WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **4299/19**
Applicant: **Robert James Pearce**
Respondent: **Edmund G & Grahame L Shepherd**
Date of Determination: **11 December 2019**
Citation: **[2019] NSWWCC 395**

The Commission determines:

1. The applicant did not suffer injuries to his lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot arising out of or in the course of his employment with the respondents on 3 February 2016 within the meaning of section 4(a) of the *Workers Compensation Act 1987*.

The Commission orders:

2. Award for the respondents in relation to the applicant's claimed injuries to his lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot on 3 February 2016.

3. The matter is remitted to the Registrar for referral to an Approved Medical Specialist for assessment pursuant to the *Workplace Injury Management and Workers Compensation Act 1998* as follows:

Date of injury:	3 February 2016.
Body System:	The spine (cervical spine); the left upper extremity (left shoulder); right lower extremity (right hip); and the skin (scarring – right hip and left shoulder – TEMSKI).
Method of Assessment:	Whole Person Impairment.

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

    (a) Application to Resolve a Dispute dated 21 August 2019 and attached documents;

    (b) Reply dated 12 September 2019 and attached documents;

    (c) Applicant's Application to Admit Late Documents dated 1 November 2019 and attached documents;

    (d) Respondent's Application to Admit Late Documents dated 5 November 2019 and attached documents, and

    (e) Applicant's Application to Admit Late Documents dated 8 November 2019 and attached documents (Calvary North Adelaide Hospital).

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

Anthony Scarcella
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 OFANTHONY SCARCELLA, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A MacLeod

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

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Mr Robert James Pearce, is a 78-year-old man who was employed by Edmund G and Grahame L Shepherd (the respondents) as a truck driver during grape harvest season transporting grapes between the farm and various wineries in Victoria and New South Wales.

2. In or about 2012, Mr Pearce underwent a right total hip replacement with a good result.

3. On 3 February 2016, at the premises of Qualia Wines, Mr Pearce alleged that, whilst climbing up into the cab of his truck, his right foot slipped on grape juice, leaving him hanging onto the truck's hand rail dangling about one metre off the ground before he fell to the ground. As a result of this incident, Mr Pearce alleged that he suffered injuries to his cervical spine, left shoulder, right shoulder, lumbar spine, right hip, right knee, left knee, right ankle, right hind foot, left ankle, left hind foot and consequential surgical scarring to his right hip and left shoulder.

4. On 30 January 2019, Mr Pearce claimed permanent impairment compensation under section 66 of the *Workers Compensation Act 1987* (the 1987 Act) in respect of the right lower extremity (right hip, right knee, right ankle and right hind foot); the left lower extremity (left ankle and left hind foot); the spine (cervical spine and lumbar spine); the left upper extremity (left shoulder) and the skin (scarring – right hip and left shoulder).[1]

5. On 23 May 2019, the respondents, through their insurer, Employers Mutual NSW Limited (EML) issued a Dispute Notice pursuant to section 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) denying that Mr Pearce had suffered injuries to his lumbar spine, right knee, left knee, right ankle, left ankle, right hind foot and/or left hind foot as a result of the work-related incident on 3 February 2016.[2]

6. The respondents accepted that Mr Pearce sustained injuries to his cervical spine, left shoulder and right hip in the course of his employment on 3 February 2016 and consequential surgical scarring to the left shoulder and right hip but disputed that he was entitled to lump sum compensation in relation to his left knee because his own forensic medical expert assessed no impairment in this regard.

ISSUES FOR DETERMINATION

7. The parties agreed that the following issues remain for determination:

    (a) Did Mr Pearce suffer injuries to his lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot on 3 February 2016 within the meaning of sections 4(a) and 9A of the 1987 Act?

    (b) Is Mr Pearce entitled to lump sum compensation within the meaning of section 66 of the 1987 Act in relation to the disputed body systems?

Matters previously notified as disputed

8. The issues in dispute were notified in a Dispute Notice pursuant to section 78 of the 1998 Act dated 23 May 2019.[3]

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[1] Application to Resolve a Dispute dated 21 August 2019 at page 5
[2] Application to Resolve a Dispute dated 21 August 2019 at pages 7-13
[3] Application to Resolve a Dispute dated 21 August 2019 at pages 7-13

Matters not previously notified

9. No other issues were raised.

PROCEDURE BEFORE THE COMMISSION

10. The parties attended a conciliation conference/arbitration in Albury on 8 November 2019. Mr Jarryd Malouf of counsel appeared for Mr Pearce and Ms Sarah Warren of counsel appeared for the respondents.

11. I am satisfied that the parties to the dispute understood the nature of the application and the legal implications of any assertion made in the information supplied. I 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 had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

EVIDENCE

Documentary evidence

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

    (a) Application to Resolve a Dispute (ARD) dated 21 August 2019 and attached documents;

    (b) Reply dated 12 September 2019 and attached documents;

    (c) applicant's Application to Admit Late Documents dated 1 November 2019 and attached documents;

    (d) respondent's Application to Admit Late Documents dated 5 November 2019 and attached documents, and

    (e) applicant's Application to Admit Late Documents dated 8 November 2019 and attached documents (Calvary North Adelaide Hospital).

Oral evidence

13. Neither party sought leave to adduce oral evidence from or to cross-examine any witness.

FINDINGS AND REASONS

Did Mr Pearce suffer injuries to his lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot on 3 February 2016 within the meaning of sections 4(a) and 9A of the 1987 Act?

14. Section 4(a) of the 1987 Act defines "injury" as a personal injury arising out of or in the course of employment.

15. The onus of establishing injury falls on Mr Pearce and the standard of proof is on the balance of probabilities, meaning that I must be satisfied to a degree of actual persuasion or affirmative satisfaction: *Department of Education and Training v Ireland*[4] (*Ireland*) and *Nguyen v Cosmopolitan Homes*[5] (*Nguyen*).

[4] *Department of Education and Training v Ireland* [2008] NSWWCCPD 134
[5] *Nguyen v Cosmopolitan Homes* [2008] NSWCA 246

16. The issue of causation must be based and determined on the facts in each case and requires a commonsense evaluation of the causal chain: *Kooragang Cement Pty Ltd v Bates*[6] (*Kooragang*). As I understand it, when referring to applying "common sense", Kirby, P in *Kooragang* was not suggesting that it be applied "at large" or that issues were to be determined by "common sense" alone but by a careful analysis of the evidence, including a careful analysis of the expert evidence: *Kirunda v State of New South Wales (No 4)*[7] (*Kirunda*). The legislation must be interpreted by reference to the terms of the statute and its context in a fashion that best effects its purpose.

