WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **3424/19**
Applicant: **Neshan Nader**
Respondent: **A O Family Trust**
Date of Determination: **14 October 2019**
Citation: **[2019] NSWWCC 331**

The Commission determines:

1. The applicant has not discharged the onus of proving on the balance of probabilities that the incident on 13 June 2012 caused injury pursuant to section 4(a) of the *Workers Compensation Act 1987* to his lumbar spine or thoracic spine.

2. Award for the respondent.

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 Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr Neshan Nader (the applicant) was employed as a fitter and joiner by A O Family Trust (the respondent). On 13 June 2012, the applicant was attempting to lift a cabinet when the cabinet dropped, lacerating the dorsal aspect of his left hand.

2. A claim for workers compensation was made on 24 July 2014 and eventually came before the Commission in proceedings 4968/18. On 23 October 2018, the Commission issued consent orders at teleconference in those proceedings, making an award for the respondent in respect of allegations of injury to the applicant's neck and bilateral carpal tunnel syndrome. The respondent was ordered to pay weekly compensation up to 3 September 2015 and medical expenses up to $10,000 pursuant to s 60 of the *Workers Compensation Act 1987* (the 1987 Act).

3. On 13 March 2019, the applicant, through his solicitors, made a claim for lump sum compensation pursuant to s 66 of the 1987 Act. On 10 July 2019, the respondent's insurer issued a notice pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act), declining liability for injury to the applicant's thoracic and lumbar spine. It was further disputed that the applicant had sustained a degree of permanent impairment greater than 10% as a result of the accepted injury to his left hand.

4. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) filed in the Commission on 10 July 2019, seeking lump sum compensation pursuant to s 66 of the 1987 Act for permanent impairment of the thoracic spine, lumbar spine and skin resulting from the injury on 13 June 2012.

PROCEDURE BEFORE THE COMMISSION

5. The parties appeared for conciliation conference and arbitration hearing on 9 September 2019. The applicant was represented by Mr John Gaitanis, instructed by Mr Andrew Tohme. The respondent was represented by Mr Andrew Combe of counsel.

6. 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

7. During the conciliation conference, the applicant raised for the first time an argument that the Certificate of Determination Consent Orders issued in Commission proceedings 4968/18 raised an estoppel which prevented the respondent from disputing liability for injuries to the lumbar and thoracic spines. Submissions on an application pursuant to s 289A(4) of the 1998 Act were made and recorded at the commencement of the arbitration hearing and for reasons given orally, the application declined.

8. The parties agreed that the following issues remained in dispute:

    (a) Whether the applicant sustained injury to his thoracic spine and lumbar spine on 13 June 2012, and

    (b) The applicant's entitlement to lump sum compensation pursuant to s 66 of the 1987 Act.

9. The parties agreed that in the event of determinations favourable to the applicant in respect of the disputed body parts, the matter should be the subject of a referral to an Approved Medical Specialist (AMS) which also included the skin (TEMSKI). It was noted that although the respondent accepted liability for an injury to the applicant's left hand on 13 June 2012, the only evidence of permanent impairment resulting from the accepted injury involved the skin.

EVIDENCE

Documentary evidence

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

    (c) ARD and attached documents;

    (d) Reply and attached documents;

    (e) Documents attached to an Application to Admit Late Documents filed by the applicant on 1 August 2019;

    (f) Documents attached to an Admit Late Documents filed by the respondent on 9 September 2019, and

    (g) A supplementary report of Dr Charles New, dated 30 August 2019, filed by the applicant on 9 September 2019.

11. An Application to Admit Late Documents filed by the applicant on 15 August 2019 was withdrawn during the conciliation conference on 9 September 2019.

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

Applicant's evidence

13. The applicant 's evidence is set out in a written statement dated 11 July 2017.

14. The applicant said he commenced employment with the respondent in 2001. The applicant said that in the course of his duties he would lift approximately 100 cabinets per day. In 2008, he began to feel back pain, which he described as a "severe twinge". The applicant would see his doctor on a regular basis and his back became increasingly tender and sore after work.

15. On 13 June 2012, the applicant lifted a cabinet weighing 20 kg. As he lifted the cabinet, his right foot slipped and the applicant experienced a twisting motion of his lower back. Immediately, the applicant was in sudden pain. It was the same pain he had experienced between 2008 and 2012 but would now not go away and was much worse.

16. The applicant said he had been in severe pain since the injury and struggled to walk without the assistance of a cane. The applicant stayed off work for approximately two months, slowly progressing and hoping to return to employment. The applicant said he was unaware of his workers compensation rights at this stage and English was his second language. The applicant struggled to explain the injury to anyone he worked with and thought he had to return to work and keep working.

17. The applicant attempted to return to pre-injury duties in August 2012. The applicant thought he would get better, however, over time his injury worsened as he attempted to perform heavy lifting. The applicant's boss noted he was a bit slower and eventually told him that he was no longer needed. The applicant ceased employment with the respondent on 20 April 2013.

18. The applicant said he was seeing his general practitioner, Dr Gias Swid, who had been issuing WorkCover certificates of capacity. Dr Swid referred the applicant to Dr Van Gelder. Dr Van Gelder performed surgery in May 2016. Despite the surgery, the applicant continued to have chronic back pain and pins and needles in his legs.

19. The applicant said he eventually lodged a worker's compensation claim on the advice of his neighbours who referred him to his previous solicitors.

20. The applicant managed his pain with Lyrica, Panadol and Tramal.

The applicant's treating doctors

21. Hand-written clinical notes from the applicant's general practitioner, Dr Gias Swid are in evidence. A summary at the commencement of the clinical notes refers to:

> "L-S (x-ray) 20-12-06 – degenerative spondylitis and marginal osteophytes L2/3, L3/4, L4/5 & L5/S1".

22. A report accompanying an x-ray and CT scan of the lumbar spine dated 1 September 2009 noted a clinical history of low back pain and right-sided sciatica. The impression was of early L4/5 degenerative disc disease and mild, uncomplicated intervertebral disc prolapse.

