WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **6735/19**
Applicant: **Fernando Michael Gorostiza**
Respondent: **State of New South Wales**
Date of Determination: **6 April 2020**
Citation: **[2020] NSWWCC 106**

The Commission determines:

1. The applicant sustained a secondary psychological condition as a result of the injury on 1 September 2008.

2. The applicant was totally incapacitated as a result of the injury on 1 September 2008 between 14 March 2009 and 29 November 2009.

3. The applicant was partially incapacitated as a result of the injury on 1 September 2008 between 30 November 2009 and 10 April 2011.

The Commission orders:

4. The respondent to pay the applicant weekly benefits as follows:

    (a) From 14 March 2009 to 31 March 2009 at the rate of $381.40 per week;
    (b) From 1 April 2009 to 30 September 2009 at the rate of $389.10 per week;
    (c) From 1 October 2009 to 31 March 2010 at the rate of $396.10 per week;
    (d) From 1 April 2010 to 30 September 2010 at the rate of $403.70 per week;
    (e) From 1 October 2010 to 31 March 20111 at the rate of $409.10 per week; and
    (f) From 1 April 2011 to 10 April 2011 at the rate of $417.40.

5. The parties have liberty to apply on 3 days' notice in relation to the figures above.

6. That the respondent to have credit for payments already made.

7. The respondent to pay the applicant's reasonably necessary medical expenses in respect of the injury to the applicant's cervical spine and secondary psychological condition pursuant to s 60 of the *Workers Compensation Act 1987* on production of accounts, receipts and/or valid Medicare Notice of Charge.

8. Pursuant to s 66 of the *Workers Compensation Act 1987*, the respondent to pay the applicant $8,250 in respect of 6% whole person impairment of the cervical spine as a result of injury on 1 September 2008 in accordance with the Medical Assessment Certificate of Dr Peter Holman dated 26 February 2013.

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

Rachel Homan
Arbitrator

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

A Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr Fernando Michael Gorostiza (the applicant) was employed as a Registered Nurse by the State of New South Wales (the respondent) at St Vincent's Hospital. On 1 September 2008, the applicant sustained an injury to his cervical spine when the chair he was sitting on slipped whilst he was reaching into a drawer.

2. Liability for an injury to the applicant's cervical spine was accepted and he received in excess of 26 weeks of weekly benefits before liability to pay ongoing weekly benefits and medical expenses was declined in a dispute notice issued pursuant to s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) on 1 July 2009. A further dispute notice maintaining that decision was issued on 11 November 2009.

3. In Commission proceedings 14945/12, the applicant was assessed as having 6% whole person impairment (WPI) of his cervical spine as a result of the injury on 1 September 2008 according to a Medical Assessment Certificate (MAC) issued by Dr Peter Holman on 26 February 2013. Lump sum compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act) was not, however, awarded as the proceedings were discontinued on 22 March 2013.

4. In the current proceedings, commenced by an Application to Resolve a Dispute (ARD) filed on 20 December 2019, the applicant seeks compensation for weekly benefits from 14 March 2009 to 10 April 2011, incurred medical expenses pursuant to s 60 of the 1987 Act and an award of lump sum compensation pursuant to s 66 of the 1987 Act based on Dr Holman's MAC.

PROCEDURE BEFORE THE COMMISSION

5. The parties attended a conciliation conference and arbitration hearing on 3 March 2020. The applicant was represented by Mr Craig Tanner of counsel, instructed by Ms Jacqueline Bates. The respondent was represented by Mr Andrew Parker of counsel.

6. During the conciliation conference, leave was granted to the applicant to amend the description of injury in the ARD to include a secondary psychological condition. Leave was granted to the respondent, pursuant to s 289A(4) of the 1998 Act to dispute the secondary psychological condition. The parties reached agreement that lump sum compensation under s 66 of the 1987 Act should be awarded in the amount of $8,250 pursuant to Dr Holman's MAC.

