WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **182/20**
Applicant: **Peter John Browning**
Respondent: **Manildra Flour Mills (Manufacturing) Pty Ltd**
Date of Determination: **8 April 2020**
Citation: **[2020] NSWWCC 112**

The Commission finds:

1. I am not satisfied on the balance of probabilities that the applicant suffered injuries to his lumbar and thoracic spines on 28 December 2015.

2. Award for the respondent on the claims for lump sum compensation and medical expenses.

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

NICHOLAS READ
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 NICHOLAS READ, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Peter Browning was employed by Manildra Flour Mills (Manufacturing) Pty Ltd, the respondent, as a maintenance fitter/fabricator.

2. On 28 December 2015, Mr Browning suffered an injury lifting a steel grate at the top of a silo.

3. From around October 2016, Mr Browning started to experience worsening back pain and referred pain to his left leg. Subsequent investigations revealed a damaged disc in Mr Browning's lumbar spine for which he underwent surgery.

4. Mr Browning made a claim for lump sum compensation and medical expenses, including the surgery. The respondent conceded Mr Browning had suffered an injury to his abdomen (hernia) but disputed the claimed injuries to Mr Browning's thoracic and lumbar spine.

ISSUES FOR DETERMINATION

5. During the conciliation/arbitration the issues for determination were agreed as follows:

   (a) whether Mr Browning suffered an injury to his lumbar and thoracic spines in the course of his employment on 28 December 2019;

   (b) whether the medical expenses claimed by Mr Browning, including the surgery performed by Dr David Bell on 15 September 2017, are reasonably necessary medical expenses resulting from the injury, and

   (c) whether Mr Browning has an entitlement to lump sum compensation pursuant to section 66 of the *Workers Compensation Act 1987* (the 1987 Act)?

6. It is agreed between the parties that if I find issue (a) in Mr Browning's favour, an award will follow on the claim for medical expenses.

7. It is also agreed that is I find in favour of Mr Browning on issue (a) the matter is to be remitted to the Registrar for referral to an to assess the degree of permanent impairment of the injury.

8. The key issue in this matter is one of factual and medical causation. In other words, whether there is adequate evidence that provides a basis for accepting Mr Browning suffered an injury to his lumbar and thoracic spines on 28 December 2015.

Matters previously notified as disputed

9. The issues were notified in a notice issued under sections 74 and 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) dated 8 December 2016, 14 November 2017 and 31 May 2018. At a teleconference leave was granted to the respondent to raise the issue of whether Mr Browning suffered a specific injury to his thoracic spine.

PROCEDURE BEFORE THE COMMISSION

10. The parties attended a conciliation conference and then arbitration on 10 February 2020.

11. Mr Tony Baker of counsel appeared for Mr Browning. Mr Ross Hanrahan of counsel appeared for the respondent.

12. I was satisfied that the parties to the dispute understood the nature of the application and the legal implications of the assertions made in the information supplied. I used my best endeavours to attempt to bring the parties to the dispute to a settlement acceptable to all of them. I was satisfied that the parties had sufficient opportunity to explore settlement and that they were unable to reach an agreed resolution of the dispute.

EVIDENCE

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

    (a) the Application to Resolve a Dispute (ARD), and attachments, and
    (b) the Reply, and attachments.

14. There was no application to adduce oral evidence or to cross-examine any witness.

EVIDENCE

15. Mr Browning was employed by the respondent as a maintenance fitter/fabricator and welder.

16. On 30 December 2015, Mr Browning suffered an injury when lifting a grill from the top of a silo. Mr Browning completed an injury report in which he recorded the details of the injury as "pulled muscle in stomach area whilst pulling out a small grill in the top of silo for repair" (Reply page 63).

17. On 5 January 2016, Mr Browning attended the Dr Steven Peterson, general practitioner. Mr Browning complained of straining his stomach bending over to pull up a grill (Reply page 434). The record states that Mr Browning reported some muscular pain, however no specific complaint was made of back pain or leg pain.