23. On 18 November 2011, Dr Swid's notes referred to back pain and stiffness and walking slowly.

24. A medical certificate issued by Liverpool Hospital on 13 June 2012 indicates that the applicant was treated at the hospital on that date for a "hand injury". A WorkCover certificate issued by the hospital the same day gave a diagnosis of left-hand laceration.

25. On 14 June 2012, Dr Swid's notes referred to a left-hand laceration after carrying a wooden cupboard. The applicant was noted to have attended Liverpool Hospital where he was given stitches.

26. Further consultations in relation to the applicant's hand appeared on 18 June 2012, 20 June 2012 and 23 June 2012 without reference to any spinal symptoms. Dr Swid issued a WorkCover certificate on 20 June 2012 referring to the laceration, dorsally on the applicant's left-hand requiring six stitches. Subsequent WorkCover certificates issued by Dr Swid indicated that an injury occurred when a heavy cabinet fell on the applicant's left hand and it got stuck between two objects.

27. On 25 June 2012, Dr Swid's notes referred to lower back and mid back symptoms secondary to sneezing. The applicant was advised to take analgesia. The applicant's gait was noted to be ok.

28. On 28 June 2012, the applicant reported his hand was feeling better but again complained of lower back and leg pain. The applicant was sent for x-ray.

29. The report of an x-ray of the lumbar spine dated 28 June 2012 indicated loss of expected lumbar lordosis. There was 4-5 mm of retrolisthesis at L4/L5 and L5/S1.

30. Dr Swid's notes indicate that the applicant then attended multiple consultations between July 2012 and May 2013 without mention of any spinal symptoms until 25 May 2013, when the applicant brought an MRI of the thoracic spine done by "Dr Khaleal". Dr Swid arranged for the applicant to be referred to a spinal surgeon.

31. The report of an MRI scan dated 10 May 2013 indicated a large right acute paracentral disc extrusion at T8/9 causing moderate canal stenosis with effacement of the cord and displacement of the cord to the left and probable compression of the right T9 nerve root in the lateral recess.

32. Back surgery was discussed with Dr Swid on 7 June 2013. On 9 July 2013, the applicant described pain and being unable to sleep.

33. On 18 July 2013, Dr James van Gelder, neurosurgeon and spine surgeon wrote to Dr Swid. Dr van Gelder said the applicant described a work-related injury in June the previous year where he strained his back twisting and lacerated his hand. The applicant was currently principally concerned about low back pain radiating into his right leg. Dr van Gelder said initially the applicant had thoracic back pain but this had become more focused in his lumbar spine. The applicant had been finding it hard to work and lost his job two months earlier. The applicant was experiencing numbness in his lateral thigh and leg on the right side and lateral right foot and was limping. Dr van Gelder said the applicant had a history consistent with a work-related back injury and referred the applicant for CT scan of his thoracic spine and MRI of the lumbar spine.

34. The report of a CT scan of the thoracic spine performed on 24 July 2013 indicated evidence of a partially calcified right posterolateral disc protrusion at T8/9, causing deformity upon the right anterolateral aspect of the theca and impingement on the right sided nerve root. There was narrowing of the spinal canal.

35. Spinal symptoms were reported again to Dr Swid on 3 August 2013, 16 August 2013 and 6 September 2013.

36. The report of an MRI of the lumbosacral spine performed on 5 September 2013 indicated disc dehydration and loss of disc height at L4/5 which, in conjunction with thickening of ligamenta flava, hypertrophic facets and shortened pedicles, was resulting in mild cauda equina and lateral recess stenosis. There was a small left far lateral disc protrusion establishing minor contact with the L4 nerve root but without significant compression. There was mild narrowing of the exit foramina bilaterally at L5/S1 due to facet hypertrophy and thickening of ligamenta flava.

37. The thoracic symptoms were discussed with Dr Swid again on 14 September 2013. The applicant complained of back pain and right-sided sciatica again on 23 September 2013.

38. The first reference to spinal symptoms in a WorkCover certificate appeared on 31 October 2013. Dr Swid referred to a large posterior lateral disc herniation at T8/9 and exacerbation of lower back pain. The injury was said to have occurred through recurrent lifting and twisting in June 2012.

39. There are a series of reports from neurologist, Dr Paul Teychenne in evidence, dating from 3 April 2014. In his first report, Dr Teychenne took a history of injury on 13 June 2012, when the applicant was carrying a cabinet going down steps and the cabinet fell and the edge of the cabinet lacerated the dorsal aspect of the applicant's left-hand requiring seven stitches. Dr Teychenne said the applicant reported pain over the back, more noticeable when lying down, and found disc lesions at L3/4, L4/5 and L5/S1 plus spinal stenosis. Dr Teychenne indicated that an MRI of the lumbar spine was required.

40. On 10 April 2014, Dr Teychenne noted the applicant reported numbness over the top of his right foot extending into toes, pain and right buttock and posterior right thigh as well as weakness in the right leg. The applicant tended to limp on the right leg. Dr Teychenne's findings on examination were consistent with a right L5/S1 and left S1 radiculopathy. Dr Teychenne again recommended an MRI scan of the lumbar spine.

41. On 14 April 2014, Dr Teychenne noted that the applicant could not sit straight in a chair and his gait was slow due to pain over the right parathoracic region. Dr Teychenne said this was no doubt arising from the disc prolapse at T8/9.

42. The report of an MRI of the lumbar spine performed on 2 May 2014 indicated disc narrowing and signal loss at L4/5 and facet joint degenerative hypertrophy but no significant spinal stenosis and potential L5 origin impingement.

43. General surgeon, Dr AJ Sanki, prepared a report for the applicant's former representatives dated 4 May 2014. Dr Sanki said the applicant had been referred to him by Dr Swid and was first seen on 6 January 2014. The applicant explained that he had an injury at work involving the skin on the back of his left hand being cut. The applicant was taken to Liverpool District Hospital for surgical treatment. The applicant had been trying to lift a cabinet to put it on to a table from a pallet. As he did that, the applicant twisted his back and at the same time his foot slipped. The applicant did not fall to the ground. The twisting of his back gave the applicant back pain radiating to the right leg.

