WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**2519/19**
Applicant:	**Johne Delinicolis**
Respondent:	**Melissa Confectionary Pty Ltd**
Date of Determination:	**19 September 2019**
Citation:	**[2019] NSWWCC 306**

The Commission determines:

1. The applicant sustained injury to his cervical spine as a result of the nature and conditions of his employment with the respondent pursuant to s 4(b)(ii) of the *Workers Compensation Act 1987*.

The Commission orders:

1. The matter is remitted to the Registrar for referral to an Approved Medical Specialist for assessment as follows:

Date of injury:	14 April 2016 (deemed)
Body parts:	Cervical spine Left upper extremity (shoulder) Right lower extremity
Method:	Whole Person Impairment

2. The material to be referred to the Approved Medical Specialist is to include the Application to Resolve a Dispute and all attachments; the Reply and all attachments; documents attached to an Application to Admit Late Documents filed by the applicant on 9 July 2019; and documents attached to an Application to Admit Late Documents filed by the respondent with the exception of the report of Dr David Wilcox, dated 19 July 2019, apart from paragraph 1 of that report.

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

Rachel Homan
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 RACHEL HOMAN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Jackson

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

STATEMENT OF REASONS

BACKGROUND

1. Mr Johne Delinicolis (the applicant) was employed as a general hand by Melissa Confectionary Pty Ltd (the respondent).

2. The applicant claims that as a result of the nature and conditions of his employment with the respondent, which involved repetitive use of a spatula to cut Turkish Delight, repeated lifting of heavy bags of sugar, lifting of trays of Turkish Delight onto racks, and repetitive lifting of trays of cookies onto a hopper, he sustained injury to his cervical spine and left shoulder. As a consequence of that injury, the applicant further claims to have a sustained a condition affecting his right lower extremity, when he required a right iliac artery bypass graft following the onset of right leg symptoms after a surgery to his left shoulder.

3. The applicant made a claim for compensation, initially in relation to his left shoulder injury only. Compensation in the form of weekly benefits and medical expenses was paid. The applicant later made a claim for lump sum compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act) on the basis of a report by Dr Peter Endrey-Walder, dated 7 February 2019, which assessed the applicant as having 26% whole person impairment (WPI) of the cervical spine, left upper extremity and right lower extremity.

4. On 15 May 2019, the respondent issued a notice pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) disputing that the applicant was entitled to lump sum compensation. Specifically, the respondent did not accept that the applicant had sustained an injury to his cervical spine pursuant to s 4 of the 1987 Act. Further, it was disputed that the accepted injury to the applicant's left upper extremity and the consequential condition in the applicant's right lower extremity had resulted in a degree of permanent impairment greater than 10% WPI.

5. On 24 May 2019, the applicant filed an Application to Resolve a Dispute (ARD) in the Commission seeking lump sum compensation pursuant to s 66 of the 1987 Act in respect of permanent impairment to his cervical spine, left upper extremity (shoulder) and right lower extremity.

PROCEDURE BEFORE THE COMMISSION

6. The parties attended a conciliation conference and arbitration hearing on 20 August 2019. The applicant was represented by Mr Paul Stockley of counsel, instructed by Mr Victor Panaretos. The respondent was represented by Mr Gregory Young of counsel.

7. 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.

ISSUES FOR DETERMINATION

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

   (a) Whether the applicant sustained injury to his cervical spine as a result of the nature and conditions of his employment with the respondent pursuant to s 4 of the 1987 Act; and

   (b) The quantum of the applicant's entitlement to lump sum compensation.

EVIDENCE

Documentary Evidence

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

    (a) ARD and attached documents;

    (b) Reply and attached documents;

    (c) Documentss attached to an Application to Admit Late Documents filed by the applicant on 9 July 2019; and

    (d) Documents attached to an Application to Admit Late Documents filed by the respondent on 12 August 2019, with the exception of the report of Dr David Wilcox, dated 19 July 2019, apart from paragraph 1 of that report.

10. Submissions in respect of the respondent's Application Admit Late Documents were heard and recorded at the commencement of the arbitration hearing. My decision and reasons for decision were given orally and were also recorded so are not reproduced here.

11. Neither party applied to adduce oral evidence or cross-examine any witness.

Applicant's evidence

12. The applicant's evidence is set out in written statements made by him on 18 May 2016 and 24 October 2018.

13. In the first statement, prepared with the assistance of an investigator, the applicant described his duties as including carrying bags of icing sugar weighing up to 24 kg to a work area and transferring the sugar into a large bucket. The applicant was also required to lift large trays of set Turkish Delight, some from above shoulder height, and place them onto a workbench. The applicant estimated that the trays weighed 18 to 20 kg each and said he would lift up to 60 trays per day. The applicant then used a spatula to cut around the edges and divide the Turkish Delight into two pieces to be cut with a machine. The applicant then put the sliced product, weighing about 10 kg, onto a trolley. The applicant cleaned the floor, workbench and instruments at the end of each day.

