WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**1923/20**
Applicant:	**Rainer Rohl**
Respondent:	**Flincept Pty Ltd**
Date of Determination:	**14 July 2020**
Citation:	**[2020] NSWWCC 236**

The Commission determines:

1. The applicant suffered an injury to his left shoulder in the course of his employment with the respondent on 6 January 2009.

2. As a result of the injury referred to in (1) above, the applicant suffered a consequential condition to his left lower extremity in a fall on 28 February 2012.

3. The matter is remitted to the Registrar for referral to an Approved Medical Specialist (AMS) for assessment as to whether the degree of permanent impairment arising from the injury and consequential condition is more than 30%, pursuant to section 32A in the *Workers Compensation Act 1987*.

4. The documents to be referred to the AMS are to include the following:

    (a) This Certificate of Determination and Statement of Reasons;
    (b) Application to Resolve a Dispute; and
    (c) Reply.

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

Cameron Burge
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 CAMERON BURGE, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. On 6 January 2009, Mr Rainer Rohl (the applicant) suffered an accepted injury to his left shoulder when he fell in the course of his employment with Flincept Pty Ltd (the respondent). That injury required surgery, following which the applicant was treated with a combination of medications.

2. On 28 February 2012, the applicant felt dizzy and suffered a fall in his home. He injured his left leg in that fall, necessitating multiple surgeries and culminating in the below-the-knee amputation. The applicant claims this fall and injury were a consequence of the medication he was taking as a result of the accepted left shoulder injury, which he claimed caused the dizziness and precipitated his fall.

3. The applicant was assessed by his independent medical examiner (IME) as suffering 36% whole person impairment as a result of both the left arm and left leg injuries. On 31 March 2020, the respondent issued a section 78 notice disputing the applicant is a worker of highest needs, on the basis the claimed consequential condition to his left leg is not related to the accepted left shoulder injury.

ISSUES FOR DETERMINATION

4. The only matter in issue is whether the applicant's left leg injury and subsequent amputation is a consequential condition of the left shoulder injury. If this is the case, the matter will be referred to an Approved Medical Specialist (AMS) to determine whether the level of the applicant's whole person impairment is greater than 30%. If not, there will be an award for the respondent on the applicant's claim, as his own IME, Dr Guirgis assesses the net whole person impairment of the accepted left upper extremity injury at 10%.

PROCEDURE BEFORE THE COMMISSION

5. The parties attended a conference/hearing before me on 15 June 2020. 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.

6. At the hearing, Mr B Carney of counsel instructed by Mr J Andriano appeared for the applicant, and Mr L Morgan instructed by Ms A Markley appeared for the respondent.

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 (the Application) and attached documents;

    (b) Reply and attached documents.

Oral evidence

8. There was no oral evidence called at the hearing.

FINDINGS AND REASONS

Whether the left leg condition is consequent upon the accepted left upper extremity injury

9. It is trite to say the applicant bears the onus of proving any consequential condition arose as a result of the accepted shoulder injury. The question at issue in this matter is one of causation.

10. The severity of the applicant's left leg condition is not an issue, however, in determining the cause of a consequential condition, the Commission must apply a common-sense test of causation. In the workers' compensation context, the appropriate test was set out by Kirby P (as he then was) in *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452 (*Kooragang*). In the oft-cited passage where His Honour said:

> "The result of the cases is that each case where causation is an issue in a workers compensation claim, must be determined on its own facts. Whether death or incapacity results from the relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from', is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent death or injury, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. **What is required is a common-sense evaluation of the causal chain**. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation." (at 810; emphasis added).