44. The applicant underwent a haemorrhoidectomy under the care of Dr Khalil, a general surgeon. Immediately after the operation, the applicant noted severe pain in the back. Dr Khalil carried out investigations in the form of a CT scan and MRI.

45. Dr Sanki diagnosed "dorsal spine injury to the disc" and lumbar spine disc lesion. Dr Sanki referred the applicant to Dr Paul Teychenne for full nerve conduction studies. Dr Sanki attributed the disc injury to the applicant's dorsal and lumbar spines to the type of work he was doing and to the incident on 13 June 2012. The symptoms appeared prominently after the haemorrhoidectomy. Dr Sanki explained that the haemorrhoidectomy is carried out in a supine position and can on occasion cause acute flexion of the lumbar spine. Dr Sanki said that in his experience he had not seen one case of sciatica or severe back injury as a result of a haemorrhoidectomy procedure.

46. On 8 May 2014, Dr Teychenne reported that the MRI scan of the lumbar spine showed disc narrowing and signal loss with a broad-based central disc protrusion at L4/5. There was facet joint degenerative change but without significant spinal stenosis. There was potential irritation of the L5 nerve root. Dr Teychenne said the findings on MRI scan of the lumbar spine were consistent with the neurophysiological findings of a bilateral L5/S1 radiculopathy. Conservative treatment was recommended in respect of the lumbar spine.

47. Clinical notes of Dr Sanki commencing on 4 June 2014 are in evidence. Dr Sanki's notes on that occasion referred to the MRI of the lumbar spine and complaints of severe pain. On 7 July 2014, the applicant complained of low back pain and electric pain and numbness in his right thigh.

48. On 4 August 2014, Dr Sanki noted the applicant was walking with a stick and experiencing right foot numbness.

49. On 8 April 2015, Dr Sanki referred the applicant back to Dr van Gelder for his lower back pain.

50. The report of an MRI of the cervicothoracic spine on 17 July 2015 indicated a large right paracentral and right posterior lateral disc protrusion at T8/9 with some calcified annular material within the disc protrusion. This created marked compression of the theca and cord and marked acquired canal stenosis.

51. On 19 May 2016, Dr van Gelder wrote to Dr Sanki confirming that the applicant was admitted to Liverpool Hospital on 16 May 2016 for lumbar decompression surgery. The applicant was noted to have been suffering from unmanageable right-sided sciatica resembling an L5 distribution.
52. On 16 August 2016, Dr van Gelder reported to Dr Sanki that the applicant had reported improvement in his leg pain and there was no more numbness. The applicant was walking normally without his walking stick and without a limp.

Dr New

53. The applicant relies on medicolegal reports prepared by orthopaedic and spinal surgeon, Dr Charles New, dated 9 September 2016, 14 February 2017, 10 September 2018 and 30 August 2019.

54. In his first report, Dr New took a history of the applicant injuring himself on 10 June 2012 when he attempted to lift a cabinet. As he performed this activity, the applicant twisted his back and his right foot slipped. The applicant tried to hold his position and did not fall to the ground but the twisting motion of his back gave him very severe back pain and right-sided leg pain. The applicant went off work and stayed off work for approximately two months, being reviewed by his general practitioner.

55. The applicant was investigated by Dr Khalil, a general surgeon who suggested a disc prolapse at T8/9 as well as a disc protrusion at C7/8. The applicant was treated conservatively until reviewed by Dr van Gelder. Dr New did not have the operation report for the surgery performed by Dr van Gelder.

56. Dr New noted that the applicant walked with a cane in his right hand. Examination of the lumbar spine revealed protected sitting and standing attitude and an antalgic gait favouring the right-hand side, decreased lumbar lordosis and markedly reduced lumbar spinal movement. Neuromuscular examination of the lower limbs confirmed dysaesthesia in the L5 nerve root distribution and decreased power in the right extensor hallucis longus L5.

57. The applicant had tenderness over the mid-thoracic area with noted substantial T8/9 disc prolapse and fasciculations.

58. Dr New reviewed a CT scan of the thoracic spine dated 24 July 2013, an MRI of the lumbar spine dated 5 September 2013, a CT scan and MRI of the lumbar spine dated 15 May 2015 and an MRI of the cervical and thoracic spine dated 17 July 2015.

59. Dr New made a diagnosis that included significant sequestration of disc material at T8/9 with marked deviation of the thoracic cord, widespread lumbar spondylosis from L2 to the sacrum, severe post-operative pain at L4/5 and in the L5 nerve root distribution, signs and symptoms consistent with thoracic cord irritation, and a possible diagnosis of myelopathy.

60. Dr New reported that the applicant had stated that he was asymptomatic and holding down a full-time job without restriction until the time of the injury. Dr New concluded, therefore, that work was the substantial contributing factor to the applicant’s current presentation, particularly with regard to his lumbar spine. There were no prior problems associated with the thoracic pain.

61. Dr New expressed the view that there was a high likelihood that the applicant would need revision surgery to the lumbar spine. Dr New also expressed very significant concerns regarding the T8/9 disc prolapse.

62. In his first supplementary report, Dr New noted that the applicant had updated x-rays on his lumbar spine which confirmed lumbar spondylosis and Grade 1 retrolisthesis at L4/5. MRI of the thoracic spine revealed a very large disc at the T8/9 which was symptomatic with radicular chest pain. Dr New recommended that the applicant be referred to a spinal surgeon for consideration of surgical decompression.

63. Dr New nonetheless considered that the applicant was capable of assessment of whole person impairment (WPI) and assessed the applicant as having 21% WPI of the lumbar spine, thoracic spine and skin.

64. In his second supplementary report, Dr New noted the history of the applicant twisting his back and his right foot slipping and expressed the clinical opinion that the twisting motion that the applicant experienced on the date of injury did contribute to the applicant's pathology.

65. In his most recent supplementary report, Dr New indicated that he had reviewed the applicant on 29 August 2019. The applicant confirmed the history set out in his report of 9 September 2016 in terms of causation. Dr New said he had attempted to review the clinical notes of Dr Swid but said they were difficult to review. Dr New acknowledged the liability dispute with respect to the lumbar and thoracic spine and the pre-existing history of lumbar spinal pain. Dr New again noted that he was yet to review Dr van Gelder's operation report.

