WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **3143/19**
Applicant: **Craig Graham**
Respondent: **Tristate produce Merchants Pty Ltd**
Date of Determination: **10 September 2019**
CITATION: **[2019] NSWWCC 295**

The Commission determines:

1. The Commission is not satisfied on the evidence available that the applicant suffered injury to his neck on 12 January 2016.

2. Award for the respondent.

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

Paul Sweeney
Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OF PAUL SWEENEY, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

INTRODUCTION

1. Craig Graham (the applicant) is a long-term employee at Sydney Markets. On 12 January 2016, he was employed by Tristate Produce Merchants Pty Ltd (the respondent) as a forklift driver/machine operator and occasional supervisor. In that latter role, he was involved in an argument with a colleague regarding a pallet. During the confrontation, he was assaulted and suffered physical and, possibly, psychological injury.

2. By these proceedings, the applicant claims compensation for permanent impairment of his cervical spine pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act). The respondent accepts that the assault on 12 January 2016 arose out of or in the course of the applicant's employment. It denies, however, that the applicant suffered an injury to his neck in the incident or that he suffers permanent impairment of the cervical spine. The resolution of these issues is complicated by symptoms arising from a prior injury sustained by the applicant on 18 August 2015, when he was run over by a forklift in the course of his employment.

PROCEEDINGS BEFORE THE COMMISSION

3. When the matter came on for conciliation and arbitration at Penrith on 23 August 2019, Mr Brown of counsel appeared for the applicant and Mr Grant of counsel appeared for the respondent. I was informed by the parties that they were unable to resolve the threshold issue of whether the applicant sustained injury to his neck on 12 January 2016. I am satisfied that the parties had ample opportunity to resolve the dispute but were unable to reach a mutually acceptable resolution of the matter.

EVIDENCE

4. The documents before the Commission are as follows:

    (a) Application to Resolve a Dispute (the Application) and documents attached;
    (b) The Reply and documents attached;
    (c) Application to Admit Late Documents dated 16 August 2019, and
    (d) copy of the CCTV video of the assault which was forwarded to the Commission by way of an email.

5. There was no objection to the material contained in the documents referred to above.

SUBMISSIONS

6. The submissions of the parties are recorded and I do not propose to reiterate those submissions in these short reasons. Both counsel referred to the clinical record and the opinions of their respective medical experts on the issue of whether the applicant sustained injury to the neck.

7. Mr Brown referred me to the decisions of the NSW Court of Appeal in *Davis v Wagga Wagga Council* [2004] NSWCA 34 (26 February 2004)(Davis) and *Fitzgibbons v the Waterways Authority & Ors* [2003] NSWCA 294 (3 December 2003) and submitted that the written evidence of the applicant and the opinion of Dr Teychenne should not be disregarded or discounted because of inconsistencies in the clinical evidence relating to the injury. Mr Brown also placed considerable weight on the CCTV footage of the incident which was emailed to my iPad with the consent of the respondent so that I could view it during the arbitration hearing.

8. In order to understand the submissions of the parties and the way in which the Commission has resolved the dispute, it is necessary to briefly set out the extremely economical evidence of the applicant and the fairly sparse record of his treatment in respect of the injuries in 2015 and January 2016.

THE EVIDENCE OF THE APPLICANT

9. By his statement of 19 June 2019, the applicant states that on 18 August 2015 a "forklift driver reversed and I was ran over [sic]". He next describes the incident of 12 January 2016. He recounts that he was pushed back onto a pallet. He continues:

> "I then hit the back of my head on a pallet and my neck snapped back severely in the assault. I sustained a laceration to the back of my head which required five stitches. My head was spinning after the impact.
>
> Following the injury, I began to suffer increased, persistent headaches in the back of my head and neck as well as pain extending into the right eye as well as blurring of vision and nausea. I feel pain radiating from my neck and into my hands.
>
> These chronic headaches and neck pain flare up following up any lifting or when I am driving a forklift, particularly on an uneven surface. I would often go to sleep and wake up with a headache. The headaches intensify if I am stressed and extend to my neck and right eye."

10. The applicant says that he attempted to return to work following the injury but was unable to cope. He ceased work on 25 August 2016. He was referred to Dr Dowla, a neurologist, who apparently diagnosed polyneuropathy and subarachnoid haemorrhage. He says that he became forgetful and unable to focus on his work. He also suffers anxiety and depression.

