WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **2524/19**
Applicant: **Jamy Cook**
Respondent: **Farrawell Aluminium**
Date of Determination: **12 September 2019**
CITATION: **[2019] NSWWCC 298**

The Commission determines:

1. I find that there was a material contribution made to Mr Cook's cervical condition by the injury of 12 May 2003. The claim for lump sum compensation to the lumbar spine has been accepted.

2. Therefore, I remit this matter to the Registrar for referral to an Approved Medical Specialist of whole person impairment assessment on the following bases:

   (a) Date of injury: 12 May 2003
   (b) Matters for assessment: lumbar spine and cervical spine
   (c) Evidence:
      (i) ARD and attached documents.
      (ii) Reply and attached documents.

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

John Wynyard
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 JOHN WYNYARD, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Jackson

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

STATEMENT OF REASONS

BACKGROUND

1. Jamy Cook (the applicant) brings a claim for compensation against Farrawell Aluminium, a company which has been deregistered.

2. Mr Cook, who was born in 1970, sustained an injury on 12 May 2003 when he was lifting a 5 metre box weighing about 20kgs onto his right shoulder in his capacity as an aluminium fabricator. When he had the box on his right shoulder, a truck backed into the box and pushed it towards the ground causing him to suffer an acute strain to his lower back.

3. On 22 April 2005 a Certificate of Determination was issued noting an agreement between the parties that the respondent will pay the applicant $11,250 in respect of a 9% whole person impairment (WPI).[1] Although the agreement did not identify the injury for which Mr Cook was being compensated, I assume it was for the right shoulder.

4. Mr Cook now brings an action for lump sum compensation in relation to his lumbar and cervical spine, which he alleges are consequential conditions to the 2003 injury.

5. Section 74 notices issued on 6 December 2018, 10 December 2018 and 4 April 2019 denying liability in relation to the cervical spine. A s 74 notice also issued on 15 September 2014 denying liability for surgical treatment to the cervical spine upon the basis that it was not liable for any constitutional condition.

6. The Application to Resolve a Dispute (ARD) was issued on 22 May 2019 and the Reply on 14 June 2019.

ISSUES FOR DETERMINATION

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

    (a) Is the cervical spine condition consequential to the injury of 12 May 2003?

PROCEDURE BEFORE THE COMMISSION

8. This matter was heard in Port Macquarie on 22 July 2019. Mr Josh Beran of counsel appeared for the applicant instructed by Messrs Schofield King Lawyers and Mr Dewashish Adhikary of counsel appeared for the respondent instructed by Messrs Gair Legal. 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

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

    (a) ARD and attached documents;

    (b) Reply and attached documents.

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[1] Reply 379

Oral Evidence

10. No application was made in relation to oral evidence.

FINDINGS AND REASONS

11. Mr Cook made a statement dated 22 November 2018 which he described both the injury to his back and the subsequent onset of the neck condition. The injury to the back is not in dispute but Mr Cook described how over time the restrictions and pain he experienced in his back continued to worsen. He said that he initially thought that he had pulled a muscle in his back but the pain did not resolve as he expected. He said that in April 2005 he received a lump sum payment, the Certificate of Determination for which was lodged dated 22 April 2004[2]. He said that he was able to work for a time following receipt of that compensation and he worked for about seven months driving his brother-in-law, using Fentanyl patches which increased in strength as time went on. Nonetheless he was unable to continue working because the back pain continued to deteriorate.

12. He has been unable to work since. He said that the pain began in his lower back and right testicle but he would also experience some pain in his legs with some sciatic pain. He continued to believe he would improve but he found that he got worse. He said [at 11] that his current symptoms are of constant pain in his neck and suffering terrible "migraines" as a result of which he has been prescribed Mobic. He described constant pain in the lower back and right buttock, pain in in the muscles in the middle of his back, stabbing pain at the top of his thighs, aching pains behind his knees especially his left knee, numbness in his left foot and stabbing pain in the heel of his right foot if he put pressure on his hamstring. His current condition also has affected his sex life.

