shane who was referred to me for back pain but on further examination and assessment had predominately groin and buttock pain and the scan and xray are suggestive of some early arthrosis changes. We have tried intra articular cortisone injection but it had given him limited relief only. He still limps and complains of groin pain and on examination has mildly positive hip impingement test.

Xray show [sic] mild CAM type phenomenon of the head but the joint space is reasonably well maintained. I would appreciate if you could consider him for arthroscopy/decompression procedure."

55. Some reports from Dr Dewar appear in the ARD. A Direction for Production was issued to Dr Dewar because of his unwillingness to provide a report for the purpose of these proceedings. No consultation notes were produced.

56. Dr Dewar saw Mr Clarke on 11 November 2016 and recorded a history of the work injury on 23 February 2011. Dr Dewar noted that Mr Clarke had a mild Trendelenburg gait and a mildly irritable right hip which was worse with impingement provocation. An MRI scan of the right hip was undertaken on 20 November 2016.

57. On 22 November 2016, Dr Dewar sought approval from Whiteley's insurer for hip arthroscopy and labral repair. On the same day, Dr Dewar wrote to Dr Salaria and said that the MRI was consistent with femoral acetabular impingement (which is abbreviated in later reports to FAI). He noted that Mr Clarke was keen to proceed to surgery.

58. Dr Dewar wrote to Whiteley's insurer on 2 December 2016. He was asked why the proposed surgery was the most appropriate treatment (6) and how the surgery was related to the "lumbar spine workplace injury" (7). He said:

> "6. This is the most appropriate treatment because he has hip pain consistent with femoral acetabular impingement.
>
> 7. He attributes his injury to a work place accident where he was lifting a pallet in 2001[sic]. He tells me that he injured his hip at that time and that this hip injury is a second injury compared to the lumbar spine injury."

The insurer's response

59. Whiteley's insurer requested a report from A/Prof L Kleinman to respond to that request and the report is dated 13 April 2017. A/Prof Kleinman recorded a history of the injury which stressed immediate and severe stabbing pain down Mr Clarke's right leg and a significant history of right leg pain throughout initial treatment. Mr Clarke said that he developed right hip pain three years ago and was referred to Dr Salaria for investigation of that pain. A/Prof Kleinman undertook an examination and reviewed radiology. He said:

> "Mr Clarke has failed back surgery for a back injury sustained at work in February 2011 which has left him with ongoing signs of a right L5 radiculopathy and a stiff back and ongoing pain.
>
> He has constitutional degenerative changes in his right hip which are not related to his back injury. The pain in groin could have occurred whether he injured his back or not. Management is a problem at this stage because he is significantly disabled by the groin pain of which he complains. He is young for total hip replacement surgery but Inevitably he will come to hip replacement surgery.
>
> It is not unreasonable therefore to attempt to relieve his pain by debriding his hip arthroscopically in attempt to provide him with a few more years of function before he comes to hip replacement surgery."

60. In answer to specific questions, A/Prof Kleinman reiterated that the right hip injury was not related to the original back injury. He considered that Mr Clarke suffered permanent impairment as a result of the back injury which resulted in ongoing pain and signs of right L5 radiculopathy.

61. Whiteley's insurer issued a notice under s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) on 27 July 2017 declining liability in respect of the alleged right hip injury.

Requests for medico-legal reports

62. On 21 August 2017, Mr Clarke's solicitors wrote to Dr Dewar requesting a report. The letter summarised the surgery undertaken and attached Dr Ghabrial's report dated 13 July 2016. It said:

> "We understand our client's right hip has become symptomatic and requires treatment.
>
> The question has arisen as to how your patient's right hip condition is related to his injury or the condition caused by his injury on 23 February 2011."

63. Dr Dewar responded on 29 August 2017 that he did not provide medico-legal reports but was willing to provide a copy of his notes. There are no clinical notes in the file.

