WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **5736/20**
Applicant: **Melissa Bonnefin**
Respondent: **JMB – JOBNET**
Date of Determination: **5 February 2021**
Citation No: **[2021] NSWWCC 39**

The Commission determines:

1. The applicant suffered injury to her lumbar spine and left lower extremity (hip and leg) in the course of her employment with the respondent on 23 June 2012.

2. As a consequence of the injury referred to in (1) above, the applicant was totally incapacitated for employment from 18 August 2014 to 18 February 2017.

3. The respondent is to pay the applicant weekly compensation as follows:

    (a) From 18 August 2014 to 17 November 2014 pursuant to section 36 of the *Workers Compensation Act 1987* at the rate of $1,563.70 per week, as appropriately indexed where appropriate.

    (b) From 18 November 2014 to 18 February 2017 pursuant to section 37 of the *Workers Compensation Act 1987* at the rate of $1,316.80 per week as appropriately indexed where appropriate.

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.

L Golic

Lucy Golic
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. On 23 June 2012, Melissa Bonnefin (the applicant) was assisting a co-worker to transfer an obese, post-cardiac surgery patient in the course of her employment with JMB-Jobnet (the respondent). There is no issue the patient began to fall and grabbed the applicant around her lower back, causing injury and pain requiring medical attention.

2. The applicant brings a claim for weekly benefits between 18 August 2014 and 18 February 2017, which is disputed by the respondent on the basis the applicant's incapacity is not caused by the injury at issue.

ISSUES FOR DETERMINATION

3. The only issue for determination is one of causation. That is, whether the applicant's incapacity was caused by the alleged injury.

4. By section 74 Notice dated 12 September 2012, the respondent's insurer disputed liability on the basis the applicant had not suffered an injury as defined in section 4 of the *Workers Compensation Act 1987* (the 1987 Act) and that her employment was not a substantial contributing factor to the injury. The fact of an injurious event was not, however, disputed at hearing. Rather, the respondent argued the nature of the applicant's injury did not cause her incapacity for the period in issue.

5. At the hearing, the respondent sought to rely on a *novus actus interveniens* (that is, an intervening act which severs the chain of causation between the workplace incident and a subsequent state of affairs). The alleged intervening act was said to be the actions of a doctor who performed a manipulation on the applicant after the workplace incident. The respondent alleged that treatment was grossly negligent.

6. The applicant opposed the respondent's application to rely on the intervening act, noting the defence was not raised in the section 74 Notice and that it was first sought to be raised some eight years following the workplace incident at issue, without prior notice.

7. After hearing submissions from both parties, the respondent's application to raise a *novus actus* as a defence was refused, and the dispute limited to the question of causation.

PROCEDURE BEFORE THE COMMISSION

8. The matter was listed for a conciliation/arbitration hearing before me on 16 December 2020. On that occasion, Mr B McManamey of counsel appeared for the applicant instructed by Mr S Butcher solicitor. Mr R Hanrahan of counsel instructed by Mr A Davis solicitor appeared for the respondent.

9. The respondent's Application to Admit Late Documents (AALD) was admitted over objection, but only insofar as the documents attached to it go to the question of causation, not to any separate issue sought to be raised by way of *novus actus*. Additionally, given the voluminous records attached to the AALD, it was agreed that only documents specifically referred to by counsel in their submissions would be taken into account.

EVIDENCE

Documentary evidence

10. The following documents were before the Commission and taken into account in reaching this decision:

    (a) Application to Resolve a Dispute and attached documents (the Application);
    (b) Reply and attached documents;
    (c) Applicant's AALD and attached documents dated 4 December 2020, and
    (d) Respondent's AALD and attached documents dated 11 December 2020.

Oral evidence

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

FINDINGS AND REASONS

12. The applicant bears the onus of proving that her claimed periods of incapacity were caused by work-related injury. In determining whether that is the case in the workers compensation context, the appropriate test for causation was set out by Kirby P (as he then was) in *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452 (*Kooragang*) where His Honour said at [810]:

> "Whether therefore incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from', is now not 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 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 compensation." (emphasis added)

13. The common-sense approach to causation as set out in *Kooragang* nevertheless requires a careful analysis of the evidence in any given matter.

14. In order to properly analyse the chain of causation in this matter, it is necessary to briefly set out a lengthy series of events leading up to and including the claimed period of incapacity.