13. Mr Cook specifically addressed his neck pain. He said[3]:

> "MY NECK
>
> 16. My neck pain is definitely because of my back.
> 17. There was nothing wrong with my neck before I injured my back.
> 18. Because of my back I have abnormal posture. I lean forward from the hips to try and relieve the pain. This requires me to lift my head (so I am not looking at the ground). This puts strain on my neck.
> 19. Also, my doctor told me that because of the tension and spasms in the muscles in my back it causes my neck pain.
> 20. I can't move my neck. I can't swivel it from side to side. I have to turn my entire body to look at something."

14. Mr Cook said that he constantly had to have Fentanyl patches on 24 hours a day and that he took Mobic when needed. He said that he takes two Panadol Osteo per day and when his pain is really bad he takes Panadol Forte. He said that when combined with the Fentanyl the Panadol Forte "really knocked me out".

15. The first complaint recorded in the documentation was in the clinical notes of Dr Malak of the Rocks Fair Medical Practice. On 15 August 2014 the following entry appears:[4]

> "Jamy was talking about the back pain and a neck pain which is the effect of his posture."

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[2] ARD 5, Reply 379
[3] ARD 31
[4] ARD 23

16. On 18 August 2014 the clinical notes revealed that an xray of the cervical spine was taken by the Mid North Coast Diagnostic Imaging Centre. A Dr M Loff reported:

> "There is a minor cervical curve to the left.
> There is moderate loss of disc height at C5/6
> Small osteophytes are seen at the lower cervical spine with mild encroachment on the right C5/6 foramen.
> There is moderate lower cervical neurocentral and facet joint degeneration demonstrated.
> There are no cervical ribs."

17. Mr Cook's back condition was the subject of considerable medical attention. As early as 2 December 2003 Dr Drew Dixon reported to the then insurer[5] that on examination:

> "There was stiffness of the lumbar segment with forward flexion past his knees with slow recovery and pain on back extension and lateral flexion to the right….."

18. Dr Dixon again commented after reviewing Mr Cook on 23 January 2004 that Mr Cook "has significant stiffness of the lumbar segment with forward flexion to his knees and slow and jerky recovery and pain on back extension"[6].

19. Dr Dixon reported on 8 March 2004, having reviewed Mr Cook on 5 March 2004, that a lumbar discogram and an injection of cortisone had been administered. The stiffness again was commented on following a further review on 7 May 2004 in a report of Dr Dixon of 10 May 2004[7]. The same symptoms were recorded after review on 18 June 2004, namely "lumbar stiffness with forward flexion to his knees and slow and jerky recovery and he does have pain on back extension".

20. On 2 August 2004 Dr Dixon recommended surgical intervention but Mr Cook has resisted such a form of treatment whenever it was recommended to him over the subsequent years.

21. Dr Dixon last saw Mr Cook on 22 February 2005, noting that Mr Cook had decided against surgery and again noting the lumbar stiffness with forward flexion to the knees and slow recovery and pain on back extension.

22. On 18 March 2004 Dr RL Thompson, Consultant Surgeon, reported to the insurer. He took a consistent history and on physical examination reported[8]:

> "The worker presented with little movement of any part of his body today and moved slowly around the consultation room generally.

23. Dr Thompson noted a good lumbar lordosis and no paraspinal muscle spasm as being evident. He said "All movements of the lumbar back were reduced to negligible/zero on account of pain claimed thereat". Dr Thompson noted widespread areas of constant pain which he said would be "difficult to concede on rational clinical grounds". Dr Thompson found some inconsistency on examination and thought that Mr Cook was "at least" less disabled than claimed.