17. In order to establish that a "personal injury" has been suffered within the meaning of section 4(a) of the 1987 Act, Mr Pearce must establish, on the balance of probabilities, that there has been a definite or distinct "physiological change" or "physiological disturbance" in his lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot for the worse which, if not sudden, is at least, identifiable: *Kennedy Cleaning Services Pty Ltd v Petkoska*[8] (*Kennedy*) and *Military Rehabilitation and Compensation Commission v May*[9] (*May*). The word "injury" refers to both the event and the pathology arising from it: *Lyons v Master Builders Association of NSW Pty Ltd*[10] (*Lyons*). While pain may be indicative of such physiological change, it is not itself a "personal injury".

18. *Castro v State Transit Authority*[11] (*Castro*) provides a useful review of the authorities and makes it clear that what is required to constitute "injury" is a "sudden or identifiable pathological change". In *Castro*, a temporary physiological change in the body's functioning (atrial fibrillation: irregular rhythm of the heart), without pathological change, did not constitute injury.

19. I now turn to the issue for determination and apply the legislation and legal principles referred to above.

20. The parties made oral submissions at the arbitration hearing which were sound recorded. The sound recording is available to the parties.

21. The thrust of the respondent's submissions was that the evidence failed to establish that Mr Pearce had sustained frank injuries to his lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot. There was a lack of contemporaneous evidence in relation to the disputed injuries. The respondent relied on the expert evidence of Dr Graeme Doig, General Orthopaedic and Trauma Specialist.[12]

22. The thrust of Mr Pearce's submissions was that the circumstances and mechanism of the work-related fall on 3 February 2016 were consistent with all the injuries alleged. Mr Pearce fell backwards off the steps of a truck from a height and struck his head. Mr Pearce relied on the expert evidence of Dr Eugene Gehr, Orthopaedic Surgeon.[13]

23. In evidence, there is a statement by Mr Pearce dated 5 June 2019.[14] Mr Pearce stated that, on 3 February 2016 at the Qualia Wines weighbridge, he stepped up onto the steps of his 22-tonne truck which was laden with grapes. He grabbed the handrail on the truck with his left hand. His right foot slipped on the top step of the truck and he fell backwards striking his head on the door frame and landed on the cement ground below him. Mr Pearce's first recollection was regaining consciousness whilst on the cement. He was aware that his head

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[6] *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796
[7] *Kirunda v State of New South Wales (No 4)* [2018] NSWWCCPD 45 at [136]
[8] *Kennedy Cleaning Services Pty Ltd v Petkoska* [2000] HCA 45
[9] *Military Rehabilitation and Compensation Commission v May* [2016] HCA 19
[10] *Lyons v Master Builders Association of NSW Pty Ltd* (2003) 25NSWCCR 496
[11] *Castro v State Transit Authority* [2000] NSWCC 12; (2000) 19 NSWCCR 496
[12] Reply at pages 1-7
[13] ARD at pages 14-27
[14] ARD at pages 1-4

was bleeding. He had a headache. He had pain in the left arm, left shoulder and neck. The pain in his neck went all the way down his back. He had pain in his legs and feet. Workers at the winery unloaded his truck. He then drove home, which was about 30 km away.

24. Mr Pearce stated that, in the morning, he had difficulty moving. He had "seized up".[15] He telephoned his girlfriend, who conveyed him to Mildura Hospital, where he was treated for a head wound, right hip pain and left shoulder pain and discharged home after two days.

25. Mr Pearce explained that he also had pain in his lower back, knees, feet and ankles but did not complain about them because the pain in his head, neck, left hip and left shoulder were greater. He thought these other minor pains would resolve.[16] Counsel for Mr Pearce submitted that it was entirely reasonable for Mr Pearce to be focussing on the accepted serious injuries he had suffered, namely, the injuries to his right hip and left shoulder.

26. In his evidentiary statement, Mr Pearce provided no indication of the dates on which he complained to his general practitioners about the pain he experienced in his lower back, right knee, hind feet and ankles following the fall from the truck on 3 February 2016. The medical records of his treating general practitioners and specialists, to which I refer below, indicate a lack of contemporaneous complaints in this regard.

27. Whilst I have no reason to doubt Mr Pearce's credibility, I have concerns about the reliability of his evidence regarding the disputed injuries. I will refer to those concerns below. Mr Pearce's statement was completed with the assistance of his lawyer on 5 June 2019, more than three years after the work-related incident. I must balance the weight to give to Mr Pearce's evidentiary statement against the considerable delay in complaints to his various medical treatment providers. The value of contemporaneous evidence has been repeatedly endorsed by the courts.

28. In *Onassis and Calogeropoulos v Vergottis*[17] (*Vergottis*), Lord Pearce said of documentary evidence:

> "It is a truism, often used in accident cases, that with every day that passes the memory becomes fainter and the imagination becomes more active. For that reason, a witness, however honest, rarely persuades a Judge that his present recollection is preferable to that which was taken down in writing immediately after the accident occurred. Therefore, contemporary documents are always of the utmost importance."

29. More recently, in *Watson v Foxman*[18] (*Foxman*), McLelland CJ in Equity said:

> " … Human memory of what was said in a conversation is fallible for a variety of reasons, and ordinarily the degree of fallibility increases with the passage of time, particularly where disputes or litigation intervene, and the processes of memory are overlaid, often subconsciously, by perceptions or self-interest as well as conscious consideration of what should have been said or could have been said. All too often what is actually remembered is little more than an impression from which the plausible details are then, again often subconsciously, constructed. All of this is a matter of human experience."[19]

30. Histories in medical records are often used to challenge the reliability of an injured worker's evidence. Reference is made either to a failure to mention relevant matters, or a description in a medical record which is different to what the worker now says in evidence, as the respondents have done in their submissions in this case. Care should be taken when

[15] ARD at page 2 at [19]
[16] ARD at page 2 at [21]
[17] *Onassis and Calogeropoulos v Vergottis* [1968] 2 Lloyd's Rep 403 at 431
[18] *Watson v Foxman* (1995) 49 NSWLR 315
[19] *Watson v Foxman* (1995) 49 NSWLR 315 at 319

considering such evidence, not to place too much weight on the clinical notes of treating doctors, given their primary concern with treatment. Experience demonstrates that busy doctors sometimes misunderstand, omit or incorrectly record histories of accidents or complaints by a patient, particularly in circumstances where their concern is with the treatment or impact of an obvious frank injury: *Davis v Council of the City of Wagga Wagga*[20]; and applied in *King v Collins*[21] and *Mastronardi v State of New South Wales*[22].