14. The applicant said he first noticed pain in his left shoulder during the busy Christmas period in 2015. The applicant complained of pain to other staff but did not complain to his supervisor or make a formal report. The applicant had holidays from 24 December 2015 to 13 January 2016 and did not seek medical attention during this time. The applicant resumed work on 13 January 2016 but left halfway through the day as he was sick and had pains all over his body. The applicant consulted his doctor, Dr Sofe Aravanis, and mentioned the pain in his left shoulder. The applicant managed his pain using Panadol Osteo and Voltaren. The pain got worse during March but the applicant continued to manage it with hot showers, thinking it would improve.

15. The applicant said that on 11 April 2016, he had a physical argument over a cigarette with his flatmate. The flatmate jumped up from a lounge and grabbed the applicant around the throat from the front for a few seconds. The flatmate did not hit or push the applicant.

16. The applicant went to work as usual the next day, on 12 April 2016. The applicant told his colleague, Amelia about the argument with his flatmate. The applicant continued to work as normal on 12 and 13 April 2016.

17. On 14 April 2016, the applicant worked until 1pm, at which point the pain in his left shoulder, elbow and hand became so severe that he was shaking. The pain went into the applicant's lower back and hips. The applicant complained to Amelia and went straight to the doctor.

18. The applicant consulted Dr Aravanis and told her about what happened with his flatmate as well as the pain in his left shoulder. The applicant obtained a medical certificate for light duties in relation to left shoulder pain and stress and was referred for an MRI. The applicant was later referred for physiotherapy and to an orthopaedic surgeon, Dr Kuo, whom the applicant consulted on 24 May 2014.

19. In the second statement, the applicant described his duties in more detail. The applicant said,

> "During my entire shift I was always on my feet never sitting down and in order to cut the trays I would be standing and stooped over the table. I have no doubt that this contributed to my neck and shoulder problems."

20. The applicant indicated that Dr Kuo had recommended surgery to his left shoulder which was performed, paid for by the insurer, on 5 July 2016. Following his discharge from hospital, the applicant developed a blockage in his iliac artery which required surgery. That surgery was performed on 22 August 2016.

21. With regard to his neck, the applicant stated:

> "During the time I was consulting Dr Aravanis I cannot recall that I specifically explained to her that I was suffering symptoms of pain in my neck. I was more focused with the problems in my left shoulder. I did not raise any neck problems that I was having with Dr Kuo as I understood that I was referred to him solely in relation to my left shoulder problems. Whilst I was still working at Melissa Confectionery I can say that apart from shoulder problems I was having pain at the base of my neck. I don't think anyone took notice of this history until I consulted with Dr Con Costa in approximately April 2017. Dr Costa sent me off for an x-ray of my neck and by May 2017, he had arranged for an MRI of my neck as well."

Evidence from the applicant's treating practitioners

22. In a letter to the insurer dated 3 May 2017, the applicant's new general practitioner, Dr Con Costa, stated that he saw the applicant on 4 March 2017 when he requested a change of nominated treating doctor. The applicant was complaining of chronic pain mainly affecting the left side of the neck and the shoulder as well as left upper limb radiculopathy symptoms. Dr Costa stated,

> "My concern was that there was chronic pain and his condition slow to improve following the surgery, and particularly left upper limb radiculopathy symptoms and I felt that he was under investigated to date, i.e., shoulder pain often contributed from the level of the neck ie need to exclude also a neck injury contributing to the left shoulder symptoms, which had been under investigated to date and contributing to the left shoulder and left upper limb radiculopathy symptoms.
>
> In my experience, shoulder injury can result in some limited radiculopathy to the arm, but rarely below the level of the elbow. Where there is radiculopathy affecting most of the upper limb, it is essential to check also for cervical IV disc lesion. I note that he has a long history of heavy work and occupational overuse injury- and this was accepted as an occupational overuse injury of the left shoulder- and in my experience occupational overuse injuries or history of heavy work is usually associated with multiple pathology, i.e., unusual to be restricted to one joint."

23. Dr Costa referred the applicant for plain x-ray which confirmed "two-level IV disc lesions" probably contributing to the left shoulder and left upper limb symptoms. With regard to causation, Dr Costa commented:

> "In regards to attributability, I believe that all of his symptoms and his injuries are reasonably due to the history of work including long history of heavy lifting and manual handling and repetitive concentrated use of the upper limbs. There is no history of previous injury or previous symptoms prior to his work at Melissa Confectionery. There is no history of further injury subsequent to the Workers' Compensation claim."

24. Dr Costa referred the applicant to neurosurgeon, Dr Simon McKechnie, who in a report to Dr Costa, dated 23 June 2017, referred to a work injury on 14 April 2016 causing the onset of pain radiating across the left side of the neck, shoulder and upper arm. Dr McKechnie confirmed that an MRI of the cervical spine demonstrated a small C6/7 protrusion and moderate C5/6 disc protrusion, causing mild central and bilateral foraminal stenosis, worse on the left side with left C6 nerve root impingement. Dr McKechnie agreed that the applicant's residual symptoms were mainly due to a left C6 radiculopathy.