24. Professor Y.A.E Ghabrial reported to Dr Dixon on 20 June 2004[9]. He took a consistent history and on examination said:

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[5] Reply 304
[6] Reply 306
[7] Reply 308
[8] Reply 314
[9] Reply 317

> “Examination of the back on 29 June 2004 showed a protected sitting and standing attitude. There was a list when walking and decreased postural lordosis. The spinal movements were markedly stiff with flexion from the fingertips to above the knee. There was marked paraspinal lumbar spasm……”

25. Professor Ghabrial commented on the investigations, saying that CT scanning of 3 July 2003 showed “defects of the L5 pars interarticularis without any spondylolisthesis.” He thought that feature was probably as a result of stress fractures of the pars interarticularis.

26. A discography followed by CT scanning on 4 March 2004 Professor Ghabrial thought showed a normal L4/5 disc, but rupture of the L5/S1 disc. Professor Ghabrial recommended surgical intervention.

27. On 20 August 2004 Mr Cook was seen by Dr A Adler, Specialist in Rehabilitation Medicine for Mr Cook’s then solicitors. He took a consistent history and on examination found[10]:

> “There is a 50% global reduction of back movements in flexion, extension and lateral flexion. ……’

28. On 15 October 2004 Mr Cook was seen by Dr James Bodel, Orthopaedic Surgeon, at the behest of the insurer. He again took a consistent history and on examination said:

> “Mr Cook is a man of 34 years who is uncomfortable throughout the Interview and he rises slowly. His back is stiff and he is seen to stand erect. There is no spinal deformity or leg length inequality. …”

29. In his opinion Dr Bodel said[11]:

> “This gentleman's complaints are quite genuine and there is definite disc pathology in the lumbosacral region which is leading to the ongoing complaints.”

30. Many years later Mr Cook was referred to the Port Macquarie Chronic Pain Clinic, and on 20 February 2014 Dr Frederik Lips, Pin Specialist, reported to Dr Malak.

31. Dr Lips’ history was consistent although again there was some confusion as to when Mr Cook last worked. Dr Lips thought that Mr Cook had been unable to work from 2012 onwards. On examination Dr Lips confirmed the antalgic gait noted by other medical specialist. He also confirmed that Mr Cook had reduced forward flexion and restricted rotation to the right of his thoracolumbar spine. Dr Lips noted in summary:

> “In case conference with myself, Jeremy Rourke (physiotherapist), and Dr Deborah Hennessey (clinical psychologist), the problem is that surgical opinion has recommended avoiding certain activities that aggravate his pain and this has confirmed a belief in Jamy that further damage and pain can occur in the presence of activity.”

32. A further surgical opinion was accordingly recommended with Dr Steven Ruff and it was recommended that Mr Cook read some books on dealing with pain.

33. Dr Lips noted[12] that walking caused Mr Cook an increase in pain and was done with a guarded gait in a leaning forward posture. While walking was generally better than standing, nonetheless pain occurred after several minutes.

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[10] Reply 321
[11] Reply 329
[12] Reply 362

34. Dr Lips said:

> "The beliefs which Jamy holds regarding movement and activity in his back seem likely to be contributing to the disability he exhibits. These beliefs about movement, (that it should be avoided and poses significant risks to his spine, that if he overdoes it he may require fixative surgery) need to be allayed by a thorough assessment and discussion with a relevant specialist whom Jamy (and his GP) chooses and trusts. I would be surprised if in any such specialists' opinion the changes demonstrated in his lumbar spine preclude him from being able to sit for longer periods, stand up without needing to lean on a wall or even carry a light weight; tasks which Jamy finds most difficult at present. In my view, until these fears about the risks of movement are properly addressed then significant and sustainable improvements in his functional capacity or work tolerances seem unlikely."

35. As indicated above, Mr Cook first reported his neck symptoms on 15 August 2014.

36. On 29 August 2014, Dr Malak reported to the insurer in answer to questions which were not lodged[13]:

> "4. The current presentation of Mr Cook is not attributable to external factors separate from the original incident from 12 May 2003
>
> 5. The back affects the way Mr Cook walks and his posture which causes pain and stiffness of the neck."