31. The caution referred to above was confirmed by Roche DP in *Winter v NSW Police Force*[23] as follows:

> "It is important to remember that clinical notes are rarely (if ever) a complete record of the exchange between a patient and a busy general practitioner. For this reason, they must be treated with some care (*Nominal Defendant v Clancy* [2007] NSWCA 349; *Davis v Council of the City of Wagga Wagga* [2004] NSWCA 34; *King v Collins* [2007] NSWCA 122 at [34-36])."[24]

32. I acknowledge that caution must be taken when relying upon clinical records. I have exercised caution in this regard and considered all the evidence.

33. In late 1996, Mr Pearce's right knee was first treated by Dr David Martin, Orthopaedic Surgeon. In evidence, there are reports by Dr Martin dated 11 November 1996, 9 December 1996, 24 February 1997 and 14 March 1997.[25] Dr Martin diagnosed either right persistent lateral meniscal or right patellar-femoral joint damage. On 9 December 1996, Mr Pearce underwent medial femoral condyle, lateral femoral condyle and patellar chondroplasties. He noted post-operative improvement in the condition of the right knee.

34. In evidence, there are Mr Pearce's Mildura Base Hospital clinical records.[26] In an entry dated 3 February 2016, the clinical records referred to the unloading of grapes at 3.00 am; hopping into truck; hitting head on cabin; ball of foot hitting tyre; body jerked; twisted knee; left knee pain; and headache at site of head graze. The left knee was described as "stabbing" and rated at 8/10 on movement. There was no reference to Mr Pearce's lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot. On 4 February 2016, Mr Pearce underwent a left knee x-ray, which demonstrated a small joint effusion; mild narrowing lateral joint compartment; but demonstrated no fracture or loose body.[27]

35. In an entry dated 11 February 2016, the Mildura Base Hospital clinical records referred to injuries to the left shoulder and the left knee on 3 February 2016, whilst getting out of a truck striking his head and falling. The clinical records queried whether Mr Pearce had dislocated his left shoulder. There was a reference to an upcoming consultation with Dr Gardiner on 15 February 2016. There was no reference to Mr Pearce's lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot.

36. In evidence, there are Mr Pearce's One Health clinical records (the general practitioner clinical records).[28] On 11 February 2016, there is an entry by Dr Mandeep Kaur recording that Mr Pearce had sustained a left knee injury at work on 3 February 2016 and that he had attended hospital. Dr Kaur referred Mr Pearce to Dr Douglas Gardiner, Orthopaedic

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[20] *Davis v Council of the City of Wagga Wagga* [2004] NSWCA 34
[21] *King v Collins* [2007] NSWCA 122
[22] *Mastronardi v State of New South Wales* [2009] NSWCA 270
[23] *Winter v NSW Police Force* [2010] NSWCCPD 12
[24] *Winter v NSW Police Force* [2010] NSWCCPD at [183]
[25] ARD at pages 28-32
[26] Applicant's Application to Admit Late Documents dated 1 November 2019 at pages 6-17 and Respondent's Application to Admit Late Documents dated 5 November 2019
[27] Applicant's Application to Admit Late Documents dated 1 November 2019 at page 15
[28] ARD at pages 35-85

Surgeon.[29] On 26 August 2016, Dr Gordon, general practitioner recorded that Mr Pearce complained of a cold and painful right foot. On examination, the foot had good pulses. The reason for the visit was described as peripheral arterial disease.[30] On 27 September 2016, Dr Gordon referred to Mr Pearce as having been diagnosed in the past with gout.[31] On 11 January 2017, Mr Pearce reported to Dr Gordon that he had gout, causing Dr Gordon to note "No wonder he has so much pain."[32]

37. On 11 February 2016, Mr Pearce consulted Dr Gardiner, on the referral of Dr Kaur.[33] Mr Pearce provided Dr Gardiner with a history of injury on 3 February 2016, which was consistent with his evidence. Dr Gardiner reported to Dr Gordon that Mr Pearce complained of immediate severe pain in his left shoulder and pain and swelling in the left knee at the time of the fall from the truck. He also complained of having lacerated his scalp which bled significantly. Dr Gardiner reported that at the consultation, Mr Pearce complained of ongoing pain and swelling in his left knee as well as a painful stiff left shoulder. He noted that Mr Pearce's scalp wound had healed. Dr Gardiner did not record any complaints of symptoms in the lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot. Dr Gardiner ordered a repeat x-ray of the left knee and an x-ray and ultrasound of the left shoulder.

38. On 12 February 2016, Mr Pearce underwent the repeat x-ray of his left knee and an x-ray and ultrasound of his left shoulder as recommended by Dr Gardiner.[34]

39. On 15 February 2016, Dr Gardiner reported to Dr Gordon that Mr Pearce had consulted him and that they had discussed the recent x-rays and ultrasounds of the left shoulder and left knee.[35] Dr Gardiner opined that no surgical intervention was presently anticipated. Dr Gardiner did not record any complaints of symptoms in the lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot.

40. On 3 March 2016, Dr Gardiner reported to EML that he had reviewed Mr Pearce who had informed him that his right knee and left shoulder were still causing him significant discomfort.[36] Mr Pearce submitted that this reference to the right knee was important because it was the first such reference to that disputed body part and was within a month of his fall from the truck. The respondent submitted that the reference to the right knee was a typographical error. I agree with the respondent's submission in this regard, when one looks at the report as a whole. Later in that same report, Dr Gardiner referred to seeking acceptance of liability from EML for referral for physiotherapy to the left knee and left shoulder.

41. On 4 April 2016, Dr Gardiner reported to EML that he had reviewed Mr Pearce on that date in relation to his injured left shoulder and left knee.[37] At the consultation, Mr Pearce informed him that when he fell against a rail near the truck at the time of his fall, he sustained a direct impact to his right hip, where he already had a hip replacement in situ. Thereafter, he had been experiencing pain and bruising in that region. As a result of this information, Dr Gardiner reported that he ordered x-rays of Mr Pearce's right hip replacement. According to Dr Shahram Shahrokhi, Orthopaedic Surgeon, Dr Gardiner performed Mr Pearce's right total hip replacement about four years earlier.[38] Dr Gardiner included the right hip in

[29] ARD at page 35
[30] ARD at page 41
[31] ARD at page 43
[32] ARD at page 46
[33] Reply at pages 39-40
[34] ARD at page 86 and Reply 48
[35] Reply at page 41
[36] Reply at page 42
[37] Reply page 43
[38] ARD at page 94

Mr Pearce's "list of injuries". However, he did not record any complaints of symptoms in the lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot.