18. In a statement dated 6 November 2019 Mr Browning provided more detail in respect of his injury:

    > "On 29 December 2015, whilst at work, I was working at the top of the silo. My job on the day was to remove a cumbersome and awkward metal grate and get it to the workshop for repairs and modifications. It was a very difficult job. I was working alone. The metal grate measured approximately 900mm square and it was set to prevent falling down into the silo. I was working in an awkward situation, hands and knees possibly try to put the great out.
    >
    > I was jolting and forcibly the great which was below the lid by 100mm. It was a difficult job because I was working on my hands and knees and at the same time reaching forwards and downwards, manually handling the grate.
    >
    > At the time I felt significant pain and strain in my abdomen, and it was a very uncomfortable feeling" (ARD page 1).

19. Mr Browning carried the grate down a number of steps to a workshop to undertake repairs on it.

20. Mr Browning said he struggled with pain and had difficulties sleeping and shortly afterwards he was diagnosed with a hernia. Surgery was recommended.

21. Mr Browning continued to work with modified duties up until the surgery on 11 March 2016. The surgery was undertaken by Dr Robert Knox, colorectal surgeon.

22. After the surgery on 29 March 2016, Dr Knox completed a certificate of capacity in which he said Mr Browning was unfit for work from 11 March 2016 to 18 March 2016 and would be fit for suitable duties from 18 March 2016 to 13 April 2016, with lifting restrictions (Reply page 166).

23. On 13 April 2016, Dr Knox certified Mr Browning as being fit for suitable duties. The certificate recorded that Mr Browning "would be" fit to resume full duties from 28 April 2016 (Reply pages 66, 164).

24. In his statement, Mr Browning said he was never able to return his preinjury duties, but returned to work on light duties (ARD page 2). Mr Browning's evidence is not consistent with the evidence from the respondent's workers. However, the respondent's evidence is simply based on the certificate of capacity and not on observations of Mr Browning returning to work and carrying out work tasks (Reply pages 34, 39).

25. On or around 12 September 2016 Mr Browning sustained a further strain to his abdominal muscles and right groin. He completed an injury report which stated: "Strain to abdomen muscles, obviously not fully healed from recent hernia operation." The form stated the injury was caused by overstraining and lifting heavy loads (Reply pages 53,42).

26. Mr Browning saw Dr Tim Chen, general practitioner, who certified him as having capacity to work with restrictions from 19 September to 27 September 2016 (Reply page 141).

27. On 23 September 2016, Mr Browning had and ultrasound on his abdominal wall and groin. The clinical history on the ultrasound report said "abdominal muscle and right groin strain" (ARD page 32).

28. On 27 September 2016, Dr Chen referred Mr Browning for physiotherapy treatment (ARD page 43).

29. On 18 October 2016, Dr Chen certified Mr Browning as being fit for preinjury duties on 19 October 2016 (Reply page 56).

30. According to Mr Cain, Mr Browning's former supervisor, did not recall Mr Browning returning to preinjury duties after the aggravation injury on 12 September 2016 (Reply page 39).

31. In his statement, Mr Browning said "despite the surgery for the hernia" he began to notice that his left leg was giving way and that he was suffering mild, but bearable back pain. Mr Browning did not provide any precision as to the timing of the onset of this pain but said that when it became troublesome, he saw Dr Levi, general practitioner (ARD page 2). The first reports of Dr Levi are on 4 October 2016 and 13 October 2016 (ARD pages 107-108).

32. The clinical record of Dr Levi of 4 October 2016 records that Mr Browning complained of muscle weakness, varying paraesthesia and abdominal pain. The note recorded that Mr Browning reported tingling in his feet after sitting and in his hands regularly. The note also recorded that Mr Browning continued to experience pain from the lifting incident on 28 December 2015 in his left side in proximity to the hernia. The note recorded that Mr Browning was "very definite" that the pain came on during the lifting incident, and not after the hernia operation. Mr Browning reported that the pain was worse after eating and was never completely absent (ARD page 108).

33. On 12 October 2016, Mr Browning had an MRI scan on his cervical spine in order to identify whether the cause of the tingling in his hands was due to nerve radiculopathy from his cervical spine. The MRI report identified no significant disc lesion or other cause for neural compromise (ARD page 33).