37. On 8 August 2015, Mr Cook was seen by Dr Val Kirychenko, an expert in Occupational Medicine, for the insurer. He recorded that Mr Cook was then 45 and divorced, the cause of which he claimed was his continuing back injury. He took a consistent history of the injury and the subsequent medical attention to which I have referred. On examination Dr Kirychenko thought that Mr Cook was mildly confused and had difficulty concentrating. He said[14]:

> "He seemed to be in pain and could not sit for long without getting up. Whilst standing, he would stand on the right leg taking the weight off the left leg".

38. Dr Kirychenko noted that back movement was very restricted, flexion was to 30º and he declined to extend his back. He had a reduced lumbar lordosis and there was spasm in the back muscles on both sides. Muscle wasting was present in the left leg and Dr Kirychenko though that there was pathology in the L4/5 and L5/S1 area of the lumbar spine.

39. He said he discussed the matter with Dr Malak. He said that Dr Malak told him that he had tried every possible treatment apart from operative treatment including physiotherapy, chiropractic, neurosurgical medical opinion, rheumatologist and pain management courses but none of those treatment modalities made any difference. He noted "Dr [Malak] considers that he is very pain-centred and his prognosis is guarded"[15]. In his conclusion Dr Kirychenko agreed and he again thought that spinal fusion was perhaps the only available option.

40. He noted that the high level of narcotic analgesics reduced Mr Cook's cognitive function and he was unable to concentrate to perform certain activities.

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[13] ARD 6
[14] Reply 369
[15] Reply 370

41. On 15 September 2014 a s 74 notice advised Dr Malak that his explanation in a response to a fax from the insurer of 29 August 2014 was not sufficient to establish that there was any link between the cervical spine symptoms and those emanating from the lumbar spine[16].

42. Dr Murray Hyde Page, Orthopaedic Surgeon, was retained by Mr Cook as his medico-legal referee. He first reported on 15 March 2016. He took a consistent history and noted that Mr Cook had not worked since he was driving for his brother-in-law, which Dr Hyde Page recorded as being some five or six years ago (I note that in keeping with the generality of his statement, Mr Cook did not indicate when he undertook that work).

43. Dr Hyde Page recorded "since then he has not work. He has led a very quiet lifestyle. He had ongoing back pain and stiffness. To compensate for this he is taking increase strain through his cervical spine where he now has pain and stiffness as well." Dr Hyde Page noted that the neck and pain stiffness was slowly getting worse particularly with pain on the left side.

44. In his opinion[17] Dr Hyde Page said:

> "[Mr Cook] has developed a secondary cervical spine pain and stiffness with muscle guarding in asymmetrical neck movement and this is related to compensating for his low back pain and stiffness over the last 12 years. He has had no actual injury to his cervical spine and his present cervical spine symptoms are a consequence of favouring or secondary to his lumbar spine injury."

45. On 30 August 2018 Dr Malak reported to his current solicitors[18]:

> "Jamy's back injury sustained on the 12 May 2003 in the course of his employment causes Mr Cook to have altered posture due to the pain, this altered posture in turn has brought about neck pain. We investigated and found moderate lower cervical neurocentral and facet joint degeneration."

46. Dr Hyde Page gave a further report dated 3 October 2018[19]. He recorded:

> "He has had ongoing pain and stiffness in his neck that is slowly getting worse. The pain shoots into the left side of his head where he has had severe headaches. He has no pain shooting down his arms. He finds that elevation of his shoulders and arms aggravates his neck pain and stiffness."

47. On examination whilst noting that Mr Cook had normal neurological examination of the upper limbs, Dr Hyde Page noted that on examination of the shoulders, there were complaints of increased pain in Mr Cook's neck but overall with reasonably full bilateral shoulder movement.