42. On 26 April 2016, Mr Pearce underwent x-rays of his pelvis and right hip. The total right hip replacement with prosthesis was noted. There was no periprosthetic lucency or fracture demonstrated.[39]

43. On 27 April 2016, Dr Gardiner reported to EML that Mr Pearce continued to suffer from proximal right femoral pain at the site of his hip replacement, which caused an intermittent limp. He informed EML that he had organised a bone scan to investigate the right hip replacement to ascertain whether there was any mechanical loosening as a result of the workplace fall on 3 February 2016.[40] Dr Gardiner did not record any complaints of symptoms in the lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot.

44. On 16 May 2016, Dr Gardiner reported to EML that he had investigated Mr Pearce's right hip with a bone scan and that it demonstrated a slight increase in uptake at the tip of the prosthesis. He opined that this was a long-term finding and probably not related to the fall at work. However, he did opine that Mr Pearce had sustained a soft tissue injury around the proximal femur as a result of the fall at work.[41] Dr Gardiner did not record any complaints of symptoms in the lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot.

45. On 29 August 2016, Dr Gardiner reported to EML that Mr Pearce was making minimal progress. He continued with a stiff, painful left shoulder due to the exacerbation of the underlying arthritis caused by the fall on 3 February 2016. He also reported that Mr Pearce complained of ongoing pain in the lateral aspect of his right groin and in the lateral aspect of his right thigh, for reasons he was unable to ascertain in the absence of radiological abnormalities. The bone scan revealed no clear evidence of loosening or injury to the prosthetic joint. He concluded, therefore, that there must have been a soft tissue impact injury. Dr Gardiner opined that Mr Pearce may require a left shoulder replacement, but that he would be unable to carry it out due to his retirement from private practice by the end of October 2016.[42] Dr Gardiner did not record any complaints of symptoms in the lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot.

46. On 15 September 2016, Dr Shahrokhi reported to Dr Griffiths, general practitioner that he had consulted Mr Pearce and diagnosed right hip pain on a background of right total hip replacement exacerbated by a fall in February 2016; and left shoulder osteoarthritis exacerbated by a fall in February 2016. Dr Shahrokhi opined that Mr Pearce either had a healing fracture or periprosthetic loosening since his fall. He reported that he had organised a CT SPECT scan of the right hip and a left shoulder CT scan for preoperative planning purposes, as he felt that he would require a left total shoulder replacement given the advanced nature of his arthritis. Dr Shahrokhi considered the right hip as the most urgent issue and intended to investigate and treat it prior to proceeding with treatment to the left shoulder.[43] Dr Shahrokhi did not record any complaints of symptoms in the lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot.

[39] ARD at page 87
[40] Reply at page 44
[41] Reply at page 45
[42] ARD at page 88
[43] ARD at page 91

47. On 16 September 2016, Mr Pearce underwent the CT SPECT scan of the right hip arranged by Dr Shahrokhi. The findings were suspicious for loosening of the right hip femoral prosthetic component.[44] On the same date Mr Pearce underwent the left shoulder CT scan arranged by Dr Shahrokhi. The findings were one of advanced glenohumeral osteoarthritis.[45]

48. On 20 September 2016, Dr Shahrokhi reported to Dr Griffiths that he had again consulted Mr Pearce.[46] Dr Shahrokhi opined that Mr Pearce's x-rays demonstrated periosteal reaction and thickening of the cortex along the shaft of the femur and that the CT SPECT scan demonstrated quite significant increased uptake and signs of periprosthetic loosening at the tip of the stem. Given the history, examination and investigation finding, he opined that Mr Pearce's hip replacement had developed loosening as a result of the fall from the truck on 3 February 2016. He discussed a revision hip arthroplasty with Mr Pearce and its alternatives and left Mr Pearce to consider his options.

49. On 26 September 2016, Dr Gardiner reported to EML that a recent bone scan demonstrated a lot more activity in the area of Mr Pearce's right hip prothesis, which indicated that the tip of the prosthesis was probably moving and was now loose and symptomatic as a result of the fall on 3 February 2016. He recommended that it be treated with a revision procedure. Due to his impending retirement, he would have no further management of Mr Pearce and that Dr Shahrokhi had taken over.[47] Dr Gardiner did not record any complaints of symptoms in the lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot.

50. On 28 October 2016, Mr Pearce underwent a revision of his right total hip replacement plus osteotomy of the femur and a synovectomy by Dr Shahrokhi at Calvary North Adelaide Hospital.[48] In evidence, are Mr Pearce's Calvary North Adelaide Hospital clinical records.[49] In the Patient Health Assessment document completed by Mr Pearce and dated 28 October 2016 (being the admission for the revision of his right total hip replacement), he referred to being admitted to the hospital for a hip injury as a result of falling out of a truck in Mildura.[50] He referred to pain in the hip of his right leg and pain in the left shoulder. In response to a question as to whether he had suffered a fall in the past 12 months as a result of being unsteady on his feet, he responded in the affirmative and referred to "foot back hands foot".[51]

51. On 25 January 2017, almost one year after the fall from the truck, Dr Gordon reported Mr Pearce complaining of pain in his ankles, knees and shoulder.[52] He diagnosed arthralgia and made no reference or link to Mr Pearce's fall from the truck.

52. On 7 February 2017, Dr Shahrokhi reported to Dr Gordon that in relation to the right hip, Mr Pearce's main complaint was of some lower back pain. He was no longer experiencing thigh pain. A major complaint was pain in the plantar aspect of the right foot. Mr Pearce was also experiencing issues with his left shoulder and established osteoarthritis. Dr Shahrokhi diagnosed Morton's neuroma in the right foot.[53] This was the first reference in any of the medical evidence or clinical records of lower back pain and right foot pain post 3 February 2016.