64. Mr Clarke's solicitors sought a further report from Dr Ghabrial which he provided on 27 November 2017. He said:

> "I have done an assessment regarding Mr Clarke, as in my report of 13 July 2016, regarding the lumbar spine and the scarring (according to TEMSKI.
>
> However, I understood that, as mentioned in your letter, he had an injury to the right hip."

65. Dr Ghabrial said that Mr Clarke had recurrent symptoms in his lower back with sciatica and sought approval to re-excise the relevant disc. He said that he proposed to organise an x-ray of Mr Clarke's right hip and provide an assessment of permanent impairment.

66. Dr Ghabrial reported to Mr Clarke's solicitors again on 27 February 2018 in response to a request for a report. He said that he had performed right L5/S1 disc re-excision on 6 February 2018 but had not yet reviewed him following the surgery. Dr Ghabrial said that he understood Mr Clarke had seen Dr Dewar "with a right hip problem due to an injury on 23 February 2011." Dr Ghabrial summarised Dr Dewar's treatment and stated that Mr Clarke's "right hip condition is the result of the injury of 23 February 2011." He also said:

> "It is highly likely that the altered gait, as the result of the back injury, has accelerated and aggravated the right hip problem. I believe that the injury of 23 February 2011 has injured the right hip as well."

67. Dr Ghabrial did not provide any reasoning in support of those statements.

68. Dr D Lewington saw Mr Clarke as an Approved Medical Specialist (AMS) and prepared a MAC dated 17 April 2018. He was asked to determine if Mr Clarke's degree of permanent impairment was fully ascertainable. The AMS had a history of the back injury only. Mr Clarke told him that the pain radiating down his right leg was worse than before the surgery in February 2018. The AMS said:

> "Mr Clarke had a lifting back injury 23 February 2011 which culminated in a right L 4-5 partial laminectomy & discectomy/rhyzolysis of the right L 5 nerve root/ right L 5-S 1 foraminotomy on 27 January 2015. Despite initial improvement there was recurrence of symptoms. On 6 February 2018 Dr Ghabrial performed an L 5-S 1 disc re-excision describing a right L 5-S 1 recurrent disc herniation into the foramen with compression on the exiting right L 5 nerve root. If anything there has been a worsening of symptoms since that surgery and he now presents with a right S 1 (not L5) radiculopathy."

69. The AMS said that maximum medical improvement had not been reached. There is no reference to any right hip injury or complaint in the MAC.

Requests for surgery and responses

70. On 24 July 2018, Mr Clarke's solicitors wrote to Whiteley's insurer and said:

> "Given the opinions of Professor Ghabrial and Dr Dewar - ie: our client's altered gait and constant limping has caused the right hip condition, surgery is required urgently and therefore we request you review your decision.
>
> In the alternate [sic], it is quite obvious that if our client suffers a pre-existing condition of the hip of which he was not aware and the constant limping caused by his back injury, has aggravated, accelerated and exacerbated the pre-existing condition and the right hip has become symptomatic, then the right hip condition at this time is as a consequence of the injury to his back."

71. The insurer issued a further notice under s 74 of the 1998 Act on 7 September 2018. The notice denied that Mr Clarke had suffered an injury to his right hip and said that the insurer preferred the report of A/Prof Kleinman to that of Dr Ghabrial.

72. Whiteley's solicitors qualified Dr J Powell, orthopaedic surgeon who reported on 3 December 2018. Dr Powell recorded that Mr Clarke felt a severe pain across his low back at the time of the injury. He was able to straighten up slowly and the pain did not radiate elsewhere. Pain in his right leg came on in the weeks after the incident and radiated down the right buttock and into the medial thigh calf and foot. Dr Powell recorded that Mr Clarke noticed more pain in the right groin region around the time of the first operation "and investigations showed that he had worn out the lining of his hip." He had been offered hip replacement.