34. On 13 October 2016, Mr Browning saw Dr Levi. The clinical notes record that Mr Browning complained of abdominal pain that was "inside" and not in the spinal muscles or in abdominal wall. Dr Levi undertook a musculoskeletal examination of Mr Browning's lumbar spine and recorded there were normal movements other than forward flexion, which was limited by pain (ARD page 107). Dr Levi referred Mr Browning to Professor Mark Arnold, a rheumatologist in Dubbo for further investigations.

35. On 13 October 2016, Dr Chen certified Mr Browning as having no capacity to work due to "recurrent abdominal pains" (Reply page 134).

36. On 18 October 2016, Dr Chen certified Mr Browning as being fit for pre-injury duties from 19 October 2016 (Reply page 127).

37. On 25 October 2016, Dr Levi referred Mr Browning to Dr Hugh Lukins, general and vascular surgeon, for examination of his left sided abdominal pain. The referral letter stated that Mr Browning's abdominal pain was a deep persistent pain and was usually worse after eating and prolonged sitting and sometimes radiated to his back (ARD page 46).

38. One 8 November 2016, Mr Browning saw Dr Levi complaining of worsening back and abdominal pain, which radiated down the back of his leg to below the knee on his left side (ARD page 104).

39. On 23 November 2016, Mr Browning returned to Dr Levi continuing to complain of left leg pain. Dr Levi referred Mr Browning for a CT scan of his lumbar spine in order to identify whether pain down the back of his legs was caused by lumbar spine radiculopathy (ARD page 102).

40. On 23 November 2016, Mr Browning had a CT scan on his lumbar spine. The CT scan identified a left paracentral L5/S1 disc extrusion displacing and compressing the S1 nerve root (ARD page 35).

41. On 12 October 2016, Mr Browning had a CT-guided injection to treat his back pain.

42. On 31 January 2017, Dr Levi referred Mr Browning to Dr David Bell, orthopaedic surgeon. In a referral letter Dr Levi referred to Mr Browning's worsening pain in his left leg (ARD page 67).

43. In a report dated 1 June 2017, Dr David Bell took a history that Mr Browning's left leg sciatica had started in October 2016 and ran down the back of his left leg to his calf and it was thought in an S1 distribution pattern. Dr Bell said Mr Browning's pain was not improving and the CT-guided injection had provided limited relief. Dr Bell said Mr Browning's symptoms were undoubtably due to the disc herniation seen on the CT scan and said he thought Mr Browning would need an operation in the form of a left L5/S1 discectomy (ARD page 63).

44. On 15 September 2017, Mr Browning had surgery in the form of a lumbar spinal discectomy.

45. Dr Bell reviewed Mr Browning following the surgery. In a report dated 9 November 2017 Dr Bell said:

> "I'm pleased to report that he is improving. The wound has healed nicely. The pain doesn't go down to his foot anymore. The pain only now goes down into his hamstrings. It is not completely resolved, but it is a lot better than it was preoperatively, and he is requiring much less medication.
>
> I explained to Peter that the nerve had been squashed for a long time, and there probably some residual nerve damage..." ARD page 62).

46. Mr Browning said he continued to suffer from back pain which radiated into his left buttock and intermittently into his left leg. He said he sometimes requires the use of walking stick (ARD page 2).

47. Mr Browning said he was of the view that the initial abdominal pain "masked" the symptoms in his back (ARD page 3).

Medical opinion evidence

48. The respondent relied on a forensic medical report from Dr John Bosanquet, orthopaedic surgeon.

49. In a report dated 20 April 2018, Dr Bosanquet recorded that since his lumbar spine surgery Mr Browning was no longer experiencing the deep abdominal pain he had previously complained about. Dr Bosanquet said Mr Browning continued to complain of low back pain and pain in his left buttock with radiating into the leg to the left knee and slightly beyond (Reply page 384). Dr Bosanquet recorded there was no past history of back injury (Reply page 385).