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 sustained a secondary psychological condition as a result on the injury on 1 September 2008;

    (b) Extent and quantification of incapacity resulting from the injury on 1 September 2008 during the period 14 March 2009 to 10 April 2011; and

    (c) Entitlement to s 60 medical expenses.

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;

    (b) Reply and attached documents; and

    (c) Documents attached to an Application to Admit Late Documents filed by the applicant on 21 February 2020.

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 written statements made by him on 10 November 2010, 30 May 2011, 19 November 2019 and 30 January 2020.

12. The applicant said that on 1 September 2008, he sustained an injury while admitting a patient. The applicant was sitting on a chair, taking the patient's blood pressure reading. The applicant's left arm was outstretched towards the blood pressure machine and his right hand was reaching into a desk drawer, when suddenly his chair moved and the applicant was jolted. The applicant's right hand was caught in the open drawer and to extricate himself from this awkward position, the applicant used his left hand on the edge of the table and pulled himself upwards. The applicant felt a snap in his back and a spreading sensation of warmth and pain from the back of his neck.

13. The applicant continued with the patient admission but the pain and sensation of warmth persisted. The applicant reported the matter to his nursing supervisor. The following day, the left side of the applicant's neck, shoulder and back were affected.

14. The applicant subsequently developed a range of symptoms including "trance-like" dizzy spells, headaches, muscular tension, buzzing in his left ear, difficulty swallowing and a sensation of choking. In early 2009, the applicant burped continuously for three days and found it difficult to breathe. The applicant retched intermittently, felt breathless and exhausted. The applicant would wake up a number of times in the middle of the night.

15. The applicant found this distressing. As he was not getting better and no one could tell him what was going on, the applicant became increasingly anxious and worried. The applicant's treating doctors told him his symptoms were psychological, however, the applicant felt his psychological distress was caused by physiological factors.

16. In March 2009, the applicant was diagnosed with left-sided Bell's palsy and his other symptoms increased. The applicant started to feel numbness in his arms and fullness in his left ear, blurring vision, and a high-pitched sound in his ear which pulsated with his heartbeat and synchronised with every step or bite.

17. The applicant said the facial disfigurement caused by the Bell's palsy heightened his feelings of distress, anxiety and hopelessness. The applicant recalled feeling lost, sad and alone and unsupported at work. The applicant felt abandoned by his doctors.

18. The applicant was in pain constantly and felt uneasy within his workplace. The applicant's colleagues did not understand his disability and would make comments such as "why can't you just get over it". The applicant was criticised for doing his exercises at work. There was uncertainty as to whether the applicant could perform his job.

19. Prior to the injury, the applicant was a very active person leading a healthy lifestyle. After the injury, the applicant felt restricted in all areas of his life. The applicant said his life was shaken. He felt sad, depressed, helpless, frustrated and anxious about the future.

20. Eventually, the applicant began to see a new general practitioner, Dr Janet Kim, whom he felt was more proactive in the management of his case.

21. The applicant received weekly compensation from the insurer until 13 March 2009. On 16 November 2009, the applicant was stood down from work as a result of the injury. The applicant applied for and began to receive Centrelink benefits.

22. The applicant felt his self-esteem had been badly affected and the uncertainty around going back to work made it difficult for him to plan for or even see a future. The applicant's depression negatively affected his personal life, relationships and sexual drive. The applicant withdrew from activities and became less trusting.

23. The applicant received counselling from Ms Kristina Xavier. After the claim for compensation was denied, the applicant saw Ms Yolanda Waldman on one occasion and subsequently Ms Tony Ovadia, a clinical psychologist, paid for by Medicare under a Mental Health Plan.

24. The applicant felt his psychological symptoms and need for treatment were the direct result of the work injury. There was no other cause.

25. The applicant eventually returned to full-time work with the respondent on 10 April 2011, where he remained employed until that employment was terminated in August 2013.

Respondent's evidence

26. Attached to the Reply are meeting minutes from a series of meetings held between the respondent and the applicant in 2009 and 2010.

