WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **786/20**
Applicant: **Pero Sikoski**
Respondent: **Dolci Doro Pty Limited**
Date of Determination: **6 May 2020**
Citation: **[2020] NSWWCC 140**

The Commission determines:

1. The applicant has not discharged the onus of proving on the balance of probabilities that his sleep apnoea and hypertension result from the injury to his lumbar spine on 11 August 2011.

The Commission orders:

2. Award for the respondent in respect of the claim for sleep apnoea.

3. Award for the respondent in respect of the claim for hypertension.

4. The respondent to pay the applicant lump sum compensation of $17,902.50 (inclusive of 5% uplift) for 12% whole person impairment of the lumbar spine as a result of the injury on 8 August 2011 pursuant to s 66 of the *Workers Compensation Act 1987*.

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 Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr Pero Sikoski (the applicant) was employed as a process worker by Dolci Doro Pty Limited (the respondent) between 1989 and March 2017. On 8 August 2011, the applicant injured his lumbar spine when he slipped and fell. Liability for the applicant's lumbar spine injury was accepted by the respondent.

2. On 9 July 2019, the applicant made a claim for lump sum compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act). The applicant claimed compensation for 31% whole person impairment (WPI) as a result of the injury on 8 August 2011. The claim comprised 12% WPI of the lumbar spine, 10% WPI for consequential hypertension and 9% WPI for consequential sleep apnoea.

3. The respondent's insurer declined liability in respect of the consequential conditions of hypertension and sleep apnoea in a dispute notice issued pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act), dated 18 October 2019.

4. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) lodged in the Commission on 13 February 2020.

PROCEDURE BEFORE THE COMMISSION

5. The parties attended a telephone conference on 13 March 2020 and conciliation conference and arbitration hearing, conducted by telephone, on 15 April 2020.

6. The applicant was represented by Mr Richard Petrie of counsel, instructed by Mr Gary Koutzoumis. The respondent was represented by Mr Lachlan Robison of counsel, instructed by Mr Mark Van der Hout.

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

ISSUES FOR DETERMINATION

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

    (a) Whether the applicant suffers from the condition of hypertension and, if so, whether the condition has resulted from the injury on 8 August 2011;

    (b) Whether the applicant's sleep apnoea has resulted from the injury on 8 August 2011; and

    (c) The degree of permanent impairment resulting from the injury on 8 August 2011 and quantification of the applicant's entitlement to lump sum compensation.

EVIDENCE

Documentary Evidence

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

    (a) ARD and attached documents; and

    (b) Reply and attached documents.

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

Applicant's evidence

11. The applicant's evidence is set out in a written statement made by him on 4 February 2020.

12. The applicant stated that on 8 August 2011 at about 7pm, he was filling up a hopper with vanilla flavoured paste when he slipped and fell off an extruder machine. The applicant looked down and noticed some oil had come off the machine. The applicant landed on his buttocks and his body jarred. The applicant felt immediate, excruciating pain in his back.

13. The applicant was assisted by his workmates but remained at work until the end of his shift. The applicant took some painkillers and went to bed thinking he would be okay the next day.

14. After a few days, the pain was not going away and the applicant went to see his family doctor. Dr Nigro sent the applicant for some scans and the applicant learned that he had fractured his spine as result of the fall.

15. The applicant experienced pain into both of his legs but his main source of pain was still his back. The pain in the applicant's back made it hard for the applicant to move around and the applicant was not as active as he used to be. The applicant said,

> "It caused me a lot of stress.
>
> Since the accident, I have put on about 20 kilos. With all of the pain medication and lack of movement, I have put weight on and this upsets me.
>
> Before the accident, I never had any issues with sleeping and since the accident and having put all of this weight on, I can no longer sleep as I did before.
>
> I had investigations for both my blood pressure and sleep studies to see what was going on with me.
>
> In 2012 I was diagnosed with hypertension. I have never prior to the accident in August 2011 had problems with my blood pressure.
>
> On 19 April 2018, I had a sleep study and I was diagnosed with obstructive sleep apnea [sic]. I now sleep with a machine to help me sleep at night."

Evidence from the applicant's treating practitioners

16. The clinical records of the applicant's general practitioner, Dr Anthony Nigro, dating from 15 August 2011 to 27 August 2018, are in evidence. The first entry on 15 August 2011 referred to lower back pain. An x-ray of the lumbar spine was inconclusive.

17. On 31 August 2011, the applicant reported his lumbar back pains were slightly better but radiating to the right buttock and lower right abdomen. Dr Nigro recorded on that date that bloods were okay and cholesterol was normal. A CT scan of the applicant's lumbar spine was requested.

18. On 16 September 2011, the notes refer to the results of the CT scan of the applicant's lumbar spine. An L2 compression fracture, 30% loss of vertebral body height with no canal stenosis were noted.

19. On 16 January 2012, the applicant reported slightly better lower back pains but worsening right iliac fossa and right hip pain. The applicant was referred for physiotherapy. Long discussions regarding the same took place on 23 January 2012 and 15 February 2012. On 16 February 2012, Dr Nigro reported that a CT scan had showed improvement.

20. On 14 May 2013, the applicant reported a variety of symptoms including lethargy, fatigue and depression. During examination, the applicant's sitting blood pressure was recorded at 125/78. On 17 May 2013 the applicant's blood pressure reading was 129/84.

21. On 2 July 2013, the applicant's blood pressure reading was 122/79. Dr Nigro recorded having a long discussion regarding the effects of stress.

22. On 14 May 2014, Dr Nigro reported that the applicant was back from overseas, well clinically and eating and drinking well. The applicant's blood pressure reading was 113/81.