53. The second post 3 February 2016 reference to Mr Pearce's lumbar spine appeared in an entry in the general practitioner clinical records made on 24 February 2017 by Dr Gordon, just over a year after the fall from the truck and some four months after the revision of his

[44] ARD at page 92
[45] ARD at page 93
[46] ARD at page 94
[47] Reply at page 47
[48] ARD at page 96
[49] Applicant's Application to Admit Late Documents dated 8 November 2019
[50] Applicant's Application to Admit Late Documents dated 8 November 2019 at page 69
[51] Applicant's Application to Admit Late Documents dated 8 November 2019 at page 71
[52] ARD at page 46
[53] ARD at page 100

right total hip replacement.[54] There was no link to Mr Pearce's fall from the truck. The brief entry made a note of osteopenia of the femoral neck and noted that the lumbar spine was of no added fracture risk.

54. On 18 April 2017, some 14 months after the fall from the truck, Dr Bose in the general practitioner clinical records referred to Mr Pearce complaining of left-sided back pain radiating down to the left foot. The entry noted no history of fall or trauma and recorded that the back pain was getting worse and had been "exaggerated" four days previously.[55] Thereafter, there were complaints by Mr Pearce of lumbar spine pain with radicular symptoms recorded in the GP clinical records. However, such complaints must be considered on the background of a longstanding history of recurrent lower back symptoms going back as far as 1972 (L4 fracture; neurosurgery; shearing accident),[56] 1999 (accident whilst moving onto freeway; hit by post truck going at 110 kph; loss of consciousness; right knee fracture; lumbar spine injury),[57] June 2007 (no trauma; drove 220 km and when got out of car leg gave way; four days in hospital; physiotherapy; pain relief),[58] 1 January 2008 (exacerbation of chronic back pain radiating into the right buttock)[59] and 30 November 2010 (presented to Mildura Base Hospital with acute and chronic right-sided leg pain; diagnosis: right-sided sciatica on the background of known spinal canal stenosis L2/3).[60]

55. On 4 May 2017, on the referral of Dr Gordon, Mr Pearce underwent a CT guided epidural injection into the epidural space with satisfactory dispersal and no complications. The finding was one of multilevel canal stenosis (L2-3, L3-4 and L4-5 levels) without specific radiculopathy.[61]

56. On 26 May 2017, Dr Andrew Sales, Orthopaedic Surgeon and colleague of Dr Shahrokhi, reported to Dr Gordon that Mr Pearce had sustained a periprosthetic fracture of his right hip replacement and stirred up underlying osteoarthritis in his left shoulder in the fall from a truck in February 2016. He did not believe that Mr Pearce required a total shoulder replacement at that point in time and advised that pain should be the main reason for him to pursue such a course.[62] Dr Sales did not record any complaints of symptoms in the lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot.

57. On 21 September 2017, Dr Ponnaren Pak, Orthopaedic Surgeon reported to Dr Gordon that since the fall from a truck on 3 February 2016, Mr Pearce had been complaining of significant pain in his left shoulder and that it had reached the stage where it had become functionally constraining for him and causing a lot of pain. He recommended that Mr Pearce undergo a left shoulder replacement for which he would seek WorkCover approval.[63] Dr Pak did not record any complaints of symptoms in the lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot. Dr Pak prepared a similar report for EML recommending a left shoulder replacement dated 23 September 2019.[64]

58. On 3 November 2017, Mr Pearce underwent a left shoulder replacement by Dr Pak at the Mildura Private Hospital. The reference in the operation report refers to a right shoulder replacement which is clearly a typographical error.[65] In his report to Dr Gordon dated 17 November 2017, Dr Pak referred to the left total shoulder replacement.[66]

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[54] ARD at page 48
[55] ARD at page 50
[56] Respondent's Application to Admit Late Documents dated 5 November 2019 at page 8
[57] Respondent's Application to Admit Late Documents dated 5 November 2019 at page 8
[58] Respondent's Application to Admit Late Documents dated 5 November 2019 at page 8
[59] Respondent's Application to Admit Late Documents dated 5 November 2019 at page 7
[60] Respondent's Application to Admit Late Documents dated 5 November 2019 at page 10
[61] ARD at page 103
[62] ARD at page 104
[63] ARD at pages 105-106
[64] Reply at page 54
[65] Reply at pages 51-53
[66] ARD at page 107

59. On 21 September 2017, Dr Pak reported to Dr Gordon that Mr Pearce was doing well following his left total shoulder replacement. He opined that it was reasonable for Mr Pearce to obtain a lift chair in order to reduce the stress on his left upper limb when rising from a seated position. Dr Pak did not record any complaints of symptoms in the lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot.

60. On 19 January 2018, Dr Fonseka, in a referral letter to Line Therapy, referred to Mr Pearce having chronic lower back pain mainly on the right side with pain radiating down to the right buttock and back of the thigh after a fall at work.[67] Dr Fonseka did not record any complaints of symptoms in the right knee, right ankle, right hind foot, left ankle and left hind foot.

61. On 15 May 2018, on the referral of Dr Bose, Mr Pearce underwent an ultrasound of both feet. The finding in the left foot was one of a bursa/neuroma at the 2/3 interspace and a disruption of the plantar plate at the fourth MTP. The finding in the right foot was one of a bursa neuroma complex at the 2/3 and 3/4 interspace.[68]

62. On 15 June 2018, Dr Patel in the general practitioner clinical records referred to an accident at work "a few years back" where Mr Pearce had a "massive fall".[69] Mr Pearce attended upon Dr Patel to discuss the results of the ultrasound of both feet related to the pain he was experiencing. A diagnosis of bursa/neuroma complex was made. Importantly, in a "non-visit" entry on 25 June 2018, Dr Patel noted that there were no previous documents to suggest that Mr Pearce's feet were injured in the work accident and that, bursa/neuroma can happen without injury.[70]

63. On 22 June 2018, Mr Pearce underwent an ultrasound of both feet and three bursa neuroma injections without complications.[71]

64. On 12 July 2018, Dr Patel in the general practitioner clinical records noted that Mr Pearce had chronic lower back pain, mainly on the right side, after a fall at work in the past. The lower back pain radiated down to the right buttock and the back of the thigh but there was no weakness. Reflexes were sluggish bilaterally and spinal movements were relatively preserved with some restrictions and mid spine tenderness in the lower lumbar region. He also recorded Mr Pearce referring to "nagging neck pain on and off" in relation to the same work-related incident.[72] On the same date, Dr Patel repeated that which was recorded in the general practitioner clinical records referred to above in a referral letter to Lime Therapy.[73]

