WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **4938/19**
Applicant: **Paul James Robbins**
Respondent: **Burkes Transport (Services) Pty Ltd**
Date of Determination: **10 December 2019**
Citation: **[2019] NSWWCC 394**

The Commission determines:

1. The Application to Resolve a Dispute is amended so that:

    (a) The claim for injury to the right shoulder is deleted;
    (b) After the word "back" there is inserted the words "(lumbar and thoracic)", and
    (c) The claim for lump sum compensation for the right upper extremity is deleted.

2. There are Awards for the respondent with respect to the applicant's claims for injury to the left upper extremities (shoulder) and thoracic spine on 6 January 2017.

3. The matter is remitted to the Registrar for referral to an Approved Medical Specialist for assessment or whole person impairment according to the following:

    (a) Injury on 6 January 2017 (personal injuries)
    (b) Body System: Cervical Spine and Lumbar Spine
    (c) Documents to be provided to AMS (with attachments unless excluded):

        (i) The Application to Resolve a Dispute.
        (ii) The Reply and Application to Admit Late Documents dated 19 November 2019.

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

Gerard Egan
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 GERARD EGAN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Paul Robbins (the applicant) was employed by Burkes Transport (Services) Pty Limited (the respondent) when, on 6 January 2017, an industrial palate fell from the back of a truck onto him while he was bending over working. He suffered undisputed injuries to his cervical and lumbar spines. As part of a claim for lump sum compensation from impairments resulting from injuries, he also claims that he suffered injury to his left shoulder and thoracic spine in the incident.

2. The respondent disputes that he suffered the injuries alleged to his left shoulder and/or his thoracic spine.

ISSUES FOR DETERMINATION

3. The issues to determine are:

    (a) Whether the applicant suffered injury to the left shoulder in the incident on 6 January 2017, and/or

    (b) Whether the applicant suffered injury to the thoracic spine in the incident on 6 January 2017.

4. The parties agree that regardless of the outcome regarding these issues, the matter must be remitted to the Registrar for referral to an Approved Medical Specialist (AMS) for assessment of impairment resulting from injury.

PROCEDURE BEFORE THE COMMISSION

5. The parties attended arbitration in Port Macquarie on 26 November 2019. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

6. Mr Goodrich of counsel appeared for the applicant who was also present. Mr Perry of counsel appeared for the respondent.

EVIDENCE

Documentary evidence

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

    (a) Application to Resolve a Dispute (the Application) and attached documents;
    (b) Reply, and
    (c) Application to Admit Late Documents dated 19 November 2019.

FURTHER BACKGROUND – THE EVIDENCE

General basic facts

8. The applicant is currently a 54-year-old man who has worked in undoubtedly heavy work. Whilst he has completed a statement dated 20 August 2019, it gives no direct history of the nature of the incident involved in his injuries. This is somewhat understandable as other records would suggest that he was either unconscious or at least stunned and was amnesic of those events upon arrival at the Orange Hospital immediately after on 6 January 2017.

9. However, it appears from the long history of GP clinical notes in evidence (dating back to 1989) that in August 2004 he "pulled" his right shoulder while lifting objects. He has suffered bad knees over a long period of time and has been prescribed strong painkillers, including Panadol Forte, Tramadol and Celebrex over many years.

10. Additionally, histories provided to medico legal practitioners disclose a work injury around April 2016, described slightly differently by different examiners, but all referring to the acute onset of low back pain while lifting large truck tires in about April or May 2016. There is some reference to a CT scan of 2 May 2016 showing disc pathology at L3/4 but that is not in evidence, or at least I have not been taken to it.

11. In any event, the applicant returned to work and continued to work for the respondent over the subsequent six or seven months until the further subject injury on 6 January 2017.

VARIOUS DESCRIPTIONS OF THE INCIDENT ON 6 JANUARY 2017

12. The applicant has a statement dated 9 April 2019 in evidence. It does not provide any details of the mechanism of the incident, which is understandable given that the applicant reportedly potentially lost consciousness or was at least stunned. He was amnesic by the time he reached the hospital in Orange by ambulance immediately after the accident. It is common ground that the applicant was bending over attempting to lift a fallen industrial pallet when another pallet fell off a truck and hit him in the back of the head.

Emergency Department notes (ED notes)

13. In the ambulance notes immediately after the incident he has recorded that he was struck

> "IN THE BACK OF THE HEAD, WHILST BENDING OVER. PT WHEN [SIC] TO GROUND AND PER WITNESSES ? LOC, DISORIENTATION, CONFLICTING WITNESS StateS LOC. PT C/O OF PAIN C4, C5 REGION OF THE NECK, PAIN LEFT SHOULDER, WEAKNESS NOTED IN THE L HAND …"

14. The ambulance officer recorded an initial assessment of closed head injury and suspected spinal cord injury due to the left-hand weakness.

15. The ED notes at the Orange Hospital recorded the following on presentation:

> "Bending over with head flexed near the crown, when a heavy (approx. 40kg) pallet slipped from about 1.5m and hit him in back of head and neck.
>
> Dazed for about 15 mins, but no LOC. GSC 14 on arrival OM (sic) ambulance.
>
> Amnesic to events. C/O severe posterior head and neck pain and weakness/numbness L arm …"

16. The ED notes record the complaints as posterior head and neck pain and "weakness/numbness L arm". There is also entries as follows:

"Tender over L lateral clavicle and anterior shoulder" there was slightly diminished power in the left upper limb compared to the right. Sensation was diffusely decreased in the left upper limb with no definite dermatome."

and

"Log roll: moderate tenderness T3-T8 (not as severe as C-spine tenderness)"

17. The admitting practitioner in the ED notes recorded an impression and plan of "blunt trauma to posterior head/neck. ? cervical spine injury with neurology L upper limb."