11. The medical background to this matter is largely uncontentious in that there is no question the applicant was prescribed certain medication for both his left shoulder injury and for psychological/psychiatric sequelae. The controversy arises as to whether the mixture of drugs prescribed to the applicant caused the dizziness which led to the fall in which his left leg was injured and ultimately required amputation. The medical history is summarised by Dr Rastogi, Consultant Psychiatrist IME for the applicant in his report dated 16 September 2019:

> "On 6 January 2009, Mr Rohl was unloading a load of timber from the back of the truck and pulling the straps with force when one of the straps gave way. This resulted in him falling backwards on the floor with excessive force. He fell with his arms stretched backwards. He felt a pop in his left shoulder straight away. He did not lose consciousness but reported feeling disorientated for a few minutes...
>
> The pain did not settle and exacerbated with left shoulder stiffness and he was unable to move his left side. He struggled to lie in bed given the excruciating nature of pain. Subsequently he had an ultrasound of the left shoulder on 27 February 2007 [sic] that reported subdeltoid bursitis and partial thickness bursal surface tear of supraspinatus tendon. He had arthroscopic surgery in May 2009 under the care of Dr Burrows who performed reconstruction surgery of torn rotator cuff...
>
> He saw Dr Burrows and X-rays showed displacement of the screws. He had another surgery in November 2009 needing synovectomy, bursectomy and debridement. He received post-operative physiotherapy, but pain persisted and he had restricted movement. He was deemed unfit to work as a truck driver and needed vocational rehabilitation.

Given his poor response to two surgeries with ongoing pain and restricted movement with inability to recommence driving, Mr Rohl was very depressed and was grieving over the loss of career and risk of being disabled. He reported hopelessness, worthlessness and a sense of despair. He was on Tramal XR 200 mg twice a day and oral anti-inflammatory medication. He was commenced on Lovan by his GP and was referred to a psychiatrist Dr Baker who diagnosed with treatment resistant depression. He increased the dose of Lovan to 40 mg and added Risperidone 1 mg with gradual increase in dose to 2 mg in 2011...

Mr Rohl reported feeling lightheaded, muscle twitching, tremor, shakiness and episodic dizziness with feeling of generalised weakness and losing control. He was fearful of falling due to feeling loss of movement. He saw his GP and presented with these non-specific symptoms but was given reassurance and was advised that it was due to low blood pressure.

He had a fall in February 2012 at home due to excessive dizziness and feeling lightheaded when his left leg collapsed and wedged under the sofa sustaining a fracture of shaft of the left tibia and fibula. He needed initial open reduction and internal fixation with screw insertion. The surgery failed and was complicated needing removal and exploration seven times and resulted in having a bone graft and culminating into below knee amputation in 2014."

12. Mr Carney noted that there seemed no dispute between the doctors as to which drugs the applicant had been prescribed. He noted the medication recorded in the report of Dr G Smith, psychiatrist IME for the respondent in his report at page 28 of the Reply. In that report, Dr Smith reported the Emergency Department clinical record of Liverpool Hospital on 28 February 2012 which noted the applicant's fall after feeling dizzy at home and that his medications included Fluoxetine, Risperidone, Panadeine Forte, Mogadon, Adalat, Irbesartan-hydrochlorothiazide and Zydol SR 200 mg nocte.

13. The basis for the applicant's claim of consequential condition is grounded in the report of Dr Rastogi, in which the doctor noted:

> "The fall sustained by Mr Rohl on 28 February 2012 was possibly attributed to side effects of combination of medications he was taking perhaps due to interaction between pain medications and antidepressants. He was on Lovan in 2011 and denied any side effects or presence of dizziness or giddiness at that time…
>
> The combination of antidepressants such as Lovan with Tramal in high doses can result in serotonin syndrome. The combination results in an increase in serotonin levels and it is associated with a range of symptoms such as muscle twitching, headaches, dizziness and muscle weakness and loss of control that Mr Rohl was experiencing at the time whilst being on a combination resulting in a significant fall and associated complications…"

14. By contrast, Dr Smith's view as set out in his report at page 30 of the Reply was as follows:

> "In my opinion, the most relevant documentation regarding the causation of the fall is in the discharge summary from Liverpool Hospital after the fall itself. Mr Rohl had a lengthy admission to Liverpool Hospital where he received treatment after the fall and he was investigated for presyncopal episodes. The conclusion of the medical team after that was that the fall was likely secondary to a presyncopal episode due to postural hypotension. There was a question of whether Risperidone might have contributed to the postural hypotension. There was no documentation regarding serotonin syndrome or any adverse effect of the combination of Fluoxetine and Tramadol that was continued on discharge including with Risperidone 4 mg daily.