27. The minutes of meeting held on 2 March 2009, indicate that the applicant continued to complain of discomfort and increased tension in his neck. The applicant had difficulty sleeping due to the discomfort and was also dwelling on stress/anxiety he had been experiencing at work.

28. The applicant was advised that he should not be taking time off work under the WorkCover scheme to deal with issues that were non-injury related. The applicant was advised that there was a difference between his physical injury and his anxiety/stress at work. The applicant complained of difficulties completing his clinical competencies due to his injury. The applicant was advised he had been provided with extensive support in completing his competencies and his original injury should have resolved about four to six weeks post injury. Reference was made to a formal complaint the applicant had made about a staff member on 26 February 2009, which the applicant considered was related to his injury.

29. It was confirmed that the applicant was essentially performing all pre-injury duties with the exception of lifting patient luggage, tilting beds and assisting with patient transfers.

30. A formal meeting was held with the applicant on 16 June 2009 to allow the applicant to respond to a number of concerns the respondent had in relation to his behaviour and performance as a registered nurse. An allegation was made that the applicant was verbally aggressive when communicating to a clinical nurse educator and had inappropriately requested that person's private contact details during the conversation. It was also alleged that the applicant had spoken in a loud and aggressive manner to the same person on a separate occasion. Concern was raised regarding the applicant's refusal to discuss work issues with management. The applicant denied the allegations and said his inability to do his job was due to his injury.

31. One interaction in this meeting was recorded as follows,

> "SW: Fernando, the hospital also has concerns regarding your behaviour at work. It appears that your behaviour at work has changed over the past few months. It appears that you have become aggressive on occasions, shouting at colleagues in front of patients, you appear to be apathetic towards your learning contract and competencies, and when we try and meet with you to discuss our concerns you appear to become highly anxious getting sudden headaches and having to go home sick. Do you have any comments in relation to this? Is there something you wish to share with us about this?
>
> FG: I am not hiding anything, you can have any information from my doctors etc, the treatments etc. I feel dizzy all of the time and it is draining me, it is exhausting."

32. At a meeting on 23 June 2009, the applicant was informed that the respondent was conducting further investigations into his behaviour and performance. The applicant was stood down in the intervening period, during which time the applicant would be required to undergo a formal independent psychiatric/psychological assessment to assist in determining his ability to undertake the inherent requirements of a registered nurse.

33. On 21 September 2009, the applicant was advised that he was required to attend an appointment with psychiatrist, Dr Howe Synnott on 22 September 2009.

34. At a meeting on 13 November 2009, the applicant was advised of Dr Howe Synnott's opinion that the applicant was not fit for the inherent requirements of a registered nurse. The applicant's status was changed from being stood down on pay of four hours a day at five days per week to that of sick leave. The applicant was advised that he had eight to nine days of annual leave and no sick leave entitlements left. The applicant was advised to contact Centrelink with regard to accessing additional financial support.

Medical evidence

Dr Scott Burne

35. Sports medicine physician, Dr Scott Burne prepared a report for the respondent on 29 September 2008. Dr Burne took a history of the injury that was consistent with the applicant's evidence. Dr Burne gave the opinion that the applicant had pain of cervical origin stating,

> "I anticipate that as he has rotated and turned away from the left side whilst at work he has suffered a cervical disc or facet joint problem."

36. An MRI of the cervical spine was taken on 16 October 2008. Dr Burne reported on 21 October 2018 that this showed,

> "…an abnormality particularly at C6/7 with an osteophytic narrowing at his facet joint bilaterally, worse on the right side. This is the side Fernando is noticing most symptoms. There is some suggestion of impingement of the C6 nerve at this level."

37. With regard to the applicant's capacity for work, Dr Burne reported,

> "I have reassured him that this does not necessarily preclude him from most nursing duties but it is possible that some restrictions will need to be placed on him in the long term, especially involving lifting unassisted."

