WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **2010/19**
Applicant: **Octavian Cruceanu**
Respondent: **Vix Technology (Aust) Ltd**
Date of Determination: **5 July 2019**
Citation: **[2019] NSWWCC 235**

The Commission determines:

1. Award for the respondent in respect of the allegation of injury to the applicant's neck.

2. Dismiss the claim for permanent impairment compensation.

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

Paul Sweeney
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 PAUL SWEENEY, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

INTRODUCTION

1. Octavian Cruceanu (the applicant) suffered injury in the course of his employment with Vix Technology (Aust) Ltd (the respondent) on 10 April 2012. It is common ground that the applicant suffered injury his right knee. He asserts, however, that he also suffered injuries to his lower back and cervical spine. The respondent disputes these injuries. Thus, the dispute raises the perennial problem in workers compensation cases; whether there is causal nexus between a work incident and a medical condition.

PROCEDURE BEFORE THE COMMISSION

2. When the matter came on for arbitration hearing at Penrith on 11 June 2019 Mr Mirsic, of counsel, appeared for the applicant and Mr Callaway, of counsel, appeared for the respondent. I was informed by counsel that the parties were unable to reach an agreement in respect of the threshold issues of injury to the neck and back. I am satisfied that the parties, who were represented by experienced counsel, had ample time to consider settlement but were unable to reach a mutual satisfactory resolution of their dispute.

EVIDENCE

3. The documents before the Commission are as follows:

    (a) Application to Resolve a Dispute (the Application) and the documents attached;
    (b) the Reply and the documents attached.

4. There was no objection to the material referred to above. Neither party sought to adduce further evidence. There was no application to cross-examine the applicant.

ISSUES OF DETERMINATION

5. It is evident from what I have said above that the issues are whether the applicant suffered injury to his neck and/or his back in the subject incident. The Application pleads injury simpliciter to the lumbar spine and also pleads an aggravation, acceleration, exacerbation and/or deterioration of a disease of the applicant's lumbar spine and cervical spine.

SUBMISSIONS

6. The submissions of the parties are recorded and it is unnecessary to reiterate all that was said in argument in these short reasons. Mr Callaway relied upon the absence of any reference to neck or back pain in the contemporaneous medical record. He submitted that the contemporaneous medical record should be preferred to the evidence of the applicant in this case. He submitted that the applicant's statement, prepared years after the subject accident, involved a “reconstruction” of events in a manner that was favourable to his case.

7. Mr Mirsic relied primarily upon the opinion of Dr Farey, the orthopaedic surgeon, who had operated on the applicant's cervical spine to relieve spinal cord compression. Dr Farey had expressed an opinion based on the applicant’s statement. He supported a connection between the injury and the applicant’s cervical pathology. There was no countervailing evidence in respect of important aspects of his opinion.

8. To understand the submissions of the parties and the way in which the Commission has resolved the issues in dispute, it is necessary to set out aspects of the applicant's evidence and the fairly lengthy medical record arising from his treatment since 10 April 2012. I do not propose to refer to the entirety of the evidence. Rather, I set out the salient points, which underlie the submissions of the parties and illuminate my reasons for this decision.

THE EVIDENCE OF THE APPLICANT

9. The applicant's evidence is contained in a statement dated17 April 2017. He says that he commenced work with the respondent in 2007. His duties involved the development and maintenance of ticketing machines. This involved physical work. In 2010, he was promoted to the position of supervisor. There were administrative and supervisory aspects to this role. But the applicant continued to perform physical work, including "bending over a desk in an office chair in the work shop repairing things".

10. The applicant recollects occasional neck and shoulder pain prior to 10 April 2012, for which he may have sought treatment from his general practitioner.

11. On 10 April 2012, at approximately 10.00 am the applicant attended the Regents Park depot of the respondent (or of a client company), where he entered a warehouse by a side door. He describes the incident that led to his injury in the following terms:

> "As I stepped through the door my foot stepped on to the edge of a block of wood which was lying on the floor causing me to stumble.
>
> As I stumbled I overbalanced and my body jerked back and I tried to regain my balance as my toolbag swung forward. My toolbag swinging on my shoulder made it more difficult to regain my balance. My right knee twisted and I reached out with my right hand to grab a concrete pillar to arrest my fall. I was leaning over half fallen by this time. As I crashed into the pillar with my right hand there was a sudden jolt up my body and I heard a cracking sound. I was still holding the box of parts in my left hand.
>
> I immediately felt severe pain in my right knee and right wrist. I tried to place weight on my right leg but I could not do it, so I hobbled over to the depot office.
>
> I was in a considerable amount of pain. I sat down for a while to see if I could recover. The pain got worse and after a while I realised that it was not going to go away and I left the office sometime in the afternoon."