Although I agree with Dr Rastogi that the combination of Fluoxetine and Tramadol can be associated with serotonin syndrome, there is no evidence in the available documentation that Mr Rohl had suffered from serotonin syndrome. Therefore, it is not likely that he had suffered from serotonin syndrome and that is not likely a cause of his fall.

On the basis of the documentation, I consider that the most likely cause for the fall was a presyncopal episode due to postural hypotension as documented in the medical notes."

15. The applicant also relied upon a report of Dr Prasad, injury management consultant, dated 24 October 2014 and found at page 17 of the Application. Dr Prasad took a history of the applicant ceasing work in 2010, following which:

> "Mr Rohl was prescribed Tramadol for his pain. He also became extremely depressed and was prescribed Lovan 20 mg by his general practitioner. Mr Rohl's insurer then approved consultations with a psychiatrist for Mr Rohl.
>
> At that time Mr Rohl was taking Lovan 20 mg one tablet daily. However, seeing Dr Baker, his Lovan was increased to 40 mg one tablet in the morning and Risperidone 1 mg one tablet in the morning. He was also still taking his Tramadol.
>
> Mr Rohl, from time to time, felt giddy when taking this medication. When Mr Rohl felt giddy and disoriented, he would stop taking this medication and then after a couple of days when the giddiness subsided, he would start taking it again. His medication was reduced to Lovan 20 mg once daily. In March 2011 his Risperidone was changed to two tablets by his psychiatrist, Dr Baker.
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> On the day of his second injury in February 2012 Mr Rohl was taking his medication, however, he was feeling giddy and disoriented.
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> Mr Rohl fainted at home and as he fell his left leg became wedged under the sofa and consequently broke his leg."

16. Dr Nguyen, Liverpool Health Service gastroenterologist and hepatologist noted in a report to the applicant's general practitioner on 13 February 2013 the history of "collapsed, left distal tibia and fibula fracture March 2012, cause of collapse undetermined with ongoing neurological follow-up complicated recovery from fracture with pin and plate requiring revision, ongoing external orthopaedic framework for leg traction at time of review."

17. Dr Makris, treating nephrologist at Liverpool Hospital, provided a report to the applicant's GP dated 2 March 2013, at which time she described the cause of the fall at issue as "still to be determined."

18. Mr Carney noted that Dr Smith's opinion relied on the hospital notes, however, at page 224 of the Application is a discharge summary for health service which serves:

> "This 53-year-old gentleman presented with a closed fracture of left distal tibia after having a syncopal episode on 28/02/2012.
>
> He has a history of presyncopal episodes in the past, but nil syncope. All associated with postural symptoms.
>
> No further investigations for the presyncope episodes."

Mr Carney submitted this entry establishes there were no investigations as to the cause of the applicant's fall from the point of view of serotonin syndrome. That is, he submitted the syndrome could not be ruled out by virtue of the clinical records.

19. There is some force in that submission, as there are no available investigations conducted by the Liverpool Hospital in relation to potential serotonin syndrome. Rather, the hospital seemed to be content with an explanation of postural symptoms causing the applicant's fall rather than enquiring further as to what the cause of those symptoms may be. The fact the underlying cause of the applicant's fall was not determined during the applicant's prolonged stay in Liverpool Hospital is reinforced by the dual opinions of staff specialists Dr Nguyen and Dr Makris, each of whom described the underlying cause of the fall at issue as unknown.

