WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **2741/20**
Applicant: **Billy Jurd**
Respondent: **Programmed Skilled Workforce Limited**
Date of Determination: **16 July 2020**
Citation: **[2020] NSWWCC 243**

The Commission determines:

1. Award for the respondent in respect of the claim for injury to the lumbar spine and to the right upper extremity (shoulder).

2. The claim pursuant to section 66 in respect of the cervical spine does not reach the relevant threshold so as to entitle the applicant to any benefits.

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

Deborah Moore
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 DEBORAH MOORE, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Billy Jurd, was employed by the respondent, Programmed Skilled Workforce Limited, as a labourer.

2. On 23 February 2016, he fell into a pit and sustained a number of injuries.

3. By an Application to Resolve a Dispute (the Application) registered in the Commission on 19 May 2020 he claimed lump sum compensation in respect of injuries to his cervical spine, his right upper extremity (shoulder) and his lumbar spine.

4. Liability in respect of the injury to the cervical spine was accepted by the respondent (a self-insurer) but denied in respect of the other injuries.

ISSUES FOR DETERMINATION

5. The parties agree that the following issue remains in dispute:

    (a) Whether the applicant sustained injuries to his lumbar spine and right shoulder
    in the incident on 23 February 2016.

PROCEDURE BEFORE THE COMMISSION

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

Documentary 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 and attached documents;

    (b) Reply and attached documents.

FINDINGS AND REASONS

8. In his statement dated 29 April 2020, the applicant described the circumstances of his injury as follows:

> "At the time I suffered my injury, I had been working on the Nambucca to Urunga bypass. One of the tasks I was required to perform required me to walk around the site and collect the pit lids which were placed atop metal grates covering the stormwater drain pits… I believe that these lids weighed between 10kg and 20kg.

> On 23 February 2016, I picked up one side of a pit lid that lay flat on the floor. I stepped forward anticipating there to be a metal grate but suddenly fell into the drain pit hole.
>
> As I fell in, I hit my right shin and thigh against the Reo bars, followed by my right hip/lower back and right rib cage.
>
> As I fell, I stuck my elbows out to slow my fall which caused my right elbow to collide with the topmost Reo bar and my left elbow to hit the wall of the pit. My arms hyperextended above my shoulders like a chicken wing. I was suspended in this position above the ground and my head was slightly above the level of the pit hole. The raised pit lid, which I had released seconds earlier fell, hitting me in the head."

9. The applicant was taken to Coffs Harbour Hospital for treatment but later discharged. He then came under the care of his general practitioner, Dr Oliver.

10. He was subsequently referred to a pain management specialist, Dr Clarke.

11. He added:

> "On 24 February 2016, I saw Dr Oliver… I complained of pain in my neck along with a funny feeling down my right leg. I had bruising on the right side of my chest and bruising under my left and right arm.
>
> As time wore on and I started to move more, the pain in my right shoulder blade, hip and lower back became more obvious.
>
> Physiotherapy initially helped with the neck pain however the pain in my right shoulder increased. I attempted to return to work to perform light duties but my neck hurt too much…
>
> On 12 April 2016, I consulted with Dr Oliver to discuss the results of the neck MRI. complained of feeling a cracking sensation in neck my which would travel down the whole of my back. I would suffer occasional pain running down my right arm and numbness in my right shin…
>
> I felt minor improvements during my brief rest period but the neck pain and right leg numbness persisted and I started to feel niggles in my right hip.
>
> On 24 August 2016, I attended an appointment with Dr Clarke. I told Dr Clarke that the pain was present in my neck and right shoulder but I often suffered from the feeling of pins and needles in my right arm. I advised that there was also a constant feeling of numbness in my right foot since the incident.
>
> I consulted with Dr Oliver on 16 September 2016. I again informed him of my right shoulder blade pain, right hip pain and pain in my right shin area. Dr Clarke performed nerve block injections to my neck on 1 November 2016. I saw Dr Oliver on 11 November 2016, where I again complained about pain in my neck, lower back and hip.
>
> Dr Clarke recommended a further nerve block injection which I had on 9 February 2017.