12. The applicant recalls that "a few days later", when his knee had improved sufficiently to enable him to put weight upon it, he experienced a sharp pain in his lower back. It became a constant pain aggravated by walking and generally moving around.

13. The applicant says that he had three weeks off work. When he returned to work, he experienced low back pain getting in and out of his car. He also says that after his return to work he began to "regularly experience numbness" in his right leg. He continues:

> "I was also by this time experiencing pain and stiffness in my neck and across between my shoulders. This had gradually developed since the accident, and after 1-2 months was becoming quite a problem for me. I thought maybe it was because I was leaning over tables more at work and was more sedentary. It was gradually worsening but I did not think there was anything I could do about it. My right leg and back were my main problems."

14. The applicant came under the care of Dr Sorial, an orthopaedic surgeon, in July 2012. He was certified unfit for work. Dr Sorial recommended right knee surgery. The applicant underwent that surgery on 21 September 2012. He returned to work in November 2012, working very reduced hours from his home.

15. In February 2013, the applicant returned to his usual duties at his workplace on a part-time basis. He says that he had constant back pain at that stage. He also recounts that:

> "The main problem with my right leg by this time were shooting pains going down my right leg and numbness."

16. The applicant says that he was next referred to Dr Biggs, another orthopaedic surgeon who performed further surgery on his right knee on 10 October 2013. He says that he:

> "Continued to experience regular pain in my low back with shooting pain and occasional numbness in my right leg."

17. The applicant recounts that the neck symptoms which he had experienced "in the weeks following the accident" continued to worsen. He says he was getting numbness in his hands, and losing the feeling "in the last two fingers of each hand."

18. From February until May 2014, the applicant performed light duty work one day a week. In 2014, he was referred to Dr New, another orthopaedic surgeon. That doctor informed him that the radiological investigations of his neck demonstrated pressure on his spinal cord and that he should see Dr Farey, a spinal surgeon.

19. The applicant recalls that:

> "Dr Farey told me that the accident had caused one of the discs in my cervical spine to press on my spinal cord and this was causing my neck pain, stiffness and the numbness in my hands and fingers."

20. Dr Farey performed a decompression and fusion of the applicant's cervical spine on 11 June 2015. The applicant underwent a wider fusion on 15 July 2015.

21. He says that he still experiences neck pain and has difficultly with numbness in his hands. He also experiences back pain and right knee pain. He is unable to work.

THE MEDICAL RECORD

22. The applicant's general practitioner from, at least, 22 March 2010 was Dr Kodsi. That doctor saw the applicant on 23 March 2012 for a complaint of lower neck pain. On 12 April 2012, he treated the applicant following the subject injury. He recorded the following in his clinical notes:

> "While walking tried to avoid falling when was tripped in a piece of wood on the floor. Hold on pill with his hand.
>
> Tripped & to avoid falling hit his R Hand hard on a pillar- pain in The R wrist with Tender sunfbox [sic]."

23. On examination, the applicant had a swollen right wrist with tenderness at the right snuffbox. He was tender at the right knee and limped during the doctor's examination.

24. Dr Kodsi diagnosed possible tenosynovitis of the right wrist and a right knee ligament injury. He referred the applicant for an ultrasound of the right forearm and scans of the right knee. He treated the applicant's right wrist with a (steroid) injection, apparently with a reasonable initial response.

25. On 2 June 2012, Dr Kodsi recorded that the applicant's right wrist was "good after the injection". He also considered the report an ultrasound of the applicant's right knee and referred him to Dr Sorial, an orthopaedic surgeon.
26. On 24 July 2012, Dr Kodsi recorded that the applicant's right knee was "getting worse". On 22 August 2012, he noted that the applicant would undergo surgery of his right knee under Dr Sorial. On 12 September 2012, he recorded that the applicant was still in pain in his right knee. He had mild swelling and had limited "his R knee movement".

27. On 3 November 2012, the applicant reported to Dr Kodsi that he had a recurrence of pain in the right wrist and was still limping.