15. As already noted, there is no issue that on 23 June 2012 the applicant suffered injury when a patient whom she was assisting lost balance, panicked and grabbed her about her waist, twisting the applicant's hips and lower back. The applicant was admitted to Royal North Shore Hospital that day and remained overnight. Before attending hospital, the applicant attempted to continue working, however, she was unable to do so and left her shift early.

16. The applicant states that she continued to suffer severe muscle spasms and pain in her left hip and back region. At [19] of her statement, the applicant recited her attendance at Dalcross Hospital and recorded the following history:

> "On 28 June 2012, I was seen by Dr Ayscough, whom I initially thought was an orthopaedic surgeon but I was told later that was not the case. He was accompanied by the nursing unit manager. Dr Ayscough told me to sit on the side of the bed, with my legs dangling, and I did so. He sat on the other side of the bed, behind me, and asked me to bend forward he then ran his thumbs down my back, either side of my spine and over my pelvis so that he was feeling the top of my hips. After he did this,

he commented to himself and the nursing unit manager words to the effect: 'yes, it's the SI-joint'. My mother, Leanne Bonnefin, was asked to leave the room. Dr Ayscough told me to lie on the bed, face down with the pillow underneath my hips so my pelvis was higher than the rest of my body. He then pulled my left leg up behind me so that my knee was bent and the sole of my foot was facing the roof. Then, without any warning, he pulled my legs and hips slightly out of the socket and then forcefully drove my thigh into my hip socket, holding my calf in the back of my thigh whilst doing it.
20. The force was so strong it felt my leg was being pushed through my pelvis into the bed. I screamed out loudly in pain. My mother heard me scream from the far end of the corridor. I felt extreme pain shoot down the outside of my left leg, across my lower back and down the outside of my right leg. I also felt extreme internal left hip pain. I heard Dr Ayscough say 'shit' at this time."

17. After the manipulation, the applicant states her left hip pain was particularly severe, much worse than had been beforehand. She was given pethidine injections regularly thereafter.

18. On 29 June 2012, the applicant underwent an MRI at Dalcross Hospital which showed the presence of 3-4 cm ovarian cyst. It was thought the ovarian cyst may be causing the applicant's ongoing pain and discomfort. In early July 2012, the applicant underwent a left ovarian cystectomy. She was discharged home on 6 July 2012.

19. The applicant then continued to suffer severe pain on the left side of her hip, upper leg, back and abdomen. She was readmitted by ambulance to Sydney Adventist Hospital where she remained for approximately one week as her mobility improved. Upon her discharge home, the pain in the applicant's left leg increased again and she was once again transferred to hospital where she remained until late July 2012.

20. In early August 2012, the applicant states she was at university when she passed out following palpitations. She was admitted to Royal Prince Alfred Hospital where, on 9 August 2012 she was again found face down on the floor, unconscious and unresponsive. Among the investigations which followed her collapse at the hospital was an MRI of the left hip and pelvis reported on by Dr Shnier, who identified quadratus femoris impingement. In late September 2012, the applicant had an ultrasound-guided injection of the quadratus femoris muscle to reduce swelling which was apparently compressing her sciatic nerve.

21. The applicant continued her recovery, and in November 2012 began a return to work as a nurse on modified duties.

22. In late 2012, the applicant was offered a job at the Harley Street Clinic in London as a paediatric intensive care nurse. As she felt better following the steroid injection into her hip, she decided to take this job and commenced employment there in December 2012. Throughout 2013, the applicant continued to have medical issues including but not limited to severe abdominal pain consequent upon bowel impaction which she alleges she first suffered following treatment received at Dalcross Hospital after the work-related incident.

23. In or about July-August 2013, the applicant began to have slowly increasing left leg pain. She states there was no specific incident which accounted for the increase in pain, and her work duties at that time were relatively light. On 21 August 2013, the applicant was admitted to the Princess Grace Hospital, London for surgery at the hands of Dr Curry. That surgery consisted of a release of the left sciatic nerve and partial excision of the lesser trochanter. Postoperatively, the applicant suffered complications by way of spasms in her left hip and an avulsion fracture of the lesser trochanter, a haematoma in her groin and a severe iliopsoas tendon tear.

24. In February 2014, the applicant was seen by Dr Ponsford for nerve conduction studies which allegedly confirmed sciatic nerve dysfunction affecting both peroneal and tibial divisions. Later that month, she was readmitted to hospital and had a transforaminal epidural block and ultrasound-guided Botox injection into her left hip, which she states gave her some temporary relief of pain. In July 2014, the applicant was again admitted to hospital where she underwent an L4/5 and L5/S1 epidural nerve block with a lidocaine and Botox injection into the muscle of her left hip.

