WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **4086/19**
Applicant: **Heughan Su**
Respondent: **OSI Foods Pty Limited**
Date of Determination: **11 October 2019**
Citation:

The Commission determines:

1. The applicant did not sustain an injury to his left shoulder on 12 August 2005.

2. The applicant's lower digestive tract condition is not a consequence of spinal surgery or spinal cord damage which results from the injury sustained by the applicant on 12 August 2005.

3. The applicant's lower digestive tract condition is a consequence of his intake of opioid medication which results from the injury sustained by the applicant on 12 August 2005.

The Commission orders:

1. This matter is remitted to the Registrar for referral to an Approved Medical Specialist (AMS) as follows:

Date of injury:	12 August 2005
Body Parts:	Lumbar spine; scarring (left wrist); lower digestive tract (consequential condition)
Method of Assessment:	Whole Person Impairment

2. The following documents are to be referred to the AMS:
   (a) Application to Resolve a Dispute and attachments, with the exception of the report of Dr Lai dated 5 March 2019;
   (b) Reply and attachments;
   (c) Application to Admit Late Documents filed by the applicant on 23 August 2019, and;
   (d) The Statement of Reasons from this Certificate of Determination.

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

John Isaksen
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 ISAKSEN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Heughan Su, claims that he sustained injury to his lumbar spine, left wrist, left thumb, left elbow, left shoulder and left knee when he slipped and fell on two occasions on 12 August 2005 whilst employed with the respondent, OSI Foods Pty Limited.

2. The applicant has made a claim for 52% permanent impairment as a result of injury to the lumbar spine and left upper extremity, and a consequential condition affecting his lower digestive tract due to the effects of spinal surgery that he underwent on 3 November 2017, spinal cord damage due to the injury to the lumbar spine and/or taking opioid medication.

3. The respondent admits that the applicant sustained injury to the lumbar spine and left hand and wrist but disputes that the applicant sustained injury to the left shoulder or that the applicant's lower digestive tract condition is as a consequence of the work injury of 12 August 2005.

ISSUES FOR DETERMINATION

4. The parties agree that the following issues remain in dispute:

    (a) Whether the applicant sustained an injury to his left shoulder on 12 August 2005, and

    (b) Whether the applicant has a lower digestive tract condition that is as a consequence of the injury the applicant sustained on 12 August 2005.

PROCEDURE BEFORE THE COMMISSION

5. The parties attended a conference and hearing on 3 October 2019 at Penrith. 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. Mr Horan appeared for the applicant, instructed by Ms Grant-Nilon. Mr Rickard appeared for the respondent.

7. A claim made by the applicant that he sustained a consequential condition affecting his left shoulder was withdrawn by the applicant at the commencement of the arbitration.

8. Mr Rickard for the respondent relied upon Regulation 44 of the Workers Compensation Regulation 2016 to object to two forensic medical reports being admitted into evidence by the applicant, being the reports of Dr Berry dated 13 March 2019 and Dr Min Fee Lai dated 5 March 2019. Dr Berry describes himself as a "Specialist General Surgeon". Dr Lai writes that he practises in "General Surgery, Plastic and Reconstructive Surgery".

9. The applicant has been treated by many specialists over the years for the injuries that he sustained on 12 August 2005, including orthopaedic surgeons and a neurosurgeon. He was treated for his left hand and wrist injury by Dr Nicholas Smith, who writes that he practices in "Upper Limb Reconstructive Surgery". Although Dr Lai states that he practices in "Reconstructive Surgery", no further information was provided to me that would allow me to conclude that Dr Lai specialised in upper limb reconstructive surgery.

10. Regulation 44 (3) provides:

> "(3) Where the injury has involved treatment by more than one specialist medical practitioner, with different qualifications, then an additional forensic medical report may be admitted from a medical practitioner with qualifications in that specialty."

11. Given that I could not be satisfied that Dr Lai had qualifications in the same specialty as Dr Nicholas Smith, I did not admit the report of Dr Lai into evidence.