50. Dr Bosanquet said there had been no specific injury to Mr Browning's lumbar spine. He said:

> "I have scanned the literature looking for a connection between deep abdominal pain and intervertebral disc prolapse. This is seen in lower thoracic disc prolapse and in one case in the upper lumbar spine at L1/2 to my knowledge there has been no recorded history of abdominal pain caused by disc lesion at L5/S1. If there has been no specific injury to his spine then the L5/S1 disc prolapse is coincidental. The other possibility is that the abdominal pain was caused by another disc lesion more proximately in the thoracic spine. This is unlikely as it requires yet another pathology to explain his symptoms" (ARD page 386).

51. Dr Bosanquet opined that Mr Browning's work was not the main contributing factor to his L5/S1 disc lesion (Reply page 306).

52. In a further report dated 16 May 2018 Dr Bosanquet noted there was no contemporaneous report of an injury to Mr Browning's back. Dr Bosanquet opined that in his clinical experience of over 40 years an acute rupture of a lower lumbar disc causing sciatica is always accompanied by pain in the back, which was not reported by Mr Browning (Reply page 388).

53. Dr Bosanquet maintained his view that there was no history of injury or contribution from Mr Browning's employment and therefore employment was not a substantial contributing factor to the injury (Reply page 389).

54. Mr Browning relied upon forensic medical reports from Dr WGD Patrick, general and vascular surgeon, trauma surgeon and medicolegal specialist.

55. In a report dated 20 December 2018, Dr Patrick recorded the history of Mr Browning's injury on 28 December 2015 and stated that after the incident Mr Browning experienced widespread abdominal pain which was persisting and radiating to his flanks and groins (ARD page 25).

56. Dr Patrick said it was significant that Mr Browning experienced radiation of pain laterally towards the flanks and groins prior to the umbilical hernia surgery. Dr Patrick noted the complicated history of Ross River virus and said it was in around October 2016 that Mr Browning's pain significantly worsened with the same pain radiating into his buttocks and legs (ARD page 26).

57. Dr Patrick opined that Mr Browning had sustained significant workplace injuries on 28 December 2015. He said Mr Browning's injuries were related to the incident. He opined the lumbar spine surgery was reasonably necessary as a result of the injury.

58. Dr Patrick disagreed with the opinion of Dr Bosanquet. He said:

> "As a trauma surgeon, I can state that it is not at all infrequent that diagnosis of a lumbar spine disc protrusion consequent upon a traumatic event is not discovered until one or two years subsequently. Dr Patrick gave an example of a passenger in the receipt of a motor vehicle accident."

59. Dr Patrick said:

> "I do believe that dissecting carefully the history as given by Mr Browning and with the sequence of events as they have unfolded, I do believe on the balance of probability that Mr Peter Browning's lumbar spinal disc protrusion is as a consequence of the events which have occurred on 28/29 December 2015 on the balance of probability. The situation has been somewhat difficult for trading GPs during 2016 in that the situation was complicated by the flareup of his Ross River virus and/or glandular fever" (ARD page 29).
>
> Dr Patrick disagreed strongly with Dr Bosanquet's comment that an acute rupture of the lower lumbar disc causing sciatica is always accompanied by back pain. He said an acute lumbar disc protrusion can be accompanied by significant low back pain alone, or by sciatic pain into the league, or a combination of both together" (ARD page 29).

60. In a further report dated 17 April 2019 Dr Bosanquet confirmed his view that there was no causal link between Mr Browning's disc prolapse and the work injury on 28 December 2015 (Reply page 393).

61. In a report dated 17 July 2019, Dr Levi said that Mr Browning had reported worsening left abdominal pain as well as back pain radiating down his left leg. Dr Levi said that Mr Browning had not been investigated for spinal causes of his ongoing pain. Dr Levi believed that history provided by Mr Browning and the mechanism of his injury was consistent with a likely prolapsed disc with radicular pain. Dr Levi said the CT scan performed on 25 November 2016 confirmed a left paracentral L5/S1 disc extrusion displacing and compressing the left S1 nerve root (ARD page 49).

62. Dr Levi opined that the disc prolapse was causally related to the work accident. Dr Levi said:

> "I believe that the mechanism of injury, the symptoms and the timing of this fit with the described activity at the time of the accident and the mechanical load exerted during this. Unfortunately, when Peter first sought medical advice, the attention was placed on the concurrent umbilical hernia without detailed questioning about other injuries. It was not until 10 months later I met Peter

and felt his leg and back pain were related to the injury and began investigations around this... I believe the mechanism of injury and history of symptoms concur that the accident [on 29 December 2015] was the major contributing factor to Peter spinal injury" (ARD page 50).