23. On 23 May 2014, Dr Nigro recorded that the applicant's cholesterol was 7.0. Advice was given and a long discussion took place regarding a lower cholesterol diet. The same was recorded on 30 July 2014. On 6 August 2014, the applicant's cholesterol was higher at 7.3 and he was prescribed Crestor 10 mg one daily.

24. On 30 October 2014, Dr Nigro noted lethargy and fatigue. The applicant's cholesterol was 7.3 again after 2 months on crestor. On 7 November 2014, Dr Nigro recorded that the applicant's cholesterol was "high still" and he was continued on crestor.

25. On 27 May 2015, Dr Nigro recorded that the applicant's cholesterol was high and he had not taken Crestor. On 19 October 2015, the applicant's cholesterol was recorded at 7.0. On 18 July 2016, the notes recorded the applicant's cholesterol was normal.

26. The applicant's blood pressure was recorded again on 25 January 2017 at 138/90. The applicant was noted to be on crestor 10 mg one daily. For the remainder of 2017, the notes indicate the applicant's cholesterol had returned to normal.

27. On 6 March 2018, Dr Nigro recorded complaints of recurrent lumbar back pain since the workers compensation injury, worsening over time. Reference was made to right leg paraesthesia and radiating right leg pains.

28. On 20 March 2018, the notes state:

> **"Tuesday March 20 2018 15:01 :56**
> Dr. Anthony Nigro
> **Visit type:**
> Surgery Consultation
> dizziness
> lethargy and fatigue
> falls asleep
> ?OSA
> Benign Positional Vertigo 1 /7
> Right flank pains and abdomen distension

Examination:
General:
BP (Sitting): 129/77
Pulse (Sitting): 81"

29. The applicant's blood pressure on 26 March 2018 was recorded by Dr Nigro at 134/83.

30. A polysomnography report dated 19 April 2018 recorded the applicant's weight at 85 kg and his BMI as 29.8. The applicant's evening blood pressure was 135/87. The applicant's morning blood pressure was 128/82.

31. The sleep physician reported:

> "Adequate sleep efficiency with all stages of sleep seen. Bursts of repetitive obstructive respiratory events were seen, associated with oxygen desaturation to a nadir of 82%. Events were more common in REM sleep. No significant PLMs. Normal ECG.
>
> Conclusion & Recommendations:
> Mild-moderate OSA, predominantly REM-related."

32. On 17 May 2018, Dr Nigro's notes recorded a consultation with regard to "moderate OSA", including a long discussion regarding use of a CPAP. The applicant was recorded to be well clinically and eating and drinking well.

33. On 26 July 2018, Dr Nigro recorded a consultation in which he noted that the applicant had been a smoker for 40 years, since he was 15 years old, and "10-15/day". The applicant reported "lethargy and fatigue, anterior wt gain, bloated abdomen".

34. Dr Nigro prepared a report for the applicant's lawyers on 27 November 2018. Dr Nigro said the applicant sustained injuries after a fall at work including a traumatic fracture of the lumbar vertebra. The applicant had been unable to exercise as a result of the workplace injury and resultant chronic pain. Dr Nigro said:

> "This has resulted in significant weight gain of 18kg, which subsequently has resulted in the development of Type 2 Diabetes, Hypertension, Obstructive Sleep Apnoea, erectile dysfunction, high cholesterol and gastroesophageal reflux. Mr Sikoski has been prescribed various medications to treat his condition, including cialis, levitra, crestor, parzol, panadeine forte."

35. On 5 April 2019, interventional and consultant cardiologist, Dr James Roy reported to Dr Nigro that the applicant had presented for coronary angiography to assess his atypical chest pain and exertional dyspnoea. Dr Roy reported that there was no significant coronary stenosis but there was moderate LAD stenosis. Dr Roy recommended that the applicant continue on crestor 10 mg daily as well as natrilix.

Applicant's medicolegal evidence

Dr Peter Giblin – orthopaedic surgeon

36. The applicant relies on a medicolegal report by orthopaedic surgeon, Dr Peter Giblin, dated 24 September 2018. With regard to the present dispute, it is relevant to note that the applicant reported severe disabling pain, treated by physiotherapy once a week for a long time.

37. The applicant gave a history that included:

> "He was back doing supervisory duties only until the company went bankrupt and then he found himself another job in a packaging company in March 2017. He still does this job 22 hours a week on light duties and he travels to and from work each day by car about a 40 minute round trip. His current treatment is physiotherapy every couple of weeks, analgesics and Voltaren tablets and he sees his GP once every couple of weeks."

38. Dr Giblin noted that the applicant's main complaint was constant ache. Dr Giblin noted that most days the applicant could walk about 300 m, stand for 10 minutes and sit for 15 minutes. At night, the applicant got less than three hours sleep at a stretch. The applicant was cautious about not lifting weights and reported difficulty getting dressed and undressed when pain flared up.

39. Dr Giblin noted that during his physical examination that the applicant was 169cm tall and weighed 87 kg giving a BMI of 30. Dr Giblin noted the applicant was 72 kg at the time of the fall.

40. Dr Giblin assessed the applicant as having 12% WPI of the lumbar spine as a result of the injury.

Dr Mark Herman - cardiologist

41. The applicant also relies on a medicolegal report prepared by consultant cardiologist, Dr Mark Herman, dated 12 March 2019. Dr Herman's history included the following:

> "Since the accident, he has been in constant pain, has gained 18kg of weight, has been on non-steroidal anti-inflammatory drugs, has decreased his mobility and has been diagnosed with sleep apnoea.
>
> In 2012, he was diagnosed with hypertension which has not required medication as yet. He maintains a low salt diet, is not getting much exercise and drinks alcohol rarely.
>
> Over the past few years, he reports symptoms strongly suspicious of angina with exertional chest pain and dyspnoea rapidly relieved by rest.
>
> His cardiac risk factors include a 40 year history of smoking with a current consumption of 10 per day, type 2 diabetes, hyperlipidaemia and the hypertension."