28. On 12 January 2013, Dr Kodsi reported that the applicant had pain in the front and back of his knee following the arthroscopy. On 2 February 2013, he recorded that the applicant had pain in the right knee "with pens [sic] & needles & numbness…. all the way to the R knee."

Dr Sorial

29. Dr Sorial saw the applicant at the request of Dr Kodsi on 23 July 2012. Dr Sorial noted a past history of juvenile rheumatoid arthritis but stated that it had no specific bearing on the applicant's presentation. On examination, the applicant had signs consistent with a medial meniscus tear. Dr Sorial requested an MRI scan, which he interpreted as demonstrating a "complex tear" of the posterior horn of the medial meniscus. He recommended a partial meniscectomy and performed that operation on 21 September 2012.

30. On 1 February 2013, Dr Sorial recorded that the applicant had "continued to experience pain in the leg and the pain is fairly global around the knee but also extends into the calf from the popliteal space". He noted the applicant reported instability affecting the ankle and weakness and "paraesthesia and tingling" affecting the thigh muscle.

31. Relevantly, Dr Sorial said this:

> "This gentleman is reporting occasional back pain and I am concerned that the symptoms he is describing may be due to a neurogenic claudication, although clearly there is a history of knee pathology the pain does not appear to correlate with the pathology found."

32. Dr Sorial thought that the applicant should undergo a back-care program and an MRI with a view to referral to a spinal surgeon if the scan identified stenosis or nerve root impingement.

33. The applicant saw Dr Pope, a neurosurgeon on 1 May 2013. He noted the applicant's back symptoms and numbness over the anterior thigh. He expressed the opinion that the applicant's symptoms were "more consistent with a large nerve distribution such as a nerve root or nerve such as femoral or obturator." After reviewing the radiology, he expressed the opinion that the applicant was suffering from an obturator neuropathy on the right side.

34. The applicant saw Dr Owler, another neurosurgeon, on 21 September 2013. He expressed the opinion that the applicant's thigh symptoms related entrapment of the lateral cutaneous nerve of the thigh and that his back pain arose from a facet joint. He recommended physiotherapy and exercise.

35. On 23 September 2013, Dr Biggs an orthopaedic surgeon specialising in knee surgery, saw the applicant at the request of Dr Kodsi. He expressed the opinion that the applicant required further surgery by way of lateral meniscectomy and chondroplasty of the right knee. The applicant accepted that advice and underwent surgery.

36. On 23 January 2014, the applicant saw Dr Charles New an orthopaedic surgeon for his back pain and right sided radicular pain. Dr New expressed the opinion that the applicant should obtain an updated MRI, a bone scan and nerve conduction studies.

37. On 26 February 2014, Dr New reported to Dr Kodsi that the MRI scan did not show "frank neurological compromise of the lumbar spinal canal". He recommended weight loss and physical therapy for the applicant's back. He noted, however, that the applicant:

> "has some minor changes in C8 on his EMG but I am concerned that the stenosis he has at C5/6 is causing some early cervical myelopathy, noting there is a minor change in his cord."

He suggested referral to Dr Ian Farey.

38. On 15 May 2014, Dr Farey wrote to Dr Kodsi advising that the applicant required anterior decompression, stabilisation and fusion at the C5/6 level as a result of cervical spondylotic myelopathy. He took a history that the applicant had experienced "intermittent neck pain for a period of six months" and that the symptoms were of spontaneous onset. He also noted a history of the injury at work. He recorded that following this:

> "He developed low back pain and right lower limb pain paresthesia. Most of his pain was in relation to his right knee. He subsequently underwent arthroscopic surgery on two occasions without benefits."

39. Dr Farey expressed the opinion that the applicant had symptoms of cervical spondylotic myelopathy and symptoms of lumbar degenerative disc disease. He operated on the applicant's neck at North Shore Private Hospital on 11 June 2014.

40. Dr Farey continued to review the applicant following surgery. On each of these occasions, he noted that the applicant complained of "constant neck pain". On 19 June 2015, Dr Farey expressed the opinion that the applicant had neck pain secondary to failure of his fusion. Consequently, the applicant underwent further surgery at C5/6 and a C4 to C7 fusion on 15 July 2015. On 17 June 2016, Dr Farey advised that the applicant had residual neck pain following his surgery and that there was "no indication for further surgery". He continued:

> "His neurological symptoms were related to spinal cord damage occasioned by his initial injury which produced C5/6-disc protrusion and spinal cord compression. There is residual damage within the spinal cord as evidenced by myelomalacia at the C5/6 level."