> Dr Clarke performed a radiofrequency treatment to my neck on 17 May 2017. Following this, I found that the intensity of my symptoms reduced. Further radiofrequency treatment was performed on my back on 4 December 2017. I continue to suffer pain in my neck, hip, right shoulder blade and lower back. Pain radiates down my right leg and through my right arm and I have found no relief from these symptoms."

12. The balance of his statement referred to some difficulties with activities of daily living.

13. Notes from the Coffs Harbour Hospital confirm that the applicant attended on the day of the accident and his symptoms were reported as follows:

> "Fell into pit approx 2.1 metres. Injuries to right lateral chest and right lower leg. Hit on head with concrete lid. No LOC. Neck sore following but no [sic] ok. No tenderness on palpation. Tender to lower leg. Abrasion to chest with ice burn."

14. Further details were reported as follows:

> "9am today working on the roads Fell into a 2.1 m deep pit. Hit right chest and right thigh on the way down Landed on his feet. Wearing helmet. metal plate fell down on his head. No LOC was confused for a few minutes. No vomiting/ no neurological sx. Took a break from work to gather himself. Wanted to keep working but health and safety officer ordered him to present to ED… Pain on right side of chest - pleuritic, worse over 6-8 rib anteriorly, non-radiating, no SOB Also painful right thigh and shin Neck pain also, though has FROM neck.
> XRs C-spine, no bony injury identified CXR, no overt abnormality."

15. There was no reference to any injury to the back or right shoulder.

16. The applicant saw a physiotherapist, Ms Steindl, on 7 March 2016. She reported as follows:

> "Billy Jurd presented to the clinic on the 7 /3/16 complaining of neck and right arm pain after falling into a 2m deep pit at work. Billy also reports some pain + pins and needles + numbness in his right lateral shin that has been unchanged since the Injury as well as some right rib pain that has been gradually improving since the injury. Currently I have been focused on treating Billy's neck and associated R arm pain as he reports this is his worst pain…
> Billy also experiences radicular pain radiating down into his R arm when he is driving or working in a sustained posture…"

17. Again, there is no reference to any back injury or shoulder injury. Ms Steindl referred to right *radicular* arm pain *associated* with the neck injury.

18. Clinical notes from Coffs Central Medical Centre, and particularly Dr Oliver confirm that the applicant attended on 24 February 2016. The entry reads:

> "note ED letter- big fall into hole, then metal plate hit head managed to get arms out to prevent fall bruising right chest, under both arms, right shin and right thigh…currently feels better than expected- sore neck, but FROM sore chest sore thigh and funny feelings right leg full exam and x-rays done in ED so not repeated…"

19. That entry was essentially the same as the history recorded at the hospital.

20. The entry on 2 March 2016 reads: “pains going ok, but has been a bit painful posterolateral right chest- aching muscle pain 4/1 0 most days…”

21. On 7 March 2016, the entry reads: “still not sleeping well neck tight and sore and right chest hurts to lie on it. no radicular features no severe pains at rest mostly tender musculature of neck and great ROM no tenderness chest wall.”

22. On 11 March, the entry reads: “with time off and physic is finally making some improvement. pain continues in right chest- very tender… this would suggest fracture also right trapezius…”

23. On 16 March 2016, Dr Oliver recorded that the applicant, now back at work, felt bullied by his boss. Dr Oliver said: “Although Billy physically able to work, psychologically he doesn’t feel able.”