25. The applicant was also referred to neurologist Dr Paul Teychenne who provided a report to Dr Costa on 3 May 2018. Dr Teychenne took a detailed history of symptoms and recorded his findings upon clinical examination. Dr Teychenne concluded that the applicant's clinical picture was consistent with incomplete cervical cord lesion most probably related to the cervical spine stenosis at C5/6. A series of further reports were prepared by Dr Teychenne for Dr Costa between 16 May 2018 and 7 November 2018.

Dr Endrey-Walder

26. The applicant relies on a medicolegal report prepared by general and trauma surgeon, Dr Peter Endrey-Walder, dated 7 February 2019. Dr Endrey-Walder took a history of the applicant's duties consistent with the applicant's evidence.

27. Dr Endrey-Walder recorded that the applicant reported that from the time of the significantly increased left shoulder pain in April 2016, when he was initially referred to Dr Kuo, he continued to experience pain at the neck, especially with rotation, looking up. The applicant said,

> "The pain was there from the very beginning with the shoulder problem but the shoulder was much worse, I didn't mention it much."

28. Dr Endrey-Walder noted that in early 2017, the applicant came under the care of Dr Costa who requested an x-ray and later MRI of the cervical spine. Dr Endrey-Walder indicated that he had reviewed the reports of the x-ray, dated 5 April 2017, and MRI, dated 12 May 2017, of the applicant's cervical spine.

29. Dr Endrey-Walder's physical examination noted that there was well localised tenderness at the posterior lateral aspect of the right neck and associated muscle tension. The applicant lacked 20° at the limit of extension of the neck and could not turn his head beyond 40° to the right.

30. With regard to causation, Dr Endrey-Walder opined,

> "Mr. Delinicolis reported neck related symptoms from pretty much the time of the onset of left shoulder pain, and it is not difficult to see how an area of mild to moderate disc degenerative and spondylotic changes in the mid-cervical spine would be exacerbated and aggravated by lifting of heavy trays above shoulder level, necessitating strenuous repetitive extension of the neck in the process."

31. Dr Endrey-Walder assessed the applicant as having 26% whole person impairment (WPI) including 6% WPI for the cervical spine.

The respondent's evidence

32. Attached to the Reply is a Worker's Injury Claim Form signed by the applicant on 29 April 2016. The applicant described his injury as "left shoulder pain subacromial + subdeltoid bursitis + calcific tendonitis".

33. The respondent also relies on a written statement prepared by the managing director of the respondent, Mr Chris Ladas, dated 19 May 2016. Mr Ladas confirmed that the applicant was employed as a general hand and said his primary work involved cutting Turkish Delight. This involved picking up trays full of Turkish Delight which had been stacked on trolley stands. These trays, which weighed between 12 and 18 kg, and were stacked at a height between 0.4 m to 1.5 m, would be carried to the extraction table. The applicant would use a handheld scraping/cutting utensil to cut between the cured Turkish Delight and the edge of the tray. The applicant would then cut the piece of Turkish Delight in the middle to create two pieces. Each piece would weigh about 5 to 9 kg and would be transferred to a cutting board and placed into a cutting machine operated by the applicant. The product was then transferred to stacking trolleys, again ranging from 0.4 to 1.5 m in height. This procedure was repeated throughout the day. The number of trays cut throughout the day would vary but range between 30 to 40. Mr Ladas confirmed that the applicant might also at times be required to carry 25 kg bags of icing sugar from a pallet outside the cutting/packing room into his work area and empty the bags into product bins.

34. Mr Ladas confirmed that the factory was busier during the Christmas period. Whilst there may have been an increase in production, the applicant would have had an assistant from another area as required.

35. Mr Ladas said that the applicant did not advise him of any injury. Mr Ladas said he did not receive any report from the applicant regarding injury or inability to perform his role between 13 January 2016 and 14 April 2016. On 14 April 2016, the applicant commenced work as usual and advised a colleague that he could not work anymore at 1:30pm. The applicant told him that he needed to go to the doctor as he was unwell and needed to see the doctor to give him something to calm down. Mr Ladas said the applicant did not report any pain or injury.

36. Mr Ladas said that the applicant had told him that his flatmate had tried to kill him earlier in the week but the applicant did not go to the police. The applicant told him the man was like an uncle to him. The applicant appeared very distressed and the incident appeared to have affected him deeply.

37. Also attached to the Reply are a functional upgrading program closure report and a file review report by Injury Management Consultant, Dr Con Kafataris.

Dr Wilcox

38. The respondent has qualified consultant surgeon – trauma specialist, Dr David Wilcox to provide medicolegal reports dated 23 April 2019 and 19 July 2019.