73. Dr Powell diagnosed osteoarthritis of the right hip and said that the back injury was most likely an acute L4/5 disc prolapse with right nerve root compression developing into sciatica. He considered Mr Clarke's prognosis poor. He said:

> "He has been found to have osteoarthritis of the right hip and some limitation of motion and some of his medial thigh symptoms may be arising from this pathology. He does not however have significant fixed flexion deformity and so it is unlikely that his hip pathology is mechanically driving or influencing his lumbar spine pathology as it is not forcing him into lumbar extension when trying to adopt an upright posture.
>
> Managing a combination of a painful lumbar back condition and a painful hip condition concurrently is difficult and management of his hip pathology with total joint replacement may reduce any mechanical influence that his hip might be having on his lumbar pathology and symptoms but is unlikely to be complete."

74. Dr Powell provided an amended report of the same date which clarified the material he had reviewed. He said:

> "There is no association of the work incident in 2011 nor of Mr Clarke's work in general as being a contributing factor to his hip arthropathy which is principally constitutional and age related in nature and possibly related to developmental dysplastic change about the hip."

75. Dr Powell assessed permanent impairment in respect of Mr Clarke's lumbar spine only.

76. Dr Ghabrial prepared a further report dated 15 August 2019. He said that he had referred Mr Clarke for x-rays and a CT scan of the right hip and said that he had recommended right hip CT guided steroid injection. He said that Mr Clarke continued to complain of right groin pain at a review on 8 August 2019. Dr Ghabrial said:

> "Mr Clarke sustained an injury to his lower back and right hip on 23 February 2011. He reported developing symptoms in the right hip region, with pain in his right groin, immediately after the injury. He also developed pain in the right leg with numbness in the right toes.
> …
> His symptoms continued in the right groin and, to some extent, in the right leg and MRI scanning performed in July 2017 showed recurrent right L5 /S 1 disc protrusion with compression on the right S 1 nerve root. His investigations also suggested early osteoarthritic changes in the right hip.
> …
> I believe that accident of13 February 2011 has produced an injury to the lumbo-sacral junction as well as the right hip with the development of disc herniation at the L5/S1 segment and post traumatic osteoarthritis of the right hip . The right hip has been aggravated by his altered gait as the result of his injury.
>
> In summary, I believe that the incident of 23 February 2011 is the cause of his back problem, right leg symptoms and right hip symptoms.
> …
> There are no constitutional or non-related factors regarding his condition. He had no pre-existing problems regarding the back or the right hip."

77. Despite supporting the claim for surgery, Dr Ghabrial considered that Mr Clarke's condition had stabilised for the assessment of permanent impairment.

Dr Hopcroft

78. On 26 June 2020, Mr Clarke's solicitors sought a medico-legal report from Dr A Hopcroft. The letter of instructions included:

> "Our client instructs us that he injured his back on 23 February 2011 when he was lifting a pallet. Such is conceded by the insurance company. He also says he had a minor injury to the right hip although it was quite minor.
>
> Subsequently, he says that as a result of surgery, changes in gait and favouring one leg he developed further symptoms and condition in his right hip.
> …
> He has instructed us that his hip started causing problems initially but much more significantly after the first bout of surgery such that he started mentioning this to his doctors in late 2015 or early 2016. The right hip progressively got worse since both bouts of surgery such that he was ultimately referred to specialist Doctor Dewar who now wants to perform surgery in the form of a right hip arthroscopy and labral repair.

> In a general sense regarding the hip and its relationship to the injury to the back you should note that in such a claim of a resulting injury one would need to prove that the injury to the back was a material contributing factor to the symptoms or condition in the right hip."

79. Dr Hopcroft was provided with the information attached to the ARD.

80. Dr Hopcroft's report is dated 9 July 2020. He recorded the following history of the injury:

> "He was leaning forward and lifting the pallet with his dominant right hand when he developed sudden severe pain which radiated from his low back into his right leg, but also, significantly, he can recall as a constant feature, pain radiating into his right groin."

81. Dr Hopcroft summarised the history. He said:

> "He was reviewed also by independent medical examiners during those years, but failed to bring to their attention the fact that the patient had a significant component of right groin pain which was made worse if he put his right hip joint under any particular strains."