20. Mr Carney also submitted there was nothing to support the conclusion of postural hypotension. Rather, the investigations carried out by the hospital were more concerned with whether the applicant had suffered a form of epilepsy. Mr Carney submitted that posed a problem in accepting Dr Smith's conclusion, as although the clinical notes referred to postural issues, there is no identification of the underlying cause behind those issues.

21. He submitted that, based upon the reports of Dr Rastogi and Dr Prasad, the Commission would be satisfied that the mixture of drugs which the applicant was taking were the cause of his fall.

22. For the respondent, Mr Morgan noted that the various drugs which the applicant had been prescribed were being taken for more than a year before his fall, and there was no documented evidence of complaint regarding dizziness. He submitted the applicant's statement post-dated the incident and, understandably, looks to explain the cause of the fall after the event.

23. Mr Morgan submitted Dr Rastogi only posits serotonin syndrome as a possible cause of the fall, rather than stating it was the cause on the balance of probabilities. Mr Morgan conceded there was no need for an absolute degree of certainty in establishing the cause of medical outcome, and in that sense conceded that Dr Rastogi's opinion could be enough to establish causation, but only if the treatment background before the fall is sufficient to support the conclusion which the doctor reached. He submitted that was not the case in this matter.

24. Moreover, Mr Morgan submitted the fact the treatment regime in relation to medication did not change after the fall suggests there was no serotonin syndrome present.

25. Mr Morgan also took the Commission to the history recorded by Dr Teoh, treating general practitioner at page 140 of the Application in which there was no mention of serotonin syndrome. Likewise, whilst it is true that the applicant moderated his medication in or about February 2011, Mr Morgan submitted the entry at page 184 of the Application supports an inference that the moderation was in fact linked to financial issues rather than dizziness.

26. In order to succeed, Mr Morgan submitted the applicant must prove the giddiness in the lead up to the fall which led to the left leg injury was associated with the medication he was taking for the accepted shoulder injury. He submitted the applicant did not meet that threshold, as there was no contemporaneous medical evidence establishing a complaint of dizziness or other symptoms ahead of the fall in question.

27. In reply, Mr Carney took the Commission to the applicant's evidence contained at paragraph 25 of his statement, in which he noted that after the fall he stopped taking medication except for Lovan, and the dizziness which he previously experienced had not returned. He submitted this was uncontested evidence and important as a persuasive factor concerning the cause of the applicant's dizziness.

28. On balance, I am satisfied that the applicant's fall which led to his left leg injury was a consequence of the accepted left shoulder injury. I prefer the views of Dr Rastogi and Dr Prasad to those of Dr Smith. Dr Smith's opinion is predicated on the assumption the records of Liverpool Hospital rule out the presence of serotonin syndrome in the applicant. In my view, the records do no such thing, as the hospital did not undertake testing for serotonin syndrome in the aftermath of the fall. In my view, that presents a difficulty in accepting Dr Smith's report, for the reasons already set out at [18]-[20] above.

29. Moreover, I accept the applicant's evidence in his statement that when he stopped taking the medication he was using before the fall save for Lovan, his dizziness stopped.

30. I note the history taken by Dr Prasad that, even before the fall in issue, the applicant would from time to time cease taking his medication when he felt dizzy, and his symptoms would improve after a couple of days, whereupon he would resume taking them. Although Dr Prasad's report is some two years after the fall, the history he takes from the applicant is consistent with that later given by the applicant in his statement. Each of the history to Dr Prasad and the statement are consistent with the known effects of the combination of drugs the applicant was taking before the 2012 fall.

31. Each of those histories is in turn consistent with that provided to Dr Guirgis, IME for the applicant. At page 12 of the Application, Dr Guirgis records the following:

> "The problems in his left shoulder and his inability to go back to work made him extremely depressed and was prescribed Lovan 2Qmg by his general practitioner. Mr Rohl's insurer then approved consultations with a psychiatrist and he was referred to Dr Baker who advised increasing the Lovan to 40mg and added Risperdal 1mg one tablet in the evening. He was also still taking his Tramadol These medications were making him feel giddy.
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> The giddiness eventuated into his consequential injury in February 2012, when he fell down at home and his left leg became wedged under the sofa sustaining a fracture of the shafts of the middle third of the left tibia and fibula."