39. Dr Wilcox took a history broadly consistent with the applicant's evidence. Dr Wilcox reported that the applicant complained of constant pain at the base of his right neck and pointed to a spot 4 cm to the right of midline at the level of T1/2. The applicant said this was not aggravated by doing anything except for turning his head frequently.

40. Dr Wilcox's examination elicited no tenderness over any part of the neck or upper back except for a show of discomfort with pressure on the right occiput. There was an absence of muscle spasm and the applicant had good range of movement of the cervical spine. Rotation was measured at 45° to the right and to the left, however, at the extreme left, the applicant complained of a sharp pain in the same spot 4 cm to the right of the midline at level T1/2.

41. Dr Wilcox noted there were differences between Mr Ladas' statement and that given by the applicant with regard to the weight of trays and the height at which they would be stacked. Dr Wilcox stated,

> "On that basis, Mr Delinicolis' current history would appear to be somewhat exaggerated in respect of the heavy nature of his duties. Even the number of trays handled each day was considerably less than Mr Delinicolis stated. This was the first of many inconsistencies that can be found when the current history and examination together with the documentation is critically analysed."

42. Dr Wilcox suggested that although the applicant had reported to Dr Costa that he had a long history of heavy work and occupational overuse, he did not consider two years and three months to be "a long history". Dr Wilcox also asserted that the applicant had given an incorrect history to Dr McKechnie of an onset of pain across the left side of his neck on 14 April 2016 having regard to the available documentation and the applicant's history. Dr Wilcox was critical of Dr Teychenne's examination of the applicant saying there were contradictions which should have been queried by Dr Teychenne rather than accepted

43. Dr Wilcox noted that clinically there was no evidence of active underlying cervical spine pathology nor any indication of neuropathy. There was an absence of any loss of sensation, reflexes or other radicular signs. Dr Wilcox said the radiological abnormalities should be regarded as coincidental and not indicative of symptomatology.

44. Dr Wilcox noted that the only consistent spot of tenderness was in the upper back rather than the neck and on the right rather than the left. Dr Wilcox said it was difficult to understand how this could occur as the result of symptomatic cervical spondylosis at C5/6, more on the left than the right. Dr Wilcox noted that the other consistent apparent tenderness was at the back of the skull but said this location was always somewhat tender and this was a quite normal experience of no significance.

45. Dr Wilcox concluded that the applicant's ongoing complaints did not accord with the clinical findings and this should take precedence over the interpretation of degenerative changes seen in the investigations. Dr Wilcox said objective clinical signs such as wasting of muscle, loss of reflex or consistent muscle spasm were much more important when determining the presence or absence of symptomatology. Dr Wilcox found the applicant's cervical spine fell within DRE Cervical Category I and assigned 0% WPI.

46. Dr Wilcox provided a second report also dated 23 April 2019 in which he reviewed and was critical of most aspects of the report of Dr Endrey-Walder.

47. Only the first paragraph of Dr Wilcox's 19 July 2019 report has been admitted into evidence. In that paragraph, several typographical errors in his previous reports are corrected.

Applicant's submissions

48. Mr Stockley suggested that the basis for the respondent's decision to dispute liability for injury to the cervical spine was the late reporting of symptoms and the contradictory clinical findings of Dr Wilcox.

49. Mr Stockley took me to the applicant’s statements and noted that the symptoms he described on 14 April 2016 were consistent with the diagnosis of radiculopathy found by Dr Costa, although not described by the applicant in those terms.

50. Mr Stockley conceded that Dr Costa was the first clinician to record the applicant’s complaints in regard to his neck in early 2017 but noted that the referral to Dr Kuo had been in relation to the left shoulder only. The applicant had told the Commission, Dr Costa and those doctors to whom he was referred by Dr Costa that he had experienced symptoms in his cervical spine from the outset. There was no basis for impugning the applicant’s credibility.

51. Mr Stockley noted that Dr Costa considered the applicant’s complaints warranted radiology and referrals to a neurologist and neurosurgeon. Dr McKechnie took a history of work injury and agreed that the applicant’s residual symptoms were mainly due to a left C6 radiculopathy. Dr Teychenne found a clinical picture consistent with an incomplete cervical cord lesion, most probably related to cervical spinal stenosis at C5/6. Mr Stockley noted that although Dr Teychenne’s diagnosis appeared different to that of Dr McKechnie, both referred to C5/6 stenosis which was demonstrated on the radiology.

52. Mr Stockley took me to through Dr Endrey-Walder’s report and submitted that he had provided an opinion on causation which supported a finding that there was a nature and conditions type injury.

53. Mr Stockley acknowledged that Dr Kuo did not record neck symptoms but said this had been explained by the applicant. Mr Stockley said Dr Kafataris had provided an injury management report which did not deal with causation or diagnosis.