25. In approximately April 2014, the applicant returned to work as a paediatric intensive care nurse, however, she found work too difficult given the problems she was having and stopped working in August 2014.

26. The applicant continued to have difficulties in relation to her back and left hip, including further injections under general anaesthetic on 12 September 2014. She states there was little to no improvement in her symptoms.

27. Eventually, and owing to lack of improvement in her medical condition, the applicant self-discharged from hospital on 1 October 2014 and, with the help of her family, arranged for a medical transfer flight to Australia, returning on 10 December 2014.

28. Since her return to Sydney in December 2014, the applicant has continued to see many doctors and specialists owing to the symptoms in her back, left hip and, she alleges, consequential conditions to her right hip. Since her return, the applicant has had left hip stabilisation surgery in February 2015, right hip stabilisation procedure on 4 May 2015 and surgery to her left foot on 13 July 2015.

29. In or about March 2017, the applicant consulted Dr Mobbs, neurosurgeon who suggested she consult a pain specialist. Following a fall at a shopping centre in June 2017 which she attributes to a sudden onset of pain down her left leg and loss of power in both lower limbs, the applicant was taken to hospital by ambulance where she underwent a procedure to stretch the iliopsoas tendon. Following this procedure, the applicant was transferred to North Shore Private Hospital for pain management at the hands of Dr Nathan Taylor, pain specialist. She states that at this time she was experiencing severe left leg dystonia as often as four times a day, often lasting for three hours at a time.

30. The applicant had a spinal cord stimulator inserted on a trial basis to manage her left sciatic pain, however, it worsened. Notwithstanding that experience, the applicant was readmitted to North Shore Private Hospital and consented to the insertion of a permanent spinal cord stimulator. She states she experienced severe pain postoperatively, and a week later was taken back to theatre and the middle anchors of the stimulator were removed and replaced with stitches. She complained of severe left leg dystonia daily.

31. Three months after this admission to North Shore Private Hospital, the applicant underwent hip surgery involving the release of the sciatic nerve at the hands of Dr Paul Stalley. Dr Stalley found that the applicant's peroneal nerve had accidentally been stitched to the back of her hip capsule during surgery at the hands of Dr Sean Curry in August 2013. The applicant said Dr Stalley's surgery led to some improvement for a time, before increasing symptoms returned.

32. By 2018, the applicant had consulted Dr Pope, neurosurgeon who noted a history of left buttock and lower limb pain for over six years. In June 2018, neurologist Dr John Parratt diagnosed left leg dystonia due to sciatic nerve dysfunction and arranged for transforaminal epidural steroid injections under sedation into the sciatic nerve roots. The applicant states that after those injections the dystonia episodes stopped, and she was discharged after a seven-week admission.

33. Approximately two weeks after her discharge, the applicant states the left leg dystonia returned. By August 2018, the applicant states that her condition had worsened to the point where she was experiencing full body dystonia and the episodes were lasting for several hours at a time. She was administered transforaminal epidural steroid injections from L3/4 to S1/2 which provided good relief of the left leg dystonia, however, the brain dystonia which she states causes full body seizure-like symptoms still occurs two to three times per day. According to the applicant, Dr Parratt informed her the brain dystonia had developed due to her being in constant long-term pain from 2012.

34. In her statement, the applicant provides history from February 2019 to the date of her statement in 2020 of ongoing episodes of dystonia.

The applicant's submissions

35. Mr McManamey took the Commission to the triage form from Royal North Shore Hospital dated 23 June 2012, the date of injury. The presenting information on that occasion was as follows:

> "Lumbar back pain for past three days. Pain described as shooting pain down legs at times. Commenced after lifting heavy objects Thursday, today bent over and onset of severe pain. HX chronic back pain. O/E distressed with pain at triage".

36. Mr McManamey noted that the history of lumbar back pain for three days was incorrect, but otherwise the entry accurately described the applicant's symptoms at that time. He then referred to the Dalcross Adventist Hospital notes of the following day, which recorded the following, accurate history:

> "Was helping patient at work yesterday and patient grabbed her suddenly – low back pain –…legs giving away and…bladder urgency."

37. Progress notes from 25 June 2015 refer to a loss of strength in both lower limbs causing a fall which a staff member witnessed.