24. Subsequent entries in March 2016 refer to neck and chest symptoms and psychological problems.

25. On 12 April 2016, the entry reads:

> “Discussed scans- all reassuring- right rib fractures as I suggested and old injury to left knee- no current symptoms. MRI no concern, prolapsed disc unlikely to be contributing to his symptoms which are: regular cracking sensation in neck and along T/l spine, constant 5/10 ache that even stops him sleeping, in neck occasional pains, right scapula that radiate down his arm at times feeling of inability to work more than two hours…
> Tone/power/reflexes and sensation normal in arms and legs…some tenderness mostly right scapula border and over C6 reduced movement to looking over left shoulder but other movements C/T/L spine normal…
> Explained Billy developing a chronic pain syndrome- whiplash like- suggest work is the most important thing to his recovery and return to health…
> I would suggest he has multiple yellow flags and doubt any intervention likely to benefit him and may even prolong his illness but he wants to see a specialist for a second opinion, have arranged this with Dr Clarke”

26. There is no reference to any right shoulder or low back injury at this time.

27. The notes from Dr Oliver are comprehensive: the applicant attended regularly.

28. In an entry on 27 July 2016, Dr Mulvey in the same practice noted:

> “Discussion re why not better after 5-6 months with nothing major showing up on MRI scan. Complaining of neck-head pain…
> Reason for visit: Neck injury…
> o/e cs-rom-lateral rotation down by 10 both ways ext down by 10 flexion-nad side flexion *very good-shoulder abduction* (my emphasis)…”

29. The first reference to any shoulder condition appears in an entry on 16 September 2016 which reads: “pain in neck, R shoulder R hip and R lateral calf continue…reduced ROM neck, some tenderness over it FROM shoulder FROM T and L spine can fully squat, walk on tiptoes and SLR…”

30. There remains no reference to any lumbar spine injury, and the entry referred to above suggests that there was a full range of movement not only in the spine but also the right shoulder.

31. The first reference to any back condition appears in an entry on 11 November 2016 which reads:

> "recent injections Dr Clarke not made any difference to his pain constant daily pains…pains in lower back and right hip continue does have tenderness right buttock and also over greater trochanter- worse with stretching this side suggest rather than more injections to try exercise physio first…"

32. Subsequent entries do not add anything as regards the lumbar spine.

33. Dr Oliver completed regular medical certificates. In one dated 15 April 2016 he described the injuries as "soft tissue injuries" adding:

> "Fell into 2.1 m pit- pains arms, legs, right chest-CLINICALLY FRACTURED RIB and MUSCULAR PAINS in Cervical spine.
> MRI and bone scan show fractures 6 and 7th ribs, with some arthritis in neck, acromioclavicular joints. MRI shows slight C6/7 prolapse although not likely to be causing symptoms. Explained the arthritis probably from his hard physical labour and not due to this injury. rib fractures present for nearly six weeks. whiplash type injury/chronic pain syndrome developing. Referred to pain specialist, but would recommend WorkCover refer to their own independent medical examiner as well as I think Billy will be best served by return to work as soon as possible, but he continually tells me he is unable to manage even slight duties at work."

34. A Centrelink certificate prepared by Dr Oliver on 2 September 2016 described the applicant's condition as "Chronic pains" and confirmed that the condition was "temporary."

35. Dr Clarke prepared a number of reports. He first saw the applicant in August 2016.

36. In his initial report dated 1 September 2016 he said:

> "Billy presents with musculoskeletal pain after suffering a 'whiplash type Injury.' In support of this he transiently responded to facet Joint injections…Amongst the differential would be scapulothoracic syndrome. He is describing what sounds more like tension type headache then cervicogenic headache…
> Billy sustained his injury at work on 23/02/2016. He states he fell down a 2 metre deep hole and was then hit in the head by the heavy metal pit lid. He states that he fell primarily onto his right side…he was experiencing severe pain in his neck, right ribs, hip and leg.
>
> Billy has pain at the base of his head, neck and right shoulder…
> Billy also complains of pain above his right scapula that radiates down his right arm causing pins and needles and paresthesia. He states that this pain is exacerbated by forward extension of his arms…
> Billy also mentioned that he is experiencing constant paresthesia in his right foot since his injury. He explains that it often 'feels asleep' and is 'tingly' especially when squatting down at work. He denies any pain in this area…
>
> I reviewed MRI and bone scan reports… from 7 / 4 /16. Apart from some right rib fractures 6/7 and right acromioclavicular joint arthritis there was not much to see. The MRI was reported to do much as normal. Mild CS/6 annular disc bulge was noted with no nerve root compression.
>
> Shoulder examination was unremarkable and he had a normal range of motion. Beyond 120 of abduction he did experience pain. There were mild impingement signs on the right. Of note was the significant crepitus of the scapula…"

37. Dr Clarke did not record any history of a back injury.

38. Examination of the shoulder was “unremarkable” but there was evidence of some pathology in the scapula, and again, symptoms *radiated* to the right arm.