48. In his diagnosis, Dr Hyde Page said[20]:

> "Mr Cook, who is 48 years of age, continues to have marked muscle guarding and stiffness in his lumbar spine and associated left sided radiculopathy with weakness and sensory changes in the SI distribution and positive sciatic tension sign.
>
> He has developed secondary muscle guarding and asymmetrical movement or dysmetria in his cervical spine. I closely questioned him about the onset of symptoms in his cervical spine and these came on a few years after he had injured his lumbar spine, secondary to the marked pain and stiffness and reduced function of his back. He

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[16] Reply 386
[17] ARD 10
[18] ARD 22
[19] ARD 26
[20] ARD 27

did not actually injure his neck and shoulders in the work injury in 2003. However, it is important to note that he has only developed the symptoms in his cervical spine secondary to his lumbar spine injury and severe symptoms and he has no problem or symptoms in his cervical spine in the past otherwise [sic]."

49. Dr Hyde Page noted that over the last two years there had been further deterioration which involved not only increased pain in the neck and back but also evidence of radiculopathy in the left lower limb where muscle wasting and weakness was now apparent.

50. The respondent relied upon the opinion of Dr Richard Powell, Orthopaedic Surgeon. In his report of 14 June 2016 Dr Powell took a consistent history, but noted that he returned to the workplace driving for Mr Cook's brother-in-law occurred in 2007. He noted that further investigations had been carried out in 2009 and 2012, and that further opinions had been obtained from various specialists. On examination, Dr Powell noted that Mr Cook was compliant and cooperative. He said that there was no suggestion of overreaction or exaggeration and that he presented in a fairly genuine fashion[21]. Significantly, Dr Powell only examined the lumbosacral spine which is some confirmation of Mr Beran's submission that Dr Powell was only asked at that stage to give an opinion of the lumbosacral spine.

51. Dr Powell noted that Mr Cook had a "slow, stiff gait with a shortened stance phase on the left side. He had a stick which he held in his right hand". He noted that the range of motion was restricted with forward flexion to the mid thigh and that lateral flexion was only 10^0 bilaterally and rotation was 1/3 the normal range bilaterall.

52. Dr Powell referred to the investigation of the lumbosacral spine. Dr Powell's diagnosis on this occasion was of chronic lower back pain related to degenerative disc disease of the L4/5 and L5/S1. He said[22]:

> "….. examination today was characterised by evidence of significant discomfort, lower lumbar tenderness, marked stiffness and restriction in range of motion and features of a left-sided L5/S1 radiculopathy."

53. Dr Powell supplied a further report dated 25 March 2019 to the insurer. Dr Powell on this occasion referred to the neck. He said[23]:

> "Mr Cook also complains of chronic neck pain. He Indicates pain has been present for many years, though his attention was focused primarily on his lower back symptoms in the past. He describes Intermittent muscular pain and spasms involving the paraspinal and trapezial musculature bilaterally which typically occurs during significant exacerbations of his lower back pain. He is aware of marked stiffness and restriction in range of motion in the head and neck. The neck pain is accompanied by headaches which occur every few days. The symptoms are well localised to the cervical spine and he reports no radiating upper limb pain or paraesthesia."

54. On examination Dr Powell said:

> "Mr Cook was a most compliant and cooperative patient throughout the taking of the history and examination. There was no suggestion of overreaction or exaggeration."

55. Dr Powell noted on examination of the cervical spine that Mr Cook held his neck and head in a slightly stiffened fashion.

56. Dr Powell noted on examination of the lumbosacral spine that "Mr Cook has a slow stiffened gait. He was able to stand on his heels and toes, though with difficulty and discomfort."

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[21] Reply 4
[22] Reply 5
[23] Reply 12

57. In his diagnosis Dr Powell repeated that Mr Cook had developed chronic lower back pain as a result of advanced degenerative disc disease. He noted that examination was:

> "characterised by marked generalised stiffness and restriction in range of motion, as well as persistent features of a left sided radiculopathy.
>
> In addition to his chronic lower back problems, Mr Cook has also complained of chronic neck pain. Clinically this most likely reflects some cervical spondylosis. His examination was characterised by some stiffness and restricted range of motion, though no features of a cervical radiculopathy."