38. Mr McManamey submitted that these entries all evidenced early clinical recording of not only hip and back pain, but problems with the applicant's legs as soon as the day of and immediately after the incident at issue. He referred to an entry on 26 June 2012 in the Dalcross notes referring to severe thoracic and lumbar spine pain and knees giving way when walking. By 27 June 2012, the notes recorded the applicant remaining very unsteady when mobilising and requiring assistance at all times.

39. The applicant submitted her complaints with respect to low back and leg issues are clearly borne out as early as the 25 June 2012 in the history provided in the MRI report of that day. The relevant history was "workplace injury with severe thoracolumbar pain spasm and some decreased leg power." The findings of that MRI were that the thoracic and lumbar spine canal was widely patent throughout and the spinal cord appeared normal with no visible evidence of signal change or external compression.

40. Mr McManamey submitted there was no basis for finding the presence of ovarian cysts were the cause of the applicant's ongoing problems. He noted that years after those cysts were removed, she continued to suffer from symptoms in her abdomen, lower back, hips and legs. He said the report of Dr Drummond, Independent medical Examiner (IME) for the respondent who attributed the applicant's problems to the ovarian cysts should be discounted both because Dr Drummond does not explain how such a diagnosis was within his area of expertise as an orthopaedic surgeon; or how, given the removal of the cysts as early as July 2012, the applicant has continued to suffer symptoms in her back, hip, buttock and legs for many years afterwards.

41. Mr McManamey referred to the report of Dr Harvey-Sutton dated 7 December 2012, in which the doctor noted the applicant continuing to suffer pains in her lower back and into the left buttock region which become worse during the day and which were aggravated by activity. She complained of pains down the left thigh and into the left calf together with numbness down the back of the left thigh and into the calf and the outside of the left foot. On examination, Dr Harvey-Sutton noted the presence of an antalgic gait and neurological abnormalities in the lower limbs with less left ankle reflex than on the right. The doctor noted reduced sensation over the lateral aspect of the left foot with positive nerve root tension tests and diagnosed clinical radiculopathy.

42. Mr McManamey submitted the contemporaneous evidence clearly disclosed significant problems suffered by the applicant shortly after the workplace injury at issue. He submitted that throughout the applicant's time in London and since her return, the problems have continued and have indeed worsened.

43. In terms of the manipulation carried out by Dr Ayscough, Mr McManamey submitted that conditions suffered as a consequence of treatment are part of a workplace injury unless there was gross negligence sufficient to establish an intervening act, a defence not at issue in these proceedings. He noted the respondent was not granted leave to plead a *novus actus*. He submitted there was insufficient evidence for the Commission to determine Dr Ayscough's actions were grossly negligent and referred to the High Court decision in *Lindeman Ltd v Colvin* (1946) 74 CLR 313 (*Colvin*).

44. Mr McManamey then submitted that the Commission would accept the findings of Dr Bodel in his supplementary report dated 30 November 2020 in which the doctor opined that the workplace injury and manipulation were both causative of the requirement for treatment of the applicant's injury in the United Kingdom.

45. In summary, the applicant submitted the causal chain had been established and that on a common-sense basis, the Commission would find on the balance of probabilities that the applicant's incapacity for employment, which is not an issue, was brought about by the workplace injury at issue.

The respondent's submissions

46. Mr Hanrahan submitted that a common-sense chain of causation had not been established by the applicant. He said the mechanism of injury was unclear despite the applicant's version of events being put before the Commission in her statement. He submitted that in making that statement, the applicant had considered all of the events and put her statement together. In so submitting, Mr Hanrahan was not being critical of the applicant, rather he suggested it was a natural human trait to attribute matters post-fact to events which had taken place in circumstances where there is uncertainty as to their actual causation.

47. Mr Hanrahan submitted that from a comparison of the applicant's history in her statement with those provided to the various doctors, it is not clear at all which body parts were initially injured at work.

48. With respect, I do not accept that submission. It is apparent from the contemporaneous records of Royal North Shore Hospital, Dalcross Hospital and Sydney Adventist Hospital that even before the manipulation at the hands of Dr Ayscough, the applicant was experiencing pain and weakness in her legs, hip and low back.

49. Mr Hanrahan submitted there was a lack of connection between the initial strain experienced by the applicant and the enormous symptoms which she now experiences. He noted that even Dr Bodel said the applicant's condition is very complex.

50. The respondent submitted that there was a lack of sufficient causal connection between the work injury and the applicant's current condition, and the real issue was whether a muscular strain to the applicant's back was such that by examining the causal chain on a common-sense basis there is a nexus between what was experienced in the period of incapacity and what happened in the workplace.