18. Radiology, including a CT of the head, cervical spine, thoracic spine, and x-rays of the cervical spine and left shoulder were organised.

19. The referring history to the radiologist for the CT of the thoracic and cervical spine confirmed the nature of the incident and recorded, "cervical spine pain, moderate upper thoracic tenderness". There was multi-level changes found in the cervical spine, including the presence of osteophytes. The thoracic spine was said to show "mild degenerative change but no evidence of acute injury".

20. Similarly, the referring history for the left shoulder x-ray referred firstly to the "left arm weakness and reduced sensation". It also referred to "left clavicular and shoulder tenderness". The left shoulder x-ray reported, "satisfactory alignment with no evidence of a fracture".

21. The applicant attended upon his GP, Dr Mackey on 9January 2017 but he did not record any legible details of the mechanism of injury. I am only able to decipher a reference to head and neck injury from the handwritten and typed clinical notes from that day.

22. In doing so, I conclude that the applicant was struck on the back of the head, sustaining a forced flexion of the spine and fell to the ground. This is supported by the notation in the ambulance notes (I interpret the word "when" to mean "went".) I accept the respondent's submission that this is plausible and most likely circumstances involved in the incident.

CONTEMPERONEOUS MEDICAL EVIDENCE

General practitioner's (GP) notes

23. As noted above, copious medical records from the GP are in evidence. These include those from the Anson Medical Centre in Orange at which the applicant attended various GPs. The last substantive injury in those notes seems to be February 2017.

24. At some stage the applicant moved from Orange to Tamworth, although the date of that move is not disclosed. The GP records do not assist in that regard. However, it is noted that the applicant attended the Orange Hospital Emergency Department again, on 8 August 2017, indicating that he probably remained in Orange for that period. By November 2017 radiology reports indicate referrals from Tamworth based practitioners from Castlereagh Imaging, Tamworth, suggesting by that stage he had moved.

25. The records of the Anson Medical Centre are largely unhelpful. They are handwritten and mostly illegible, or if not, contain scant detail of the nature of the attendance or complaints of the applicant.

26. On 14 February 2017, however, Dr C Bielenberg referred the applicant to Dr Mathew Tait, Neurosurgeon. She noted the injury and that the applicant "woke up with severe neck pain radiating to the L arm and lower back pain radiating to his L leg."

Paul Clarke's records, Physiotherapist

27. In a letter to Dr Mackey dated 17 January 2017, Mr Clarke says that he treated the applicant's "CS problem four times". Whilst MrClarke's handwritten records are in evidence, they contain some short remnants of previous attendance but substantively commence on 17 January 2016.

28. Mr Clarke goes on to say that the applicant's symptoms and signs are consistent with severe whiplash. Pain was said to be quite localized to cervical spine (and marked headache). The applicant was noted to have been "from the outset" concerned regarding the increase in his lumber spine pain since the injury and said that the forced flexion injury was "mechanically consistent with such an aggravation of symptoms".

29. On 30 January 2017 Mr Clarke said that he continued to treat the applicant twice weekly, treating both his "neck and LS (his TS also, coincidentally in relation to his CS: in insurers terms – LS & CS)."

30. There is no further material from Mr Clarke in evidence.

Radiology

31. I have reviewed the reports of 6 January 2017 concerning a CT Scan of the cervical spine and thoracic spine, and an x-ray of the chest and left shoulder. CT Scan of the brain occurred on that day also.

32. On 2 February 2017 an MRI scan of the lumber spine occurred but there is no report of any aspect of the thoracic segments in the subsequent report.

33. On 17 March 2017, Dr Tait's requested bone scan of the lumber spine occurred. The only history was that of the low back and there is no mention of other segments in the report.

34. On 30 March 2017 a further MRI scan of the cervical spine occurred. This noted significant pathology at C6/7 including a possible herniation with neurological impingement.

35. The radiologist also reported on the C7/T1 level: "No disk herniation, canal stenosis or nerve root impingement is seen."

36. On 13 November 2017 an MRI scan of the cervical spine including scanning in report down to the T1/T2 levels. A "broad posterior bony bar with disc bulging was said to flatten the spinal cord at C6/7. Widespread foraminal stenosis and osteophyte spurs recorded from C2 to C6."

37. The radiologist reported: "The C7/T1 and T1/2 level(s) are normal."

38. On 17 August 2017 an MRI Scan of the cervical spine also recorded that there was no significant canal stenosis at C7/T1.

Dr Tait, Neurosurgeon

39. Two serial reports of Dr Tait are in evidence. On 7 March 2017 he said the applicant's principle complaint was incapacitating back pain. He noted the 2016 injury to the back (without identifying the particular spinal area). He recorded the incident then, on the background of initially "intermittent" pain on 6 January, including the impact from the pallet hitting him on the head and worsening his back pain. He noted the applicant was not knocked out, but was dazed and also developed neck pain. He does not refer to thoracic pain, but noted lumber MRI scanning showing pathology at L3/4, right sided disc protrusion and arranged the bone scan to which I have already referred.