39. Dr Clarke performed injections in the cervical spine.

40. Dr Oliver wrote to Dr Clarke on 12 October 2016 as follows:

> “As per our chat on the phone I certified Billy fit for 4hours, 3days, 5kg weight limit everything else as he feels able. He wasn’t happy…
> He has been complaining of right shin numbness and hip pains. I've examined him several times in the past and the examination has been essentially normal.
>
> His bone scan was normal but he feels he is not being listened to when this is discussed 'I don’t think this is just soft tissue or nerve pain, it feels like I need to be straightened by a chiropractor'. I attempted to explain the gate theory of pain and explain what I see is the cause for his pain. I told him I see no indication for further scans, but he will discuss with you your opinion on this. He's also seen a psychiatrist at the request of his insurer. I do feel he has a clinical depression, although there are some parts of the mental state examination that do make me wonder if it’s as severe as he makes out…”

41. Dr Clarke reviewed the applicant in November 2016, February 2017, July 2017 and September 2017.

42. In a report dated 18 September 2017 he said:

> “Today, he pointed out pain in the right suprascapular area and the right iliac crest. I previously injected the ‘trigger point’ on the right suprascapular area with local and this helped…”

43. Although in the region of the shoulder, again, the complaint was in respect of the scapular area, and there was no complaint of any low back symptoms, the closest being the right iliac crest.

44. The final report is dated 4 December 2017, and again there is no reference to any shoulder or back injury or symptoms.

45. In light of the comments made by Dr Oliver in his certificate dated 15 April 2016 referred to above, the respondent arranged an examination with Dr Smith.

46. In a report dated 5 May 2016, after setting out details of the incident, Dr Smith said:

> “He said that Dr Oliver put him off work and diagnosed whip lash, rib fractures and organised CAT scans, bone scans and MRI's. He resumed light duties about six weeks ago working two hours a day four times a week and he has just seen Dr Oliver yesterday and he is now going to be working three hours a day four times a week.
>
> He complains of stiffness and pain in the back of the neck and the back of the head. There is a sore jarred feeling which is made worse by walking. There is pain around the right shoulder blade and into the right shoulder blade. There is stiffness there as well. He said that the shoulder crunches and locks up from time to time.

He also has pain with his jaw.

There are some pins and needles in the right leg over the anterior shin. He had
a blow to the anterior shin on the right leg and he also had a blow to the thigh.
There is bruising there.

He also had bruising under the arm and he fractured three of his ribs.
He also has pain in his navel when he extends his back…"

47. Dr Smith continued:

"On 12 April 2016, Dr Oliver wrote that he seems to be getting chronic pain syndrome and that it is important to his recovery that he suggests that work is the most important this for him to recover and return.

He was referred to Dr Clarke who is a pain management specialist.

Included in the correspondence is a bone scan result from 7 April 2016. There is x-ray evidence of fractures to the right 6th and t h ribs. There is arthritis of both AC joints more marked on the right than left. Degenerative disease is seen in the thoracic and cervical spine. There is also increased uptake in the left knee.

An MRI of the neck was done on 7 April 2016. There is a mild annular bulge at CS/6. No other abnormality is described."

48. On examination, Dr Smith said:

"Clinical examination demonstrates him to be a tall man. He is in no distress.
He has got a normal cervical lordosis. There is pain complained of with cervical extension, which are about one and a half the expected range. Neck movements are otherwise unremarkable.

The shoulders move normally in range and rhythm. He is a little tender over the right chest wall but he has a normal respiratory excursion and can compress the chest wall bilaterally equally on both sides. He does not have any neurological deficit in either upper limb."