MEDICOLEGAL OPINION

Dr Casikar

41. Dr Casikar, a neurosurgeon, saw the applicant at the request of the respondent on 21 March 2013. He noted a history "pins and needles and a funny sensation in the anterior part" of the right thigh from the time of the injury. He concluded that this was indicative of meralgia paraesthetica in the right thigh. Dr Casikar also accepted that the applicant may have some back and knee pain but opined that this did not relate to the injury. The back pain merely reflected the applicant's obesity. The knee pain did not improve following surgery which negated a causal connection with the injury.

Dr Antoun

42. On 25 July 2013, the applicant saw Dr Antoun, probably a general practitioner, who also took a history that the applicant experienced pins and needles in the right thigh and the outer side of the thigh from shortly after the injury. He expressed the opinion that the applicant had some back and knee pain but also findings on examination "which appeared to be in distribution of the lateral cutaneous nerve of the thigh."

Dr Field

43. On 27 November 2014, the applicant saw Dr Field, an occupational physician. Dr Field took a history that when the applicant:

> "consulted with Dr Sorial around June 2012 … he had begun to develop right thigh pins and needles sensations (paresthesia) and difficulty walking. He also had pain in the right lower back".

Dr Field did not accept that the applicant's spinal problems were related to the subject injury. She stated that "his other medical comorbidities and constitutional factors which are now significantly limiting his return to work, rather than his original right knee work related injury per se."

Dr Richard Powell

44. Dr Richard Powell, an orthopaedic surgeon, saw the applicant to at the request of the respondent's insurer on 10 June 2016. By a report dated 8 July 2016, Dr Powell addressed the issue of the applicant's low back symptoms as follows:

> "There were no reports of injury to the lower back in the initial incident. He was reviewed by Dr Kodsi and referred for multi—positional MRI scans of the lumbar spine in February 2013, 10 months after the workplace incident. The scans revealed some degenerative disc disease of the L3/4, L4/5 and L5/S1. Specialist opinion was obtained from associate Prof Brian Owler in September 2013. He reviewed the MRI scans indicating that they did not reveal significant pathology with no evidence of neural compromise and suggested that the right by symptoms may reflect some neuralgia paraesthetica".

45. Dr Powell addressed the question of injury to the cervical spine as follows:

> "There is no history of direct injury to the cervical spine in the incident. Investigation of the neck in February 2014 demonstrated spondylosis at the C5/6 with associated spondylolisthesis and moderate canal stenosis with some flattening of the cord and some alteration in cord signal suggestive of myelopathy. Disc osteophytes complex is resulted in significant bilateral C5/6 and to a lesser extent C6/7 foraminal narrowing. After being reviewed by Dr New, Mr Cruceanu, was referred to Dr Farey, Orthopaedic Surgeon at the Royal North Shore Hospital. He recommended surgery and he underwent sequential surgical procedures".

46. Dr Powell expressed the following opinion in respect of the relationship between the applicant's neck and back symptoms and injury:

> "The mechanism of injury that he describes is not consistent with him having sustained injury to the cervical spine, lumbar spine bilateral shoulders or left knee. Subsequent investigations of the cervical and lumbar spine clearly demonstrate the presence of well-established pre-existing degenerative

changes in those regions. There is no evidence that his employment or the specific workplace injury on 10 April 2012 would be considered the substantial or main contributing factor in the development or aggravation of these disease processes."

APPLICANT'S MEDICOLEGAL REPORTS

Dr Harrison

47. Dr Harrison, an orthopaedic surgeon, saw the applicant on 28 April 2015 and 15 March 2016 and prepared a series of reports at the request of the applicant's then solicitors. By a report of 28 April 2015, he expressed the following opinion:

> "As a sequel to an accident at work on 10 April 2012, this man clearly twisted and injured his right knee and he appears to have jarred and injured his right neck in the impact forced through the extended right arm out to the side and behind him, …. but the focus was on his right knee pain and problems and the elements of lower back and neck pain became clearer some months after the accident and have increasingly troubled him since as I have recorded above."