12. I also observed when making this ruling during the arbitration that Dr Berry did assess impairment of the applicant's left upper extremity, and expressed no limitation on his ability to make such an assessment.

EVIDENCE

Documentary evidence

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

    (a) Application to Resolve a Dispute and attached documents, with the exception of the report of Dr Lai dated 5 March 2019;

    (b) Reply and attached documents, and

    (c) Application to Admit Late Documents filed by the applicant on 23 August 2019.

Oral evidence

14. There was no application to cross examine the applicant or to adduce oral evidence.

FINDINGS AND REASONS

Whether the applicant sustained an injury to his left shoulder on 12 August 2005

15. There are two statements in evidence from the applicant, dated 15 August 2006 and 8 August 2019.

16. In his statement dated 15 August 2006 (which is included in the Reply), the applicant states that on 12 August 2005, he and two co-workers were directed to break up ice that had formed in a large freezer with a crow bar and sledge hammer. He states that while chipping away at the ice he slipped and fell on his back. He states that he got up and slipped again and landed on his face and "injuring my left wrist, left elbow, left knee and lower back." He states that he reported the injury but continued on working that day and "noticed that my neck and shoulders started aching."

17. In that statement dated 15 August 2006 the applicant also states:

> "I continue to suffer from severe pain and restriction of my lower back, my left wrist and my neck, as well as my left knee. I am having severe difficulties using my left hand and am now forced to wear a brace on my hand."

18. In his second statement dated 8 August 2019, the applicant states that following the two falls at work on 12 August 2005 "I suffered immediate pain in my wrists, mostly my left hand and wrist, my left elbow, left knee and my lower back." The first reference to problems with the left shoulder in that statement is when the applicant states that he felt immediate and strong pain in his shoulders when he was pulling himself out of bed about two weeks after undergoing lower back surgery (which was in November 2017).

19. The claim form completed by the applicant on 22 August 2005 states that the parts of his body that were injured were “wrist, back.”

20. The entry of clinical notes on the first occasion that the applicant attends his general practitioner, Dr Chin, on 23 August 2005, records low back pain “up to both shoulders”, and a sore left wrist running up to the elbow, and a sore left knee.

21. The applicant was referred to Dr Hale, orthopaedic surgeon, and saw the applicant on 27 September 2005, some six weeks after the subject injury. Dr Hale records that the applicant said he injured his lower back, left wrist and left knee, and makes a diagnosis of left medial meniscus tear, low back pain and ganglion left wrist.

22. In a later report dated 19 December 2005, Dr Hale records the applicant having pain radiating upwards from his low back to his thoracic spine, neck and towards the left shoulder.

23. In February 2007, the applicant was referred by the Commission to Dr Assem, Approved Medical Specialist, to assess permanent impairment of the cervical spine, lumbar spine and left upper extremity (wrist and shoulder) resulting from the injury on 12 August 2005. Dr Assem records that the applicant sustained injury to his lower back, left wrist and left knee but “did not report any other injuries.” Dr Assem recorded a full range of movement of the shoulders and “no rateable impairment.”

24. There is no mention of an injury to the left shoulder in a report from Professor Ehrlich dated 8 September 2006 or in reports from Dr Guirgis dated 5 March 2009 and 16 March 2009. There is no record of an injury to the left shoulder in a report from Dr Conrad dated 25 May 2006, although he does record that as a result of the two accidents on 12 August 2005, the applicant has continued to suffer left shoulder pain.

25. Dr Berry in his report dated 13 March 2019 records that the applicant injured his left wrist, left elbow, left knee and low back on 12 August 2005, but there is no reference to the left shoulder being injured. Dr Berry records that the applicant found that his shoulder was very painful after he woke from surgery to his left wrist in 2005.

26. The second fall that the applicant had on 12 August 2005, whereby he fell forward and his left arm impacted on a hard, cold surface, was certainly capable of causing injury to the left shoulder. The applicant in his first statement states that he noticed aching in his shoulders as he continued to work that day following the incident. I would accept that it is not unusual for the full impact of an injury not to be immediately apparent to the person who is injured and for symptoms to manifest themselves over the hours following an injury.