40. On review of the applicant on 4 April 2017, Dr Tait again noted the complaints of severe back pain and severe neck pain. He noted the findings of the bone scan concerning the lumber spine and sacroiliac joints and hips. The absence of any substantive findings meant his opinion remained that the source of the lumber pain was L3/4 disc. He recommended discogram and also recommended that the applicant see Dr Nathan Taylor, a pain specialist. There is no evidence that the applicant attended Dr Taylor, but there is reference to various intentions for him to do so. In any event, there is no evidence from any pain specialist.

Dr John Christie, Neurosurgeon

41. After the applicant moved to Tamworth, he was referred to Dr Christie. In report dated 15 August 2018, Dr Christie noted the incident in January 2017 and said the applicant described burning pains and pins and needles in the back of his neck, with headaches and the persist of left arm weakness, also described in the left leg. He noted there was a few episodes of paresthesia in the right arm as well and pain in the lower back, with a burning radiating pain into the left leg. Dr Christie noted the referral to the pain specialist but the applicant had not yet been.

42. He examined the applicant's left arm and whilst there was weakness comparative to the right hand there was no "focal weakness". He could not detect sensory loss. Lower limb examination was said to be "essentially normal" although his reflexes were "generally absent".

43. After reviewing the MRI scans of the cervical spine and lumber spine, he suggested that surgery on the presentation at that time was not warranted but emphasized it was important that the applicant was "seen by the pain service in Tamworth".

Orange Hospital ED notes, August 2018

44. Somewhat confusingly, there are further notes from the Orange Hospital dated 18 August 2017, that is after Dr Christie's report to Tamworth GPs and referral to the Tamworth Pain Service. In any event, the discharge summary from Orange ED refers to "acute exacerbation of his chronic background secondary to workplace injury". He referred to collapses in his legs. There is no reference to any thoracic complaints. It was noted that the applicant was "due to see chronic pain team on Monday". Examination noted a hunched posture and tenderness "down entire spine. Focal tenderness over C6/7 and C4/5". The examiner's impression was exacerbation of chronic back pain secondary to known herniated discs and low mood with probably depression.

Medical certificates: Dr C Dielenberg.

45. There are a few Medical Certificates from Dr Dielenberg in evidence. The first is by Dr Mackey dated 6 February 2017 and refers to the lumbar and cervical disc injuries. The second is by Dr Dielenberg and whilst formerly undated, seems to be around 14 February 2017. Dr Dielenberg refers only to the injury to the lumbar intervertebral disc.

Independent Medical Report – (not forensic report regarding this claim for lump sum compensation)

46. The respondent had the applicant examined by Dr Neil Cochrane, Neurosurgeon. In report of 31 March 2017 Dr Cochrane referred to the injury and transfer to Orange Base Hospital. He said the applicant recalled having severe headache and posterior neck pain from the time he regained consciousness post injury, and a burning sensation in the lower back at Hospital. Dr Cochrane referred to the previous injury in May 2016 involving the development of low back pain with a burning sensation in the lower back. He referred to a CT Scan which the applicant understood to show bulging disc and "a pinched nerve" but he continued working.

47. Dr Cochrane noted the applicant was attending physiotherapy but had recently discontinued because his symptoms worsened. The applicant's symptoms were described by Dr Cochrane:

> "Mr Robbins described neck pain which is his cardinal symptom – he describes right nuchal pain or a throbbing pain up towards the vertex of his head. He states this pain is worse with extension of his neck. This pain descends through his shoulder blade region into the lumbar region. He has also had transient left sided numbness in his limbs (upper limbs and lower limbs) …"

48. Headaches, thought by Dr Cochrane to be a cervicogenic headache, were described.

49. More specifically regarding the applicant's low back pain Dr Cochrane said that the applicant "actually describes the pain in his right flank, as he indicates today". There was also a burning sensation down the inner left thigh, sometimes extending into the calf and left foot.

50. On examination Dr Cochrane noted what he referred to as "give way phenomenon" which he thought was an incongruity. On examination of the cervical spine there was limitations of movement in various planes.

51. Dr Cochrane recorded "thoracic range of movement was generally 50 percent predicted".

52. Details of the lumbar spine and the upper and lower limbs also was reported, none of which have been suggested to be relevant to my task in determining whether the thoracic spine or left shoulder was injured in the incident on 6 January 2017.

53. Dr Cochrane was hampered by the absence of any available radiological studies. He had a lumbar MRI report dated 2 February 2017 and the CT of the lumber spine formed on 2 May 2016 following the previous episode of lumbar pain prior to the subject injury.

54. When expressing his conclusion, he did not refer to any findings relevant to injury to the thoracic spine. Notably, he did not have the reference to early reports of thoracic tenderness in the Orange ED notes on the day of injury.

55. When reviewing the mechanism of injury in the context of his diagnosis Dr Cochrane conceded that a falling object could reasonably have caused a primary neck injury or an aggravation of a neck injury as well as concussion. He concluded on the balance of probabilities that the neck and arm symptoms were likely to be entirely caused by the work injury.

56. However, he said he could not find a link between the work injury and the low back symptoms. As I read his overall report, this is essentially because he escribes the pathology in the low back to the injury in May 2016 and appeared to address the question on an "either/or" basis rather than consider that the two injuries could be jointly at work. Nevertheless, this conclusion is not relevant to me as the respondent has not contested that the applicant injured his lumbar spine in the subject injury in January 2017.

57. A further report of 25 September 2017 was prepared by Dr Cochrane without the review examination of the applicant. This report essentially responded to a number of specific questions, none of which are particularly relevant to the issues before me.