82. Dr Hopcroft noted that Mr Clarke continued to complain of pain in his lumbosacral spine and that he suffered significant and increasing pain in his right groin. He said:

> "This patient suffered a significant injury in the course of his work on 23 February 2011 where an injury to his back with sciatica dominated his clinical presentation, right groin pain which occurred at the same time being either overlooked or assumed to have been a result of his back injury rather than the underlying and later proven (radiologically) a tear and fraying of the acetabular labrum.
>
> While I understand that Dr David Dewar would like to attempt arthroscopic repair of this patient's damaged right acetabular labrum, at the age of 50 I believe he is unlikely to see a successful outcome from that, and this patient is a candidate as a result of his work-related injury of 23 February 2011, for a right total hip replacement procedure.
>
> I do not believe that any other surgical intervention other than right total hip replacement will resolve this patient's significant ongoing right groin pain.
>
> I have detailed treatment to date including operations and clinical investigations.
>
> There is a direct relationship between the patient's right hip pathology and symptoms to the work-related injury of 23 February 2011.
>
> I believe the injury to his back was the material contributing factor to his symptoms and that the pathology in his right hip occurred concurrently but was overlooked by the predominating back and sciatic syndrome.
>
> While Dr Dewar is entirely competent and produces good results from arthroscopic acetabular labral repairs, I believe when taking a total overview, that this patient would be a far safer candidate for right total hip replacement surgery at the age of 50 as a more reliable treatment program for his work-related injury."

83. Dr Powell prepared a report dated 19 November 2020 in response to Dr Hopcroft's report. He disagreed that the 2011 injury was the cause of Mr Clarke's hip arthropathy, noting that osteoarthritis is common. Dr Powell said that his practice on both a first and second examination is to retake the history to determine if there are any discrepancies. He said:

> "On giving history on both occasions Mr Clarke indicated that right groin pain developed some time after his first decompressive procedure in the lumbar spine. He also indicated that the acute lumbar pain had arisen in the course of the lift, not in going down prior to commencing it, nor at the immediate commencement of the lift, but rather when he had started to elevate the pallet.
>
> Mr Clarke was assessed by Dr Kuru and Professor Ghabrial, Orthopaedic Surgeons with considerable experience in broadly in assessing patients with orthopaedic conditions.
>
> As it is not uncommon for patients with painful spinal conditions to have coexisting pathology elsewhere in the musculoskeletal system, particularly at the hips, that may influence their presentation, hip pathology is often specifically checked for, generally through movement and focal irritability which might alert the examining surgeon to possible troubles at the hips. Even this is not the case, components of physical examination involving the lower limbs in patients with hip pathology will frequently show dysmetria or some other sign that alerts the surgeon to the possibility of hip pathology which can be looked at.
>
> It is difficult to appreciate that both of these experienced surgeons were not alerted to some form of hip difficulties in the early stages of Mr Clarke's presentation, if they had existed, while assessing Mr Clarke's lumbar spine and progression of management."

84. Dr Powell noted that Mr Clarke's imaging showed similar changes in his left hip, noting an x-ray undertaken in October 2016. He said:

> "Mr Clarke has been found to have structural changes about the anterior aspect of the hip which in certain positions of the proximal femur and the acetabulum may allow physical impingement, with deformity and possible contusion of the interposed labrum, which may in time lead to structural failure (tear) of the labrum particularly once age related change starts to stiffen the soft tissue and alter its biomechanics and capacity to handle such deforming loading.
>
> Labral failure, however, is only part of the degenerate process of the hip joint and is not a specific cause that progresses into degeneration elsewhere in the joint.
>
> …
>
> Should Mr Clarke have suffered an acute labral tear at the time of the incident, I would expect, as in the lumbar spine, there to be an acute pain at the time. Irritability in the hip would be obvious to any practitioner assessing Mr Clarke after this incident. This was not case for Mr Clarke."