42. Dr Herman recorded in his examination that the applicant weighed 89 kg. His blood pressure was initially 151/99 settling to 146/98 and finally to 148/97. Dr Herman made a diagnosis as follows:

> "Mr Sikoski is a 55 year old man with mild to moderate hypertension off drug therapy. His hypertension occurs in the setting of several cardiac risk factors which started after his work related injury in August 2011."

43. Dr Herman concluded:

> "Mr Sikoski does have hypertension and has probable angina which requires further evaluation (I have recommended he see his general practitioner forthwith).

> His hypertension occurs in the setting of weight gain, chronic pain, anti-inflammatory consumption, decreased mobility and the development of sleep apnoea (all of which provoke hypertension).
>
> He does have evidence of target organ damage with left atrial hypertrophy on the ECG."

44. Dr Herman declined to assess WPI on this occasion as he considered the applicant had probable angina requiring further evaluation.

45. In a supplementary report dated 1 July 2019, Dr Herman noted he had considered the reports from Dr Roy dated 5 April 2019 and an echocardiogram report dated 5 March 2019. Dr Herman considered he was now in a position to assess WPI. Dr Herman reported:

> "In this regard, his WPI is 10% with no deduction for pre-existent disease given that he was not hypertensive prior to his accident. The assessment takes into account documented target organ damage in the form of left atrial hypertrophy on the ECG and dilatation of the aorta on echocardiography performed by Dr Roy."

Dr George Hamor - respiratory and sleep physician

46. Also in evidence is a medicolegal report, dated 22 February 2019, by Dr George P Hamor, respiratory and sleep physician. Dr Hamor took a history of the lumbar spine injury consistent with the other evidence. Dr Hamor said the applicant worked with the respondent until 2017 avoiding lifting any significantly heavy objects and then in a similar position with a different employer.

47. Relevantly, the history included:

> "Fatigue had been a factor for at least two years. He gained about 15kg in weight since the accident, blaming this on the fact that he was unable to be as active as he had been prior to the accident. He even finds it difficult to walk now. His sleep is also very fragmented, in part because of back pain and because of paraesthesia in his legs, on the right side more so that the left. He admits to being drowsy during the day and this includes drowsiness driving."

48. Dr Hamor referred to the sleep study performed in April 2018, which noted very mild sleep apnoea, somewhat worse in REM sleep. Dr Hamor noted the applicant had trialled a CPAP for a six-month period but did not find it beneficial in terms of gaining any improvement in fatigue or daytime somnolence.

49. Dr Hamor concluded:

> "Mr Pero Sikoski has mild sleep apnoea, in part almost certainly related to his weight gain and due to inactivity following the accident in 2011. He is unable to shed the weight. He is in fairly constant discomfort requiring regular paracetamol, but despite this his sleep is fragmented and interrupted, also contributing to daytime fatigue and somnolence."

50. Dr Hamor assessed 9% WPI noting the applicant's Epworth Sleepiness Scale score on the sleep study done in 2018 was 11, indicating mild pathological sleepiness.

Respondent's medicolegal evidence

Dr Richard Powell – orthopaedic surgeon

51. The respondent relies on a medicolegal report prepared by orthopaedic surgeon Dr Richard Powell, dated 16 September 2019. The employment history taken by Dr Powell was as follows:

> "He does not recall having any time off work, though was placed on light duties for approximately 6 months. He completed a graduated return to work programme regaining his full pre-injury duties. He continued with the company though moved to a permanent part time role (32 hours a week), performing his normal duties until the company went into liquidation in 2016. He subsequently obtained employment with a packaging company where he worked in a permanent part time role for 22 hours a week between April 2016 and his recent termination in February 2019."

52. Dr Powell's examination indicated that the applicant weighed 87 kg.

53. Dr Powell also assessed the applicant as having 12% WPI of the lumbar spine as a result of the injury.

Dr Richard Haber - cardiologist

54. In relation to the alleged hypertension, the respondent relies on a medicolegal report by cardiologist Dr Richard Haber, dated 20 August 2019.

55. Dr Haber took a history broadly consistent with the other evidence. The applicant reported becoming short of breath on exertion over the last two years, waking up at night mostly because of pain in the back and leg and occasionally because of shortness of breath. The applicant was reported to have weighed 72 kg at the time of the accident. For the last two years, the applicant had experienced headaches and stress and was found to be hypertensive although the applicant was not sure of his blood pressure readings. The applicant had been referred to a cardiologist for assessment. The applicant's blood sugar had been noted to be raised on one occasion.

56. Dr Haber's physical examination revealed the following:

> "He did NOT take his BP tablets today. His BP was 142/87 with a heart rate of 89 per minute initially and later 135/92 with a heart rate of 84 per minute in the right arm lying down. Later when he was sitting his BP was 140/90 in the left arm with a heart rate of 91 per minute. He weighed 85.9 kgs and was 167 cms tall, giving him a BMI of 31, i.e. he is overweight."