REASONS

Did Mr Browning suffer an injury to his lumbar spine on 28 December 2015?

63. Mr Browning has the onus of proving that he suffered an injury to his lumbar and thoracic spines on 28 December 2015.

64. The standard of proof is the balance of probabilities (see *Nguyen v Cosmopolitan Homes* (NSW) Pty Ltd [2008] NSWCA 246).

65. In *Military Rehabilitation and Compensation Commission v May* [2016] HCA 19 (11 May 2016) the plurality of the High Court observed:

    "[45] …As Gleeson CJ and Kirby J explained in *Kennedy Cleaning Services Pty Ltd v Petkoska*, if 'something ... can be described as a *sudden and ascertainable or dramatic physiological change or disturbance of the normal physiological state*, it may qualify for characterisation as an 'injury' in the primary sense of that word' (emphasis added).

    [46] That physiological change or disturbance of the normal physiological state may be internal or external to the body of the employee. It may be, for example, the breaking of a limb, the breaking of an artery, the detachment of a piece of the lining of an artery, the rupture of an arterial wall or a lesion to the brain. Each would be described as an 'injury' in the primary sense.

    [47] However, as the Full Court correctly held, 'suddenness' is not *necessary* for there to be an 'injury' in the primary sense. A physiological change might be 'sudden and ascertainable'. A physiological change might be 'dramatic'. The employee's condition might be a 'disturbance of the normal physiological state'. That an 'injury' in the primary sense can arise, and can be described, in a variety of ways does not mean that 'suddenness' is irrelevant. As the Full Court said, 'suddenness' is often useful where there is a need to distinguish a physiological change from the natural progress of an underlying (and in one sense, closely related) disease (as occurred in *Zickar v MGH Plastic Industries Pty Ltd* and *Kennedy Cleaning*). But it is the *physiological* change – the nature and incidents of that change – that remains central (footnotes omitted)."

66. In order to succeed Mr Browning must establish on the balance of probabilities that the traumatic event on 28 December 2015 caused a physiological change in his lumbar and thoracic spines.

67. I am satisfied that the event at work on 28 December 2015 had the capacity to cause an injury to Mr Browning's back. It was an event that involved significant strain so to cause a hernia that required surgery.

68. However, the difficulty in this matter is the absence of a temporal connection between the event and the onset of back pain and/or the referred (or radicular) pain to Mr Browning's leg.

69. Mr Browning does not provide any specific evidence about the timing of the onset of back pain or referred leg pain. The initial complaints in October 2016 to Dr Levi are not entirely consistent with radicular pain stemming from an L5/S1 disc injury. Mr Browning reported tingling in both his hands and feet. He denied any back pain other than on forward flexion. The first reports of symptoms that are consistent with L5/S1 radicular pain was on 8 November 2016 when Mr Browning reported pain radiating down the back of his leg to below the knee.

70. I find on the basis of the medical records that Mr Browning first experienced referred pain from the L5/S1 injury no earlier than October 2016.

71. Having made this finding, it is necessary for there to be a logical explanation for the significant delay in the onset of symptoms. Mr Browning says the initial abdominal pain "masked" the symptoms in his back, however that seems unlikely given the extended period of time that passed since the injury and that Mr Browning had returned to some type of employment with the respondent in the intervening period.

72. The issue of whether Browning's injury was caused by the event on 28 December 2015 is to be determined primarily by reference to the medial opinion evidence. The expert medical opinion relied upon by Mr Browning must provide a satisfactory basis to make a finding that Mr Browning suffered an injury to his thoracic and lumbar spines on 28 December 2015 (see *Hancock v East Coast Timber Products Pty Ltd* at [79] (*Hancock*) and discussion in *Westpac Banking Corporation v Chauhan* [2019] NSWWCCPD 63 (10 December 2019) at [80]-[82]).