66. Dr New said the pre-existing lumbar spinal pathology would be relevant for the whole person impairment assessment with a deduction of $1/10^{th}$ being the usual formula. Dr New said he could only comment on the history given to him by the applicant in 2016 and further to that the physical examination. Dr New said that based on that history, he was of the view that the injury on 13 June 2012 was likely to have resulted in the development of the applicant's current injury presentation and that employment was a substantial contributing factor to the current presentation. Dr New said he was not aware of any restrictions that the applicant had prior to this injury.

Dr Min Fee Lai

67. The applicant also relies on a medicolegal report prepared by general surgeon, Dr Min Fee Lai, dated 21 November 2017.

68. Dr Lai noted that the applicant complained of a gradual onset of neck and back pain from 2008 which he attributed to the nature of his work. On 13 June 2012, the applicant was lifting a cabinet weighing 20 kg when he suddenly slipped and fell. The applicant felt a sudden sharp pain in his back resembling the pain he had experienced previously but more intense and excruciating. The pain did not go away. The applicant attributed this to the twisting action of his back during the fall. At the same time, the applicant lacerated the dorsum of his left hand after the edge of the cabinet fell onto his left hand and forearm. Following the injury, the applicant experienced pain radiating down his legs, mainly on the right, and also other back pain radiating into the posterior lower chest on the right side.

69. The applicant was referred to general surgeon, Dr Khalil who carried out investigations in the form of MRI and CT scan, which revealed T8/9-disc herniation with impingement of the T9 nerve and disc bulges at L4/5 and L5/S1. The applicant was then referred to orthopaedic surgeon, Dr van Gelder. The applicant's lower back symptoms deteriorated and eventually he was operated on by Dr Van Gelder who performed laminectomy to relieve the pressure on the L5 nerve on the right side.

70. Dr Lai considered an x-ray and CT of the lumbar spine dated 1 September 2009, x-ray of the lumbar spine dated 20 June 2012, MRI of the thoracic spine dated 10 May 2013, MRI scan of the cervicothoracic spine dated 18 July 2015, an undated presumably post-operative MRI of the lumbar spine and nerve conduction studies dated 10 November 2016 by Dr Paul Teychenne.

71. Dr Lai's physical examination revealed a 5-cm oblique scar across the index and middle finger metacarpal rays. The scar was white in colour and obvious in comparison to the surrounding darker skin. There was absence of sensation to pinprick for about 1.5 cm to each side of the scar.

72. The thoracic spine was tender to palpation over the lower thoracic spine region with paravertebral muscle spasm. There was tenderness to palpation over the right posterior lower chest and loss of sensation to pinprick over the right upper abdominal region in the distribution of the T9 dermatome.

73. There was tenderness to palpation in the lower lumbar spine region on the right side as well as right paravertebral muscular spasm. There was loss of movement to flexion, extension, lateral flexion and lateral rotation. There was loss of sensation to pinprick in the distribution of the L5 dermatome.

74. Dr Lai diagnosed lumbar laminectomy with residual radiculopathy and thoracic spine disc herniation at T8/T9 with compression of right T9 nerve root with radicular symptoms.

75. Dr Lai assessed the applicant as having 2% WPI for scarring of the hand.

Dr Frank Machart

76. The respondent relies on medicolegal reports prepared by orthopaedic surgeon, Dr Frank Machart, dated 11 August 2014 and 16 April 2019.

77. In his first report, Dr Machart noted that the applicant's English was not adequate for the conduct of the consultation and his wife interpreted for him. Dr Machart noted that the history was difficult. Dr Machart said he was able to establish that the applicant was injured on 13 June 2012. The applicant was taking a delivery, putting cabinets on pallets. The floor was uneven and wet. The applicant slipped, twisted his torso and suffered a crush injury to his left hand, which got stuck between two cabinets. The applicant was treated for the laceration at Liverpool Hospital with stitches.

78. Dr Machart noted that the applicant was off work for three or four months but said he could not give clear indication as to why he was off work for this length of time or why he was sacked a year later.

79. The applicant reported low back pain radiating into the right leg. Dr Machart said he "quizzed" the applicant about this. The applicant's recollection was that at the time he suffered a laceration to his left hand, he also twisted his back. The applicant said he was unable to report the pain in his back because he was under medications, "antibiotics".

80. The applicant reported seeing his general practitioner about two weeks after the injury. The doctor organised x-rays. The applicant continued to suffer low back pain and pain in the right leg. The applicant was unable to explain how his pain had progressed from being able to work without medical restrictions to now experiencing difficulties walking.

81. The applicant reported that he had suffered from "normal back pain" since about 2009 but this did not prevent him from conducting normal employment.

82. Dr Machart's examination noted the use of a walking aid and stooped posture. There was spasm on the right in the paraspinal region of the lumbar spine and tenderness over the lowest two lumbar levels. There was tenderness in the upper lumbar levels and over the cervicothoracic junction. The applicant demonstrated near-normal flexion and lateral flexion. There was reduced sensation on the plantar aspect of the right foot.

83. Dr Machart accepted that the applicant suffered a laceration of the dorsum of his left hand on 13 June 2012 but said there was little contemporaneous evidence in support of the other injuries, specifically the thoracic injury at T8/9. Dr Machart found no evidence of injury radiologically to the lower lumbar spine. It was noted that the applicant reported low back pain and right sided sciatic symptoms in 2011. There was no contemporaneous evidence of disc injury or back pain immediately after the injury on 13 June 2012.

84. Dr Machart concluded that the disability in the lower lumbar spine could not be related to the injury on 13 June 2012 and that the symptoms developed to the present degree only after the applicant stopped working. On the balance of the evidence, Dr Machart said it did not appear that the incident on 13 June 2012 caused anything more than laceration to the left hand.

85. In his report of 16 April 2019, Dr Machart noted that he had re-examined the applicant with the assistance of an official interpreter. The applicant reiterated the description of injury provided previously. The applicant continued to suffer lower back pain, poor balance, used a walking stick and had numbness in the right foot.