54. Mr Stockley expressed concerns over Dr Wilcox’s objectivity, saying he had undertaken an evaluation of the reliability of the reporting and the credibility of the applicant. Dr Wilcox accepted one account over another, appearing to make findings about the primary facts, which was not the job of an independent examiner. In expressing criticism of the applicant’s doctors, Mr Stockley submitted that Dr Wilcox had strayed from his task as an expert.

55. Mr Stockley submitted that the evidentiary matrix for the applicant would be readily accepted by the Commission absent a coherent and persuasive contradictor who had focussed on correct tests. Dr Wilcox had focussed instead on attacking the reliability of the applicant’s doctors’ evidence.

56. Mr Stockley submitted that Dr Wilcox had also failed to acknowledge the potential for the mechanism of injury found by Dr Endrey-Walder, that is an aggravation of underlying pathology. Dr Wilcox’s report was said to provide an insufficient basis to displace the proposition that there was an injury to the neck.

Respondent’s submissions

57. Mr Young noted that the applicant made no mention of symptoms in his neck in his first statement. Mr Young said this was significant as the statement was prepared with an interpreter and was contemporaneous to the injury. The applicant did, however, refer to pain in body parts other than the left shoulder, including his lower back and hips. In the circumstances, the failure to mention any symptoms in the neck was unexplained, if as was later claimed, the applicant had felt pain in his neck from the outset.

58. Mr Young noted that the clinical notes of Dr Aravanis were in evidence and also made no reference to any neck injury.

59. Mr Young queried the reliability of the applicant’s evidence, noting that he had suffered a violent assault a few days prior to the date of injury on 11 April 2016. The applicant did not deny telling his employer that his flatmate tried to kill him. Although the applicant did not claim that the assault hurt his neck, Mr Young said it was reasonable to infer that the applicant’s neck was affected when the flatmate grabbed him violently around the throat. Mr Young noted that the applicant’s doctors had not considered or discounted this possibility, leading to serious questions around the reliability of the applicant’s doctors’ opinions as well as the applicant’s own credibility.

60. Mr Young submitted that the only explanation for the neck injury provided by the applicant was his evidence that he was stooping and standing. Whilst Mr Young said the applicant’s failure to make contemporaneous complaints of neck symptoms was not determinative, it was significant that no consideration was given to the neck for around 12 months.

61. Mr Young further noted that the diagnosis was not straightforward. Dr Endrey-Walder found “no spinal cord or nerve root compression”, which appeared at odds with Dr Teychenne and Dr McKechnie. Mr Young noted that there was suggestion in the applicant’s history as reported to Dr Endrey-Walder that his symptoms got worse after the shoulder operation. This raised a serious question about whether the applicant’s neck problems developed after the applicant ceased work.

62. Mr Young said Dr Endrey-Walder’s examination did not support the applicant in that he found right mid-neck pain. The treating doctors found the pain worse on the left. If the pain were worse on the right, there could be no confusion about whether the symptoms were attributable to the shoulder injury.

63. Although Dr Endrey-Walder said the applicant “reported neck related symptoms from pretty much the time of the onset of left shoulder pain” this was not reflected in the contemporaneous evidence. Mr Young noted that Dr Endrey-Walder did not explain what aspect of the nature and conditions of employment caused trauma to the neck.

64. Mr Young noted that the applicant also had an x-ray of the lumbar spine which showed spondylosis but that body part had not been included in the claim. It was unclear why the neck had been claimed but not the back. The mere presence of pathology in the radiology would not lead to a conclusion that there was injury. Mr Young said Dr Endrey-Walder was filling in the gaps in order to give the applicant the benefit of the doubt.

65. Mr Young criticised Dr Costa’s report on the basis that he assumed there was no previous injury or symptoms and took no history of the assault to the applicant’s throat. Mr Young noted that Dr McKechnie appeared to be alone in finding left C6 nerve root impingement.

66. Mr Young said, like Dr Wilcox, Dr Teychenne found normal movement of the cervical spine and no cervical muscle guarding. Dr Teychenne also found nerve symptoms on the right side as well as left but did not comment on whether there was any left or right sided radiculopathy.

67. Mr Young noted that there was no mention of neck symptoms in the Worker’s Injury Claim Form or several other contemporaneous reports in evidence.

68. Mr Young submitted that Dr Wilcox did take a history of the assault. Dr Wilcox found symptoms to the right side on examination, which was inconsistent with the treating medical reports which documented complaints on the left side. Dr Wilcox also found normal movements of the cervical spine and no cervical muscle guarding.

69. Mr Young submitted that the MRI report found no evidence of nerve root impingement or radiculopathy but rather degenerative spondylosis and facet joint arthrosis. Mr Young noted that there was similar pathology in the lumbar spine but no claim of injury. Mr Young submitted that the mere existence of pathology on the radiology did not mean there were neck symptoms or indeed injury.