85. Dr Powell agreed with Dr Hopcroft that some form of joint arthroplasty would be the most useful surgical procedure if surgery was to be undertaken.

Further reports

86. On 11 August 2020, Whiteley's solicitors wrote to the Commission providing Dr Powell's reports and seeking that the AMS reconsider the finding in the MAC that Mr Clarke had not reached maximum medical improvement.

87. On 13 November 2020, Dr Dewar wrote a letter to whom it may concern and said:

> "Shane Clarke, is developing hip osteoarthritis. I consider the cause of this to be his injury at work, where he sustained a labral tear. It is really common for labral tear degeneration to continue on to hip osteoarthritis.
>
> Definitely, in the long term he is coming to hip replacement. The timing of this is personal and up to him, but I consider the development of the hip osteoarthritis, back to his original injury."

SUBMISSIONS

88. Counsel's submissions were recorded.

89. Mr Niven's submissions were exceptionally short. He took me to the opinion of Dr Ghabrial in his report dated 15 August 2019 set out at [67] above and said that Mr Clarke suffered an injury to his right hip in 2011 which had been aggravated by his altered gait.

90. Mr Baker took me through the medical evidence in chronological order. He noted that the first complaint of pain in Mr Clarke's right hip or groin was after the bone scan undertaken at Dr Salaria's request in early 2016 nearly five years after the injury. The evidence showed a sudden onset of symptoms after the bone scan.

91. Mr Baker said that an examination of Dr Dewar's reports shows that he was given a history that Mr Clarke injured his hip in the incident in 2011 and Dr Dewar's opinion as to causation is based on that history. Similarly, Dr Hopcroft's report was predicated on the history provided in the letter of instructions that Mr Clarke had suffered an injury to his hip at the same time as the back injury. Mr Baker said that did not constitute a fair climate in which to express his opinion.

92. In reply, Mr Niven said that the dispute was an argument between medico-legal examiners. He said that I would accept Mr Clarke at face value and accept the opinions of Drs Ghabrial and Hopcroft which provided a common sense explanation for the causation of a hip injury. Mr Niven said that it was common in this jurisdiction for a worker to "focus on the main game" meaning the most significant injury, which explained the lack of initial complaint. He said that in the absence of pre-existing problems, I would accept that the injury in 2011 was the main contributing factor to the aggravation of degenerative change in Mr Clarke's hip and that the proposed surgery is reasonably necessary medical treatment as a result of the injury.

FINDINGS AND REASONS

93. Mr Clarke's case is narrow – that he suffered an injury to his right hip on 23 February 2011 at the same time as his accepted back injury and that the injury included a labral tear. He does not allege that the condition in his right hip is a consequential condition, despite Dr Ghabrial's opinion in his reports dated 27 February 2018 and 15 August 2019 that it was aggravated as result of an altered gait.

94. Similarly, the relief sought in the ARD is limited to the surgery which was proposed by Dr Dewar in 2016 being right hip arthroscopy and labral repair. Despite the opinions of Drs Hopcroft and Powell, Mr Clarke did not amend the ARD to seek s 60 expenses in respect of a total hip replacement.

95. There is no evidence that Dr Dewar has seen Mr Clarke since November 2016 and nothing to show whether or not he maintains his original recommendation. There is no up to date costing of the proposed surgery or any other.

96. There is no dispute that Mr Clarke suffered a back injury which has resulted in incapacity for work and the need for medical treatment including surgery on two occasions and hospitalisation for consequential depression.