86. Dr Machart indicated he had reviewed both Dr New's and Dr Lai's medicolegal reports. Dr Machart noted that Dr New had not commented on attributability or how the present impairment was related to injury. Dr Machart said that Dr Lai's assessment for skin impairment did not follow TEMSKI instructions. Dr Machart's diagnosis did not change but he suggested that if records from Liverpool Hospital indicated additional injuries recorded at the time of hospital assessment, he would be happy to revise his opinion.

87. Dr Machart said there was no indication that the applicant suffered concurrent injuries to the lumbar spine and thoracic spine. The applicant suffered injury to the left hand to which he assigned 1% WPI for scarring.

Applicant's submissions

88. Mr Gaitanis took me to the applicant's statement and submitted that whilst the applicant admitted to having some back pain in the past, which was not long-lasting, it was clear in his mind that the incident on 13 June 2012 was the major episode causing injury to the thoracic and lumbar spines, describing this as "the straw that broke the camel's back". An x-ray of the lumbar spine was performed on 28 June 2012. The applicant was then off work for several months. Following a return to work, the symptoms deteriorated and the applicant was put off work. Mr Gaitanis noted that no evidence had been obtained from the employer to refute the applicant's claim that his employment was terminated following a diminution in his capacity to work. Mr Gaitanis said the applicant returned to work because he needed the money and only made a worker's compensation claim when informed of his rights by his neighbours.

89. Mr Gaitanis took me to Dr Swid's clinical notes and noted that the applicant had conceded that there was a prior problem with his back. Complaints of pain in the low and mid back were made to Dr Swid on 25 June 2012. Mr Gaitanis described these as contemporaneous complaints of pain. Mr Gaitanis submitted the mechanism of injury was significant and involved lifting a cabinet and twisting. Mr Gaitanis noted that the applicant complained of symptoms in the lower and mid back to his general practitioner a few days later.

90. Mr Gaitanis noted the referrals to Dr Sanki, Dr Khaleal and Dr Teychenne and the back surgery by Dr van Gelder. Mr Gaitanis submitted that the thrust of the medical evidence was that the disc herniation at T8/9 was significant and should be excised although to date this had not been done.

91. Mr Gaitanis took me to Dr New's first report and conceded that he did not have a history of the previous pain in the applicant's back. Dr New concluded that the thoracic disc prolapse was of significant concern and found profoundly debilitating lumbar pain. Mr Gaitanis submitted that the only available inference was that injury to these body parts occurred due to the significant frank incident on 13 June 2012. There was no other explanation for the applicant's condition. Dr New had clarified his opinion in his more recent report after reviewing Dr Swid's notes.

92. Mr Gaitanis submitted that Dr Machart did not find significant pathology at the lumbar spine despite the treating doctors' evidence and radiological evidence. Dr Machart considered there was no contemporaneous evidence of spinal injury despite the complaints to Dr Swid on 25 June 2012. Mr Gaitanis submitted that Dr Machart's history was wrong and he had issued a blanket denial of injury. Mr Gaitanis submitted that this was the only medical evidence on which the respondent relied. Mr Gaitanis submitted further that Dr Machart had taken on the role of advocate in the proceedings in providing an opinion "on the balance of the evidence". Mr Gaitanis said I would give little weight to Dr Machart's opinions and prefer the opinions of the applicant's doctors.

Respondent's submissions

93. Mr Combe made oral submissions and handed up a written outline of submissions. Mr Combe confirmed that liability for a left hand injury had been accepted but liability for injuries to the thoracic and lumbar spines was disputed under ss 4 and 9A of the 1987 Act. Mr Combe noted that the applicant bore the onus of proof. Mr Combe also referred me to the enunciation of the applicable principles of causation in *Duck v EB & DE Bunt*[1].

94. Mr Combe submitted that the applicant had a longstanding history of lumbar spine pain, dating back to 2006. The applicant underwent radiological examinations of the lumbar spine on 20 December 2006 and 1 September 2009, which showed degenerative change and mild prolapse at L4/5. The referral for x-ray and CT scan in 2009 identified a history of right sided sciatica. Mr Combe submitted that the pain the applicant was experiencing at this time was sufficiently serious as to warrant radiology. Mr Combe compared the 1 September 2009 report to the x-ray report of 28 June 2012 and the MRI report of 5 September 2013 and said that no new pathology was demonstrated. The report of the MRI scan of the lumbar spine on 1 May 2014 also revealed no change in presentation or remarkable pathology other than degenerative change. Mr Combe said there was no identifiable pathological change in the radiological reports between 2009, 2012, 2013 and 2014 to satisfy me that there was an injury on 13 June 2012. Dr Machart's opinion was said to accord with the radiological evidence.

95. Mr Combe submitted that the applicant's evidence contrasting his previous history of back pain with that following injury did not accord with the clinical notes. Mr Combe referred me to the entries in the clinical notes in 2006 and 18 November 2011. Following the incident on 13 June 2012, the contemporaneous medical records and certificates of incapacity referred only to the left hand injury. The records from Liverpool Hospital showed only treatment for the left hand. The applicant reported lumbar spine pain secondary to sneezing on 25 June 2012 to Dr Swid and was referred for radiological examination but at this point there was no correlation between the back pain and the work injury. Mr Combe said the medical evidence did not suggest an immediate and severe onset of back pain on 13 June 2012.

96. Mr Combe submitted that no weight should be given to the applicant's claim that he was not aware of his legal right to claim compensation in view of the fact that the applicant was issued with WorkCover certificates from the time of the injury. The only injury identified on the initial certificates was the hand laceration. On 31 July 2012, the applicant was certified as fit for pre-injury duties. Mr Combe said this certificate was inconsistent with the applicant's

[1] [2019] NSWWCC 279.

evidence that he was in severe pain since the injury and described this as "devastating" to the applicant's case. Mr Combe submitted that there was no explanation for how the applicant was able to continue in employment and be certified as fit for pre-injury duties if he had suffered a severe injury to the back on 13 June 2012 as claimed. Mr Combe noted that a claim number appeared on the 31 July 2012 certificate which was the same claim number used on the later certificates identifying a back injury.