49. Dr Smith concluded:

"This man gives a history that would suggest he has something of a whip lash injury with his head being struck by a steel plate.
He does not manufacture physical signs.
He might benefit from having somewhat more aggressive treatment…
The most likely specific diagnosis is an aggravation to cervical degenerative disease…
The blow to the head would involve acute flexion injury to the neck when the steel plate falls on his head…"

50. The balance of the report comments about the applicant's capacity for work.

51. Dr Smith certainly noted complaints of shoulder pain, but on examination, there was a normal range of movement.

52. There was no reference to any back injury.

53. The applicant was seen by Dr Bodel at the request of his solicitor on 19 September 2018. In a report dated 21 September 2018, after documenting the circumstances of the incident, Dr Bodel summarised the injuries as:

> "Injury to the neck; Injury to the right shoulder and arm with numbness and tingling to the middle finger of the right hand; Injury to the lower part of the back; Injury to the right buttock and thigh, Headache."

54. He continued:

> "This gentleman still has neck pain and bilateral shoulder girdle pain but the right is worse than the left…He has periscapular pain, particularly over the superior border of the scapula on the right side and on the medial border of the upper part of the scapula…There is also a painful stiffness and some sharp stabbing pain at times, He has numbness and tingling that radiates down the right arm to the middle finger of the right hand. He has pain in the lower part of the back and right buttock and thigh…"

55. On examination, Dr Bodel said:

> "He is uncomfortable throughout the interview and he rises slowly.
>
> There is tenderness in the trapezius muscles at the base of the neck on the right side and also in the suboccipital region. There is guarding. He has a restricted range of neck flexion, extension and rotation in all directions and this is restricted throughout but particularly on rotation to the left. There is therefore asymmetry of neck movement.
>
> He has a restricted range of shoulder movement on the right side…There is mild generalised wasting in the right shoulder girdle and there is impingement in the right shoulder but no instability.
>
> There is a good range of lateral bending and rotation of the thoracic spine but there is tenderness on palpation in the lumbosacral junction on the right side and guarding in that area…
>
> There is no evidence of nerve root irritability. There is no clinical sign of radiculopathy in the lower limbs. There is no restriction of hip, knee, ankle or subtalar movement although he does have some discomfort on palpation over the iliac crest on the right side…"

56. Dr Bodel was not provided with any investigations.

57. He concluded:

> "This gentleman suffered a soft tissue injury to the neck, the right shoulder, the back and right hip in the incident that occurred at work on 23 February 2016… This gentleman has not yet been able to return to work.
>
> This gentleman presents with ongoing mechanical symptoms in the neck and right shoulder and arm. He indicates that he is totally unfit for work. He is certainly not fit for his pre-injury labouring work. He should be able to contemplate a return to lighter duty work on a part time basis…"

58. In a separate report, Dr Bodel provided assessments of whole person impairment.

59. In a supplementary report dated 6 November 2018, Dr Bodel commented on some investigations that had been sent to him. He added:

> "At the time of my assessment, this gentleman was complaining of neck pain and shoulder girdle pain, the right side worse than the left, pain in the upper part of the scapula on the right hand side and numbness and tingling down the right hand to the middle finger of the right hand. There was also a lower back and right buttock pain with a dull, aching pain in the right leg.
>
> The investigations undertaken show some rib fractures, some increased uptake in the AC joint of the right shoulder and the MRI scan shows no significant disc pathology in the cervical spine.
>
> In response therefore to the specific questions that you have asked, I would indicate that there is no indication clinically for any form of surgical intervention."