51. Mr Hanrahan submitted there are number of incidents which potentially affect the causal connection between injury and incapacity in this case, namely:

    (a) the manipulation carried out by Dr Ayscough, which Mr Hanrahan submitted was grossly negligent;

    (b) the ruptured ovarian cysts which were removed shortly after the manipulation, and

    (c) various incidents in the United Kingdom including but not limited to a mugging referred to in the applicant's statement.

The applicant's submissions in reply

52. Mr McManamey accepted the respondent's proposition that other factors may have contributed to the applicant's current condition. However, he said the ultimate finding on a common-sense basis would be that the workplace injury took place and that treatment on and for that injury has in turn seen further symptoms flow from the injury. He submitted it was open to the respondent to bring evidence that the applicant's condition is due to other causes, but it has not done so. He noted that once the fact-finding exercise moved beyond Dr Drummond, the Commission was left with both Dr Bodel and Dr Higgs each of whom explain that the applicant's condition is complex, however, both agree the workplace injury is a causal factor in her current problems.

Consideration

53. On balance, I find that the applicant's incapacity for employment was and is a result of the workplace injury. The respondent having failed to raise a defence of intervening act until after the commencement of proceedings, is precluded from relying on that defence for the reasons set out above.

54. In my view, the contemporaneous records in the immediate aftermath of the workplace incident reveal the applicant suffering from low back, hip, pelvis and leg issues including but not limited to pain, discomfort and a sensation of her legs "giving way". In carrying out the manipulation at Dalcross Hospital, Dr Ayscough was treating the very symptoms complained of by the applicant, and in my view adopting a common-sense approach to the causal chain as required in *Kooragang* leads me to the conclusion on the balance of probabilities that the incapacity complained of was caused by the workplace injury at issue.

55. The respondent's submission that on a common-sense basis a strain injury cannot account for the severe nature and extent of the applicant's symptoms does not address the contemporaneous difficulties experienced by the applicant in the immediate aftermath of her workplace injury. The evidence discloses Dr Ayscough was of the view the applicant was suffering from sacroiliac joint issues and it was on that basis he proceeded to undertake the manipulation. In so doing, Dr Ayscough was directly addressing and treating the symptomology of which the applicant complained as a result of the workplace injury which had taken place very shortly before the manipulation took place.

56. The difficulty with the respondent's submission regarding intervening matters effecting the causal chain is the applicant presented with back and hip pain together with weakness and giving way in her legs before any of the manipulation, removal of ovarian cysts or incidents in the UK took place. True it is that following the manipulation the applicant's symptoms worsened, however, that manipulation was treatment being carried out directly on and for the symptoms caused by the workplace injury.

57. In *Colvin*, the worker was an employee of Lindeman Ltd who suffered a head injury and was unable to work for several months. He received worker's compensation payments. Whilst Mr Colvin was receiving treatment for his head injury in hospital, a doctor told him it would be a good idea to start walking to build up his strength. One day, while following his doctor's advice, Mr Colvin fell down the stairs and broke his leg. The cause of that fall was a pre-existing medical condition which made his bones brittle. At first instance, the Tribunal held that it was nonetheless a Workers Compensation claim, because Mr Colvin had fallen while performing treatment for his work injury consequent on medical advice. On appeal, the High Court unanimously held that the injury was not related to Mr Colvin's employment and that in order to be compensable, there needed to be a causal connection between the first injury and the second. The Court did not accept the mere fact Mr Colvin's doctor had recommended walking was enough to establish such a connection. Rather, Mr Colvin's leg injury was caused by bone disease, not by the head injury. The Court determined that he could just as easily have suffered the same injury at home.

58. Mr McManamey submitted, and I accept, that the circumstances of this case are distinguishable from those in *Colvin*. Here, Dr Ayscough was directly treating the workplace injury suffered by the applicant and the body part in issue. Therefore, there was a causal connection between the initial workplace injury and the consequences of Dr Ayscough's treatment. In this matter the applicant was being treated for the very injury which she had suffered, and the worsening of her symptoms as a result of that treatment forms part of the chain of causation.

59. I do not accept Dr Drummond's opinion that the applicant's symptoms were caused by ovarian cysts. The doctor's reports date from September 2012 and January 2013 respectively. The cysts were removed in July 2012. If those cysts were the cause of the applicant's symptoms as Dr Drummond indicated, one would expect those symptoms to have resolved once they were removed. Instead, the applicant's symptoms persisted and indeed worsened over time. Moreover, Dr Drummond is an orthopaedic surgeon, and it is unclear how his diagnosis regarding the cause of the applicant's problems fits within his speciality.