11. The applicant states that he is no longer as competent at driving a forklift as he was prior to the injury. He is also limited in physical work. He says:

> "Twisting my neck regularly, hurts and this has caused me to reduce the hours I work. At the moment I work Monday, Wednesday and Friday or similar so I can rest between shifts when my neck is saw [sic]."

CONTEMPORANEOUS MEDICAL EVIDENCE

12. Following the incident of 12 January 2016, the applicant came under the care of Dr Yang, a general practitioner. She furnished a certificate to the respondent's insurer dated 21 January 2016 certifying the applicant as unfit for work until 18 February 2016. The diagnosis recorded on the certificate was "head injury (laceration) due to assault" and "anxiety due to incident".

13. On 29 July 2016, Dr Yang certified the applicant as fit for work, eight hours a day four days per week for the period 29 July 2016 to 18 August 2016. The diagnosis recorded was identical to that contained in the earlier certificate.

14. On 23 November 2017, Dr Yang issued a further certificate certifying that the applicant was fit for work five days per week eight hours per day but with a lifting restriction. The diagnosis was bilateral ulnar nerve dysfunction caused by the chronic use of the applicant's hands during his employment with the respondent.

15. On 29 February 2016 Dr Dowla, a neurologist saw the applicant at the request of Dr Yang. He noted the history of injury on 10 August 2015, when the applicant was struck by a forklift causing him to fall and hit his head. Dr Dowla records that the applicant was taken by ambulance to Concord Hospital where he required seven sutures in his scalp. A CT scan of

the brain showed evidence of a subarachnoid haemorrhage and a CT of the cervical spine and x-ray (were normal).

16. The doctor addresses the injury of 12 January 2016 as follows:

> "He was on unrestricted duties when complained of persistent headache and left knee pain. On 12th of January 2016, there was an altercation at work and he was assaulted and pushed by a work mate. He fell on pallet causing laceration of the scalp. This required five stitches. He continued to suffer persistent fluctuation headaches in the occipital region and neck associated with blurring of vision."

17. Dr Dowla recorded that his physical examination was normal and he had evidence of polyneuropathy on EMG testing. He said this:

> "At this stage I would consider he had chronic daily headaches in relation to the traumatic head injury and subarachnoid haemorrhage."

18. He recommended that the applicant change his medication and stated that he would see him again in one month.

19. On 1 April 2016, Dr Dowla saw the applicant again and found that his muscle tone and reflexes were normal and symmetrical. He recommended change in the applicant's medication. He diagnosed depression, gout and traumatic brain injury as a result of the subarachnoid haemorrhage.

20. On 8 April 2016, Dr Yang referred the applicant to Peter Cox, a psychologist. The referral was in the following terms:

> "Thank you for seeing Mr Craig Graham, age 54 years, for opinion and management for psychology counselling (WorkCover). He has been depressed and anxious since he was allegedly assaulted at work (sustained head injury) he has ongoing headache with worsening of anxiety and depression when he goes to work or exposes to work environment."

21. On 8 April 2016, Hai Le, a physiotherapist wrote to Dr Yang noting that the applicant had suffered "quite bad headache from the fall after forklift at work hit him in August 2015". The physiotherapist also recorded that he had no treatment "to the neck" and that on examination he had a restricted range of movement with some spasm on both sides of the neck. She recommended physiotherapy and upgraded exercise. She recorded no history of the injury of 12 January 2016.

22. On 22 April 2016, Hai Le wrote to Dr Yang noting that the applicant had made some improvement following treatment but suffered neck pain and headaches after repetitive lifting at work.

23. On 8 June 2016 Mr O'Connell, another physiotherapist, reported to Dr Yang. He stated that the applicant was assessed "following initial trauma to the head, neck, right shoulder and left knee on 10 August 2015 and subsequent head trauma on 12 January 2016." Mr O'Connell noted, in inter alia loss of rotation and tenderness in the cervical spine. He recommended an MRI for the applicant's neck and right shoulder and a referral to another neurologist in relation to the applicant's post-concussive syndrome.

24. On 29 July 2016, Mr O'Connell reported that the applicant still had some residual neck pain. He noted the applicant could upgrade his hours but was not ready to drive a forklift.

25. In the second half of 2017, the applicant underwent a series of tests performed at the request of Dr Yang. Included among those tests was an MRI scan of the brain and cervical spine on 5 September 2017. Dr Wong reported that the relevant clinical history was:

> "History of head injury 2015. Persistent headache and neck pain since injury."

26. On 26 September 2017, the applicant saw Dr Geevasinga, another neurologist, at the request of Dr Yang. There is a report of the nerve conduction and EMG performed by Dr Geevasinga but it does not appear to be relevant to the issue of whether the applicant sustained cervical injury in January 2016.