Applicant's submissions in reply

70. Mr Stockley noted that a history of assault was given to Dr Aravanis but there was no complaint of neck symptoms. Mr Stockley submitted that this evidence should be given neutral treatment. There was no medical evidence to suggest the assault was a cause of neck injury.

71. Mr Stockley also noted that Dr Teychenne had not given a medicolegal report and so the absence of response to pertinent questions would not provide a basis for criticising his reports.

FINDINGS AND REASONS

72. Section 9 of the 1987 Act provides that a worker who has received an "injury" shall receive compensation from the worker's employer. The term "injury" is defined in s 4 of the 1987 Act as follows:

> **"4 Definition of 'injury'**
>
> In this Act:
> **injury:**
>
> (a) means personal injury arising out of or in the course of employment,
>
> (b) includes a disease injury, which means:
>
> > (i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and
> >
> > (ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, and
>
> (c) does not include (except in the case of a worker employed in or about a mine) a dust disease, as defined by the *Workers' Compensation (Dust Diseases) Act 1942*, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined."

73. The Court of Appeal in *Nguyen v Cosmopolitan Homes*[1] has found that a tribunal of fact must be actually persuaded of the occurrence or existence of the fact before it can be found, summarising the position as follows:

> (1) A finding that a fact exists (or existed) requires that the evidence induce, in the mind of the fact-finder, an actual persuasion that the fact does (or at the relevant time did) exist;

[1] [2008] NSWCA 246.

(2) Where on the whole of the evidence such a feeling of actual persuasion is induced, so that the fact-finder finds that the probabilities of the fact's existence are greater than the possibilities of its non-existence, the burden of proof on the balance of probabilities may be satisfied;

(3) Where circumstantial evidence is relied upon, it is not in general necessary that all reasonable hypotheses consistent with the non-existence of a fact, or inconsistent with its existence, be excluded before the fact can be found; and

(4) A rational choice between competing hypotheses, informed by a sense of actual persuasion in favour of the choice made, will support a finding, on the balance of probabilities, as to the existence of the fact in issue.

74. The value of contemporaneous evidence has been repeatedly endorsed by the courts: *Watson v Foxman*[2] and *Onassis v Vergottis*[3]. In the latter case, Lord Pearce commented upon what is often recollected and said by witnesses, many years after an event, as opposed to what is contemporaneously recorded in documents at the time of the event, in the following terms:

> "Witnesses, especially those who are emotional, who think that they are morally in the right, tend very easily and unconsciously to conjure up a legal right that did not exist. It is a truism, often used in accident cases, that with every day that passes the memory becomes fainter and the imagination becomes more active. For that reason a witness, however honest, rarely persuades a Judge that his present recollection is preferable to that which was taken down in writing immediately after the accident occurred. Therefore, contemporary documents are always of the utmost importance. And lastly, although the honest witness believes he heard or saw this or that, is it so improbable that it is on the balance more likely that he was mistaken? On this point it is essential that the balance of probability is put correctly into the scales in weighing the credibility of a witness. And motive is one aspect of probability. All these problems compendiously are entailed when a Judge assesses the credibility of a witness; they are all part of one judicial process. And in the process contemporary documents and admitted or incontrovertible facts and probabilities must play their proper part."

75. There is, in this case, minimal contemporaneous evidence of complaints of symptoms relating to the applicant's neck. As Mr Young has noted, although the applicant now claims that he experienced pain in his neck whilst working for the respondent, it was not until the applicant consulted Dr Costa, almost a year after ceasing employment, that neck symptoms were first recorded and investigated. This delay is a circumstance which warrants careful consideration in assessing whether the applicant's present claim is credible.

76. The applicant's written statement of 18 May 2016 provides a relatively detailed and contemporaneous account of the applicant's complaints at the time he ceased work for the respondent. The applicant did not refer to pain in his left shoulder in isolation. Rather he described pain in his left shoulder going into his elbow and left hand which was so severe that the applicant was shaking. The applicant also described pain in his lower back and hips.

77. Mr Young said the absence of specific reference to the applicant's neck in this statement, despite complaints of pain in other body parts, was significant. Whilst I accept that the applicant failed to expressly identify neck pain, I also accept Mr Stockley's submission that his description of pain was not inconsistent with radicular pain attributable to pathology in the neck, as later found by Dr Costa and Dr McKechnie.

[2] (1995) 49 NSWLR 315.
[3] (1968) 2 Lloyds Report 403.

78. Dr Costa indicated that in his experience, shoulder injury can lead to limited radiculopathy to the arm but rarely below the level of the elbow. Where there is radiculopathy affecting most of the upper limb, as was described by the applicant in May 2016, Dr Costa considered it appropriate to check for neck injury. In these circumstances, although the applicant did not identify the source of his pain as being his neck, I am satisfied that symptoms consistent with neck injury were described by him in the statement of 18 May 2016.