48. Dr Harrison, prepared a further report of 15 March 2016 by which he stated:

> "This man sustained a jarring injury to his neck in the course of his work on 10 April 2012 as outlined in the original report of sufficient force to jar and injure his right wrist but that settled effectively with an injection of cortisone given within two months of that injury and the ongoing problems that affect him now are interplay between neck and upper limb pain and numbness, lower back pain and referred pain in his legs and bilateral medial compartmental and patello-femoral knee pain on each side, that on the right being more significant and generated through the mechanics of the accident in the twisting force through his right knee that he sustained although it has not been particularly helped by two well meaning, arthroscopic, surgical intervention by skilled orthopaedic surgeons."

Dr New

49. Dr New, the orthopaedic surgeon who treated the applicant in respect of his lumbar spine, also provided a medicolegal report of 21 August 2014. Dr New noted that following his first examination of the applicant on 21 January 2014, he referred him for an MRI scan of the neck and subsequently to the Institute of Neurological Sciences for an opinion as to whether there was interference with his motor function in the applicant's limbs. Dr New continues:

> "Physical examination confirmed at that stage a protective sitting and standing attitude, and antalgic gait favouring the right hand side, decreased lumbar lordosis, markedly reduced lumbar spinal movement and disruption of his normal lumbar pelvic rhythm."

50. In addressing causation, Dr New stated that there was "no doubt that there is a link in causation between this gentleman's accident and his knee pathology." He does not express an opinion, however, in respect of the applicant's neck. He says this:

> "With regard to his cervical spine, he states that he had not had any problems with his neck injury prior to this accident, but the spinal stenosis that he had would almost certainly pre-dated the incident.

51. He states that the applicant's back was the predominant issue after his accident rather than his neck, although he had minor neck discomfort. It was obvious that on investigation, after taking a history, that he did have significant neck pathology which "was investigated and found to be a nature that required urgent surgery." He stated that the applicant had the following diagnoses:

> "• Juvenile rheumatoid arthritis.
>
> • Derangement of his right knee consistent with Dr Sorial's arthroscopic report that the Patient required a partial meniscectomy and chondroplasty which was consistent with the MRI.
>
> • He has lumbar spondylosis.
>
> • He has bilateral referred pain into both thighs and requires perhaps further investigation with somatosensory evoked potentials for possibility of lateral cutaneous neuralgia paraesthetica.
>
> • He has C5/6 early cervical myelopathy."

52. Dr Farey provided a report to the applicant's solicitors on 2 August 2018. He had access, at that time, to the applicant's statement of 7 April 2017. Dr Farey noted and commented on some aspects of the applicant's evidence. He recorded the following:

> "Importantly he also reported numbness in his leg. This occurred on a regular basis. Although Mr Cruceanu has evidence of degenerative disc disease in his lumbar spine there is no evidence of nerve root compression which would cause numbness in his leg. Shortly following the accident, he has stated that he developed neck and bilateral shoulder pain. His back pain continued to be a problem and he continued to experience numbness in his right leg. In October 2013, he reported that he would also experience numbness in his hands and in particular the ring and middle fingers of each hand. This is a very common symptom of spinal cord compression."

53. The doctor noted that he had not been provided with a "a complete history" of neurological symptoms at the time of the first consultation. He said that he was uncertain as to why he was not provided this history at the time of his initial consultation. He assumed the fact that the applicant may have been distressed by his pain accounted for this oversight. Against the background of the additional history, Dr Farey offered the following opinion:

> "However, historically he has experienced numbness in his right lower limb from the time shortly following the accident in the absence of nerve root compression in the lumbar spine. The numbness is likely to have arisen from the cervical spine and spinal cord compression which as I have stated is a painless condition other than neck pain secondary to underlying cervical spondylosis. He subsequently developed major symptoms of spinal cord compression. Myelomalacia within the spinal cord does not develop acutely unless there is an acute spinal cord injury. Generally, this is a finding which develops with the passage of time secondary to spinal cord compression.
> I have no doubt that Mr Cruceanu had pre-existing cervical spondylosis as evidenced by his history of intermittent neck pain with his work-related activities as is detailed in his statement. He had significant degenerative changes at the C5/6 level with a degree of instability. It is entirely possible that the tripping injury with the weight bag swinging on his shoulder has caused further problems in his cervical spine in view of the experience of neck pain following the accident."

54. The doctor then expressed the following opinion:

> "In my opinion, the onset of neck pain following the accident the description of intermittent numbness in the right lower limb and the subsequent development of more advanced symptoms in the upper limbs including numbness coupled with the presence of instability at the C5/6 level as manifested by the retrolisthesis and presence of myelomalacia which takes time to develop is indicative of an exacerbation of his underlying condition following his accident on 10 April 2012."