DISCUSSION AND FINDING

27. As the claim before the Commission is solely for permanent impairment compensation, my enquiry is limited to whether the applicant has suffered injury or a consequential medical condition resulting from that injury. If the Commission is satisfied of the occurrence of injury or a consequential medical condition, then any further consideration of the matter is solely within the province of an Approved Medical Specialist (AMS).

28. It follows from the reasoning of Deputy President Roche in *Jaffarie v Quality Castings Pty Limited* [2014] NSWWCCPD 79 that whether the injury is transient or permanent, whether it results in whole person impairment, or the proportion of that impairment, which is due to a pre-existing condition are exclusively matters for the AMS.

Dr Teychenne

29. The medical opinion evidence on which Mr Brown relied to establish injury to the neck on 12 January 2016 is largely contained in the lengthy report of Dr Teychenne, a neurologist dated 7 May 2018. Importantly, Dr Teychenne obtained a detailed history of both the incidents of 18 August 2018 and the subject injury.

30. Dr Teychenne records that subsequent to the fork lift injury on 18 August 2015 the applicant suffered from chronic daily headaches commencing in the forehead and extending to the right occipito-cervical junction. He recorded that the applicant also suffered "pain over the right paracervical region with rotation of his head to the right". He experienced aching in the right arm, episodic weakness of both legs, inability to run and weakness of the left knee.

31. One month after the forklift injury, the applicant developed painful numbness in the whole of the right and left arm. While there had been some improvement in his left arm symptoms "he was still waking up with painful numbness in the right arm and hand numbness in the left arm and hand".

32. Dr Teychenne saw the CCTV imaging of the incident on 12 January 2016. He recorded the following:

> "This was quite a significant assault. He was pushed back against a stack of boxes. He was pushed forcibly over the top of the box. He fell back, hitting the back of his head on a solid wooden rail. He had an acute flexion of the head. He was also concussed."

33. Dr Teychenne recorded that, following the assault, the applicant experienced a "marked increase the severity of his previous headache". He also experienced episodic numbness in the left and right lower arms which would occur daily. He also experienced urinary symptoms of urgency resembling incontinence.

34. Probably, a year after the injury the applicant reported that he "had been dropping articles out of either hand." He also felt pain in the right paracervical region, arm and into the right shoulder when lifting. While he was back on full duties, his lifting limit was 10 kg.

35. Based on this history and his clinical findings, Dr Teychenne expressed the opinion that, in addition to his head injury, the applicant suffered an injury to the cervical spinal cord in the incident of 18 August 2015. He said this:

> "The vertigo that he experienced in the immediate period after the accident on 18 August 2015 was consistent with a traumatic brain injury, but it was also consistent with a spinal cord injury. The description of his headaches was quite typical of the type of headache that I have frequently seen in patients with incomplete spinal cord lesions, that is, patients may present with sharp pain extending from the neck and into the head. The pain may be a throbbing headache. It may have features consistent with post-traumatic migraine. It is not infrequent for the pain to extend into the eyes."

36. On his history of an increase in the severity of headaches and episodic numbness in his arms, following the assault of 12 January 2016, Dr Teychenne opined that the applicant suffered an exacerbation of the incomplete spinal cord lesion suffered as a result of this incident. He said this:

> "based on his previous history, I suspect that he had sustained a potential exacerbation of his cervical cord lesion."

37. The applicant's history of urinary urgency and of dropping articles over the 12 months prior to the consultation supported such an opinion as did the doctor's neurological examination. Dr Teychenne recorded his findings on examination in great detail. The following extract may not encompass the entirety of those finding but it contains the clinical basis for his hypothesis that the applicant suffered a partial chord lesion at the cervical spine in the forklift accident, which was exacerbated by the assault:

> "He had imbalance to both left and right sides on formal testing of balance. He had a mild sway to the left and right on Romberg examination. He tended to fall forward on his toes and back on his heels again consistent with imbalance. He was slow getting up from a chair. He was weak in the thigh and knees when standing up from the chair without pushing up. He had sharp pain over the lower cervical spine on movement of the neck.
>
> On sensory examination, he had hyperalgesia over the left posterior torso from the C4 down to Tl 0. This was not inconsistent with an incomplete cervical cord lesion, that is, a posterior hemicape decrease in pain sensation. He had decreased pain, temperature and touch sensation over the ventral aspect of the left fifth finger, medial left wrist and medial left arm, most probably secondary to the previous injury to the left ulnar nerve. However, superimposed on this he had areas of numbness within the left and right lower arm, down the ventral and dorsal aspect of the left and right lower arm into all fingers. He stated this numbness came on a month after the forklift injury and was most probably consistent with an incomplete cervical cord lesion.
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> I found non-sustained weakness within the left and right C4 to T1 spinal segments predominantly involving the upper motor neuron distribution with weakness in the intrinsic muscles of the hands. He also had myelopathic weakness on right hip flexion. He had weakness in dorsiflexion of the left and right first to fifth toes. He had brisk reflexes within the upper limbs, brisk knee jerks, acrossed adductor reflexes, 1 + patellar and 1 + adductor reflexes. He had brisk ankle jerks. Both plantar responses were flat.

> He had weakness in the intrinsic muscles of both hands and upper motor neuron weakness within the C4 to C6 spinal segments. He also had probable myelopathic weakness on right hip flexion and weakness in dorsiflexion of the left and right big toe and second fifth toes. The distribution of weakness in the lower limbs was also within an upper motor neuron distribution. This was consistent with the brisk reflexes.
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> The bilateral imbalance, the upper motor neuron muscle weakness, the intrinsic weakness within the hands, the brisk reflexes, the flat plantar responses and the hyperalgesia to pain sensation within a left posterior hemi-cape distribution as well as the decreased pain, temperature and touch sensation within the lower arms was not inconsistent with an incomplete cervical cord lesion."

Dr O'Sullivan

38. The history and findings of Dr O'Sullivan, the neurologist retained by the respondent, are strikingly different to those of Dr Teychenne. In his initial report of 14 September 2017, he records a history of the applicant developing "quite significant neck pain" following the injury on 10 August 2015. He does not record a history of the applicant suffering neck pain following the subject incident.

39. Dr O'Sullivan, also records that Dr Geevasinga, the neurologist, saw the applicant on 8 August 2017 and "obtained a similar history to mine". Dr O'Sullivan states that Dr Geevasinga apparently made a comment with regards to the applicant's neck "which had resulted from a previous injury". This report of Dr Geevasinga is not in evidence and it would be improper to a draw any inference from it in respect of the occurrence of neck pain after the injury of 12 January 2016. Patently, however, Dr O'Sullivan did not believe that the applicant suffered a neck injury in that incident.

40. Dr O'Sullivan's neurological examination, which may have been more limited than that subsequently performed by Dr Teychenne, did not disclose any abnormality. He said this:

> "on examination of the upper and lower limbs, there was no muscle wasting with normal tone, power and coordination. All the deep tendon reflexes were symmetrical and equal. There was no sensory loss and his gait was normal."

41. Dr O'Sullivan saw the applicant again on 8 May 2019 and provided a report bearing date 14 May 2019. He took a detailed history from the applicant and carried out a further, possibly more extensive, neurological examination. As before, he took no history of symptoms which were suggestive of a cervical injury following the incident of 12 January 2016. Further, his neurological examination was inconsistent with the cervical cord lesion hypothesised by Dr Teychenne. In respect of the incident of 12 January 2016, he said this:

> "the reason behind that it was a relatively minor head injury and there is no evidence on my examination that he had an incomplete cervical cord lesion as a result of that injury. Also from my history the only major symptom that he developed following that injury was and exacerbation of his pre-existing headaches that occurred as a result of the injury in 2015."

42. Dr O'Sullivan provided a further report bearing date 16 August 2019, after reviewing the CCTV footage of the incident of 12 January 2016. He concluded that the video did not establish injury to the neck. He reiterated that his history and findings were inconsistent with an injury to the neck and inconsistent with the occurrence of a cervical cord lesion as a result of the incident.

43. The diametrically opposed histories and findings of the neurologists must, of course, be considered in the context of all the evidence tendered on the issue of injury. Unfortunately, the applicant's evidence is of very limited assistance on the issue.

44. Obviously, the applicant suffered a significant neck injury in August 2015. The extent of the injury and whether it caused a spinal cord lesion is disputed. But the uncontroverted history of both neurologists is that there was a neck injury at that time.

45. In his statement, the applicant merely says that he was “run over by the forklift”. There is no clear account of the symptoms experienced by the applicant as a consequence of the accident. There is no account of the symptoms which the applicant suffered in his neck immediately before the assault. It is difficult to attribute symptoms to an injury by way of exacerbation or aggravation, as Dr Teychenne suggests, when the evidence of the worker does not address the extent of the symptomatology before the injury.