79. Mr Young has identified an alternative possible cause of neck symptoms in the violent altercation with the applicant's flatmate on 11 April 2016. Whilst I accept that it is theoretically possible that an assault, as described by the applicant, could give rise to neck injury, the evidence does not suggest this was the case. The applicant reported the assault to a colleague and to his managing director, Mr Ladas, but there is no suggestion in the evidence of neck injury or symptoms as a result. The assault was also reported to the applicant's general practitioner at the time, Dr Aravanis. There is, however, nothing in Dr Aravanis' notes to suggest that the assault had caused injury to the neck. The applicant's main complaint in relation to the assault was the impact on his mental health.

80. Mr Young has suggested that the failure to report the assault to Dr Costa and the other practitioners involved in the applicant's case casts doubt over the applicant's credibility and the reliability of his medical evidence. Had there been anything in the evidence to suggest a sudden onset of new or different neck symptoms in the context of the assault I would be inclined to accept Mr Young's submission. There is, however, nothing to suggest an attempt to conceal the incident. If, as appears to be the case, the assault did not cause any new or different symptoms in the applicant's neck, there is a reasonable explanation for the applicant's failure to report it to his doctors. I am not satisfied that this omission impacts significantly on the applicant's credibility.

81. I am also not persuaded that the omission impacts on the reliability of the applicant's medical evidence. I note that although Dr Wilcox was apprised of the incident, he has not suggested that it was causative of the applicant's reported symptoms.

82. Mr Young has also submitted that the reference in Dr Endrey-Walder's report to an increase in neck symptoms following the applicant's shoulder surgery, being at a time after the applicant's ceased work, raised the possibility of some non-work event causing injury. The difficulty with this submission is that apart from an increase in symptoms at a later time there is nothing identifiable in the evidence to suggest an alternative cause of injury.

83. Mr Young has drawn my attention to differences in the clinical findings of the practitioners involved in the case. Dr Costa's report provides a description of symptoms consistent with the applicant's first statement. It also provides an explanation for the delayed reporting of symptoms, suggesting that the left-sided radicular symptoms reported to him could have been conflated with the applicant's left shoulder pathology. The failure of the applicant's condition to improve following left shoulder surgery and the nature of the symptoms prompted Dr Costa to order further investigations and make appropriate referrals.

84. Like Dr Costa, Dr McKechnie recorded a complaint of pain radiating across the left side of the neck, shoulder and upper arm. Dr McKechnie found this to be consistent with the MRI of the cervical spine and in particular a moderate C5/C6 disc protrusion causing mild central and bilateral foraminal stenosis worse on the left side with left C6 nerve root impingement. After examining the applicant, Dr McKechnie agreed that the applicant's symptoms were mainly due to a left C6 radiculopathy. In this regard, the opinions of Dr Costa and Dr McKechnie appear consistent.

85. I accept that the report of the MRI scan, dated 12 May 2017, does not expressly identify C6 nerve root impingement. It is possible, although he does not expressly say so, that Dr McKechnie reviewed the MRI imaging himself and formed that opinion. It is noted that Dr McKechnie's opinion of what the MRI demonstrated is not expressed in the same language as the report, suggesting this may have been the case. In the circumstances, I do not infer that Dr McKechnie's opinions were necessarily inconsistent with the MRI report or unreliable in any way. As a neurosurgeon, Dr McKechnie was qualified to express an opinion on what the MRI demonstrated.

86. Dr Teychenne's history was also suggestive of a left sided radiculopathy since December 2015, reported as:

> "painful freezing tingling extending from the left paracervical region into the left suprascapular region and down the dorsal aspect of the left arm into the left thumb and 2nd finger."

87. Dr Teychenne then recorded the onset of similar symptoms on the right side since December 2017. Dr Teychenne's clinical examination produced findings on both the left and right side. Whilst right sided symptoms or clinical findings were not reported by Dr McKechnie or Dr Costa, this is not inconsistent with the history provided to Dr Teychenne of the onset of right sided symptoms in December 2017, that is, at least six months after the reports of Dr Costa and Dr McKechnie. This is also not inconsistent with the bilateral foraminal stenosis noted on the MRI scan and in the report of Dr McKechnie. Dr Teychenne considered the applicant's symptoms to be consistent with the stenosis at C5/6 demonstrated on the MRI.

88. I am not satisfied on this analysis that there is any material inconsistency between the opinions of the applicant's treating doctors. That is, all three took a history consistent with left sided radiculopathy as described by the applicant in his initial statement. All three found the reported symptoms to be consistent with pathology revealed on the MRI scan after examining the applicant.

89. Dr Wilcox's examination in April 2019 produced different findings to those reported by Dr Costa, Dr McKechnie and Dr Teychenne. Dr Wilcox found good range of movement, an absence of muscle spasm and no tenderness other than on the right side of the upper back. Dr Wilcox's examination does not, however, necessarily lead me to the conclusion that the pathology noted in the MRI was either asymptomatic or inconsistent with the applicant's claim of injury. I note that the history taken by both Dr McKechnie and Dr Wilcox was of intermittent pain through the left arm. I also note the passage of time between Dr Wilcox's examination and the applicant's last date of employment. An injury may progress or improve over time. That does not necessarily mean that there never was an injury.