27. However, the weight of evidence does not support a finding that the applicant did sustain an injury to the left shoulder. The first piece of contemporaneous evidence following the incidents of 12 August 2005 is the claim form completed by the applicant on 22 August 2005, which states that the body parts that he injured were the wrist and back. There is no mention of an injury to the left shoulder.

28. There is no record of an injury to the left shoulder on the first occasion that the applicant attends Dr Chin after the incidents, although there is a record of pain going up from the lower back to the shoulders. However, I could not locate any reference to a left shoulder injury or even left shoulder symptoms in the clinical notes of Dr Chin for the ensuing 12 months.

29. There is no record of an injury to the left shoulder in the history recorded by Dr Hale some six weeks after the subject injury.

30. The applicant in his own statements does not state that he injured his left shoulder at the time he fell. He does state that his shoulders started aching later that day as he continued to work and I have already acknowledged that the full impact of an injury might not be immediately apparent to a person who is injured. However, the details in the claim form completed by the applicant and the history obtained by treating doctors support a finding that the applicant did not sustain an injury to his left shoulder on either or both of the two occasions when he fell on 12 August 2005. That finding is enhanced by there also being no history of injury to the left shoulder that is recorded by Dr Conrad in May 2006, by Prof Ehrlich in September 2006, by Dr Assem, Approved Medical Specialist, in February 2007, or by Dr Guirgis in March 2009.

31. The referral by the Commission for an assessment of permanent impairment in February 2007 did include an assessment of the left shoulder. Mr Rickard submits that this was a mistake and no estoppel can arise from this referral. Mr Horan did not argue against that, although submits that there was evidence available in 2007 that allowed for the referral of that body part for assessment.

32. The respondent disputes that the applicant did sustain an injury to his left shoulder on 12 August 2005 and there has never been a previous determination on this issue. I agree with Mr Rickard that the referral for assessment of the left shoulder in 2007 does not amount to an estoppel. The evidence that I have summarised overwhelmingly supports a finding that the applicant did not sustain an injury to his left shoulder on 12 August 2005. There will be an award for the respondent for that claim.

Whether the applicant has a lower digestive tract condition that is as a consequence of the injury that he sustained on 12 August 2005

33. The applicant underwent a L4-S1 decompression laminectomy and instrumented spinal fusion from L4 to L5 on 3 November 2017, performed by Dr New.

34. In his statement dated 8 August 2005, the applicant states that about three weeks after that surgery he began to experience pain in the upper abdomen and had severe constipation whereby he could not move his bowels for four to five weeks. In early 2019, he was referred to Dr Kwok, a specialist in gastroenterology and hepatology.

35. The applicant was admitted to Norwest Private Hospital from 12 February 2019 to 23 February 2019, under the care of Dr Kwok, for investigations and management for his severe constipation. The applicant underwent an endoscopy, CT scan and a colonic transit study. In a report to the applicant's solicitors dated 19 August 2019, Dr Kwok states that he reviewed the applicant daily during this 12-day admission. He also writes that he has not seen the applicant since his discharge from hospital, despite attempting to follow up the applicant.

36. Dr Kwok writes that an upper endoscopy revealed an incidental finding of heliobacter pylori gastritis and a colonoscopy was unremarkable. However, the colonic transit study found the applicant's colonic transit to be extremely slow, with 75% of ingested food that was not absorbed being still present in the large bowel at day five.

37. Dr Kwok writes that he changed the applicant's analgesic medication from Endone to Targin, as Targin should theoretically not cause constipation, and then tried to reduce the applicant's intake of Targin. However, Dr Kwok records that the pain was so severe that the applicant could not sleep or mobilise and after 48 hours the usual analgesia doses were recommenced.

38. Dr Kwok opines that "the spinal surgery has probably made Mr Su's constipation worse." He writes that spinal surgery is associated with constipation but cannot comment on whether this occurred during the spinal surgery or whether there was pre-existing cord damage. He writes that "I am satisfied other causes of constipation have been ruled out."