65. On 25 September 2018, Dr Shahrokhi reported to Dr Patel that Mr Pearce was making excellent progress following his right hip revision arthroplasty two years ago. He noted Mr Pearce's main complaint at the time as one of pain in both feet. The pain was a sharp pain when placing weight on the foot. He also reported that Mr Pearce complained of paraesthesia in both legs and that an epidural injection had given him relief in the past. However, the cortisone injections in his feet had not provided much relief. Dr Shahrokhi opined that the x-rays revealed a well healed femoral osteotomy without periprosthetic complications as far as the right hip was concerned. Examination of Mr Pearce's foot demonstrated some paraesthesia over the distribution of L4 and a positive Mulder's click and a painful forefoot. Clinically, Mr Pearce appeared to have a neuroma. Arrangements were made for Mr Pearce to undergo x-rays and MRI scan of his right foot.[74]

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[67] Applicant's Application to Admit Late Documents dated 1 November 2019 at page 5
[68] ARD at page 108
[69] ARD at page 73
[70] ARD at page 74
[71] ARD at page 109
[72] ARD at page 80
[73] Applicant's Application to Admit Late Documents dated 1 November 2019 at page 1
[74] ARD at page 111

66. On 26 September 2018, Mr Pearce underwent the x-ray and right foot MRI scan arranged by Dr Shahrokhi. The x-ray disclosed dorsal osteophytosis at the first MTPJ and a plantar calcaneal spur. The MRI scan concluded that there was a third intermetatarsal space neuroma, which was quite central rather than plantar; and that there was mild fraying at the central fourth plantar plate.[75]

67. In evidence, there are Certificates of Capacity and other medical certificates.[76] With the exception of one medical certificate, the certificates made no reference to the lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot. The medical certificate issued by Dr Gordon dated 14 November 2017 did refer to a past history of back injury and right hip replacement.[77] Dr Gordon stated no link between the back injury referred to in the certificate and Mr Pearce's work.

68. On 22 January 2019, Mr Pearce consulted Dr Eugene Gehr, Orthopaedic Surgeon at the request of his lawyers.

69. In evidence, there is a report by Dr Gehr dated 22 January 2019. [78] I will now refer to the relevant parts of that report.

70. Dr Gehr acknowledged that he had received and read the documentation supplied to him. However, he did not identify such documentation. He summarised the contents of certain medical records under the heading "Medical Treatment".[79] He also summarised the contents of imaging in his possession.[80]

71. Mr Pearce provided Dr Gehr with a history of injury which was consistent, in the main, with the evidence.

72. Mr Pearce provided a history to Dr Gehr that, immediately after the accident, he injured his head with bleeding, experienced pain of the right hip and pain of the left shoulder. Initial right hip x-rays at hospital did not reveal any fracture. He then consulted Dr Gardiner, who arranged for scans of the right hip, but again, no fracture was found. Dr Shahrokhi arranged for further x-rays which demonstrated a fracture and Dr Shahrokhi performed a right hip replacement on 28 November 2016. The latter date should have read 28 October 2016 and the procedure was actually a revision of the right total hip replacement plus osteotomy of the femur and a synovectomy.

73. I found Dr Gehr's second paragraph under the heading "History of Symptoms and Treatment Following the Accident" difficult to follow. In particular, the second sentence which read:

> "In fact he was able to shear eight months prior to the accident and that obviously involves significant use of both arms, back and legs and also pain in the mid lumbar area of his back and pain radiating down the right leg, and also pain over the both feet and the midfoot to forefoot area and some pain in the anterior aspect of both these."[81]

In the quoted passage, there was a reference to mid-lumbar pain with radiation down the right leg and pain over both feet and the midfoot to forefoot area and also in the anterior aspect. However, I could not comprehend what Dr Gehr was attempting to explain. This raises some concern, as this is the expert evidence on which Mr Pearce relied to connect the disputed injuries to the fall from the truck on 3 February 2016 on a background of a lack of contemporaneous complaints.

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[75] ARD at page 110
[76] Reply at pages 8-38
[77] Reply at page 38
[78] ARD at pages 14-27
[79] ARD at pages 15-17
[80] ARD at pages 17-18
[81] ARD at page 19

74. Dr Gehr opined that Mr Pearce had developed no other conditions apart from those from the subject accident.[82] However, whilst he summarised the entry in the general practitioner clinical records in relation to gout, he did not refer to the gouty arthritis referred to by Mr Pearce's general practitioner and its effect on joint pain in other parts of the body. Nor did he take into account the surgical procedures and treatment to Mr Pearce's right knee in the mid-1990s, as reported by Dr Martin or his prior lumbar spine injuries. Dr Gehr did not take into account Dr Patel's exclusion of the bursa/neuroma in Mr Pearce's feet as being related to the work.

75. Dr Gehr reported Mr Pearce's current symptoms as pain in his mid-lumbar spine to the right thigh; pain of the anterior aspect of the left shoulder; and pain in both feet. There was stiffness of the left shoulder, the lumbar spine, the right hip and both feet. There was also a sensation of heaviness in both feet[83]. There was no reference to the cervical spine or the knees.

76. On examination, Dr Gehr observed, amongst other things, antalgic limp; difficulty standing on toes, heels, inverting or everting; inability to squat; tenderness in the mid cervical area with guarding and dysmetria but no spasm; tenderness in the right paralumbar area with guarding and dysmetria but no spasm; positive slump test on the right; decreased sensation at L5-S1 on the left; absent left knee reflexes; radiculopathy; 28 cm surgical scar to the lateral aspect of the right hip; right hip flexion of 90°, extension 10°, abduction 30°, adduction 0°, external rotation 30°, internal rotation 10°; right knee range of motion 10° to 100°; left knee range of motion 0 to 110°; right ankle range of motion dorsi flexion 0°, plantar flexion 20°, inversion 10°, eversion 0°; left ankle range of motion dorsi flexion 10°, plantar flexion 30°, inversion 0°, eversion 0°; normal range of motion in the right shoulder; left shoulder flexion 70°, extension 30°, adduction 0°, abduction 80°, external rotation 40°, internal rotation 40°; positive impingement of the left shoulder; and surgical scar to the anterior aspect of the left shoulder.[84]

77. Dr Gehr diagnosed a fracture around the previous right total hip replacement; injury to the left shoulder requiring left shoulder arthroplasty; lumbar spine soft tissue injury with radiculopathy; cervical spine soft tissue injury; bilateral soft tissue injuries of the knees with pain and reduced range of motion; bilateral ankle injuries with pain and reduced range of motion; and bilateral hind foot injuries with pain and reduced range of motion. There was no reasoning provided to link the disputed injuries to the fall from the truck on 3 February 2016, despite having been provided with clinical records demonstrating a delay in the reporting of symptoms. Dr Gehr did not provide an opinion as to whether work was a substantial contributing factor in relation to the disputed injuries, in particular, the lumbar spine and right knee that had been previously subjected to injury, albeit many years ago.