DISCUSSION AND FINDING

55. The only issue on which the parties addressed at the arbitration hearing was "injury". The s 74 notices issued by the respondent's insurer also asserted that the applicant's employment was not "the main contributing factor to any injury to your cervical spine (neck)". As the applicant's injury occurred prior to the introduction of the amendment to the definition of disease injury in s 4 of the *Workers Compensation Act 1987* (the 1987 Act) (by the *Workers Compensation Legislation Amendment Act 2012*), the issue of "main contributing factor" does not arise. Section 9A of the 1987 Act applied to injuries sustained prior to 19 June 2012. The relevant test is whether the employment was a "substantial contributing factor" to the injury.

56. The medical case on each side assumes that the applicant suffered from a significant pre-existing medical condition, which can be readily characterised as a disease. Dr Powell refers to "well established pre-existing degenerative changes" in the applicant's cervical spine. Dr Farey refers to "an exacerbation of his underlying condition" by reason of the injury. Cervical spondylosis has generally been recognised as a disease in the decision making of the Commission and, prior to 2003, the Compensation Court.

57. Assuming an aggravation or exacerbation of that condition by the incident alleged, the question arises whether the relevant employment was a substantial contributing factor to the aggravation or exacerbation. If the applicant suffered a personal injury simpliciter, the test is whether the employment is a substantial contributing factor to the injury. I will return briefly to this issue after determining the injury issue.

58. In the context of the conflicting medical opinions, there is an important factual matter, which must be determined by the Commission. When did the applicant develop symptoms in his neck, his upper limbs and "intermittent numbness" in his right lower limb? On the assumption, that these symptoms developed at the time of or soon after the incident, Dr Farey has opined that it is possible that they were caused by it. This constellation of symptoms is indicative of an exacerbation of the applicant's underlying condition by the incident of 10 April 2012.

59. Mr Calloway argued that the applicant's evidence as to the development of these symptoms is a reconstruction. He refers to the obvious discrepancies between the accounts of the onset of neck/upper limb pain initially recorded by Dr Farey and that contained in the applicant's statement which was signed several years later. That raises the issue of whether the applicant's evidence is reliable.

60. The first explicit history in the medical evidence of paraesthesia in the applicant's right thigh is Dr Sorial's note, on 1 February 2013, that the applicant had "paraesthesia and tingling" affecting his thigh muscle. The finding is mirrored by that of Dr Kodsi on 2 February 2013. The doctor recorded that the applicant had "paraesthesia all the way to the R knee". Thereafter, there are numerous references to thigh symptoms in the medical histories in the reports of both treating doctors and those to whom the applicant was referred for medicolegal purposes.

61. Dr Sorial suspected that the applicant's thigh symptoms were indicative of a "neurogenic claudication", possibly caused by a back problem. In May 2013, Dr Pope expressed the opinion that the symptoms were possibly caused by an obturator neuropathy. On 21 September 2013, Dr Owler opined that the applicant's thigh symptoms arose from entrapment of the lateral cutaneous nerve. Dr Casikar and Dr Antoun posited a similar diagnosis. Dr New also seems to accept entrapment of the lateral cutaneous nerve as a possible diagnosis. It was on this basis that Dr Casikar postulated that the condition resulted from the work incident.

62. Dr Owler took a history that the numbness in the lateral thigh started after the applicant's right knee surgery. Dr Field, who saw the applicant in the following year recorded that it commenced around the time the applicant consulted Dr Sorial, which would place its onset several months after the work incident of 10 July 2010. Dr Casikar and Dr Pope recorded histories that are reasonably consistent with right paraesthesia commencing shortly after the incident in April 2012.

63. The references to symptoms in the applicant's neck, face and upper limbs in the medical records occur at a later time. Dr Farey recorded in his initial report that the applicant's neck pain commenced six months earlier and were of "spontaneous onset". On that history, the time frame for the commencement of neck symptoms is the last quarter of 2013.

64. Clearly, Dr Pope, Dr Owler and Dr Casikar took no history of such symptoms. Neither did Dr Antoun, when he examined the applicant on 29 July 2013. Dr Antoun was the only doctor who examined the applicant's neck during this period. He recorded that there was a full range of movement with no signs of radiculopathy.