39. Dr Kwok also writes that opioid medications are well known to cause constipation, although the use of Targin should reduce the effects of constipation.

40. In an earlier report to the applicant's general practitioner, dated 20 February 2019, Dr Kwok reports on his treatment of the applicant whilst admitted to Norwest Private Hospital and opines: "His slow colonic transit is related to his spinal surgery and the associated need for opioid analgesia."

41. Dr Berry, in his report dated 13 March 2019, writes that the report from Dr Kwok dated 20 February 2019 confirms "diffuse slow colonic transit consistent with nerve damage." Dr Berry opines that the applicant has "neurological interference with the function of the large bowel" and assesses 25% permanent impairment due to colonic loss of function and moderate to severe exacerbations of bowel disturbance.

42. The applicant was examined by Dr Truskett, surgeon, on 26 April 2019 at the request of the solicitors for the respondent and has provided a report dated 29 April 2019. Dr Truskett states that one of his areas of interest is gastrointestinal surgery and that he was a founding member of the ANZ Gastro-oesophageal Surgical Association.

43. Dr Truskett records that the applicant became progressively more constipated some three to four weeks after his spinal surgery in 2017.

44. Dr Truskett assesses 0% permanent impairment for the applicant's lower digestive tract for the following reasons:

> "Colonic transit is a complex entity. There is intrinsic neural complex providing motility within the wall throughout the bowel. These are modified by parasympathetic fibres carried by the vagus nerve and by sympathetic fibres supplied by the superior mesenteric plexus and the hypogastric plexus. These received fibres from the lesser and lower splanchnic nerves which are supplied from T9 to L2. There is no relationship to these nerves as relates to his back surgery as his back surgery is greatly remote from this area of nervous activity. He does suffer from diabetes. Low transit time is a known complication of diabetes due. to neuropathy. He has demonstrated some signs of peripheral neuropathy in both lower limbs as examined today.
>
> On the balance of probability, his slow transit time is more in keeping with his diabetes as a complication and there is no relationship to his back injury or its management.
>
> Causation of lower digestive tract disease cannot be established."

45. Dr Truskett does not comment on whether the applicant's slow colonic transit is at least partly caused by his intake of analgesic medication. However, Mr Rickard for the respondent submits that even if that be a cause of slow colonic transit, there can be no permanent impairment caused by this condition because Chapter 16 of the "NSW workers compensation guidelines for the evaluation of permanent impairment" provides:

> "Constipation is a symptom, not a sign and is generally reversible. A WPI assessment of 0% applies to constipation."

46. Mr Rickard submits that although the applicant states that he started to experience severe constipation soon after the spinal surgery, there needs to be more than a temporal connection between the two events and there is not sufficient evidence to draw that causal link. Mr Rickard submits that the more likely cause of the applicant's slow colonic transit, which is identified by Dr Truskett, is his diabetic condition, which he has been suffering from for many years.

47. Mr Horan for the applicant asks me to prefer the opinion of Dr Kwok, given that he is the applicant's treating specialist and had the opportunity of observing the applicant throughout the 12 days that the applicant was admitted to hospital in February 2019.

48. I am of the view that particular regard should be had to the opinion of a treating specialist because of their unique role in the care and treatment of the patient. However, the difficulty I have with the opinion of Dr Kwok, at least so far as it relates to his opinion that spinal surgery or spinal cord damage is associated with the applicant's constipation, is that he does not identify what part of the spinal cord or what part of the spinal surgery has caused this constipation to occur. This is in contrast to Dr Truskett, who explains that if colonic transit is to be affected by damaged nerves in the spine, then that would be from the T9 to L2 level, whereas the applicant's back surgery was at a lower level that is remote from the area of nervous activity that would affect colonic function.

49. It is not apparent as to whether Dr Kwok in providing his report dated 19 August 2019 had a copy of the report of Dr Truskett. The report of Dr Truskett was included in the section 78 notice dated 28 May 2019, so that Dr Kwok certainly had the opportunity of commenting on the opinion of Dr Truskett and to provide his own opinion as to whether surgery at the L4 to S1 level or spinal cord damage at an identifiable location was the likely cause of the slow colonic transit that the applicant suffers from.