78. Dr Gehr then went on to assess the impairment to Mr Pearce's right hip; cervical spine; lumbar spine; left shoulder; scarring; right knee; left knee; right ankle; left ankle; right hind foot and left hind foot.[85]

79. After Dr Gehr referred to the documents under the heading "Medical Treatment", he made no further reference to those documents or any reasoning when considering causation and making his diagnoses. Dr Gehr did not satisfactorily engage with the issue of causation in relation to the disputed injuries. He provided no comment on the mechanism of the fall from the truck and linking it to injuries to the lumbar spine, the right knee, the feet or the ankles. He fell short of linking the injuries in dispute with the work incident on 3 February 2016.

[82] ARD at page 19
[83] ARD at page 20
[84] ARD at pages 20-22
[85] ARD at pages 25-27

80. Rule 15.2(3) of the Workers Compensation Commission Rules 2011 provides that "evidence based on speculation or unsubstantiated assumptions is unacceptable." Further, it is well established in the authorities such as *Paric v John Holland (Constructions) Pty Ltd*[86] (*Paric*); *Makita (Australia) Pty Ltd v Sprowles*[87] (*Makita*); *South Western Sydney Area Health Service v Edmonds*[88] (*Edmonds*); and *Hancock v East Coast Timbers Products Pty Ltd*[89] (*Hancock*); that there must be a "fair climate" upon which a doctor can base an opinion. Whilst it is accepted that a doctor does not need to provide elaborate or detailed explanations for his/her conclusion, more is required than just a mere an assertion without proof. That seems to be precisely what Dr Gehr has done in his expert report. I agree with the respondents' submission that Dr Gehr failed to make the causal connection between the disputed injuries and the work-related incident on 3 February 2016. I found Dr Gehr's expert report unpersuasive in this regard.

81. On 25 March 2019, Mr Pearce consulted Dr Graeme Doig, General Orthopaedic and Trauma Specialist at the request of EML's lawyers.

82. In evidence, there is a report by Dr Doig dated 6 May 2019.[90] I will now refer to the relevant parts of that report.

83. Dr Doig reviewed the documentation provided to him, which he listed on pages 1 and 2 of his report and included Dr Gehr's report.[91]

84. Dr Doig referred to Mr Pearce's current status as having persistent, left-sided neck pain with associated headaches and niggling discomfort in his left shoulder with an inability to use his left arm overhead. Mr Pearce also complained of a niggling discomfort in the right hip radiating to his thigh. There was no reference to complaints of symptoms in the lumbar spine, right knee, right ankle, right hind foot, left knee, left ankle and left hind foot.[92]

85. On examination, Dr Doig observed Mr Pearce walk into his consulting rooms with a slight limp through the right leg. He was using a walking stick. In relation to his neck, Mr Pearce was tender and tight over the left trapezius muscle with restricted lateral flexion and rotation to the right with evidence of dysmetria. He had good forward flexion and extension; and there was no neurological deficit of the upper limbs. In relation to the left shoulder, Dr Doig observed a pink, discoloured, longitudinal scar in the delto-pectoral groove, which was cosmetically obvious but not causing clinical concerns. There was tenderness over the left trapezius muscle with restricted active range of motion arcs at the shoulder. In relation to the right hip, there was a 28 cm curvilinear, posterior scar with two proximal extensions as a result of the two surgical procedures. Leg lengths were equal and straight leg raising was full, with negative nerve root tension signs and there was no focal neurological deficit of the lower limbs. Crossing his legs was problematic with restricted adduction and only 80° of active flexion. Abduction and rotation were satisfactory. There was no evidence of any fixed-flexion deformity. There was difficulty with squatting and crossing the right leg.[93] Dr Doig did not refer to having conducted an examination of Mr Pearce's lumbar spine, right knee, right ankle, right hind foot, left knee, left ankle and left hind foot.

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[86] *Paric v John Holland (Constructions) Pty Ltd* [1985] HCA
[87] *Makita (Australia) Pty Ltd v Sprowles* [2001] NSWCA 305; 52 NSWLR 705
[88] *South Western Sydney Area Health Service v Edmonds* [2007] NSWCA 16; 4 DDCR 421
[89] *Hancock v East Coast Timbers Products Pty Ltd* [2011] NSWCA 11; 80 NSWLR 43
[90] Reply at pages 1-7
[91] Reply at pages 1-2
[92] Reply at page 5
[93] Reply at page 4

86. Dr Doig diagnosed a possible soft tissue injury to the cervical spine; an aggravation of a pre-existing arthritic gleno-humeral joint of the left shoulder requiring total shoulder replacement surgery; and loosening of the femoral component of the previously replaced right total hip replacement requiring revision surgery.[94]

87. Part of the instructions Dr Doig received from EML's lawyers included consideration of the "numerous body parts"[95] referred to in Dr Gehr's report as having been injured on 3 February 2016. As far as Dr Doig was aware, there were no injuries to the other body parts alluded to in Dr Gehr's report. Curiously, Dr Doig added that clarification was required from the clinical notes of Mildura Base Hospital and a follow-up of the GP clinical notes to see if other body parts were injured in the fall. It was curious because Dr Doig referred to having reviewed the general practitioner clinical records from 11 February 2016 to 29 August 2016 in the earlier part of his report. It is clear that he did not have a copy of the Mildura Base Hospital clinical notes. Dr Doig pointed out that Mr Pearce did not complain to him about right knee pain at the time of his assessment. He only complained of thigh discomfort, which was most likely as a result of his hip replacement surgery. He observed that Mr Pearce had normal movement and stability at the right knee joint. Dr Doig considered the disputed injuries, albeit very briefly and rejected them with the qualification referred to above. It has already been established that the disputed injuries were not referred to in the Mildura Base Hospital clinical records. In relation to the general practitioner clinical records and treating medical specialist reports, it has been established that there were no contemporaneous complaints of symptoms in relation to Mr Pearce's disputed injuries. For these reasons and the concerns I have already expressed in relation to Dr Gehr's evidence, I prefer the evidence of Dr Doig.

88. Dr Doig then went on to assess the impairment to Mr Pearce's left shoulder, right hip and surgical scarring. He did not assess Mr Pearce's cervical spine, even though he conceded that the mechanism of Mr Pearce's fall could have resulted in a soft tissue injury. In any event, injury to the cervical spine is not in dispute.