57. Dr Haber noted the report of Dr Roy dated 5 April 2019 and an echocardiogram performed on 5 March 2019. Dr Haber considered the reports of Dr Herman and Dr Hamor as well as Dr Nigro's clinical records. Dr Haber noted that Dr Nigro's clinical records did not report blood pressure greater than 140 systolic up until 7 May 2018 and there was no evidence of treatment for hypertension. There was also no mention of any anti-inflammatory agents.

58. Dr Haber diagnosed high normal blood pressure and said there was no evidence for significant hypertension being recorded by the applicant's local doctor nor was there any reference in the notes to any medication being prescribed for hypertension, although the applicant told Dr Haber that he took exforge and natrilix, both of which are both prescribed for hypertension.

59. Dr Haber concluded:

> "I do NOT consider that this man has hypertensive heart disease requiring any treatment and therefore his employment is NOT contributing to his "disease" . According to the report cardiac echo did not show atrial enlargement he had high normal BP when he saw me. He told me that he did NOT take any medication for BP the day he saw me."

60. Dr Haber assessed the applicant as having 0% WPI as he was not in stage I hypertension and had practically normal blood pressure on examination despite not taking medication that day.

Prof Iven Young - respiratory physician

61. With regard to the alleged sleep apnoea, the respondent relies on a medicolegal report prepared by Prof Iven Young dated 17 September 2019.

62. Prof Young conducted a review of the reports referred to above and located elsewhere in the evidence.

63. Prof Young took a history that included:

> "He remembers being off work for one day and then returned to lighter duties for around three to four months before returning to his usual pre-injury activities on the conveyor belt. Mr Sikoski continued with his usual pre-injury duties until the factory closed in March 2017, 5½ years later. Over this time, he was standing at the conveyor belt and working, usually between the hours of 7.00am and 3.00pm, 5 days a week."

64. The applicant described persistent lower back pain with symptoms down his right and left legs and being treated with regular physiotherapy and analgesics. Prof Young noted that the local doctor's records indicated that these were initially narcotics (Tramal) progressing to Panadeine Forte.

65. The applicant reported that he could walk for 300 m on the flat before needing to stop with leg pain and a sense of breathlessness. The applicant could resume walking after about a 30 minute rest. The applicant could climb about 15 stairs before needing to stop due to pain and breathlessness. The applicant believed his exercise tolerance was becoming gradually worse since the accident in August 2011. The applicant said his weight increased from about 72 kg to 86 kg, slowly over the period since August 2011. The applicant mentioned that he used to swim, run and play soccer quite regularly before the injury in August 2011.

66. The applicant told Prof Young that he was taking exforge daily for hypertension and crestor for cholesterol control. The applicant had used a CPAP treatment for his sleep apnoea from April 2018 for a period of about six months but found it of no help.

67. Prof Young's examination indicated that the applicant weighed 84 kg with a BMI of 29.1 in the high, overweight range. The applicant's blood pressure was raised at 152/105.

68. Prof Young administered the Epworth Sleepiness Scale through an interpreter with the applicant scoring 3/21. This was well within the normal range and made it unlikely that the applicant was abnormally sleepy during the day. Prof Young noted the applicant's score of 11/24 at the time of his sleep study on 19 April 2018 was only in the mildly sleepy range:

> "It is my opinion that Mr Sikoski's employment and the incident on 8 August 2011 are not significant contributors to his respiratory diagnosis of obstructive sleep apnoea. The only mechanism that could account for this association would be weight gain associated with his accident in 2011. Mr Sikoski claims that he has gained weight from 72kg before the accident to his current 84kg, however, this is uncorroborated by any other evidence from the local doctor's record or elsewhere. The only other recordings of weight that I can find was 85kg at the time of the sleep study in April 2018.
>
> Dr Herman mentions an 18kg weight gain that would confirm a similar weight increase and I assume this was obtained from Mr Sikoski who weighed 89kg at the time of Dr Herman's examination.
>
> Mr Sikoski continued to work at a physically demanding occupation for years from the end of 2011 to March 2017 and it is my opinion that any significant weight gain cannot be attributed to the accident in August 2011 and, therefore, his mild obstructive sleep apnoea cannot be significantly associated with this accident.
>
> The other possibility connecting a sleep disturbance with the accident from August 2011 is Mr Sikoski's back pain disturbing his sleep. However, there is no evidence for this on the all-night sleep study from 19 April 2018 and Mr Sikoski's responses to the Epworth Sleepiness Scale, both then and with me, would indicate an insignificant degree of excessive daytime sleepiness that could be attributed to sleep disturbance and arousals.
>
> I conclude, for the above reasons, that Mr Sikoski's employment and the incident in August 2011 are not the *main* contributing factors to his respiratory condition of obstructive sleep apnoea.'

69. Prof Young agreed with Dr Hamor's calculation of a 9% WPI due to mild obstructive sleep apnoea but could not associate this impairment with any employment factor "in a significant fashion".

Applicant's submissions

70. Mr Petrie for the applicant referred me to the applicant's evidence set out in his written statement. Mr Petrie noted that the applicant gave evidence that he experienced pain, difficulty moving and required medication as result of his lumbar spine injury. The applicant claimed that he had put on 20 kg since the injury and experienced difficulty sleeping. The applicant denied experiencing any issues with his blood pressure or sleep prior to the injury.

71. Mr Petrie then referred me to the notes of the applicant's general practitioner, Dr Nigro, Mr Petrie observed that the clinical notes covered the period up to 14 August 2018 only. Mr Petrie noted that Dr Nigro did not record the applicant's weight in the clinical notes but said there were sporadic recordings as to blood pressure. Mr Petrie took me to the various blood pressure readings and noted the prescription of the statin crestor. Mr Petrie said the clinical notes confirmed that the applicant had complained of sleep problems, was diagnosed with moderate obstructive sleep apnoea and trialled the use of a CPAP machine. The applicant was referred to see a specialist. Mr Petrie referred me to the evidence of the sleep study performed on 19 April 2018, which confirmed the presence of sleep apnoea.