60. A bone scan performed on 7 April 2016 reported as follows:

> "Thank you for referring Billy Jurd for a bone scan. Clinical Notes: Fall from height 2 months ago. Recurrent neck and chest pain.
> In the delayed images, note is made of marked intense uptake in the right 6th and 7th ribs laterally. The appearances are in keeping with acute fractures. There is arthritis of bilateral acromioclavicular joints more marked on the right, which may again be due to traumatic injury.
>
> Degenerative disease is seen in the cervicothoracic spine…
> 0pinion: The bone scan demonstrates recent fractures of the 6th and 7th ribs laterally. There is probable traumatic arthritis of the right acromioclavicular joint…"

61. The results of that scan were discussed by Dr Oliver in his certificate which appears to be dated 5 April 2016 but that date is clearly incorrect, because he said:

> "MRI and bone scan [7 April 2016] show fractures 6 and 7th ribs, with some arthritis in neck, acromioclavicular joints. MRI shows slight C6/7 prolapse although not likely to be causing symptoms. Explained the arthritis probably from his hard physical labour and not due to this injury."

62. Dr Smith saw the applicant again on two further occasions.

63. In a report dated 24 February 2017 he said:

> "Today, he describes been [sic] under the care of Dr Clarke and has further injections recommended. He is currently not working, but performed some jobs since I last saw him, including working on a tree farm for eight or nine weeks and doing some office work as well as gardening work. He was sacked from his council job two months ago.
>
> He continues with neck pain and stiffness, which is not any better. He has right shin pain, right hip pain as well as low back pain and the right shoulder grates."

64. On examination, Dr Smith said:

> "He is tall and in no distress. He has a normal cervical lordosis. There is a slight restriction in the range of movement in the neck in all directions with some grimacing at the extremes. With -powerful movements of the right shoulder, there is audible crepitus but similar movements of the left shoulder, but with much less power are unremarkable. There is actually a normal range and rhythm of shoulder movement bilaterally and there are work hardening changes on both his hands, the right side in excess of left hand. There is no sensory abnormality in either upper limb. There is a global power loss in all movements of both upper limbs, much more marked on the right than the left which extends from the small muscles in the hand through to and including shoulder elevation and neck rotation. Neck rotation to the right is weaker than neck rotation to the left."

65. Dr Smith then commented on some surveillance material he had been sent. He concluded:

> "When I first saw this man, I formed the opinion that he suffered an exacerbation to his previously asymptomatic cervical degenerative disease and considered it possible that he had not fully recovered by the time I first saw him, about nine weeks after his work incident.
>
> I would have thought based on today's examination, that he has in fact recovered. I cannot find anything objectively wrong with him.
>
> He is able to demonstrate snapping scapular on the right. He does not exert the same amount of power on the left. In my opinion, there is nothing wrong with his right scapula. The weakness he exhibits in both upper limbs, the right in particular, is unphysiological and manufactured. There is no organic illness that can produce that pattern of weakness.
>
> Shoulder elevation and neck rotation are performed by the trapezius muscles and the sternomastoid muscles respectively. These muscles are supplied by the 11th cranial nerve and could not be affected in a neck or shoulder complaint.
> Neck rotation to the right, which is weaker than the rotation to the left, is performed by the left sternomastoid muscle while the right sternomastoid muscle rotates his neck to the left with more power while shoulder elevation on the right is weak. The surveillance material would suggest there is nothing wrong with his neck as well…
>
> The condition I thought he had in the neck was the result of the reported work injury. In my opinion, it has resolved. The opinion is based on the history, the examination and the radiology that has been available as well as the subsequent examination."

66. In his final report dated 16 August 2019, Dr Smith said:

> "He continues to complain of pain in the back of the neck, in the back of the head, pain in the right shoulder, with grinding in the right shoulder and numbness and pain in the anterior right shin laterally. Basically, he said he is not any better from when I last saw him. He continues with pain in the anterior abdomen with extension of the lumbosacral spine…

He is in no distress. He is 6'2" tall and weighs 114 kg. He has a normal cervical lordosis. The neck movements are about three the quarters expected range in all directions. He does not complain of pain at the extremes of neck movements. There is no sensory abnormality in either upper limb. His shoulders actually move normal in range and rhythm.