FORENSIC REPORTS

Dr WG Patrick, dated 9 April 2019

58. Dr Patrick's report is quite long and I will attempt to extract the essence of it. Dr Patrick referred to the nature of the injury referred to him as "work related injuries to head, neck and back, with considerable effect on shoulders, and left leg and arm".
59. The incident was described by Dr Patrick generally consistent with the mechanism accepted above which he said resulted in "likely quite severe hyperflexion injury" to the neck, with quite severe headache, neck pain and back pain when he "came to". Although Dr Patrick did not record a history of the applicant going to the ground, it will be seen that when expressing his opinion, he later adopts this assumed history. It is noted that this history is consistent with the ambulance note, at least in the manner that I interpret it.

60. Dr Patrick reviewed the ED notes at the Orange Base Hospital on 6 January 2017, including all of the complaints concerning the head and neck pain, weakness and numbness of the left arm, tenderness in the thoracic spine from T3 to T8 and tenderness over the left lateral clavicle and interior shoulder. He noted the CT scan of the cervical and thoracic spines and the x-ray of the left shoulder. He reviewed the applicant's attendance on Dr Tait and various radiology, including those identified above.

61. Dr Patrick referred to the history of the previous lumbar injury in April 2016 resulting in pain but the applicant kept working. Unlike other examiners, he recorded that the applicant's lumbar pain was "gone after two weeks."

62. The applicant's complaints included "ongoing pain and some spasms at mid-back (thoracic spine)" and throbbing backpain in both the lumbar and thoracic levels occurring often. Dr Patrick reported the applicant had attended the Tamworth Hospital for back pain on "probably on or about seven or eight occasions".

63. Further symptoms relayed by the applicant included weakness of the left arm and left leg, "pain and stiffness in both shoulders, left somewhat worse than right resulting in difficulties using arm outstretched or overhead now".

64. On physical examination, relevant to the thoracic spine Dr Patrick noted "marked muscle guarding at upper/mid thoracic spine paravertebrally (some adipose tissue)". Similar findings were noted in the cervical spine. He did not report on any range of movement deficits in the thoracic area.

65. Dr Patrick reported reduced active movement in both shoulders, somewhat worse on the left than the right. He said there was no definite evidence of gleno-humeral instability at either shoulder. There was no report of tenderness to palpation or any particular localised symptoms within the arm or shoulder other than diminished sensations and in the triceps, biceps and supinator jerks on the left arm.

66. Dr Patrick said he believed the applicant's complaints and symptoms was genuine "consistent with and significantly resulting from effects of injuries sustained by him on 6th January 2017."

67. His diagnoses were expressed relevantly as follows:

    (a) A "concussive injury to occipital region" but not a traumatic brain injury.

    (b) A "significant likely hyperflexion injury to cervical spine" with radiculopathy and diminished left sided tendon reflexes and sensory deficit.

(c) A “thoracic spinal injury with likely thoracic ligamentous/facet joint injuries and with clinical signs noted at thoracic spine at the time of his presentation post-accident at Orange Base Hospital”.

(d) A “major aggravation to lumbar spine”, with radiculopathy.

(e) “Likely also that he has as well as the left upper extremity radiculopathy … sustained injury to both left and right shoulders, particularly given the nature and mechanism at the time of accident with him being crouched over forwards when struck on the back of the head by a 40kg pallet and going heavily forwards to ground”. (In this regard he said the applicant “clearly requires MRI of both right and left shoulders”. The diagnosis was “more likely than not, that there is at least some post-traumatic cuff tendinopathy and likely subacromial/subdeltoid bursitis”. Dr Patrick noted the significant and consistent diminished range of active motion.

67. Headaches, thought by Dr Cochrane to be a cervicogenic headache, were described.

Dr Gregor Bruce, Orthopedic Surgeon report dated 28 May 2019.

68. Dr Bruce examined the applicant at the request of the respondent in response to the lump sum claim. Dr Bruce recorded the history:

> “given the applicant’s lack of clear memory himself, through witnesses, that a cherry box fell from the height of about 30 meters [sic] and struck him on the back of the head and on his cervicothoracic region. This description suggests that he most likely suffered a direct impact to the cervical spine and a flexion injury to his lumber spine”. (my emphasis, see comment below)

69. Although Dr Bruce then reviewed the ambulance an ED notes, he does not specifically refer to the notes including complaints of thoracic tenderness and left shoulder tenderness.

70. The symptoms recorded by Dr Bruce on the day of attendance in May 2019 were that there were both neck pain and pain in the lower back. He described the neck pain as radiating into the trapezius region and down into the thoracic region, without “exactly located pain in his thoracic region, but only referred pain from the neck”. There was also a description of pain from the thoracolumbar junction to the sacral region. He specifically recorded that there was no localised pain or pain on thoracic movement in thoracic spine.

71. Dr Bruce suggested there was a tendency of the applicant to exaggerate his symptoms but there was no evidence of exaggeration of his physical signs. In the cervical spine there was no muscle spasm at rest but there was spasm on movement. He described normal neurological examination. Further, Dr Bruce on examination of both shoulders described “full range of movement of the shoulders (and all the other joints)”.

72. Dr Bruce reviewed radiology from May 2016 through to 17 July 2018, but unfortunately did not have the scans or the reports (or the ED notes) from the day of the injury of 6 January 2017.