72. Mr Petrie noted that in his report of 27 November 2018, Dr Nigro gave the opinion that the applicant's weight gain and other conditions were caused by the work injury. Dr Nigro gave a list of the applicant's prescribed medications including crestor.

73. Mr Petrie noted that Dr Giblin recorded that at the time of his examination the applicant weighed 87 kg, giving him a BMI of 30. Dr Giblin took a history that the applicant was 72 kg at the time of his fall.

74. Referring to the report of Dr Herman, Mr Petrie noted the high blood pressure readings recorded during the examination. Dr Herman initially considered that the applicant did have hypertension and angina in the setting of weight gain and chronic pain but required further evaluation. After receiving the results of a coronary angiogram performed by Dr Roy, Dr Herman went on to assess the applicant as having 10% WPI as a result of the injury.

75. Mr Petrie took me to Dr Hamor's report and noted the history recorded was of the applicant gaining about 15 kg subsequent to the injury and experiencing paraesthesia in the legs. Dr Hamor noted the applicant had trialled a CPAP and had obstructive sleep apnoea due to weight gain. The applicant was unable to shed weight and had fragmented disrupted sleep resulting in a 9% WPI.

76. Mr Petrie noted that the respondent relied on the report of Dr Haber. Dr Haber observed that the applicant had not taken his blood pressure medication on the date of his examination. Dr Haber took a blood pressure reading of 140/90 and recorded that the applicant weighed 85 kg, giving him a BMI of 31. Dr Haber expressed the view that the applicant had high normal blood pressure.

77. Mr Petrie submitted that in contrast to the blood pressure readings recorded by Dr Haber and Dr Herman, the applicant's general practitioner's notes recorded relatively low readings at the time of the injury and for a period thereafter. Mr Petrie said it was clear that there had been an increase in the applicant's normal blood pressure reading in that the top reading had gone from a figure in the 120's to figure in the 140's. Mr Petrie submitted that Dr Haber's conclusion that the applicant had normal high blood pressure was incorrect.

78. Mr Petrie noted the report of Prof Young but submitted that it was contradictory in parts and was based on an incorrect factual history. Mr Petrie noted that Prof Young recorded that the applicant continued with his usual pre-injury duties up until March 2017. Mr Petrie submitted that the applicant had told the other doctors that he performed only light duties for the respondent and later with another employer, following the injury. The applicant told Dr Giblin for example, that he performed supervisory duties only with the respondent and light duties, 22 hours per week with the subsequent employer.

79. Mr Petrie noted that Prof Young appeared to accept that weight gain could have been causative of the applicant's sleep apnoea although he considered the applicant's evidence as to his weight gain was uncorroborated.

Respondent's submissions

80. Mr Robison was critical of the way hypertension and sleep apnoea were pleaded in the ARD, noting that no explanation in terms of causation was provided. Mr Robison noted that the applicant's independent experts had each developed a theory that the sleep apnoea and hypertension found by them were consequential to the injury. Mr Robison said that this type of approach to the evidence was criticised in the presidential decision in *Secretary, Department of Education v Balhatchet*[1].

[1] [2020] NSWWCCPD 5 at [187]-[189].

81. Mr Robison referred to the authorities in *Briginshaw v Briginshaw*[2] and *Nguyen v Cosmopolitan Homes*[3] with regard to the relevant standard of proof and said I would not feel a sense of actual persuasion in this case that the applicant had consequential conditions of hypertension and sleep apnoea.

82. Mr Robison submitted that since the applicant's injury occurred, his age had increased and he claimed to have gained weight. There was no evidence as to fact or reason for the alleged weight gain other than applicant's evidence. The applicant continued in process work for many years after the injury. In these circumstances the theory that the applicant's cardiac and respiratory problems were due to inactivity was not persuasive.

83. Mr Robison noted that the applicant's statement gave a description of the kind of work he undertook with the respondent prior to the injury but not subsequently. The applicant did not explain the evidence on which he formed the view that he had gained weight. The weight gain alleged was recorded differently by the various doctors involved in the applicant's case and ranging between 15 and 20kg. It seemed the weight gain was simply a guess.

84. Mr Robison submitted that Dr Giblin's report was only of interest for its reference to weight gain. Dr Herman had reported an 18 kg weight gain but noted a range of factors as causative of the applicant's condition including consumption of cigarettes, diabetes and other causes. The blood pressure readings recorded by Dr Herman were significantly higher than anything recorded by Dr Nigro suggesting the possibility of an anomaly.

85. Dr Haber considered the applicant had high normal blood pressure. Mr Robison referred me to the judgement of Leeming J in *Booth v Fourmeninapub Pty Ltd*[4] at [54] and submitted that predisposition to a disease was to be contrasted with having a disease. The fact that a person is more likely eventually to suffer from the disease, does not mean that the person has the disease. Mr Robison submitted that the applicant did not have a compensable disease. The clinical material revealed low blood pressure then high blood pressure. Mr Robison submitted that Dr Haber's report indicated that the applicant had high normal blood pressure and was not in a state of hypertension.

86. Mr Robison noted that Prof Young recorded a 14kg weight gain. Prof Young noted the medications the applicant was taking and said there were suggestion that Crestor was being taken by the applicant in relation to high cholesterol rather than high blood pressure. Prof Young noted the history of smoking and said there was no evidence of a significant level of inactivity. The sleep study did not suggest the applicant's pain was interfering with sleep.