97. The first reference to lumbar and thoracic spine injuries related to work in Dr Swid's certificates and clinical notes was on 31 October 2013, after the applicant ceased employment with the respondent. Mr Combe noted that no report had been provided from Dr Swid, leaving a lacuna in the evidence.

98. Mr Combe noted that radiological investigations of the thoracic spine were not undertaken until May 2013, nearly 12 months after injury, and around a month after the cessation of employment. Mr Combe submitted that if the applicant had suffered a sudden and severe onset of pain as claimed, as a matter of commonsense, one would expect some contemporaneous evidence of such in the medical evidence.

99. Mr Combe noted that Dr Sanki's notes indicated he did not see the applicant until January 2014, although in a 2016 report he suggested he had been seeing the applicant since 2008. Dr Sanki did not take a contemporaneous history of injury and made no reference to the prior history of back pain. Accordingly, Mr Combe submitted that I should give Dr Sanki's reports no weight. Mr Combe noted that Dr Sanki provided no opinion on causation which would assist in my determination. Mr Combe submitted that the reports of Dr Sanki did not explain how significant pathology at T8/9 did not require treatment or radiological investigation until nearly 12 months after the alleged injury.

100. Mr Combe submitted that Dr Teychenne did not see the applicant until almost two years after the injury and did not refer to the evidence of right sided radicular symptoms in 2009. Dr Teychenne's first report contained no record of any pre-existing pathology or symptoms in the lumbar spine.

101. Mr Combe submitted that Dr New's reports should be given little weight as they failed to accurately record the history of pre-existing lumbar spinal symptoms dating back to 2006. Dr New failed to address why such significant pathology at T8/9 was not complained of until after the applicant's employment was terminated. Dr New also did not address the fact that the only complaint of back symptoms around 13 June 2012 was on 25 June 2012 when the applicant complained of pain secondary to sneezing. In his supplementary report, Dr New conceded that he was reliant on the history provided by the applicant. Mr Combe submitted that it was apparent that Dr New had not properly considered the clinical notes of Dr Swid.

102. Mr Combe submitted that Dr Lai did not attribute back symptoms to injury on 13 June 2012. Mr Combe said that if there was a causal relationship as alleged, the doctors would not be silent on the issue.

103. Mr Combe handed up the decision of the Compensation Court in *Castro v State Transit Authority (NSW)*[2] and submitted that because of the way the case was pleaded the Commission must be satisfied that there was an internal pathological change of the lumbar and thoracic spines caused by lifting on 13 June 2012. The case was not pleaded as a disease for the purposes of s 4(b) of the 1987 Act. A complaint of symptoms was not sufficient to establish injury. Given that there was pre-existing lumbar spine pathology and no pathology demonstrated in the thoracic spine until about 12 months after the alleged injury, Mr Combe submitted that the Commission could not be persuaded that the pathology in the lumbar and thoracic spines was caused by injury on 13 June 2012.

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[2] (2000) 19 NSWCCR 497.

Applicant’s submissions in reply

104. Mr Gaitanis said Mr Combe had attempted to identify a symmetry between the pathology before 13 June 2012 and post-injury but submitted that the applicant was not able to perform heavy and arduous duties after the injury and was eventually terminated.

105. Mr Gaitanis said I should exercise caution in interpreting the clinical notes, where reference was made to pain on sneezing. Mr Gaitanis said the notes should not be interpreted as indicating that the pain was caused by sneezing but that there had been a change in pathology.

106. Mr Gaitanis submitted that Mr Combe’s submissions ignored the diminution in the applicant’s capacity to carry out his work and the need for surgery after the incident which was not present previously. Mr Gaitanis noted that there was no previous complaint of thoracic symptoms or radiological investigation of such symptoms. Mr Gaitanis said that as a matter of common sense the pathology at T8/9 could only have arisen in a frank, traumatic injury such as the lifting of the cabinet. Mr Gaitanis submitted that I should accept that Dr Swid considered the back pathology to be work related given the WorkCover certificates issued by him. Dr Swid’s certificates did not indicate the pathology was secondary to sneezing.

FINDINGS AND REASONS

107. 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.”

108. The onus of proof as to injury and causation rests upon the applicant and depends upon examination of the evidence as a whole.

109. The Court of Appeal in *Nguyen v Cosmopolitan Homes*[3] 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;
>
> (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.

110. The value of contemporaneous evidence has been repeatedly endorsed by the courts: *Watson v Foxman*[4] and *Onassis v Vergottis*[5]. 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."

111. The consideration of clinical notes must, however, be approached with caution, consistently with the observations of Basten JA in *Mason v Demasi*[6]:

> "First, the trial judge was invited to discount the appellant's oral testimony on the basis of accounts given to various health professionals, which appeared inconsistent either with each other, or with her oral testimony, or both. The difficulties attending this kind of exercise should be well-understood; as explained in the *Container Terminals Australia Ltd v Huseyin* [2008] NSWCA 320 at [8], such apparent inconsistencies may, and often should, be approached with caution for the following reasons, amongst others:

[3] [2008] NSWCA 246.
[4] (1995) 49 NSWLR 315.
[5] (1968) 2 Lloyds Report 403.
[6] [2009] NSWCCA 227 at [2].

(a) the health professional who took the history has not been cross-examined about:
(i) the circumstances of the consultation;
(ii) the manner in which the history was obtained;
(iii) the period of time devoted to that exercise, and
(iv) the accuracy of the recording;

(b) the fact that the history was probably taken in furtherance of a purpose which differed from the forensic exercise in the course of which it was being deployed in the proceedings;

(c) the record did not identify any questions which may have elucidated replies;
(d) the record is likely to be a summary prepared by the health professional, rather than a verbatim recording, and

(e) a range of factors, including fluency in English, the professional's knowledge of the background circumstances of the incident and the patient's understanding of the purpose of the questioning, which will each affect the content of the history."

112. There is no doubt that the applicant has significant pathology at his thoracic and lumbar spine. The question for determination is whether the applicant sustained "injury" to those body parts on 13 June 2012 in the same incident in which the applicant sustained the accepted injury to his left hand.