97. To make the award that Mr Clarke seeks, I must be satisfied that the treatment is reasonably necessary medical treatment as a result of the injury on 23 February 2011. The standard of proof on the balance of probabilities which applies in the Commission was described by the Court of Appeal in *Nguyen v Cosmopolitan Homes*.[1] McDougall J, with whom the other members of the Court agreed, said[2]:

> "(1) A finding that a fact exists (or existed) requires that the evidence induce, in the mind of the fact-finder, an actual persuasion that the fact does (or at the relevant time did) exist;
>
> (2) Where on the whole of the evidence such a feeling of actual persuasion is induced, so that the fact-finder finds that the probabilities of the fact's existence are greater than the possibilities of its non-existence, the burden of proof on the balance of probabilities may be satisfied;
>
> (3) Where circumstantial evidence is relied upon, it is not in general necessary that all reasonable hypotheses consistent with the non-existence of a fact, or inconsistent with its existence, be excluded before the fact can be found; and
>
> (4) A rational choice between competing hypotheses, informed by a sense of actual persuasion in favour of the choice made, will support a finding, on the balance of probabilities, as to the existence of the fact in issue."

98. I am not satisfied on the balance of probabilities that Mr Clarke suffered an injury to his right hip on 23 February 2011.

99. Mr Clarke's first statement did not refer to a hip injury and his subsequent statements attempting to describe the injury appear to be a reconstruction, seeking to persuade that he did suffer a hip injury. He was not cross-examined but that does not prevent an adverse credit finding being made in Commission proceedings.[3]

100. The review of the medical evidence set out above shows that Mr Clarke did not make any complaint about his right hip until after the bone scan was carried out in January 2016. None of the doctors who examined him the period of almost five years following the injury make any reference to a hip injury or hip pain.

101. There are limited references to pain radiating down Mr Clarke's legs in the early reports and Dr Pillemer recorded that pain had settled in May 2011, six months before his examination in November 2011. The complaints of radiation resumed in about 2013.

---

[1] [2008] NSWCA 246.
[2] At [55].
[3] *New South Wales Police Force v Winter* [2011] NSWCA 330.

102. Some doctors specifically tested Mr Clarke's hip joints. Dr Kuru said in his report dated 17 June 2011 that Trendelenburg's test – a test for hip dysfunction - was normal and his hip joints were not irritable. Dr Sharp noted on 23 August 2013 that his sacro-iliac joints were normal. Most of the reports contain the results of straight leg raising tests. While that is a test for assessing disc injury, it may well have alerted examiners to any pain in Mr Clarke's right hip.

103. Mr Clarke said in his second statement that he walked with a limp but the early medical reports which mention his gait describe it as normal. The first reference to an abnormal gait appears to be in Dr Ghabrial's first report, though Dr Ghabrial did not record any history of a hip injury in that report.

104. There are no clinical notes from Mr Clarke's general practitioners which might be expected to record complaints of hip pain. Dr Ballantyne's letters to the insurer are very detailed and it might therefore be expected that his notes were similarly thorough.

105. Mr Clarke's complaints with respect to his right hip began after the bone scan which was ordered by Dr Salaria to test for a source of pain from the facet joints or other bony lesion. By the time of the next review with Dr Salaria, Mr Clarke was walking with a stick and limping on the right side.

106. Dr Dewar's reports are brief. When they are read together it is clear that he accepted the history provided to him that Mr Clarke suffered an injury to his hip. His concern as a treating specialist was treatment, rather than causation.

107. Despite multiple consultations and two operations, Dr Ghabrial did not mention Mr Clarke's right hip until his report dated 27 November 2017 when he was alerted to it by a letter from Mr Clarke's solicitors. He accepted in his reports dated 27 February 2018 and 15 August 2019 that Mr Clarke had suffered a hip injury but did not provide any reasoning for his opinion. His conclusion that there was a hip injury does not fulfil the requirements for probative evidence in the Commission.

108. In *South Western Sydney Area Health Service v Edmonds*, McColl JA said:

> "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.'
>
> This statement is apposite in the context of Commission hearings, and, indeed, is implicitly recognised in r 70. While it must be recognised that '[t]here is no legal right to cross-examine an applicant or other witness in the Workers Compensation Commission and decisions whether to allow cross-examination or to limit it are discretionary' (*Aluminium Louvres & Ceilings Pty Limited v Xue Qin Zheng* [2006] NSWCA 34 at [37]), the fact that cross-examination of an expert witness may be permitted indicates the desirability of expert reports conforming as far as possible to common law standards of admissibility designed to ensure they have probative value. Even if that is too stringent an approach in the face of s 354, as the rules recognise, evidence must be 'logical and probative' and 'unqualified opinions are unacceptable'.