32. The medical experts in the matter agree that the mixture of drugs the applicant was prescribed could cause serotonin syndrome and giddiness. Applying a common-sense test of causation as set out in *Kooragang*, taking into account that consensus view, I find Dr Rastogi's view is supported by and consistent with the applicant's lay evidence, which is uncontested.

33. I also take into account the evidence of the applicant in his statement to the effect he told his GP Dr Teoh about his dizziness. Although Dr Teoh's notes do not make specific reference to the dizziness, it is noteworthy he made it clear to the applicant he was only treating him for the workplace shoulder injury and was not responsible for prescribing other medication. Nevertheless, Dr Teoh's notes do contain a number of references to warnings being provided to the applicant as to the effects of the medication he was taking, albeit the majority of those warnings are recorded in general terms, whilst others relate to the addictive nature of Panadeine Forte.

34. The contention by Dr Rastogi that the mixture of drugs taken by the applicant can cause dizziness and serotonin syndrome is not disputed by the respondent's IME. The cause for the fall posited by Dr Rastogi is in my view consistent with the applicant's lay evidence as to the effects of the medication upon him, and I accept the applicant's statement he told GP Dr Teoh about the dizziness. Whilst Dr Teoh's records do not record specific warnings about dizziness, they do contain repeated warnings as to the interactions between prescribed drugs.

35. As noted, I am of the view Dr Prasad's report is also supportive of a finding the medication caused the dizziness, recording as he does an accurate history as to the effect of the medication on the applicant before the 2012 fall. The history of the medication having affected the applicant before the fall in question by causing dizziness supports on a common-sense basis a finding the medication was the cause of the fall.

36. Contrary to Dr Smith's contention, the hospital records do not rule out serotonin syndrome. Rather, the records do not assist with a diagnosis as to the cause of the fall I 2012. That much is borne out by the reports of treating hospital specialists Dr Makris and Dr Nguyen, each of whom wrote reports to the applicant's GP indicating the cause of the fall is unknown. Had the hospital been able to diagnose the cause of the fall, I have little doubt Drs Nguyen and Makris would have been privy to those findings.

37. The mere description of the fall as presyncopal or syncopal does not assist the Commission as to its cause. Rather, those terms simply describe the state of either almost or actually losing consciousness, including but not limited to symptoms of dizziness. In relying on that description as the cause of the applicant's fall, Dr Smith has not actually taken the matter any further than providing a medical description of the agreed mechanism of the fall. Although Dr Smith then attributes those symptoms to postural hypotension (low blood pressure) there is no pre-fall history of hypotension. Indeed, the clinical notes reveal the applicant had issues with high blood pressure, for which he was taking medication. It was not until the applicant was in hospital after the 2012 fall that his blood pressure was low. The clinical records predating the fall instead reveal a man who periodically required medication for high blood pressure. Absent an explanation as to why the applicant allegedly suffered low blood pressure int eh lead up to his fall, contrary to the rest of his medical history, I do not prefer Dr Smith's opinion.

38. For the above reasons and taking into account all of the medical and lay evidence, I am satisfied that the applicant's left leg condition occurred as a consequence of the left shoulder injury. As noted, I have taken into account the hospital records, records of the treating general practitioners, the views of Dr Guirgis, Dr Smith, Dr Prasad and Dr Rastogi. Having taken each of those matters into account in examining the evidence on a common-sense basis, I find that there is a causal link between the accepted injury and the fall which caused the left leg injury necessitating eventual below the knee amputation.

SUMMARY

39. For the above reasons, the Commission will make orders as set out on page 1 of the Certificate of Determination.