73. Dr Bruce conceded that it was “certainly feasible” that there were sudden strain injuries to the applicant’s cervical spine and probable injury to his lumbar spine. When asked specifically about the thoracic spine he said that the applicant wasn’t complaining of pain relevant to the thoracic spine because it was referred from the cervical spine. He said there was no tenderness and normal movement of the thoracic spine with no abnormality found on examination. Again, this is without the benefit of the ED notes and radiology from the date of the incident.

74. With respect to the upper extremities on specific question he said all symptoms in the left upper limb were referred from the cervical spine and there were “no symptoms specific to the upper limbs and no physical signs specific to the upper limbs”.

75. On this background, Dr Bruce concluded there was no injury to the thoracic spine or to his upper limbs.

APPLICANT’S SUBMISSIONS

76. Mr Goodrich made general submissions regarding the severity and nature of the injury to be gleaned from the report of Dr Patrick given the applicant’s lack of recollection. He noted that the applicant’s Glasgow Coma Score was 14/15 as recorded by ambulance officers. He suggested that the incident was of some severity and hyperflexion injury was likely, as conceded by the respondent by acceptance of both the cervical and lumber injuries.

77. Mr Goodrich’s submissions regarding the thoracic spine included:

    (a) Those references to the thoracic spine in the historical documents such as the ED notes recording moderate tenderness at T3-T8 were emphasized. The symptoms were serious enough to warrant a CT investigation of the thoracic spine as well as other areas, recording for the radiologist’s benefit the findings of tenderness on examination.

    (b) Otherwise the applicant relied upon the report of Dr Patrick, that of 9 April 2019, including the history recorded by the doctor. In summary, Mr Goodrich submitted that the following sequence of events would lead to a finding of injury to the thoracic spine on the balance of probabilities: The mechanism of injury; early report of pain in the thoracic spine in the ED notes; report of thoracic spine to Dr Patrick in 2019; finding of spasm in the thoracic spine on examination; Dr Patrick’s acceptance of the applicant’s complaints of symptoms are “genuine, consistent with and significantly resulting from the effects of injuries sustained by him on 6 January 2017”; and ultimately Dr Patrick’s bringing together of these features to provide an opinion that the applicant suffered musculoligamentous and facet joint injury to his thoracic spine in the subject incident.

    (c) Mr Goodrich criticised the opinion of Dr Cochrane in the report of 31 March 2017 in that it was clear that the doctor did not accept the applicant as an accurate or truthful historian, and was not fully cognisant of the mechanism of injury, and also had no imaging on which to base his conclusions. It is also suggested that injury was feasible, but declining to accept that it occurred was based purely on his impression of the applicant himself rather than medical fact.

78. Mr Goodrich’s submissions regarding the alleged injury to the left shoulder included:

    (a) It is clear that that there are two problems in the left shoulder – one emanating from the cervical spine by way of referred or radicular pain, and the second pathological issue within the shoulder itself.

    (b) When addressing the pathological consequences of the injurious event, the applicant relies upon the diagnosis provided by Dr Patrick of traumatic rotated cuff tendinopathy and subdeltoid bursitis.

    (c) Dr Patrick noted the applicant had developed stiffness in the left shoulder sometime after moving to Tamworth, although the exact date of the applicant’s move to Tamworth was not identified. Dr Patrick found weakness in the left arm and ultimately diagnosed the two problems effecting the left arm identified in paragraph (a) above.

(d) The ED notes record tenderness over the left lateral clavicle and anterior shoulder, presumably indicating some local pathology.

(e) The ambulance note on 6 January 2017 also notes pain in the left shoulder as a specific complaint, in addition to weaknesses in the left arm and the hand.

RESPONDENT'S SUBMISSIONS

79. Mr Perry for the respondent submitted in relation to the thoracic spine:

(a) The ED note of tenderness at T3-T8 on the date of injury does not rise to an identification of the "pathology" resultant from the injurious event.

(b) Any inferences to be drawn from a mere notation of tenderness would be drawn in the background of what was a significant injury in May 2016 involving the applicant's back. All treating doctors including the GP, physiotherapist and Dr Tait failed to mention any injury to the thoracic spine. Whilst Mr Clarke, the physiotherapist mentioned treatment for the thoracic spine it was "coincidentally to his CS" – that is, he was not treating a thoracic injury, but the accepted cervical injury.

(c) Whilst Dr Patrick recorded a complaint of thoracic muscular spasms, he did not find that on examination. Even if he did, the examination by Dr Patrick in 2019 does not mean that the applicant injured that thoracic spine in January 2017.

(d) In short, a finding of symptoms in the area of the thoracic spine even on the day of injury does not constitute the identification of pathology necessary for a finding of injury in accordance with s (4) of the Workers Compensation Act 1987 (the 1987 Act) (although I paraphrased Mr Parry's submission significantly in this record to conform with the legal requirements for the finding of an injury as a result of an injurious event).

80. Mr Perry submitted regarding the alleged left shoulder as follows:

(a) A history of pain in the left shoulder only derives from medicolegal examinations and not from the applicant himself.

(b) There is no complaint of history from the applicant to any treating doctor. The applicant says that the absence of doctor's records of complaint of shoulder pain was because he himself believed that the doctors believed the shoulder and arm problem to be a neurological problem from the neck. He says the reality was he continued to have pain and discomfort in his left shoulder even though it was less than the back and neck pain.