90. Dr Wilcox does express a view that two years and three months of employment with the respondent was not "a long history of heavy work". Dr Wilcox also appears to have taken the view that the applicant had exaggerated the heavy and repetitive nature of his work, apparently preferring the account provided by Mr Ladas. With respect, these are not matters falling within Dr Wilcox's purview as an Independent Medical Examiner.

91. Mr Young's submissions also suggested that the evidence as to the aspects of the applicant's employment said to be causative of neck injury was lacking. In my view, the applicant has provided a detailed and consistent account of the nature and conditions of his employment. The applicant's account was broadly consistent with that provided by Mr Ladas although there were some differences between their evidence as to the precise weight of trays, the heights of trolleys and the number of trays prepared by the applicant each day. Both the applicant's and Mr Ladas's accounts suggest repetitive, moderately heavy work involving lifting of trays and standing for prolonged periods looking down over a work table.

92. Dr Wilcox does not express a view as to whether this kind of work could have, during the period of employment, caused a symptomatic aggravation of the degenerative pathology demonstrated on the MRI, notwithstanding his findings on examination in 2019. Rather, Dr Wilcox appears to focus on perceived inconsistencies and deficiencies in Dr Teychenne's and Dr Endrey-Walder's reports, which, coupled with his own findings on examination, led him to assign 0% WPI to the cervical spine.

93. An opinion on this question favourable to the applicant was given by Dr Endrey-Walder. Although Dr Wilcox identified a number of possible inconsistencies in the history taken by Dr Endrey-Walder, including the precise height of the trolleys from which the trays of Turkish Delight were unloaded and loaded and the exact weight of various items, I am satisfied that his history was at least broadly consistent with the evidence given by the applicant and Mr Ladas. Dr Endrey-Walder expressed the view that mild to moderate disc degenerative and spondylotic changes in the mid-cervical spine were exacerbated and aggravated by lifting of heavy trays above shoulder level, necessitating strenuous repetitive extension of the neck in the process.

94. A similar opinion was given Mr Dr Costa who expressed the view that the long history of heavy lifting, manual handling and repetitive concentrated use of the upper limbs had caused all of the applicant's symptoms and injuries.

95. Dr Endrey-Walder's examination produced some different findings to those observed by the treating practitioners in 2017 and early 2018. Like Dr Wilcox, however, Dr Endrey-Walder's examination was performed some time later, in early 2019. This did not lead Dr Endrey-Walder to the conclusion that there was no injury, nor does it cause me any particular difficulty in accepting the applicant's claim.

96. Lastly, Mr Young sought to compare the pathology in the applicant's cervical spine shown on the MRI with that demonstrated in the lumbar spine, which does not form part of the present claim. Although an injury to the lumbar spine has not been claimed, there is throughout the evidence reference to lumbar symptoms. There may be many reasons why the lumbar spine has not been claimed and this circumstance alone does not cause me to doubt the credibility or reliability of the applicant's evidence in relation to his cervical spine symptoms.

97. I have considered the evidence as a whole and have given careful consideration to the respondent's submissions. Whilst the matter is not clear cut, I am satisfied on the balance of possibilities that the nature and conditions of the applicant's employment with the respondent gave rise to an injury to the applicant's cervical spine in the nature of an aggravation or exacerbation of mild to moderate disc degenerative and spondylotic changes in the mid-cervical spine.

98. The extent of any permanent impairment resulting from this injury will be a matter for an Approved Medical Specialist (AMS) to determine. I am not satisfied in this case, that it is appropriate for the degree of permanent impairment to be determined by me, given the significant discrepancy in the assessments made by Dr Endrey-Walder and Dr Wilcox.

99. The matter will be remitted to the Registrar for referral to an AMS together with the accepted injury to the applicant's left shoulder and consequential condition in the applicant's right leg.

SUMMARY

100. The Commission determines:

    (a) The applicant sustained injury to his cervical spine as a result of the nature and conditions of his employment with the respondent pursuant to s 4(b)(ii) of the 1987 Act.

101. The Commission orders:

(a) The matter is remitted to the Registrar for referral to an AMS for assessment as follows:

Date of injury:	14 April 2016 (deemed)
Body parts:	Cervical spine Left upper extremity (shoulder) Right lower extremity
Method:	Whole Person Impairment

(b) The material to be referred to the AMS is to include the Application to Resolve a Dispute and all attachments; the Reply and all attachments; documents attached to an Application to Admit Late Documents filed by the applicant on 9 July 2019; and documents attached to an Application to Admit Late Documents filed by the respondent with the exception of the report of Dr David Wilcox, dated 19 July 2019, apart from paragraph 1 of that report.