38. On 24 November 2008, Dr Burne noted that the applicant had been on work restrictions for his neck. Dr Burne said,

> "I feel that Fernando will need a couple more months of gradually increasing activities before he can work unrestricted. He should continue with his current lifting restrictions but can gradually increase his hours and I have discussed this with you today. He should continue to be careful in terms of rapid and uncontrolled neck movements and any hyperextension of his neck where he is looking up in a sustained fashion or use of computers and carrying heavy files."

39. On 12 January 2009, Dr Burne noted,

> "Fernando has been experiencing an increasing amount of pain in his cervical region and also headaches which are bi-frontal and associated with nausea and vomiting at times. These headaches have increased in frequency in the past 6-8 weeks. He has had physiotherapy by Tim Ellis and this has improved him temporarily. He finds that certain situations in his workplace such as any conflicts with his workplace colleagues and also any situation involving some tension in the workplace certainly does increase his headache frequency and severity. He has been seeing his local doctor to help manage these issues.
>
> I understand that you have discussed with him to have a psychology assessment and this may be also to give him some relaxation techniques."

Ms Kristina Xavier

40. An "Assessment for Psychological Treatment" was prepared by clinical psychologist Ms Kristina Xavier on 9 January 2009.

41. Ms Xavier took a history of the applicant's physical injury. The applicant reported experiencing persisting pain in his back and neck which fluctuated in intensity. The applicant also reported a moderate degree of depression, anxiety, frustration and problems at work with his boss. In addition, the applicant experienced headaches and disturbed sleep due to pain. The applicant denied experiencing these difficulties prior to the injury. The applicant reported that his pain, depression and anxiety had a significant impact on his life and ability to engage in certain activities, including work.

42. Ms Xavier formed the following impression:

> "In summary, Mr Gorostiza presents with:
> • persisting pain in his back and neck, excessive disability and associated distress; and • moderate to severe symptoms of depression and anxiety.
>
> The onset of these problems seems to be associated with an injury he sustained during the course of his duties as a registered nurse on 1/09/08.
>
> These difficulties are impacting on Mr Gorostiza's ability to engage in everyday activities such as: work, household duties, recreational activities and exercise. He currently lives a relatively sedentary and isolated life."

43. Ms Xavier recommended the applicant undergo approximately 10 psychological sessions on a weekly or fortnightly basis and suggested a range of useful resources. Ms Xavier considered the implementation of her recommendations together with cognitive behavioural therapy were likely to assist the applicant to return to work faster and more successfully.

Dr Ian Sutton

44. Consultant neurologist, Dr Ian Sutton prepared a report for Dr Burne on 25 March 2009. Dr Sutton took a history of developing left-sided otalgia the absence of aural discharge 12 days earlier. The applicant presented to his general practitioner three days later who noted the left side of the applicant's face was weak. The general practitioner diagnosed Bell's palsy and treated the applicant with prednisone for a period of seven days.

45. Dr Sutton noted that the Bell's palsy occurred on a background of chronic neck pain following a work injury which had been investigated by MRI.

46. Dr Sutton expressed the opinion:

> "Fernando presents with a left sided Bell's palsy which has been treated with steroids and is now resolving.
> …
> The Bell's palsy is unrelated to his worker's compensation claim. Currently Fernando is using Lacri-Lube eye drops and ointment appropriately. I would anticipate that the facial weakness should resolve completely.
>
> There are no clinical signs or imaging findings to suggest any significant problem with the cerebral structures of the posterior fossa and there are no signs to suggest a radiculopathy as a cause for Fernando's symptoms that relate to the episode of 1 September 2008."

Dr Ralph Mobbs

47. On 20 May 2009, neurosurgeon and spine surgeon, Dr Ralph Mobbs reported that the applicant presented with a number of symptoms, including neck pain, bilateral occipital neuralgia, dizziness and some jaw related problems. Dr Mobbs stated:

> "Current problem. Fernando states that his neck pain is the number one issue. The pain radiates into both shoulders, more on the left than the right. The pain also radiates into the back of his head in the distribution of the occipital nerves."