(c) The ED doctors, whilst noting tenderness around the left shoulder, clearly believed that it was a neurological injury despite excluding pathology by a shoulder x-ray. This focus on neurological injury is no doubt based on the symptomatology and finding on examination by subsequent treating doctors over the subsequent years until Dr Patrick's examination.

(d) The significant pathology identified in the cervical spine is clearly relevant together with the referred symptoms and potential radiculopathy.

(e) The ED notes, when identifying the injuries with precision noted "cervical spine and ? L sided weakness", not any left arm or shoulder injury. No doctor has made any explicit note of probable or suspected left shoulder pathology after the ED note, this includes the general practitioners, Dr Tait Specialist Neurosurgeon. One would expect Dr Tait to identify alternate sources of problems if he suspected them.

(f) Some doubt regarding the applicant's recollection or truthfulness must be raised by conflicting histories provided to subsequent medicolegal practitioners as to the ongoing effects of the 2016 injury. One history was that the pain persisted, the other history suggests that he recovered.

(g) Given the absence of any contemporaneous complaint after the ED notes, I would accept the opinions of Doctors Cochrane and Bruce regarding the existence or absence of any shoulder injury and accept that the whole of the left arm problems emanate from the applicant's cervical spine.

(h) Dr Patrick's view regarding shoulder injury depends upon the applicant "going forward heavily to the ground". This is speculative and is not supported by any other evidence (although, as already noted, the ambulance notes recorded he did go to ground).

(i) Although there were lay witnesses present (see the ED notes), the respondent has not provided any evidence of the mechanism of injury. Given his ability to provide that evidence himself, it is incumbent upon him to lead the evidence.

(j) Dr Patrick's diagnosis of rotator cuff tendinopathy and subdeltoid bursitis is made solely on his examination and acceptance of symptoms without the assistance of any imaging. In short Dr Patrick's reasoning is that the applicant "might have fallen", and that "might explain some pathology that might exist."

(k) The applicant has not discharged his onus in relation to either the thoracic spine or the left shoulder.

FINDINGS AND REASONS

"Injury": s 4 of the 1987 Act

81. To prove that such an injury has occurred, evidence of a sudden or identifiable pathological change is required: *Castro v State Transit Authority* (NSW) [2000] NSWCC 12; 19 NSWCCR 496.; *Yum Restaurants Australia Pty Ltd t/as Pizza Hut Restaurants v Watters* [2010] NSWWCCPD 31; see also *Trustees of the Society of St Vincent de Paul (NSW) v Maxwell James Kear as administrator of the estate of Anthony John Kear* [2014] NSWWCCPD 47, Roche DP at [60].

82. That is, "injury" refers to both the injurious event and the pathology arising from it: *Lyons v Master Builders Association of NSW Pty Ltd* (2003) 25 NSWCCR 422 (*Lyons*) per Neilson CCJ at [429].

83. In the context of this lump sum claim, I am only required to find that an injury occurred. The consequences of it will be a matter for the AMS: *Jaffarie v Quality Castings* [2014] NSWWCCPD 79 (*Jaffarie*).

84. Here, the particular issues appear to be, in relation to the thoracic spine, whether tenderness noted in the ED notes, combined with the spasm in the thoracic spine recorded and noted by Dr Patrick in April 2019, is sufficiently persuasive on the balance of probabilities for me to conclude that a sudden or identifiable pathological change in the thoracic spine occurred as a result of the incident on 6 January 2017

85. In the case of the left shoulder, the issue seems to be whether the weakness and numbness, together with tenderness over the lateral clavicle and anterior shoulder recorded in the ED notes, combined with stiffness in the shoulder noted when the applicant moved to Tamworth (on an unidentified a date), and the symptoms, examination findings and reasoning by Dr Patrick is also sufficiently persuasive.

86. Underlying these two questions is the applicant's case based on Dr Patrick's diagnoses of:

    (a) musculoligamentous and facet joint injuries in the thoracic spine, and
    (b) tendinitis and burst situs in the left shoulder.

87. These are the relevant pathological consequences of the incident relied upon by the applicant, bearing in mind the requirements to establish injury as per *Lyons* and *Castro.* Accordingly, these pathological consequences must be established to have arisen from the injurious incident.

88. Causation is a question of fact: *March v E & MH Stramare Pty Ltd* [1991] HCA 12; 171 CLR 506 per Mason CJ at [16]. It falls to be determined on the application of common sense in accordance with *Kooragang Cement Pty Limited v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796 (*Kooragang*). I must feel actual persuasion of the occurrence or existence of the fact in issue before it can be found: *NOM v DPP* [2012] VSCA 198 at [124]. See also Dixon J in *Briginshaw v Briginshaw* [1938] HCA 34; 60 CLR 336*.*

89. The Court of Appeal in *Nguyen v Cosmopolitan Homes* [2008] NSWCA 246 (*Nguyen*) summarised the approach 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." (at [55])

90. I acknowledge the passage by Spigelman CJ (Giles and Ipp JJA agreeing) in *Australian Security and Investments Commission v Rich* [2005] NSWCA 152 at [170], where he said: "[a]n expert frequently draws on an entire body of experience which is not articulated and, is indeed so fundamental to his or her professionalism, that it is not able to be articulated".

91. However, expertise can only be used to interpret and draw inferences from acceptable evidence. It cannot be used to create evidence: H*evi Lift (PNG) Ltd v Etherington* [2005] NSWCA 42; *Conargo Shire Council v Quor* [2007] NSWWCCPD 245; *Rodger W Harrison and Peter L Siepen t/as Harrison and Siepen v Craig* [2014] NSWWCCPD 48. Findings must be based on the evidence, or reasonable inferences open to be drawn from the evidence, not on the decision maker's knowledge (*Strinic v Singh* [2009] NSWCA 15 at [60]).