50. In *Hevi Lift (PNG) Ltd v Etherington* [2005] NSWCA 42 McColl JA (Mason P and Beazley JA agreeing) said at [84]: "It has been long been the case that a court cannot be expected to, and should not, act upon an expert opinion the basis for which is not explained by the witness expressing it." I am not satisfied that the applicant's constipation is a consequence of the spinal surgery which he underwent when Dr Kwok has not fully or adequately explained his reasons for this opinion. Similarly, I am not satisfied that the applicant's constipation is a consequence of any spinal cord damage when Dr Kwok is not able to identify the location of the spinal cord damage and how that then causes bowel dysfunction.

51. I prefer the opinion of Dr Truskett because he provides a cogent explanation as to what parts of the spine can affect bowel function and explains that those parts of the spine are not where the applicant underwent surgery or where he sustained injury.

52. I am given no assistance by the opinion of Dr Berry. Dr Berry merely states that there is "neurological interference with the function of the large bowel" without identifying with any more precision where that neurological interference is located at or what is the cause for such interference.

53. Nor is any assistance provided by Dr New, who operated on the applicant's lower back, and who may have been able to provide an opinion as to the causal link between the surgery that the applicant underwent or the injury to the applicant's spine, and the subsequent onset of quite severe constipation. There is only one report in evidence from Dr New that post-dates the surgery (dated 12 April 2018) and there is no mention in that report of difficulties that the applicant was having with constipation.

54. In his report to the applicant's general practitioner dated 20 February 2019, Dr Kwok opines that the applicant's slow colonic transit is also related to his need for opioid analgesia. He states he deliberately changed the applicant's analgesic medication to Targin because it is known to reduce the effects of constipation, but despite this the applicant has continued to suffer severe constipation. Although in his further report dated 19 August 2019, Dr Kwok concentrates on the effects of the spinal surgery as the cause of the applicant's constipation, he retains the opinion that the use of opioid medication can also be a cause of the applicant's constipation.

55. Dr Kwok has not been able to adequately explain how the spinal surgery or spinal cord damage has been a cause of the applicant's constipation, but I do consider that Dr Kwok's treatment, management and observation of the applicant during the time that he was admitted to hospital in February 2019 allows me to accept his opinion that the applicant's continuing intake of opioid medication is a cause of his constipation. This is despite his own concession that the use of Targin should reduce the effects of constipation.

56. The use of opioid medication need not be the only cause for the applicant's constipation. As DP Roche in *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49 (*Murphy*) said at [57]:

> "…a condition can have multiple causes (*Migge v Wormald Bros Industries Ltd* (1973) 47 ALJR 236; *Pyrmont Publishing Co Pty Ltd v Peters* (1972) 46 WCR 27; *Cluff v Dorahy Bros (Wholesale) Pty Ltd* (1979) 53 WCR 167; *ACQ Pty Ltd v Cook* [2009] HCA 28 at [25] and [27]; [2009] HCA 28; 237 CLR 656)."

57. There is no opinion that contradicts that of Dr Kwok. I acknowledge the submission made by Mr Rickard that the guidelines for the evaluation of permanent impairment mandate against a referral for permanent impairment because an assessment of whole person impairment of 0% applies to constipation. However, an arbitrator has no role in the assessment of permanent impairment. Once I am satisfied that the applicant has sustained an injury (or in this instance, a condition that is as a consequence of a work injury) then it is for an Approved Medical Specialist (AMS) to make an assessment of permanent impairment.

58. It may be that an AMS will opine that the applicant's constipation is a symptom only and assess impairment at 0%. Dr Kwok has, however, identified a 'sign' in the finding of slow colonic transit in the study that was undertaken in February 2019 and in my view the applicant is entitled to have an AMS assess whether the applicant has permanent impairment of the digestive tract due to his intake of analgesic medication, given that I accept that this is as a consequence of the injury that the applicant has sustained to his lumbar spine.