58. Dr Powell said later in his report[24]:

> "From a clinical perspective, the most likely cause of Mr Cook's cervical spine symptoms is some underlying degenerative change in the cervical spine. No investigations were available for review, though I note your letter of Introduction does refer to some investigations performed by Dr Malak which did confirm the presence of degenerative pathology within the cervical spine. This most likely represents a constitutional condition. There is no evidence that Mr Cook sustained a specific injury to his cervical spine in the initial workplace incident in 2003.
>
> Although Mr Cook has experienced chronic lower back pain since that time, there is no causal link between multilevel degenerative lumbar disc disease and multilevel cervical spondylosis. His cervical spine condition is more likely to be constitutional in nature and representative of a degenerative disease process. There is no evidence that his employment represents the main contributing factor in either the development or aggravation of the degenerative disease process nor does it represent a consequential injury."

59. I interpolate at this point to note that as the claim regarding the cervical spine is of a consequential condition caused by the altered gait and posture, which itself was caused by the workplace accident in 2003, the onus is on the applicant only to show that there is a causal link on a common sense evaluation of the evidence between the cervical spine condition and the lumbar spine injury of 2003. Factors such as employment being the main or substantial contributing factor are not relevant.

Submissions

60. Mr Adhikary referred to the reports and certificates issued subsequent to the first complaint of neck pain, noting that no neck injury was mentioned even though Dr Malak had noted that complaint.

61. Mr Adhikary submitted that I would not accept the explanation given at various points in the evidence by Mr Cook that although he had had pain in his neck for many years, his attention was focused primarily on the lower back symptoms. He referred to the reports of Dr Malak and Dr Lips.

62. An email from Dr Malak dated 9 April 2015 to the insurer referred only to the lumbar symptoms. However that email[25], referred to a letter from the insurer to which Dr Malak was replying. Mr Adhikary submitted nonetheless that it was an email written many months after Dr Malak had been told about the condition and that I could therefore infer, as I understood the submission, that Dr Malak did not think it was compensable.

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[24] Reply 15
[25] Reply 350

63. Between page 17 and 293 of the Reply were WorkCover medical certificates covering the period from 2003 to 21 May 2019. All dealt only with the lumbar spine, and none of those issued after Dr Malak became aware of the cervical spine problem on 15 August 2014 mentioned that condition. This was further proof that not even Dr Malak believe the neck condition was compensable.

64. Mr Beran countered that submission by referring to the s 74 notice of 2014 which denied liability for the cervical spine. Mr Beran submitted that Mr Adhikary's criticism of the failure by Dr Powell to investigate the cervical spine in his first report was probably best explained by the fact that Dr Powell was asked only to look at the lumbar spine, as the letter of instruction was not before the Commission. There was no criticism made of Mr Cook's presentation to any of the medical practitioners, and he was accepted as an honest and undemonstrative person. It followed, Mr Beran submitted, that one could accept his evidence that it was his altered gait that brought on the gradual cervical spine problem.

65. Mr Beran said this would explain why there is no reference made in the subsequent certificates issued as liability had been accepted for the lumbar which, as I understood the submission, was all that was necessary to ensure that Mr Cook's compensation rights continued.

66. Mr Beran however submitted that there was support for Mr Cook's assertions notwithstanding that they were so vague and general. This came from the early reports that were lodged by the respondent in the Reply to which I have referred.

Discussion

67. Mr Cook's statement was regrettably not particularly detailed. Whilst he said there was nothing wrong with his neck before he injured his back, he failed to advise when the neck pain first arose. It would appear that there was nothing wrong with his neck for some considerable time after the back injury of 2003. The first mention of it was 15 August 2014 and Mr Adhikary quite reasonably submitted that there could not be shown, even on a common sense analysis of the causal chain, that the onset of the neck pain was linked to the back pain. It was submitted that the opinion of Dr Powell, that Mr Cook was suffering from the aggravation of constitutional degenerative changes in his neck, accorded with reason.