He has a global power loss in all movements of the right upper limb, which extends from the small muscles of the hand through to and including shoulder abduction and adduction but not elevation, and he has weakness of neck rotation to the right. There is an area of altered sensation over the middle lateral one-third of the right shin but there is no other clinical abnormality one can detect in the right lower limb. He has a normal lumbar lordosis and can touch his toes. He resumes the erect position normally. Straight leg raising is normal. There is no other neurological abnormality in either lower limb. I do not have any reason to alter the opinion that I expressed when I last saw this man. In that, I considered he did in fact have a significant aggravation to his cervical degenerative disease with the work accident of 23 February 2016, and that he had in fact recovered from that. He described no improvement when I last saw him and he had nothing objectively wrong with him on clinical examination. The weakness in the right upper limb is unphysiological and manufactured. There is no organic illness that could produce that pattern of weakness."

67. He added:

"On 23 February 2016, then he sustained a soft tissue injury to the neck leading to pain around the head, in the right shoulder area and some stiffness in the shoulders. He complained that he also had pain in his jaw. There was a blow to the anterior shin on the right leg leading to pins and needles there. There was a blow to the thigh on the right as well and there were three rib fractures. He complained of pain in the anterior abdomen with extending the back…In my opinion the injury to the neck could easily result in having symptoms referred to one shoulder or other. In my opinion, there is no actual shoulder injury. At the time of the accident he was 37 years old. He would have lumbar degenerative disease, which was I think asymptomatic at that time. He did not give any history that would suggest to me that he sustained an aggravation to his lumbar degenerative disease."

68. He concluded:

"When I saw him initially on 5 May 2016, I conducted an examination of both shoulders and there was no abnormality on examination of either shoulder. I also conducted an examination of both shoulders when I saw him for a second time on 24 February 2017 and there was also a normal range and rhythm of shoulder movement on that occasion. On that occasion he was using very powerful rotary movements with his right shoulder, which led to snapping of the scapula. When he was performing similar movements on the left, he was not using the same muscle power. It was my opinion that he was manufacturing physical signs. Today his shoulders moved normally in range and rhythm and he continues to manufacture physical signs. I noted Dr Bodel conducted an examination of both shoulders and noted a restriction in the range of movement in all directions of the right shoulder, which has not been noted by me on three separate occasions, despite looking for such an anomaly. In my opinion, that is part of his manufacturing physical signs."

69. In summary, Dr Smith accepted that the applicant had sustained an injury to his neck but felt that he had recovered. He did not accept that there had been any frank injury to the right shoulder or the lumbar spine as claimed by the applicant.

70. I have no doubt that the accident was rather traumatic for the applicant and could have resulted in much more significant injuries.

71. My task however is to evaluate the evidence to enable me to determine what injuries resulted from this incident.

72. As I said, there is no dispute that the applicant injured his neck in the incident.

73. As regards the claimed injury to the lumbar spine, there is simply no contemporaneous evidence that any such injury occurred.

74. Counsel for the applicant urged that I should regard complaints of pain “in the arms and legs” as indicative of injuries to the right shoulder and back.

75. I cannot accept that argument.

76. The applicant certainly sustained an injury to his shin as reported by Ms Steindl, but there is no reference by her, the hospital or Dr Oliver to any back injury.

77. It is true that the applicant complained of “pains in lower back and right hip” to Dr Oliver in November 2016, but in my view this reflects the “chronic pain syndrome” that Dr Oliver felt the applicant was developing, in combination with a number of psychological problems.

78. The applicant’s statement was prepared over four years after the incident. Understandably, his recollection of the nature and extent of his injuries may not be entirely accurate, which makes the contemporaneous evidence more reliable.

79. Dr Bodel equally was reliant on the history given to him. The applicant said he injured his back at the time, as noted by Dr Bodel when he summarised the injuries.

80. Dr Bodel concluded that the applicant sustained a soft tissue injury to his lumbar spine. Curiously, when commenting on his current symptoms, Dr Bodel said: “This gentleman presents with ongoing mechanical symptoms in the neck and right shoulder and arm.” He did not mention the back.