65. On 13 September 2013, Dr Kodsi recorded that the applicant had right sided paraesthesia which extended to his face, arm and leg. Dr New's initial report, of 23 January 2014, does not contain any history of this paraesthesia or of neck pain. But it seems likely that the applicant may have complained of, at least, some aspect of this symptom complex at consultation as Dr New referred the applicant for scans and other investigations, which indicated spinal canal stenosis at C5/6 "causing some early cervical myelopathy" affecting the spinal cord at that level.

66. Certainly, by the time the applicant saw Dr Farey on 19 May 2019, there is a clear history of neck pain of spontaneous onset, six months previously. Thereafter, they are a prominent feature of the applicant's complaints to medical practitioners.

67. On several occasions in recent years, the Court of Appeal has cautioned against the use of medical records and the histories contained in medical reports to undermine the credibility of a witness. See *Davis v Council of the City of Wagga Wagga* [2004] NSWCA 34 (26 February 2004), *Daniel Fitzgibbon v The Water Ways Authority & Ors* [2003] NSWCA 294 (3 December 2003) (*Fitzgibbon*) and *Mason v Demasi* [2009] NSWCA 227 (31 July 2009). These cases suggest that a tribunal would be wary of preferring entries in clinical records to the sworn evidence of witnesses. They also emphasise that the primary function of medical records is to facilitate treatment and not as an unerring record of the medical history.

68. Arguably, where clinical notes are legible they may provide an objective record of the complaints made by a worker from time to time. Certainly, they have been utilised for this purpose in workers compensation cases for a very long time: see *Azzopardi v Tasman UEB Industries Ltd* (1985-86) 4 NSWLR 139 (*Azzopardi*), where Kirby P discussed the use Burke J made of the medical record. It was accepted in that case that it was open to the judge to take into account an absence of complaint by the appellant worker to his treating medical practitioners in finding that an injury had not occurred at work. While Burke J explicitly stated in his reasons for judgment that the absence of complaint did not go to the "general reliability" of the worker, it is difficult to accept that this approach is correct. However, it is unnecessary to consider this matter further in this case.

69. The circumstances of this case are not identical with *Azzopardi*. Nonetheless, there are the quite different accounts of the development of symptoms that need to be addressed and resolved if the opinion of Dr Farey is to be accepted. Dr Farey, observed that the applicant was distressed at his initial consultation, which may have influenced the history that he gave at the time.

70. The applicant did not give oral evidence at the arbitration hearing. There was no application to cross-examine him. In those circumstances, I am reluctant to make any finding about what has been described as general reliability or credibility. Nonetheless, I have considerable doubt as to whether the applicant experienced the onset of neck and upper limb symptoms as set out in his statement of 7 April 2017. The applicant states that neck and shoulder pain developed almost immediately after the incident of April 2010 and after "1-2 months was becoming quite a problem for me." Thus, on his account, there was the onset of neck pain shortly after the incident, which gradually increased in severity so that by July 2010, it was "a problem".

71. It is difficult to reconcile that evidence with the complete absence of complaint of neck pain in the medical record over a period of 18 months. During this period, the applicant had multiple consultations with his general practitioner about a variety of problems including his knee, his wrist and his low back. He was also referred to three neurosurgeons, two orthopaedic surgeons and Dr Antoun, probably a general practitioner, who he saw on behalf of the respondent. There is no reference to the onset or progression of neck pain in the histories taken by these doctors. Dr Antoun examined the applicant's cervical spine as part of his examination in July 2013. He recorded a full range of movement without radiculopathy. He did not record complaints of neck pain.

72. As the facts in *Fitzgibbon* demonstrate, doctors are fallible and mistakes are made in recording medical histories. An error in history taking may be replicated by the authors of subsequent medical reports. That, however, is unlikely to be the case here. Multiple medical examinations by doctors in different specialties have failed to elicit a history that the applicant suffered from neck and shoulder pain in the year or more after the incident.

73. The applicant says that he did not think "there was any thing that he could do about it". But, that sits uncomfortably with the fact that he did give an account of neck pain to his general practitioner some three weeks before the injury.

74. In my opinion, the evidence from the medical record is entirely consistent with the applicant's assertion to Dr Farey at his initial consultation that his neck pain commenced some six months before the consultation in May 2014. That is also approximately the time, when Dr Kodsi recorded that the applicant had right-sided paraesthesia at affecting his upper and lower limb. I am not satisfied that the applicant has established on the balance of probabilities that his cervical symptoms became manifest or, on the assumption that the applicant had some intermittent prior problems, deteriorated at the time of or following the injury. It follows from that finding that I would be cautious in accepting the applicant's account of the development of his symptoms following the injury.