73. The weight afforded to medical opinion evidence is to be determined by having regard to the correspondence of the opinion provided with the facts proved by admissible evidence (*OneSteel Reinforcing Pty Ltd v Sutton* [2012] NSWCA 282; *Hancock* at [77]).

74. Mr Browning submitted that I should prefer the opinion of Dr Patrick, which was supported by Mr Browning's general practitioner. It was submitted that Dr Bosanquet's opinion should be rejected because he failed to explain the reason for the continuing complaints of deep abdominal pain and relief that was experienced post lumbar surgery. Mr Browning submitted that Dr Bosanquet did not engage with what had potentially caused Mr Browning's groin pain. Mr Browning also submitted that there was no intervening event that caused the onset of symptoms, for example an acute rupture.

75. The respondent noted there were no contemporaneous complaints and an absence of any medical records from August 2015 to October 2016 in the documents (see Reply pages 426-427). The respondent submitted that Dr Patrick had not provided an adequate explanation of the connection between the deep abdominal pain and a lumbar disc pathology. There was no mention of a thoracic disc injury. The respondent submitted that injury to the back was more likely to have been caused by the more proximate event on 12 September 2016, after which Mr browning reported back pain to Dr Levi. The respondent submitted Mr Browning had "skated over" the injury on 12 September 2016 and had not provided an adequate explanation of the timing of the onset of his back pain (see ARD page 2, paragraph 11).

76. It is unsatisfactory that the event of 12 September 2016 is not referred to by either medical expert relied upon by the parties. There are no clinical records from Dr Chen covering other than certificates of capacity. The cotemporaneous documents and investigations support a further strain to the abdomen and a "right groin strain" (ARD page 32). As identified by the respondent, this event is closer in time to the reports of L5/S1 symptoms. This event may also provide an explanation for the potential cause of Mr Browning's groin pain. The omission of the event of 12 September 2016 from the histories taken by the medical experts causes me concern as to whether they were able to provide their opinions in a reasonable factual climate.

77. In any event, Mr Browning's case was largely the injury to his back had manifested in another way prior to causing back pain, in particular by the deep pain in his abdomen region.

78. Whilst Mr Browning may have experienced a deep pain in his abdomen, and possibly pain radiating to his flanks from 28 December 2015 and prior to his hernia operation, these are not ordinarily symptoms of a compressed nerve at the L5/S1 level of the lumbar spine. The symptoms resulting from the compressed nerve at the L5/S1 only commenced from October 2016 at the earliest.

79. Dr Patrick strongly disagreed with Dr Bosanquet on the basis that it was not "all infrequent" the diagnosis of lumbar spine disc protrusion consequent on traumatic event was not discovered until one or two years after the event.

80. Dr Patrick also strongly disagreed that an acute rupture of the disc was always accompanied by a back pain:

> "This is simply not the case. Such acute lumbar disc protrusion can be accompanied by significant low back pain alone, or by just sciatic pain into the leg, or a combination of both together" (ARD page 29).

81. Accepting that an acute rupture of a disc caused by a traumatic event must cause either back pain, referred pain to the leg or both, Dr Patrick's opinion that the work event caused Mr Browning's lumbar spine injury cannot be accepted. This is because the traumatic event on 28 December 2015 was not accompanied by back pain, referred pain to the leg, or both.

82. I accept the respondent's submission that Dr Patrick has not adequately explained the connection between what he recorded as "widespread abdominal pain radiating to the flanks and groins" after the injurious event on 28 December 2015 and the pathology in Mr Browning's back. Dr Patrick has not provided any adequate explanation for the absence of any symptoms for an 11-month period.

83. Dr Patrick's opinion is also unsatisfactory in that he has not recorded a history of the work event on 12 September 2016 which may have altered his view about the cause of Mr Browning's groin pain.

84. Dr Patrick also placed relevance on the fact that Mr Browning was not able to return to full work duties after his injury on 28 December 2015. Along with the mechanism of the injury itself, this seems to be an important matter relied upon by Dr Patrick in forming his opinion on the cause of Mr Browning's back injury (ARD page 28). This does not appear to be factually correct on the basis of the certificate of capacity. The slight discrepancy in the factual assumptions relied upon by Dr Patrick causes me to doubt whether his opinion was given in a reasonable climate.