46. In some cases, it may be feasible to adopt the history taken by one or more medical practitioners and make findings of fact consistent with it. The history is evidence of the fact by analogy with section 60 of the Evidence Act 1995, as explained in *Daw v Toyworld* (NSW) Pty Ltd [2001] NSWCA 25 (22 February 2001). Obviously, it is not appropriate to take this approach when, as here, there are diametrically opposed histories as to the injuries suffered by the applicant on 12 January 2016. I would be reluctant to accept without reservation the history taken by Dr Teychenne for this reason. It is, therefore, necessary to consider the medical evidence which I have summarised under the heading contemporaneous medical evidence.

47. The evidence from Dr Yang, the applicant’s treating general practitioner, is limited to several certificates and some desultory correspondence with medical and related practitioners to whom she has referred the applicant. As discussed above, the diagnosis of the doctor on the certificates of 21 January 2016 and 21 July 2016 is that of head injury and anxiety. It was not submitted at the arbitration that the limited material from Dr Yang in the months following the assault supported a conclusion of a cervical injury let alone an exacerbation of a cervical cord lesion.

48. Dr Dowla a neurologist saw the applicant on two occasions in the months following the injury. He records a normal neurological examination and a diagnosis of depression and a subarachnoid haemorrhage resulting from the forklift incident. There is a reference to the headaches which extend to the neck. But nothing in his reports to suggest either an exacerbation of a cervical cord lesion or a neck injury caused by the fork lift incident.

49. Subsequently, the applicant saw Dr Geevasinga, another neurologist. I accept care must be taken with the material from that doctor as it is evidently incomplete. Nonetheless, there is nothing in evidence the limited evidence adduced from him, which would support a conclusion that the applicant suffered from a cervical cord injury or a neck injury in the fork lift incident.

50. Both the physiotherapists whose reports appear in the evidence have attributed the applicant’s neck pain to the injury in August 2015. Hai Le did not have any history of the 2016 assault. Finally, Dr Wong, the radiologist recorded a history, possibly obtained from the referral, of persistent neck pain since the 2015 forklift Incident.

51. That brief survey of the medical evidence leads to the conclusion that there is nothing in the limited material from the various treating practitioners which is consistent with Dr Teychenne’s hypothesis that the applicant suffered an exacerbation of a cervical cord lesion in the assault. It does not proove that the applicant suffered even a mild neck strain at the time of the incident.

52. There is some uncertainty whether the reasoning of Hodgson JA *Ho v Powell* [2001] NSWCA 168 (13 June 2001) (*Ho*) is the correct approach to establishing proof on the balance of probabilities in a civil case. His Honour expressed the view that in making findings of fact the court could consider the evidence that was not called by a party, as well as the evidence

before the court. It was unsatisfactory to determine issues on meagre evidence when there was other evidence available. This was one aspect of the principle enunciated by Lord Mansfield in *Blatch v Archer* [1774] EngR 2.

53. The reasoning in *Ho* was discussed by the High Court in *Australian Securities and Investments Commission v Hellicar and others* [2012] HCA 17 (3 May 2012). It was made clear that the failure to call a witness in a civil case does not derogate from the cogency of the evidence actually called by a party in a case.

54. But where the evidence tendered by a party from a treating doctor is inadequate or ambiguous, as may be the case with the evidence of Dr Yang or Dr Geevasinga, it is difficult to put to one side the obvious fact that it was open to the party to adduce a comprehensive report from the doctor addressing the issue in dispute.

55. Mr Brown put to me that the CCTV footage went a large part of the way to establishing that the applicant suffered a neck injury. I unreservedly accept that the incident may have caused the applicant to suffer a neck injury. Whether it did, however, is another matter altogether. Certainly, Dr O'Sullivan preferred to approach the question of whether it did cause a neck injury on the basis of a consideration of the history following the event and the clinical findings. It is difficult to argue with this approach.

56. My consideration of the evidence in the case inexorably leads to a rejection of the evidence of Dr Teychenne. It is inconsistent both with the opinion and findings of Dr O'Sullivan. More importantly, it is not consistent with that part of the applicant's treating medical evidence, which is before the Commission. Finally, there is no sound basis for his history and opinion in the evidence of the applicant. As I have recorded above, the applicant's evidence does not elucidate the extent of his neck symptoms following the fork lift accident or before the assault.

57. In those circumstances, I am not satisfied that the applicant suffered an injury to his neck or an exacerbation of a cervical cord lesion in the incident of 12 January 2015. As this claim is only for permanent impairment compensation in respect of an injury to the neck, I make an award for the respondent.