> In my view Dr Rivett's statement that 'in general all the problems are work-related' which the Arbitrator accepted in concluding that the respondent's duties were sufficient to cause her injury (apparently within the meaning of s 16) amounted to a bare *ipse dixit*. It was not probative of the issue before the Arbitrator."[4]

109. Dr Ghabrial's evidence with respect to Mr Clarke's hip condition could be described in the same way.

110. The letter of instructions dated 26 June 2020 sent to Dr Hopcroft by Mr Clarke's solicitors appears in the file. It sets out Mr Clarke's instructions with respect to contentious matters as if they were facts. The insurer's dispute notices were enclosed but the letter did not alert Dr Hopcroft to the dispute which had been raised. The failure to direct his attention to the dispute means that Dr Hopcroft has not engaged with the dispute and his report is not probative.

111. Based on the history given, Dr Hopcroft stated that the labral tear was suffered at the time of the injury. He did not consider with the other medical evidence nor provide any reasoning for the statement. The history of ongoing groin pain from the time of the injury is not supported by the medical evidence.

112. The material put to Dr Hopcroft did not accord with the medical history and did not provide a "fair climate" for the opinion he expressed. In *Paric v John Holland (Constructions) Pty Limited*[5] the High Court said:

> "It is trite law that for an expert medical opinion to be of any value the facts upon which it is based must be proved by admissible evidence (*Ramsay v. Watson* [1961] HCA 65; (1961) 108 CLR 642). But that does not mean that the facts so proved must correspond with complete precision to the proposition on which the opinion is based. The passages from Wigmore on Evidence cited by Samuels J.A. in the Court of Appeal (Wigmore on Evidence, (1940) 3rd ed., vol.II, 680, p.800; 2 Wigmore, Evidence 680 (Chadbourn rev. 1979), p.942) to the effect that it is a question of fact whether the case supposed is sufficiently like the one under consideration to render the opinion of the expert of any value are in accordance with both principle and common sense."

113. The material provided to Dr Hopcroft and relied on by him is quite different to the history of Mr Clarke's injury.

114. A/Prof Kleinman and Dr Powell engaged with the medical evidence. Each accepted that Mr Clarke has a condition in his right hip that requires treatment but did not accept that there was an injury to his hip in 2011. Because their opinions are supported by the history, I prefer their evidence to that of Dr Ghabrial and Dr Hopcroft. Dr Powell's evidence that it is unlikely that Mr Clarke would have suffered a labral tear without significant pain in his hip is persuasive.

115. I therefore find that Mr Clarke did not suffer an injury to his right lower extremity (hip) on 23 February 2011.

116. I make an award for the respondent with respect to the claim for s 60 expenses for treatment to Mr Clark's right hip.

Reconsideration application

117. I was asked to consider Whiteley's application for reconsideration of Dr Lewington's MAC on the basis of the findings I made.

---

[4] At [130]-[132].
[5] [1985] HCA 58; 59 ALJR 844.

118. The purpose of the MAC was to determine if the extent of permanent impairment was fully ascertainable for the purpose of s 39 of the *Workers Compensation Act 1987*.

119. The reconsideration application appears in the Reply but I have not been provided with any response served on behalf of Mr Clarke.

120. The current request for reconsideration is dated 11 August 2020 and was lodged before these proceedings were commenced.

121. The request discloses that previous proceedings seeking the costs of a hip arthroscopy were discontinued on 6 June 2019.

122. An earlier request for reconsideration was filed on 6 September 2019. It was declined at a telephone conference on 31 October 2019 because Mr Clarke intended to file further proceedings.

123. Those proceedings were filed in January 2020 and discontinued in March 2020.

124. Now that the question of liability for right hip surgery has been determined, there does not appear to be any impediment to a request that the MAC be reconsidered.