85. For the same reasons I do not accept Dr Levi's opinion that Mr Browning suffered a prolapsed disc on 28 December 2015. Whilst the mechanism of the injury is consistent with a possible back injury, the timing of Mr Browning's symptoms of a radicular pattern of pain is not. For the sake of clarity, I reject Dr Levi's opinion because after the event on 28 December 2015 Mr Browning did not experience low back pain, sciatic pain radiating into his leg, or a combination of both. The onset of radicular pain started from October 2016 at the earliest. Like Dr Patrick, Dr Levi has provided no explanation for the absence of any reports of symptoms consistent with prolapsed disc at the L5/S1 level for a period of around 11 months.

86. I accept Dr Bosanquet's opinion that the deep abdominal pain experienced by Mr Browning is unlikely to be connected to any vertebral disc prolapse. A deep abdominal pain, or pain radiating into the groin, is not consistent with the distribution of sciatic pain caused by a L5/S1 disc protrusion. I accept Bosanquet's opinion that it is improbable that the radicular symptoms complained of by Mr Browning came on around 11 months post-injury.

87. It was not necessary for Dr Bosanquet to engage with the issue of what had potentially caused Mr Browning's groin pain. Dr Bosanquet's task was to provide an opinion on the cause of the claimed injuries to the lumbar and thoracic spines, in particular the L5/S1 disc protrusion, and not the cause of other complaints. Mr Browning has the onus of proving his case on the balance of probabilities.

88. I accept that there is no known intervening event that has caused the onset of Mr Browning's symptoms, other than the possibility of the event on 12 September 2016, which was not addressed by either medical expert. However, it does not follow that the event on 28 December 2015 was the cause of Mr Browning's disc protrusion. In my view, Dr Patrick's opinion does provide a satisfactory basis to make a finding that Mr Browning injured his lumbar spine on 28 December 2015.

89. Dr Patrick has not provided any explanation of how such injury might result in the deep internal abdomen pain and pain radiating to the flanks and not radicular pain consistent with the pattern of radiculopathy produced by a disc protrusion at the L5/S1 level. Dr Patrick has not provided any explanation for the absence of any symptoms from the disc protrusion for an 11-month period, in the circumstances where he identified that this type of injury would, produce at least symptoms of back pain, radiculopathy or both.

90. There will be an award for the respondent on the allegation of injury to Mr Browning's lumbar spine.

Did Mr Browning suffer an injury to his thoracic spine on 28 December 2015?

91. I accept the respondent's submission there is insufficient evidence to support the allegation of injury to the thoracic spine.

92. The claim for injury seems to have been tacked onto the claim after receipt of Dr Patrick's impairment assessment. There is no contemporaneous complaint of injury to this body part.

93. There is a reference to the scan being undertaken on the thoracic spine on 2 November 2018, however this document was not in evidence and it is unclear whether Dr Patrick had reviewed this document in making his assessment (ARD page 151). There are no other radiological investigations of Mr Browning's thoracic spine in the documents admitted into evidence.

94. Whilst I have found there to be an onset of radicular pain affecting the left leg from no earlier than October 2016, there is no evidence concerning the timing of the onset of any thoracic pain. There is insufficient evidence to link the current symptoms in the thoracic spine identified by Dr Patrick with the injurious event on 28 December 2015.

95. I am therefore not satisfied on the balance of probabilities that Mr Browning suffered an injury to his thoracic spine on 28 December 2015.

96. There will be an award for the respondent on the allegation of injury to Mr Browning's thoracic spine.

Conclusion

97. For the above reasons, I am not satisfied that Mr Browning suffered injuries to his lumbar or thoracic spines on 28 December 2015.

98. As Dr Patrick has assessed Mr Browning's injury to his digestive system (hernia) at 0% whole person impairment, the matter cannot be referred to an AMA.

99. It also follows that Mr Browning’s claim for medical expenses, including the lumbar surgery, cannot succeed. This is because I am not satisfied that the claimed medical expenses resulted from a compensable injury.

100. There will be awards for the respondent on the claim for lump sum compensation and medical expenses.