75. I return now to the opinion of Dr Farey in his report of the 2 August 2018. It should be borne in mind that Dr Farey expresses his hypothesis as a possibility. As the case law makes clear, however, that language is by no means inconsistent with a finding on the balance of probabilities that the applicant suffered injury; most recently, see the discussion in *Tudor Capital Australia Pty Limited v Christensen* [2017] NSWCA 260 (17 October 2017) at [369]–[383] by McColl JA. Indeed, medical practitioners often use the word "possible", when there is no other likely cause of the pathology addressed other than the injury. That, however, is not the case here.

76. I reiterate that Dr Farey opined, as do many of the other specialists in the case, that the applicant had a significant pre-existing spondylosis. Dr Farey stated that it was possible that the applicant's injury "has caused further problems in his cervical spine in view of the *experience of neck pain following the injury*" (my italics). The experience of neck pain was indicative of an exacerbation or aggravation of the applicant's spondylosis which, in turn, either caused or exacerbated the applicant's myelomalacia.

77. Absent an acceptance of neck pain following the incident, it is difficult to postulate how the incident caused injury to the applicant's neck. I do not doubt that the incident was capable of causing damage to a susceptible neck. The question, however, is whether it did.

78. Certainly, there are references to pins and needles in the applicant's thigh well before the onset of neck and upper limb pain and paraesthesia. However, the time of onset of these symptoms is also contestable. Further, there are other competing diagnoses which may account for these symptoms. More importantly, in the absence of neck pain it is difficult to know what to make of the symptoms. Are they a manifestation of the applicant's underlying cervical spondylosis causing the inexorable onset of myelomalacia? Or are they somehow connected with an injury to the neck in the incident? It seems to me that to connect the paraesthesia in the applicant's upper thigh, which was first noted by doctors many months after the incident with an injury to the neck involves considerable speculation.

79. I have concluded that factual assumptions upon which Dr Farey has founded his opinion have not been proven. As Mr Mirsic recognised, there is no compelling evidence which would establish injury to the neck other than Dr Farey. Dr New, possibly wittingly, did not positively assert a causal nexus between the injury and the applicant's cervical myelopathy.

80. Of course, Dr Harrison, an orthopaedic surgeon clearly posits a connection between the injury and the applicant's neck symptoms. But he also assumes that the neck symptoms came on relatively soon after the incident. He does not explain how the incident is consistent with the development of symptoms in the neck 18 months later. If it is necessary to so, I prefer the opinion of Dr Powell to that of Dr Harrison as his opinion is based upon a history which is consistent with my findings of fact.

81. A finding that the applicant has not proven an injury to his cervical spine precludes a referral of the matter to an Approved Medical Specialist for assessment of whole person impairment as the assessment's proffered by the applicant do not surmount the threshold for compensation pursuant to s 66. As the applicant makes no other claim, it follows that the claim for permanent impairment must be dismissed.

82. The applicant has also pleaded injury to the back. Because of the critical importance of the neck injury to the applicant's claim for permanent impairment, the issue of injury to the applicant's back was, understandably, given very little attention at the arbitration hearing. The evidence in relation to the applicant's back is quite different to that in respect of his neck. It is true that no back problem is identified by the applicant's treating doctors for many months after the injury. That may be fatal to the claim. On the other hand, there is evidence that the applicant's back symptoms may have been engendered by altered gait caused by his knee injury. That allegation was neither pleaded nor argued at the arbitration hearing, and I do not propose to say more about it.

83. Given the fact that no compensation entitlement turns on a finding of back injury, I do not propose to determine the issue of the relationship of the applicant's back condition to the injury in these short reasons. If necessary, it can be determined if it gives rise to a claim for compensation. That will also provide the parties with an opportunity to address the issue in a way that may be of assistance to the Commission.

84. I appreciate that this is unsatisfactory in some respects. In my opinion, however, it would not be in the interests of justice to determine a claim which has barely been addressed at the arbitration hearing, in circumstances where a finding, one way of the other, is not material to the outcome.

85. I propose to make an award for the respondent in respect of the allegation of injury to the applicant's neck and dismiss the claim for permanent impairment compensation pursuant to s 66.