87. Mr Robison submitted that Dr Nigro's notes contained no record of the applicant's weight. Mr Robison submitted that Dr Nigro must have based his views on a history from the applicant rather than clinical material. Mr Robison suggested that most of the blood pressure readings recorded by Dr Nigro suggested hypotension rather than hypertension with most readings below normal.

88. Mr Robison submitted that the applicant was unable to discharge his onus and the alleged consequential conditions should be the subject of awards in favour of the respondent.

89. Mr Robison agreed that if there were awards in favour of the respondent in respect of the consequential conditions, the applicant's entitlement to lump sum compensation could be determined by me as arbitrator on the basis of the assessments of Dr Giblin and Dr Powell.

[2] [1938] HCA 34; 60 CLR 336.
[3] [2008] NSWCA 246.
[4] [2020] NSWCA 57.

90. Mr Robison submitted that there was a medical dispute in relation to the alleged sleep apnoea notwithstanding that Prof Young and Dr Hamor both assessed 9% WPI on the basis that Prof Young did not attribute the permanent impairment to the work injury on 8 August 2011.

91. Mr Robison submitted that both the hypertension and sleep apnoea would require assessment by an Approved Medical Specialist (AMS) in the event of favourable determinations for the applicant.

Applicant's submissions in reply

92. Mr Petrie conceded that there were no recordings of weight in Dr Nigro's notes but submitted that he had been the applicant's general practitioner for many years. Mr Petrie said it was unlikely Dr Nigro would report that the applicant had gained 18 kgs if he did not agree that there had been a significant weight gain.

93. Mr Petrie said the weight gain was an estimate only, noting the variations in the weights recorded in the medical evidence.

94. Mr Petrie said Dr Hamor gave a comprehensive description of the applicant's post-injury employment indicating the applicant returned to work on light duties, consistent with the histories given to Dr Haber and Dr Giblin. Mr Petrie submitted that this indicated that Prof Young had relied on a erroneous history in giving his opinion.

95. Mr Petrie submitted that given that both Dr Hamor and Prof Young had assessed 9% WPI due to sleep apnoea, there was no medical dispute in relation to the degree of permanent impairment resulting from that condition. An award should be made in favour of the applicant for 9% WPI on the basis of those assessments.

FINDINGS AND REASONS

96. It is accepted by the respondent that the applicant sustained "injury" to his lumbar spine pursuant to s 4 of the 1987 Act on 8 August 2011. What requires determination is whether the applicant sustained consequential conditions in the nature of hypertension and sleep apnoea as claimed.

97. It is not necessary for the applicant to establish that these conditions are in themselves 'injuries' pursuant to s 4 of the 1987 Act. Deputy President Roche in *Moon v Conmah*[5] observed at [45]-[46]:

> "It is therefore not necessary for Mr Moon to establish that he suffered an 'injury' to his left shoulder within the meaning of that term in section 4 of the 1987 Act. All he has to establish is that the symptoms and restrictions in his left shoulder have resulted from his right shoulder injury. Therefore, to the extent that the Arbitrator and Dr Huntsdale approached the matter on the basis that Mr Moon had to establish that he sustained an 'injury' to his left shoulder in the course of his employment with Conmah they asked the wrong question."

98. A commonsense evaluation of the causal chain to determine whether any hypertension or sleep apnoea resulted from the accepted injury to the applicant's lumbar spine is required. The legal test of causation is that discussed by the Court of Appeal in *Kooragang Cement Pty Ltd v Bates*[6], where Kirby P said (at 461G) (Sheller and Powell JJA agreeing):

[5] [2009] NSWWCCPD 134.
[6] (1994) 10 NSWCCR 796 at [810].

> "[f]rom the earliest days of compensation legislation, it has been recognised that causation is not always direct and immediate". After referring to earlier English authorities, his Honour added (at 462E): "Since that time, it has been well recognised in this jurisdiction that an injury can set in train a series of events. If the chain is unbroken and provides the relevant causative explanation of the incapacity or death from which the claim comes, it will be open to the Compensation Court to award compensation under the Act."

99. His Honour said at 463–464:

> "The result of the cases is that each case where causation is in issue in a workers' compensation claim, must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from', is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a commonsense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation. In each case, the question whether the incapacity or death 'results from' the impugned work injury (or in the event of a disease, the relevant aggravation of the disease), is a question of fact to be determined on the basis of the evidence, including, where applicable, expert opinions. Applying the second principle which Hart and Honoré identify, a point will sometimes be reached where the link in the chain of causation becomes so attenuated that, for legal purposes, it will be held that the causative connection has been snapped. This may be explained in terms of the happening of a novus actus. Or it may be explained in terms of want of sufficient connection. But in each case, the judge deciding the matter, will do well to return, as McHugh JA advised, to the statutory formula and to ask the question whether the disputed incapacity or death 'resulted from' the work injury which is impugned."

100. The Court of Appeal in *Nguyen v Cosmopolitan Homes*[7] 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."

[7] [2008] NSWCA 246.

101. In this case, the applicant has given evidence that following the injury to his lumbar spine he experienced pain in his back and into his legs, which made it difficult for him to move around. The applicant said he was less active than he used to be. The injury also caused the applicant a considerable degree of stress. The applicant claimed to have put on about 20 kg with the pain, medication and lack of movement. Since the accident and, as a result of the weight gain, the applicant said that he could no longer sleep as he did before. The applicant also claimed to have been diagnosed with hypertension in 2012 despite never having issues with his blood pressure prior to the injury.