113. I am satisfied on the evidence before me, including the applicant's own evidence, Dr Swid's clinical notes and the radiological evidence that the applicant had experienced lumbar symptoms since at least 2006. Those symptoms were sufficiently severe or troubling to cause the applicant to consult his general practitioner and for the applicant to be referred for radiological investigation of his lumbar spine in 2006 and in 2009.

114. Whilst there is no radiological report before me, Dr Swid's notes indicate that a 2006 x-ray showed degenerative changes at several levels in the lumbar spine including L4/5 and L5/S1. By 2009, the x-ray and CT scan report dated 1 September 2009 indicated there was mild degenerative disc disease and mild, uncomplicated disc prolapse at L4/5. The clinical history recorded in that report was of low back pain and right sided sciatica. I accept Mr Combe's submission that this clinical history is not dissimilar to the symptoms complained of subsequent to the incident on 13 June 2012. Around seven months prior to the incident, on 18 November 2011, the applicant again consulted Dr Swid with regard to back pain and stiffness causing him to walk slowly.

115. The medical evidence identified above is, until this point broadly consistent with the applicant's evidence that prior to the incident on 13 June 2012, he was suffering back pain, which was becoming increasingly tender and sore after work. While there is no suggestion that the pain was causing any incapacity for work at this point, the medical evidence does indicate that there was pain in his right leg and the pain was affecting the way the applicant walked.

116. I am not satisfied that the applicant's evidence is consistent with the medical evidence from the point of the incident on 13 June 2012 onwards. In his written statement, the applicant has described experiencing immediate, sudden pain, which would not go away and which was the same as his previous pain but much worse, when he twisted his back.

117. Despite this apparently dramatic escalation in his symptoms, there is no evidence of the applicant reporting it to Liverpool Hospital or to Dr Swid at his consultations on 14, 18, 20 or 23 June 2012. I note that the full clinical file from Liverpool Hospital is not in evidence and Dr Swid's clinical notes are handwritten and, as is typical of general practitioners' notes, truncated in form. I am also cognisant of the remarks of Basten JA in *Mason v Demasi*

above. However, the applicant has not in fact claimed to have informed either Liverpool Hospital or Dr Swid of the escalation in his back symptoms immediately after the incident. The WorkCover certificates issued by Liverpool Hospital and Dr Swid in June and July 2012, identify the laceration to the applicant's hand as the only injury arising from the incident on 13 June 2012. I find, on the basis of this evidence, that no complaint of back symptoms was made to the practitioners treating the applicant in the period immediately following the incident.

118. I accept that the applicant did complain to Dr Swid of lower back and mid back symptoms on 25 June 2012, 12 days after the injury. The notes do not reveal and the applicant does not claim that he informed Dr Swid on this occasion that the symptoms commenced or increased as a result of the incident on 13 June 2012.

119. I do not take the reference to sneezing in the clinical notes of this consultation to indicate that sneezing had caused any type of injury. The reference does, however, suggest that the applicant was experiencing symptoms of back pain or perhaps an increase in back symptoms in the mid and lower back when sneezing. This tends to suggest that the symptoms were intermittent, only prominent or at least more prominent when the applicant sneezed. In this way, the note is difficult to reconcile with the applicant's written evidence that he was in constant, severe pain from the time of the injury. This severity of pain is not reflected in Dr Swid's recommendation of treatment by analgesia alone. Dr Swid noted the applicant's gait to be "ok" and appears to have recorded that there were "no bad signs". It also does not appear that the applicant was referred for radiology until his next consultation on 28 June 2012. On that occasion, the referral was only in relation to the lumbar spine (and not the thoracic spine).

120. The radiology report from 28 June 2012 does not on its face reveal any dramatically different pathology to the 2009 investigations and did not prompt any further action, including referral to a specialist by Dr Swid, other than a recommendation for analgesia. Whilst there is suggestion in Dr New's report that the referral to Dr Khaleal may have been related to the back symptoms, Dr Swid's notes and Dr Sanki's reports indicate that this referral was in fact in relation to a haemorrhoidectomy and colonoscopy performed by Dr Khaleal in July 2012.

121. It is of note that Dr Sanki's reports suggest that the spinal symptoms in fact became more prominent following the procedure performed by Dr Khaleal. It was Dr Khaleal who ordered the first investigation of the thoracic spine but not until May 2013, which was around 11 months after the 13 June 2012 incident and almost a month after the applicant ceased employment with the respondent. In the intervening period, there was no further mention of spinal symptoms to Dr Swid despite multiple consultations.

122. Mr Gaitanis' submissions rely heavily on the apparent deterioration or diminution of the applicant's work capacity when he returned to work in August 2012. There is no medical evidence to suggest that the applicant's incapacity between 13 June 2012 and August 2012 was related to back symptoms. Dr Swid issued WorkCover certificates indicating incapacity related only to the hand injury until 26 July 2012, when the applicant was certified as fit for pre-injury duties.

123. The applicant has given evidence that he was not aware of his workers compensation entitlements until some time later when he was referred to his previous solicitors. The applicant said he thought he had to return to work and continue working. Although a claim number does appear on Dr Swid's early WorkCover certificates, there is no other evidence before me of a claim having been made until 2014. I am prepared to accept that the applicant was ignorant of his legal entitlements to compensation but there is simply no explanation in the applicant's evidence for the apparent failure to identify a sudden and severe escalation in the applicant's back symptoms in the context of the work incident to his treating practitioners for around a year despite regular medical consultations.

124. I have noted that the applicant provided an explanation for the delay in reporting symptoms to Dr Machart and Dr Sanki by reference to the taking of medication in connection with the hand injury, suggesting this may have masked the back pain. I am prepared to accept that the applicant took some pain-relieving medication following his hand injury but I do not accept that this credibly accounts for the delay in associating back symptoms to the incident for almost a year. The applicant was certified as having no incapacity related to the hand injury after 26 July 2012. The applicant did report experiencing back pain on 25 and 28 June 2012 but does not appear to have related it to the incident at that time. The explanation is also inconsistent with the applicant's evidence in these proceedings that he experienced an immediate and persistent escalation in back symptoms in the incident.