68. It was conceded that there was no complaint recorded about neck pain until 15 August 2014. However, even though that complaint was made, it was submitted that the failure by Dr Malak to include it as a compensable condition thereafter in either his reports or the certificates was an indication that not even he thought the condition was compensable.

69. I did not regard that submission as being particularly helpful. Mr Cook was receiving compensation in relation to the back injury, and whilst it might have been preferable for Dr Malak to mention the neck injury once he was aware of it, he may have not wished to complicate the situation for the receipt of compensation by Mr Cook. Alternatively, as suggested by Mr Beran, it may have been that once the insurer had denied Dr Malak's request to fund x-rays of the cervical spine in its s 74 notice of 15 September 2014, Dr Malak did not then pursue the matter.

70. The question then arises as to what evidence there is to link the onset of neck symptoms to the back condition.

71. I accept Dr Lips' opinion that the source of the chronic pain is Mr Cook's belief that any movement could bring about a catastrophic collapse of his back, requiring surgery. This has been the cause of Mr Cook's strange posture, which I accept has been constant down the years. Indeed, Dr Lips' opinion is the only one which would explain the fact that the medical specialists involved in Mr Cook's treatment down the years have found him to be genuine on presentation.

72. The difficulty in this case is of course that no complaint was made about the cervical spine until 2014 - 11 years following the injury to the lumbar spine.

73. Mr Beran referred me to *Wyllie-Gray v Fitness First Australia Pty Ltd*[26]*,* a decision of Deputy President Snell which contained reference to the relevant authorities and principles, including *Kumar v Royal Comfort Bedding Pty Ltd*[27] and *Kooragang Cement Pty Ltd V Bates*[28]. *Wyllie-Gray* involved a claim for compensation regarding a consequential condition to the claimant's lumbar spine arising from a left hip injury in the course of her employment.

74. The Arbitrator in that case had cited the well known passage in *Kooragang* dealing with causation and the requirement for a "common sense evaluation of the causal chain". The application of that principle to the facts was the subject of the appeal.

75. At [37] DP Snell noted that the question to which the Arbitrator directed herself was "whether the left hip injury materially contributed to [the claimant's] back condition". That question was consistent with authority DP Snell found. In the footnote he referred to the various authorities upon which it was founded.

76. It is convenient to refer to one of those cases, *Murphy v Allity Management Services Pty Ltd*[29], a decision of DP Roche. At [58] he summarised the onus a claimant bears when alleging the existence of a consequential condition. He said:

> "[Ms Murphy] only has to establish, applying the commonsense test of causation (*Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796), that the treatment is reasonably necessary "as a result of" the injury (see *Taxis Combined Services (Victoria) Pty Ltd v Schokman* [2014] NSWWCCPD 18 at [40]–[55]). That is, she has to establish that the injury materially contributed to the need for the surgery (see the discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716)."

77. The solution to the dispute has not been easy, as on one hand common sense would dictate that it was more likely that the onset of such symptoms were the result of the aggravation of degenerative changes unrelated to Mr Cook's employment, as was argued by the respondent.

78. Balanced against that not unreasonable submission, is the fact that the various medical practitioners have found Mr Cook to be genuine and that he has not exaggerated his complaints. Mr Beran submitted that accordingly Mr Cook's credit was not in issue, but Mr Adhikary submitted that the observation by Dr Lips and Dr Kirychenko did raise a question regarding Mr Cook's credibility, which I understood to mean that it will be difficult for a reasonable person to accept that a person who has suffered a back injury could plausibly have developed such an attitude.