92. In *Luxton v Vines* [1952] HCA 19; (1952) 85 CLR 352 (*Luxton*), at 359, it was held in that:

    "[The element of causation would not be established] where it is 'quite impossible to reconstruct from any materials' the manner in which the accident occurred and where that 'can be done only by conjecture' but where 'a number of conjectures is open, equally plausible'".

93. Although *Luxton* refers to the manner in which the accident occurred, the principal remains also applicable when the question is whether the pathology found or proposed by an expert over two years after the event is sufficiently established, and/or whether that pathology can be said to have arisen or resulted from the injurious incident.

94. In *Flounders v Millar* [2007] NSWCA 238 (*Flounders*), Ipp JA said at [35]:

> "…it remains for the plaintiff, relying on circumstantial evidence, to prove that the circumstances raise the more probable inference in favour of what is alleged. The circumstances must do more than give rise to conflicting inferences of the equal degree of probability for plausibility. The choice between conflicting inferences must be more than a matter of conjecture. If the court is left to speculate about possibilities as to the cause of the injury, the plaintiff must fail".

Discussion, findings and reasons

95. I am not satisfied that the applicant has discharged his onus to establish a personal injury for the purpose of section 4(a) of the 1987 Act, in ether the left shoulder or thoracic spine for the following reasons.

96. First, some relevant factual findings. The applicant's direct evidence is somewhat lacking, and is largely a recital of clinical notes or reports. To make factual findings, I therefore supplement the direct evidence by doing my best with the available evidence appearing as recorded histories in medical and associated documents attached to the papers (see *Daw v Toyworld (NSW) Pty Ltd* [2001] NSWCA 25; *Outback Traders (Aust) Pty Ltd v Tobin* [2006] NSWWCCPD 181 at [39]; *Duncan v Roads and Traffic Authority of NSW* [2007] NSWWCCPD 113 at [127].

97. I accept of the applicant was struck on the back of the head (causing laceration) and probably fell or "went" to the ground dazed in the incident. I am not satisfied, although it was not argued with any force, that he was struck at the cervicothoracic junction, as recorded by Dr Bruce. He is the only doctor to record such impact.

98. During the incident, something caused him to become tender about the left shoulder. If I accept that is sufficient to conclude that the left shoulder was injured, the question is whether that was the tendinopathy and bursitis clinically diagnosed by Dr Patrick two years later (the pathology per *Lyons).* Was it a bruise, or the more sinister pathological change relied upon by the applicant? There is no evidence to suggest that the tendinopathy and bursitis developed later, as a consequence of the original injury, and Mr Goodrich has not suggested it was.

99. Regardless of the mechanism of injury, whether it was simply the impact, or strains to the thoracic spine or left shoulder due the impact, the medical evidence does not support the causal connection between the incident and the diagnoses proffered by Dr Patrick with sufficient clarity to discharge the applicant's onus.

Thoracic spine

100. Whilst I acknowledge the caution required when dealing with busy practitioner's clinical notes, in cases where there is genuine dispute about the recollection of the applicant as to the onset of his symptoms, the persistence or development of symptoms, and the link between any such symptoms and the accident itself, contemporaneous evidence may become important: *Department of Education & Training v Ireland* [2008] NSWWCCPD 134 (*Ireland*). This is more son my view, when the notes are numerous and cover a period of time rather than a single note in issue. It would be an error to decide the case purely on the applicant's credit, as noted in *Ireland,* the President, at [91]:

> "……. the Arbitrator wrongly directed himself that the matter could be decided based on the credit of Ms Ireland alone. The task before the Arbitrator was to weigh the evidence of Ms Ireland together with other objective evidence, or the absence of it. The Arbitrator erred in failing to give due weight to Ms Ireland's failure to make any report of injury to her back on the day of the accident. The absence of any documentary evidence from Dr Epps or Dr Baker to support any complaints of back pain, either contemporaneous to the accident or at least at intervals during the period between the accident and when it was first reported to Dr Wallace, is a significant omission in Ms Ireland's case."

101. That is not to say that contemporaneous corroboration is necessary for the applicant to succeed: *Chanaa v Zarour* [2011] NSWCA 199 at [86].

102. I acknowledge Mr Goodrich's general submissions regarding the significant impact in the incident and the applicant's dazed state at the time. I also acknowledge Dr Patrick's role as the expert to glean the history from the applicant, and contemporaneous evidence, consider his clinical findings and radiology, and arrive at a conclusion regarding diagnoses and causation. I specifically acknowledge that a hyperflexion injury likely occurred in the cervical and lumbar spines (with further observation that although injuries to these parts are not in dispute, explicit agreement on the pathological consequences of those injuries has not been argued).

103. This supports the plausibility of Mr Goodrich's argument that the thoracic spine was also injured. However, it remains for the applicant to establish, on the balance of probabilities that the pathological consequences of such a purported injury, are these described in the evidence. There is no radiological support for Dr Patrick's diagnosis of "thoracic spinal injury with likely thoracic ligamentous/facet joint injuries and with clinical signs noted at thoracic spine at the time of his presentation". The clinical changes to which he refers must have been the note of tenderness in the thoracic spine in the ED notes.