125. I am prepared to accept that the applicant's capacity to work deteriorated as a result of increasing spinal symptoms between August 2012 and April 2013, although there is no contemporaneous medical evidence or lay evidence from the employer to support the applicant's claim in this regard. I have considered Mr Gaitanis' submissions on this point but find there are other possible explanations for the decline in capacity. There is suggestion in Dr Sanki's reports that the haemorrhoidectomy in July 2012 may have resulted in symptoms becoming more prominent. The return to relatively heavy manual work, which the applicant had previously related to increasing tenderness in his back, may provide another explanation. The decline in capacity does not of itself cause me to be satisfied that there was a sudden pathological change in the applicant's spine on 13 June 2012. For similar reasons, the need for surgery in 2016 does not of itself satisfy me that there was a frank injury to the spine on 13 June 2012.

126. Mr Gaitanis has submitted that the mechanism of injury on 13 June 2012 was significant, suggesting that as a matter of common sense, the sudden twisting action described by the applicant was capable of causing injury as alleged, particularly having regard to the pathology at the thoracic spine. The applicant has, since the time of Dr van Gelder's report in July 2013 described a twisting mechanism of injury. There is, however, no mention of the applicant twisting his back in the more contemporaneous medical evidence. Dr Swid's clinical notes and initial WorkCover certificates only describe a heavy cabinet falling on the applicant's left hand and it getting jammed between two objects. I note also that there are some slight variations in the descriptions of the incident in the various histories subsequently taken, although I do not draw any adverse inference from this circumstance alone as there is at least consistent reference to the applicant twisting his back from this point onwards.

127. An opinion has been expressed by Dr New that the mechanism of injury described to him was consistent with the applicant's presentation. Dr New conceded, however, that his opinion was based on the applicant's reported history and clinical presentation. Dr New does not appear to have engaged with the clinical notes of Dr Swid. It is also fair to say that his opinion is not firmly expressed.

128. Dr van Gelder accepted that the history related to him was consistent with a work-related back injury. I accept that Dr Swid also eventually formed the view that twisting in June 2012 was causative of a back injury by the time of his WorkCover certificate dated 31 October 2013, although he also relates the condition to repetitive lifting. Dr Sanki similarly attributed the pathology to the nature of the applicant's work as well as twisting in 2012. I am unable to find a clear opinion on causation in the reports of Dr Teychenne or Dr Lai.

129. The report of Dr Machart tends to weigh against the applicant's claim. I do, however, accept Mr Gaitanis' submission that Dr Machart's report is problematic, partly because his initial history was obscured by interpreting difficulties but also because he appears to step outside his purview as a forensic medical expert and make findings of fact based on the evidence before him. Dr Machart does not give an opinion as to whether the mechanism of injury described to him was capable of causing the back pathology because he does not accept

that the incident on 13 June 2012 involved the applicant's back as claimed. To the extent that Dr Machart has purported to make findings of fact I have not taken his opinions into account. Notably, however, Dr Machart has given a qualified opinion that there was no evidence radiologically of injury to the lumbar spine, noting the complaints of back pain and sciatica prior to the date of injury.

130. I am satisfied that there is no evidence of pathology or symptoms in the applicant's thoracic spine prior to 13 June 2012. I do not, however, accept as a matter of commonsense that the pathology in the applicant's thoracic spine could only have been caused by the frank incident relied upon. That is a matter for qualified medical opinion and there is no such medical opinion in the evidence before me. Apart from the mention of mid back pain on 25 June 2012 which was not further investigated by Dr Swid, there is no medical evidence of thoracic symptoms until the MRI ordered by Dr Khaleal 11 months later.

131. In weighing the evidence, I am cognisant that the presence of pre-existing disease pathology would not preclude a finding of frank injury on 13 June 2012 consistently with *Rail Services Australia v Dimovski & Anor*[7].

132. I have also noted that only a frank injury on 13 June 2012 pursuant to s 4(a) of the 1987 Act is pleaded in these proceedings. Whilst there is lay and medical evidence suggestive of a nature and conditions type injury consistent with s 4(b), I have not been tasked with making a determination in relation to any such injury in these proceedings.

133. I have carefully considered the evidence as a whole but, the lack of contemporaneous medical evidence of back symptoms associated with the incident; the lack of credible explanation for the delay in reporting such symptoms; the inconsistency between the applicant's evidence and the contemporaneous medical evidence; the failure of Dr New to engage sufficiently with the contemporaneous medical evidence; and the identification in the materials of other possible causes for the applicant's condition; leave me unsatisfied that the applicant has discharged the onus of proving on the balance of probabilities that the incident on 13 June 2012 caused injury pursuant to s 4(a) of the 1987 Act to his lumbar spine or thoracic spine.

134. I do accept, and it has been conceded, that the incident caused injury to the dorsal aspect of the applicant's left hand. There is, however, no evidence before me of a degree of permanent impairment greater than 10% as a result of that injury. There is, therefore, no basis on which to remit the matter for referral to an AMS or award lump sum compensation pursuant to s 66(1) of the 1987 Act.

135. Whilst the matter was not formally in dispute, I note that I do not consider the findings I have made above to be inconsistent with the Certificate of Determination - Consent Orders issued by the Commission in proceedings 4968/18 on 28 October 2018. There is no evidence before me of the injury pleaded in those proceedings or the injury in respect of which the consent orders were made. There is no evidence as to what was said at the teleconference at which the orders were consented to and the issue of injury was not determined by the Commission. It is possible that the award of weekly benefits and s 60 expenses related only to the accepted hand injury. The respondent's conduct after those orders were made, including the subsequent issuing of a s 78 notice disputing liability for injury to the thoracic and lumbar spines on 13 June 2012, does not indicate a previous acceptance of liability for the injury to those body parts disputed in these proceedings.

136. There will be an award for the respondent.

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[7] [2004] NSWCA 267.

SUMMARY

137. The applicant has not discharged the onus of proving on the balance of probabilities that the incident on 13 June 2012 caused injury pursuant to s 4(a) of the 1987 Act to his lumbar spine or thoracic spine.

138. There will be an award for the respondent.