102. The applicant's account of events has been accepted by his medicolegal experts as explaining a causal link between the injury and the conditions of hypertension and sleep apnoea. The applicant's general practitioner, Dr Nigro has also prepared a report consistent with the lay and medicolegal evidence. It is, however, necessary to consider the totality of the evidence.

103. The respondent has filed evidence which casts doubt over the diagnosis of hypertension and the opinions on causation given by the applicant's medicolegal experts. There is also a particular difficulty for the applicant in discharging the onus of proof arising from a lack of corroboration in the contemporaneous medical evidence.

Sleep apnoea

104. The medical evidence before me consistently indicates that the applicant suffers from mild sleep apnoea and I accept this is the case. Dr Hamor and Prof Young both make this diagnosis and it was confirmed in the polysomnography report dated 19 April 2018. The polysomnography report gives no indication as to the cause of the applicant's condition other than to indicate that it was predominantly REM-related.

105. Dr Hamor has expressed the view that the applicant's mild sleep apnoea was almost certainly related "in part" due to inactivity following the injury on 2011 and the applicant's weight gain. Dr Hamor took a history of a 15 kg weight gain since the injury which the applicant blamed on the fact that he was unable to be as active as he had been prior to the accident.

106. Prof Young agreed that the alleged weight gain could account for a connection between the injury and the applicant's diagnosis of obstructive sleep apnoea. Prof Young could not, however, find any evidence to corroborate the applicant's claim to have gained weight from 72 kg before the accident to the 84 kg he weighed at the time of Prof Young's examination.

107. The first record of the applicant's weight that I can locate is in the polysomnography report dated 19 April 2018, where the applicant's weight was recorded at 85 kg. On 24 September 2018, Dr Giblin recorded the applicant's weight as 87 kg. Dr Herman recorded the applicant's weight was 89 kg on 12 March 2019. On 20 August 2019, Dr Haber recorded that the applicant weighed 85.9 kg. On 16 September 2019, Dr Powell said the applicant weighed 87 kg. Prof Young said the applicant weighed 84 kg on 17 September 2019.

108. The evidence above, thus shows a fluctuation in the applicant's weight over a period of around 17 months from April 2018 of around 5 kg, peaking at 89 kg on 12 March 2019, returning to 84 kg by 17 September 2019. The medical evidence consistently indicates that the applicant had a BMI score which placed him in the overweight to obese ranges.

109. There is no evidence of the applicant's weight at any time prior to the August 2011 injury other than the applicant's assertion that he weighed around 72 kg. There is no record in Dr Nigro's clinical notes of the applicant's weight at any point in time. Dr Nigro did refer to "anterior wt gain" and "bloated abdomen" in a consultation on 26 July 2018. The notes do not, however, indicate what amount of weight the applicant had gained, and it is noted that there is repeated reference to abdominal distension and other gastrointestinal issues and investigations elsewhere in the clinical notes.

110. Dr Nigro said there was a weight gain of 18 kg in his letter of 27 November 2018 but did not explain the evidence on which he relied. As Mr Robison noted, the absence of any record of the applicant's weight in the clinical materials suggests that Dr Nigro, as with the specialists in this case, was relying on the history given to him by the applicant.

111. The applicant has not explained the basis for his belief that he weighed approximately 72 kg prior to the injury. The applicant does not, for example, indicate when or how he last weighed himself prior to the injury. There is no evidence from any lay witnesses to support the applicant's claim of a significant weight gain during the period since his injury.

112. I do accept that the applicant's lumbar injury has resulted in a reduction in activity. The applicant has given evidence that he was not as active as he used to be prior to the lumbar injury. The applicant told Prof Young that he used to swim, run and play soccer quite regularly before the injury in 2011. The reports of Dr Giblin and Dr Powell both indicate the applicant was restricted in his ability to walk, stand, sit, dress and undress, and lift weights at the time of their examinations. The applicant attributed his restrictions in part to pain.

113. The evidence does not suggest that the applicant was rendered completely inactive or sedentary by the injury. The evidence indicates that the applicant took little if any time off work following the lumbar injury. The applicant continued to work for the respondent until March 2017 then gained employment with a packaging company on a part-time basis until early 2019.

114. There is a discrepancy in the evidence as to the nature of the applicant's employment duties following the injury. The applicant does not address this in his own written statement. Dr Powell's evidence suggests there was a graduated return to pre-injury duties, although a reduction in hours. Other reports, including Dr Giblin's suggest the applicant returned to supervisory or light duties only. Prof Young's report includes perhaps the most detailed history which is broadly consistent with Dr Powell's report. Prof Young recorded that after a period of light duties, the applicant's returned to process work which involved standing at the conveyor belt working.

115. It is not possible to find with confidence what the applicant's duties post-injury entailed. I am, however, satisfied that the applicant continued to work until early 2019. I am satisfied that the applicant's work was relatively physical prior to the injury, involving standing process work. I am not satisfied on the evidence before me that the applicant engaged in only sedentary work after the injury.

116. I accept Mr Robison's submission that the medical evidence indicates a number of co-morbidities, including a 40-year history of cigarette smoking, high cholesterol and type II diabetes. The applicant has also aged in the period between the injury and his diagnosis of sleep apnoea. This evidence suggests that factors unrelated to the applicant's lumbar injury could have played a role in any weight gain. There is, however, no medical opinion before me to confirm this. In any event, a consequential condition can have multiple causes and still "result from" an injury.