79. The Commission does see from time to time injured workers whom the medical experts regard as something of a diagnostic puzzle, in that the symptoms complained of and the restrictions observed appear to have no organic basis, but nonetheless the claimants present as genuinely restricted.

80. Mr Cook does have an organic basis for his back pain. He has pathology at L4/5 and L5/S1 including a transitional L5 vertebrae and the possibility of an L5/S1 slip. Surgery has been recommended by a number of medical experts, but has been rejected, no doubt in part because of Mr Cook's fear.

81. Dr Powell's opinion is soundly based. Although he did not have access to the CT scan taken on 18 August 2014, he noted reference to it by Dr Malak and accepted that his opinion was

supported, which I find that it was, by the presence on the imaging of cervical spondylosis. I accept that such condition is constitutional, but that does not, with respect, answer the relevant question which is as to whether the cervical spondylosis has been aggravated by the strange posture adopted by Mr Cook in his fear of injury. An employer takes a worker as he finds him/her and if it is established that his/her strange afflictions, even if they develop later on in life, were genuine, then the employer is liable.

82. The resolution of this dispute in the final analysis depends on whether Mr Cook's statement can be accepted. He has support from Dr Hyde-Page that the altered posture has brought about the neck condition, and that opinion regarding altered posture is supported by the observations of many medical practitioners down the years.

83. I have referred to the reports from 2004 from the various medical practitioners - Dr Bodel, Professor Ghabrial and Dr Dixon, all of whom remarked on examination on the strange posture in forward flexion adopted by the applicant. Examination results were variously described as "markedly stiff" spinal movements, "global reduction in flexion, extension and lateral flexion", "little movement of any part of his body," dating back to the observations of Dr Dixon in December 2003, who noted "stiffness in the lumbar segment with forward flexion past Mr Cook's knees and slow recovery and pain on back extension and lateral flexion". Bearing in mind that the injury occurred in May 2003, this evidence satisfies me that the chronic pain syndrome described by Dr Lips has been present almost from the outset.

84. I accept that the posture was genuine and probably as a result of the chronic pain syndrome described by Dr Lips in 2015. It becomes quite plausible therefore that if Mr Cook's posture has been compromised continually over the years, then it is quite probable that it would have a consequential effect on his neck.

85. The development of the law regarding consequential conditions is now such that although a claimant is compensated on the basis that he has suffered an injury to the body part described as the consequential condition, the burden of proof to establish such an entitlement is much lighter, as *Willey-Gray* and the cases there referred to demonstrate. The evidence satisfies me that Mr Cook's neck condition has primarily been caused because of the fears described by Dr Lips, which have not been described as a neurosis or a phobia, but as a chronic pain condition. Whatever the proper nomenclature may be for that medical condition, it has nonetheless been caused by the original 2003 back injury. The existence of the condition was demonstrated by the evidence to which I referred since 2003, and therefore it is a material factor in the onset of this condition.

86. Whilst there is some force in the opinion of Dr Powell that after the passage of 11 years it is more likely that Mr Cook is simply experiencing the effects of the cervical spondylosis, in both his reports Dr Powell noted a slow, stiff gait. He did not consider the question of whether the altered gait was connected with the eventual onset of the cervical symptoms.

87. I accept Mr Cook's statement because the evidence satisfies me that he has been restricted in his posture and his gait as a result of the injury of 12 May 2003. He has not worked since 2003 (apart from the short indeterminate date of driving for his brother-in-law) so that he has not been doing any other activities that might have caused the onset of the symptoms for the cervical spondylosis.

88. Accordingly, I find that there was a material contribution made to Mr Cook's cervical condition by the injury of 12 May 2003. The claim for lump sum compensation to the lumbar spine has been accepted.

89. Therefore, I remit this matter to the Registrar for referral to an AMS of WPI assessment on the following bases:

(a) Date of injury: 12 May 2003
(b) Matters for assessment: lumbar spine and cervical spine
(c) Evidence:
    (i) ARD and attached documents
    (ii) Reply and attached documents