60. In my view, there is insufficient evidence to satisfy me that the manipulation carried out by Dr Ayscough was, as Mr Hanrahan submitted, "grossly negligent." Indeed, to the extent that phrase potentially gives rise to a defence of *novus actus*, the respondent is precluded from relying on it.

61. Although Dr Higgs provided a report in the Supreme Court medical negligence proceedings brought by the applicant against Dr Ayscough, those proceedings were discontinued by the applicant and no findings were made as to the question of Dr Ayscough's alleged negligence. Moreover, at page 7 of his report (respondent's AALD at p.115), Dr Higgs opined that the applicant's spinal issues were likely caused by the workplace injury at issue and attributed the hip problems to what he categorised as unreasonable treatment by Dr Higgs.

62. This conclusion by Dr Higgs does not, in my view, account for the hip and leg symptoms which the applicant was experiencing before the manipulation by Dr Ayscough. Moreover, the complaints arising from the work injury were the very subject of Dr Ayscough's treatment of the applicant at Dalcross when he performed the manipulation.

63. Understandably, Dr Higgs report does not address the question of a causal connection between the workplace injury and the applicant's ongoing symptoms which caused her incapacity, because he was requested to address only the question of the reasonableness or otherwise of Dr Ayscough's treatment of the applicant. Given Dr Higgs has in my view failed to sufficiently taken into account the existence of hip and leg symptoms post-injury but pre-treatment, I find his report is of limited value to the Commission in the exercise of its role in determining the existence or otherwise of a causal connection between injury and incapacity.

64. Dr Bodel, IME for the applicant, had regard to the opinion of Dr Higgs, and indeed a number of treating doctors. Having described the complex clinical history of the applicant, Dr Bodel concluded at page 12 of his report:

> "I strongly suspect that the correct diagnosis of injury at that time therefore is a musculoligamentous strain involving the lower part of the back (the lumbosacral junction) and also damage to the left sacroiliac joint. There may have been some sciatic nerve irritation…
>
> That fairly simple and straightforward diagnosis has changed dramatically over time as a result of the other interventional treatment that has occurred in an attempt to try and relieve her initial pain."

65. When asked to categorise the applicant's initial injury, Dr Bodel said:

> "The initial incident and injury as far as I can determine, was a soft tissue musculoligamentous strain to the lower part of the back and possible irritation of the sciatic nerve in the region of the quadratus femoris behind the neck of the femur on the left hand side.
>
> There may have been a sacroiliac joint strain."

66. In terms of the applicant's ongoing condition, Dr Bodel stated "the current clinical condition has indirectly arisen as a consequence of the very poor outcome of the attempted treatment of the original injury." In reaching that conclusion, Dr Bodel in my opinion accurately sets out the applicant's clinical condition, and in doing so he importantly takes into account, unlike either Dr Drummond or Dr Higgs, the fact the applicant was suffering from symptoms in her hip, pelvis and leg as well as her back before being treated by Dr Ayscough.

67. It is trite to say that a poor outcome from treatment does not equate to negligence, let alone gross negligence sufficient to sever a chain of causation from an original injury. Sadly, it is not uncommon for patients to suffer unsatisfactory outcomes without any fault on the part of the doctor who carried out treatment upon them.

68. On balance, I am satisfied the preponderance of the medical and lay evidence establishes a common-sense causal connection between the injury at issue and the applicant's relevant incapacity. In so finding, I have had regard to the IME and treating medical material. Although the respondent sought to classify the applicant's injury as a simple back strain, that categorisation in my opinion does not take into account the spontaneous complaints of hip pain together with leg pain and weakness in the immediate aftermath of the injury at work. Dr Ayscough was treating these symptoms when he carried out the manipulation of the applicant. As such, I am of the view the applicant has established on the balance of probabilities a chain of causation between the injury and the incapacity at issue.

69. For the above reasons, I find that on a common-sense basis, there is a causal connection between the workplace injury at issue and her claimed incapacity.

Incapacity

70. The fact the applicant has been totally incapacitated for work during the period claimed is not in issue. The dispute in this matter related to only the question of causation. This being so, and having found in the applicant's favour on that question, I find as a result of her workplace injury, the applicant was totally incapacitated for employment from 18 August 2014 to 18 February 2017, being the expiration of 130-week period set out in section 37 of the 1987 Act.

71. As a result of these findings, the Commission will make the orders set out at page 1 of the Certificate of Determination.