117. There is no doubt that the applicant is presently overweight or obese. There is also no doubt that the applicant has sleep apnoea. I accept that the medical evidence supports a link between the applicant's weight and his sleep apnoea. For the applicant to discharge the relevant onus, however, I must be satisfied on the balance of probabilities that the applicant's excessive weight has "resulted from" the lumbar injury in 2011.

118. On the one hand, there is the applicant's evidence in his written statement, and the consistent history he has given to the doctors involved in his case, of a significant weight gain which the applicant has attributed to being less active as a result of pain following the injury. I accept that the applicant experienced continuing pain and restriction following his lumbar injury. I am prepared to accept that these symptoms may have reduced his ability to engage in the kinds of activities he participated in prior to injury. I have also given weight to the evidence of Dr Nigro and the medicolegal experts, who have accepted the applicant's claim of a significant weight gain attributable to the injury.

119. There is, however, no contemporaneous, corroborative evidence of any weight gain following the injury, let alone a weight gain sufficient to have been causative of the applicant's sleep apnoea. I am not satisfied that the injury rendered the applicant significantly sedentary or inactive. The applicant was able to continue working until early 2019. Although I am prepared to accept that the applicant ceased work in early 2019 and this may have resulted from the physical effects of his injury, he was diagnosed with sleep apnoea in April 2018, prior to the cessation of work. The applicant was involved in physical work prior to the injury and I am not satisfied on the evidence before me that his work after the injury was sedentary in nature other than for a period of several months immediately following the injury. The applicant's own evidence of a weight gain is problematic in several aspects. It lacks detail as to the basis on which the applicant believes he has gained weight. The applicant's evidence also suggests a greater weight gain (20 kg) than is suggested in the histories given to the doctors (12-18 kg).

120. After carefully weighing all the evidence, whilst I am prepared to accept that the injury may have resulted in some degree of weight gain, I do not feel a sense of actual persuasion on the balance of probabilities that the injury has caused a significant weight gain (ranging between 12 and 20 kg) which has resulted in the applicant's sleep apnoea.

121. In reaching this conclusion, I have not placed weight on the report Prof Young other than to note that his opinion is broadly consistent with the view I have reached. Prof Young's report is problematic in that he appears to apply an incorrect legal test in considering the question of causation. In particular, his use of the expressions "significant contributors" and "main contributing factors" suggest he erroneously considered it necessary for the applicant to meet the definition of "injury" in s 4 of the 1987 Act.

122. I am not satisfied that the applicant's sleep apnoea has resulted from the injury to his lumbar spine on 8 August 2011.

Hypertension

123. The respondent disputes both that the applicant suffers from the condition of hypertension and that any such condition resulted from the injury to the applicant's lumbar spine.

124. The applicant's case relies to a large degree on the medicolegal opinion of Dr Herman. Dr Herman took a history of an 18 kg weight gain, chronic pain, the use of anti-inflammatory drugs, decreased mobility and a diagnosis of sleep apnoea, all of which were said to provoke hypertension. The applicant also gave Dr Herman a history of being diagnosed with hypertension in 2012.

125. I am not satisfied that the applicant was diagnosed with hypertension in 2012.

126. Nothing in Dr Nigro's clinical notes suggests that such a diagnosis was made at that time. I accept Mr Robison's submission that the blood pressure readings recorded in Dr Nigro's notes indicated normal to low blood pressure. I am also not satisfied that crestor was prescribed to the applicant to treat high blood pressure. Both Dr Nigro's notes and the history given to Prof Young indicate that crestor was prescribed for high cholesterol.

127. The blood pressure readings at the time of the sleep study in April 2018 were not significantly elevated although I do accept that by 2019 the applicant was consistently recording higher blood pressure levels as evidenced in the reports of Dr Roy, Dr Herman and Dr Haber. The applicant gave a history of being prescribed blood pressure medications, exforge and natrilix to Dr Haber. Dr Nigro does not, however, record giving these prescriptions and the history given to Dr Herman was that the applicant's hypertension had not required medication as at the date of his report on 12 March 2019.

128. I am prepared to accept that at some point in 2019, probably after the review by Dr Roy in April 2019, the applicant was diagnosed with hypertension, for which he has been prescribed medication. It remains to be established that the condition resulted from the lumbar injury in 2011.

129. The findings I have made above indicate that the opinion on causation given by Dr Herman was based on an unsatisfactory history. I am not satisfied that the applicant was diagnosed with hypertension until 2019. I am not satisfied that a weight gain in the vicinity of 18kg resulted from the lumbar injury. I am not satisfied that the applicant's sleep apnoea resulted from the injury.

130. Although I am prepared to accept that the injury caused the applicant to experience chronic pain, use anti-inflammatory drugs from time to time and be less mobile, in view of the findings above, I am not satisfied that there is a fair climate for the acceptance of Dr Herman's opinion on causation.

131. I have noted that Dr Nigro has also expressed the view that the injury has resulted in the applicant suffering hypertension. Dr Nigro has, however, attributed the hypertension to an 18 kg weight gain as a result of the injury, which, for the reasons given above, I have not accepted.

132. Dr Roy's report does not provide an opinion on causation.

133. After carefully weighing the evidence, I am not satisfied that the applicant's hypertension has resulted from the lumbar injury on 8 August 2011.

SUMMARY

134. The applicant has not discharged the onus of establishing that his sleep apnoea and hypertension result from the lumbar injury on 8 August 2011.

135. The parties have, however, agreed that the applicant is entitled to lump sum compensation pursuant to s 66 of the 1987 Act in respect of 12% WPI of the lumbar spine as a result of the injury on 8 August 2011.

136. There will be an award for the applicant on the claim for lump sum compensation in respect of permanent impairment of the lumbar spine only.