104. However, after that, there is no mention of thoracic injury in any contemporaneous materials, other than a physiotherapy report to the GP that the thoracic area was being treated incidentally to the cervical spine injury. No diagnosis is offered, and the GP does not follow up on that note.

105. The applicant does say that he continued to complain about his thoracic spine. However, no contemporaneous evidence supports that assertion. This is so, even after spinal examinations on various occasions by spinal specialists, treating neurosurgeons Dr Tait and Dr Christie.

106. I need not make adverse findings of credit against the applicant to prefer the contemporaneous evidence, or simply to not accept his direct evidence. In *Daley v State of New South Wales in respect of Department of Attorney General and Justice* [2017] NSWWCCPD 4 (*Daley*), Acting Deputy President Larry King SC, said at [38]:

> "38. There is absolutely no mention that I have been able to pick up in the contemporaneous records of any complaint or mention of symptoms in the appellant's left arm, hand or fingers. Therefore, whether or not Dr Hopcroft was correct in saying that such symptoms, no doubt as described in the appellant's evidentiary statement, could only be referable to cervical injury or pathology, there is no contemporaneous evidentiary foundation for his opinion. Put another way, even accepting that trauma to the left shoulder and not directly to the neck in a fall could have produced consequential trauma (say by jolting or shaking up) to the cervical spine, in the absence of any symptoms consistent with that over a fairly lengthy period following the shoulder trauma, there is no foundation for the opinion proffered by Dr Hopcroft. Such a foundation could only exist if there were nothing to rob the appellant's evidentiary

> statement of probative value, and the contrary contemporaneous records in my opinion not only do that but make it highly probable that there were no such symptoms. This in turn means that the decision of the Arbitrator was correct fundamentally in the terms in which it was expressed.
>
> 39. This conclusion is not to say that the appellant's evidentiary statement should be regarded as in effect a deliberate rewriting of history. It can be accepted that he believed what he was saying in his evidentiary statement, possibly because over time he came to reconstruct the course of his neck symptoms. In this connection there is no doubt that he had some sort of neck complaints well before and well after the injuries upon which he relies. Moreover, the very human tendency of witnesses and parties to litigation to reconstruct events, probably unconsciously, especially when years have elapsed and recollections would naturally fade, is well recognised: *Graham v R* [1998] HCA 61; 195 CLR 606; 157 ALR 404; 72 ALJR 1491 and *Watson v Foxman* (1995) 49 NSWLR 315. Authority also recognises the weight of contemporaneous records against that very background, quintessentially as a test of what is reliable and what is not: *Onassis and Calogeropoulos v Vergottis* [1968] 2 Lloyds Rep 403 per Lord Pearce at 431, right hand column, in the para introduced by 'Credibility'.
>
> 40.The thrust of the appellant's submissions was that the learned Arbitrator was in error in failing to accept the critical parts of his evidentiary statement which would have laid a foundation for the expert medical opinion of Dr Hopcroft. As just indicated, in the light of the totality of the evidence in this case there is no warrant for that criticism. Rather, much the better view is that the other evidence, namely the contemporaneous medical records, completely overbore the criticism."

107. In *Nominal Defendant v Cordin* [2017] NSWCA 6 (generally at [165]-[167], but more particularly at [167]), Davies J said (Emmett JA agreeing):

> "167. One reason that contemporaneous statements and documents are likely to be more accurate than a recollection of events is that a statement made at the time of an event, particularly when relatively spontaneous, is likely to be more accurate than a later statement made at a time when false memories can intrude. In a minority of cases the false memories are deliberately so because of the contrivance of the maker of the statement. In the majority of cases the false memories are honestly believed either for the reasons such as those outlined by Leggatt J in *Gestmin SGPS S.A. v Credit Suisse (UK) Limited* [2013] EWHC 3560 (Comm) or because the person recalling the events has tried to assemble recollections logically so that what happened can have some rational explanation in the person's mind. As Leggatt J noted at [17] memories are fluid and malleable, being constantly rewritten whenever they are retrieved."

108. I also do not accept that Dr Patrick's expression that the applicant's complaints of symptoms are "genuine, consistent with and significantly resulting from the effects of injuries sustained by him on 6 January 2017", adequately expresses a reasoning process that allows me to conclude that the symptoms and signs he elicited resulted from the incident two years prior.

Left shoulder

109. I accept that there are probably two issues with the left shoulder and arm. One issue is clearly radicular type symptoms from the cervical spine. As I noted above, the issues are: whether there is tendinopathy and/or bursitis in the left shoulder, as clinically diagnosed by Dr Patrick; and if so, whether that was relevantly caused by the injurious event.

110. In the background is the fact that Dr Patrick recorded no complaints of symptoms in either shoulder to which he refers when expressing his conclusions on diagnosis and causation. Second, he found restricted movement in both shoulders - the left shoulder more restricted than the right (possibly consistent with the radicular features in the left), but recorded no other clinical signs by which one is to understand the reasoning he has applied to arrive at the diagnosis. The tenderness in the 2017 ED and ambulance notes (which presumably he thought relevant to causation) are not found by him in 2019.

111. Otherwise, my reasons for concluding that the applicant has not discharged the onus on proving the pathological consequences of the injury are similar to, and rely upon the same authorities and principles as expressed above regarding the thoracic spine. The development of “stiffness” in the left shoulder at an unidentified date after moving to Tamworth does not fill in these evidentiary gaps.

SUMMARY

112. There are Awards for the respondent with respect to the applicant’s claims for injury to the thoracic spine and the left shoulder.