89. There was contemporaneous evidence of left knee symptoms in the medical evidence of Mr Pearce's treating doctors and specialists and Mildura Base Hospital. I am satisfied on the balance of probabilities, to a degree of actual persuasion or affirmative satisfaction, that Mr Pearce sustained an injury to his left knee arising out of or in the course of his employment with the respondent on 3 February 2016. During the arbitration, the respondents did not challenge the injury to the left knee, despite it having been put in issue in the section 78 Dispute Notice. However, the respondents raised the issue that the left knee could not be referred to an Approved Medical Specialist (AMS) for assessment because Dr Gehr had assessed its impairment as 0%.

90. I have considered Mr Pearce's primary submissions that the mechanism of his fall from the truck on 3 February 2016 was consistent with the alleged disputed injuries and their absence from contemporaneous documents was explained by his focus on his more serious injuries, namely, his right hip and left shoulder. I am not persuaded by the submissions. I would have expected some contemporaneous documentary evidence of the disputed injuries much earlier than they appeared in the medical evidence. Overall, there is an absence of diagnostic clarity as to the cause or causes of the disputed injuries.

91. The first recorded complaint by Mr Pearce of pain in his ankles and both knees was made by Dr Gordon on 25 January 2017, almost one year after the fall from the truck. Dr Gordon diagnosed arthralgia and made no reference or link to Mr Pearce's fall from the truck.

[94] Reply at pages 4-5
[95] Reply at page 5 at [d]

92. The first reference in any of the medical evidence or clinical records of lower back pain and the plantar aspect of the right foot pain post 3 February 2016 was contained in Dr Shahrokhi's report to Dr Gordon on 7 February 2017, one year after the fall from the truck. In relation to the right foot, Dr Shahrokhi diagnosed Morton's neuroma. Dr Shahrokhi did not link the complaint of lower back pain and right foot pain to the fall from the truck. On 15 June 2018, Dr Patel noted that there were no previous documents to suggest that Mr Pearce's feet were injured in the work accident and that, bursa/neuroma can happen without injury.

93. Mr Pearce impressed me as having been a hard worker and a stoic man. He is currently 78 years of age and is suffering from multiple medical problems following a long working career. Without in any way challenging his credit, Mr Pearce fits McLelland CJ's description of the fallibility of human memory in *Foxman*.

94. There is an absence of diagnostic clarity as to the cause of the disputed injuries and an absence of contemporaneous evidence to support the disputed injuries. Mr Pearce bears the onus of proof on the balance of probabilities, an onus which I find he has not discharged.

95. I am not satisfied on the balance of probabilities, to a degree of actual persuasion or affirmative satisfaction, that Mr Pearce has established that there was a definite or distinct physiological change or disturbance in his lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot for the worse arising out of or in the course of his employment with the respondent on 3 February 2016. There was no evidence of any sudden identifiable pathological change in those parts of his body.

96. Accordingly, I find that Mr Pearce did not sustain a personal injury to the disputed body systems arising out of or in the course of his employment with the respondent on 3 February 2016 within the meaning of section 4(a) of the 1987 Act.

Is Mr Pearce entitled to lump sum compensation within the meaning of section 66 of the 1987 Act in relation to the disputed body systems?

97. In relation to a claim for permanent impairment compensation, an arbitrator's jurisdiction is limited to determining "liability" issues: refer to section 65 of the 1987 Act, sections 293 and 321 of the 1998 Act and the discussion in *Jaffarie v Quality Castings Pty Ltd*[96] and the cases referred to therein.

98. The NSW Court of Appeal concluded that the jurisdiction of the Commission, as opposed to that of the AMS, is to determine "the nature of the injury sustained": *Jaffarie v Quality Castings Pty Ltd (Jaffarie No 2)*.[97] As to whether Mr Pearce has recovered from any injury found to have been suffered; whether any aggravation, acceleration, exacerbation or deterioration has ceased; whether the impairment or any part of it results from an injury other than that referred for assessment; or whether a deduction is required pursuant to section 323 of the 1998 Act by reason of the impairment found being partly due to a previous injury or a pre-existing condition or abnormality, are issues and matters falling within the exclusive jurisdiction of an AMS.

99. During the conciliation phase, it was agreed that the non-disputed injuries to the cervical spine, left shoulder, right hip and consequential surgical scarring to the left shoulder and right hip could be referred by me to an AMS for assessment.

[96] *Jaffarie v Quality Castings Pty Ltd*[96] [2014] NSWWCCPD 79
[97] *Jaffarie v Quality Castings Pty Ltd* [2018] NSWCA 88, [80] (White JA (MacFarlane and Leeming JJA agreeing on this point)).

100. As Dr Gehr, Mr Pearce's own forensic medical specialist, assessed 0% whole person impairment in relation to the left knee, I cannot refer the left knee to an AMS for assessment.

101. Accordingly, based on the findings I have made above, I will remit the matter to the Registrar for referral to an AMS for the assessment of Mr Pearce's spine (cervical spine); left upper extremity (left shoulder); right lower extremity (right hip); and the skin (scarring – right hip and left shoulder – TEMSKI) under the 1998 Act.

CONCLUSION

102. Mr Pearce did not suffer injuries to his lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot arising out of or in the course of his employment with the respondents on 3 February 2016 within the meaning of section 4(a) of the 1987 Act. Accordingly, there is an award for the respondents in relation to Mr Pearce's claimed injuries to his lumbar spine, right knee, right ankle, right hind foot, left ankle and left hind foot on 3 February 2016.
103. The matter is remitted to the Registrar for referral to an AMS for assessment under the 1998 Act as follows:

Date of injury:	3 February 2016.
Body System:	The spine (cervical spine); the left upper extremity (left shoulder); right lower extremity (right hip); and the skin (scarring – right hip and left shoulder – TEMSKI).
Method of Assessment:	Whole Person Impairment.

104. The following documents are to be provided to the AMS:

    (a) ARD dated 21 August 2019 and attached documents;

    (b) Reply dated 12 September 2019 and attached documents;

    (c) applicant's Application to Admit Late Documents dated 1 November 2019 and attached documents;

    (d) respondent's Application to Admit Late Documents dated 5 November 2019 and attached documents, and

    (e) applicant's Application to Admit Late Documents dated 8 November 2019 and attached documents (Calvary North Adelaide Hospital).