81. Similarly, Dr Smith was not given any history of a back injury.

82. In addition, findings on physical examination by Drs Oliver, Clarke and Smith were essentially normal. For example, on 16 September 2016 Dr Oliver reported “FROM [full range of movement] T and L spine can fully squat, walk on tiptoes and SLR…”

83. For all these reasons, I am not persuaded that the applicant sustained an injury to his lumbar spine in the incident on 23 February 2016.

84. Whether the applicant sustained an injury to his right shoulder in the incident I have found more difficult to determine.

85. The circumstances of the accident where the applicant said that he was suspended by his arms above his shoulders could certainly lead to a shoulder injury, but again, I need to carefully consider the contemporaneous material.

86. To begin with, I note that much of the early material refers to pain in the right arm which was referred from the neck. This is consistent with the hospital records and those of Dr Oliver and Ms Steindl. In other words, it was not pain resulting from any shoulder injury.

87. The first mention of any shoulder symptoms was by Dr Oliver on 16 September 2016. Although he noted "pain in neck, R shoulder R hip and R lateral calf continue…" he nonetheless recorded a full range of movement in the right shoulder.

88. There were certainly complaints of scapular pain and some arthritic changes in the acromioclavicular joints, but no specific shoulder injury was recorded by either the hospital, Dr Oliver or Dr Clarke until the entry by Dr Oliver to which I have referred above.

89. The changes noted on the bone scan demonstrated "arthritis of *bilateral* [my emphasis] acromioclavicular joints more marked on the right…" which although the radiologist considered "may be due to traumatic injury" Dr Oliver regarded as consistent with years of manual labour.

90. On examination by the various doctors who have seen the applicant over the years, there was no clear evidence of any injury to the right shoulder.

91. I have had regard to the opinion of Dr Bodel in this regard. He found "mild generalised wasting in the right shoulder girdle and… impingement in the right shoulder but no instability."

92. In his supplementary report in November 2018 when he had been provided with some radiological material, he made no comment on any specific findings in relation to the right shoulder, focussing on the neck condition and the fractured ribs.

93. Dr Bodel saw the applicant in September 2018, some years after the incident. Dr Smith saw him on several occasions, most recently in August 2019, almost a year later than Dr Bodel.

94. I cannot account for the findings made by Dr Bodel: they are clearly inconsistent with those made by a number of other doctors. In addition, his opinion must be regarded as flawed to the extent that he was reliant on the history provided to him which was inconsistent with the contemporaneous evidence.

95. Dr Smith's opinion is thorough and he has clearly explained the basis for his opinion and the mechanics of certain injuries.

96. In essence, the applicant has complained over the years of multiple aches and pains in various parts of his body, but with little evidentiary basis for these complaints. It may well be a product of his psychological problems or a manifestation of some sort of chronic pain syndrome, but none of his treating doctors suggest that there is any real basis for these complaints.

97. Indeed, Dr Smith was ultimately of the view that many of the applicant's complaints were manufactured

98. "Injury" is made up of two elements: the "pathology" (pathological change) element, such as a "personal injury" or a "disease contracted" or the "aggravation (etc) of any disease"; and the "circumstance" (or injurious event/incident) element that brings the pathology element within the definition of "injury" (*Lyons v Master Builders Association of NSW* (2003) 25 NSWCCR 422 at [22]).

99. In a case such as this, where a number of frank injuries are alleged, I am thus required to consider whether any pathological changes can be demonstrated resulting from the injuries alleged.

100. The evidence as regards the claimed injury to the right shoulder is at best equivocal and at worst non-existent, having regard to the various medical opinions.

101. Having carefully considered all of the evidence, I am not satisfied that the applicant has discharged the onus upon him of establishing that he sustained an injury to either his lumbar spine or his right shoulder in the incident on 23 February 2016.

102. Accordingly, there will be an award for the respondent in respect of the allegation of injury to the lumbar spine and the right upper extremity (shoulder).

103. The claim pursuant to section 66 in respect of the cervical spine does not reach the relevant threshold so as to entitle the applicant to any benefits.