Dr Inglis Howe Synnott

48. Consultant psychiatrist, Dr Inglis Howe Synnott, conducted a psychiatric assessment of the applicant for the respondent on 22 September 2009.

49. In his report, Dr Howe Synnott took a history of the applicant's injury and his chronic physical symptoms. The applicant said he developed psychological symptoms soon after his physical symptoms in 2008. This included feeling distressed, sad, anxious, lost and hopeless.

50. The applicant first discussed his psychological symptoms with a medical professional in November or December 2008. In early June 2009, the applicant was referred to a psychologist. The applicant was not prescribed psychotropic medication and was not referred to a psychiatrist. The applicant considered that his psychological symptoms had worsened.

51. Dr Howe Synnott noted that there was no significant past medical or psychiatric history and no family psychiatric history.

52. Dr Howe Synnott made a diagnosis as follows:

> "In my opinion, at the consultation on 22 September 2009, Mr Gorostiza described sufficient psychological symptoms to meet the diagnostic criteria of an Adjustment Disorder - but, in this situation, a diagnosis of Depressive Disorder with prominent anxiety would also be appropriate. However, if, as he has indicated, medical assessments find no physical/medical cause for his physical symptoms, a diagnosis of Somatoform Disorder would have to be considered."

53. With regard to the applicant's capacity for work, Dr Howe Synnott reported:

> "In my opinion, although he said there was no psychiatric/mental incapacity for work, given his slow mentation, vagueness and apparent difficulty organising thoughts at the consultation on 22 September 2009, it would not be prudent for him to work as a registered nurse - where he would be responsible for the care and welfare of patients."

54. Asked whether the applicant was fit for suitable duties, Dr Howe Synnott responded that the applicant was "not currently psychiatrically capable of returning to work".

55. With regard to prognosis, Dr Howe Synnott said it did not look good given the deterioration over the last 12 months. Dr Howe Synnott said it would be prudent for the applicant to have follow-up by a psychiatrist.

Ms Yolanda Waldman

56. Psychologist, Ms Yolanda Waldman prepared a report for the applicant's general practitioner, on 2 February 2010. Ms Waldman noted that the applicant had attended four sessions but was unable to continue therapy on a weekly basis due to his financial situation. The applicant had described himself as friendly and outgoing before the injury, deriving great joy and satisfaction through his occupation and interaction with patients and work colleagues. Deprived of his work environment, the applicant felt increasingly sad, isolated, unsupported, anxious and lonely.

57. Ms Waldman commented,

> "Fernando has impressed as a man willing and courageous to make changes that will lead him to, in his own words, 'face life again'. He however objectively knows that this will be a long term challenge for him as he has a realistic understanding of the severity of his psychological symptoms which developed after his workplace injury and resulted in ongoing chronic physical symptoms such as pain in the back and neck area, numbness in arms and legs, headaches etc."

Ms Tony Ovadia

58. Clinical Psychologist, Ms Tony Ovadia, prepared a report for the applicant's general practitioner on 15 July 2010 after first seeing the applicant in April 2010. Ms Ovadia noted,

> "Mr Gorostiza's depression arose as a consequence of being unable to work due to a workplace injury. Psychological treatment has not been admitted as necessary under compensation. There is no previous history of a mental disorder and Fernando was functioning very well in his chosen profession of nursing…"

59. Ms Ovadia noted Dr Howe Synnott's view as to the applicant's capacity for work and reported,

> "Fernando has been receiving treatment from a new chiropractor with excellent results. Whatever the cause, be it chiropractic or psychological treatment, Fernando's mood lifted and when I saw him last on 9 July he appeared ready for work. He was to see and independent psychiatrist and if deemed fit to work, would be negotiating with his employer for a job to suit his capacity.
>
> Although Fernando now appears to have recovered, we agreed that further sessions would help to prevent relapse and assist him in dealing with return to work."

Dr Janet Kim

60. The applicant's general practitioner, Dr Janet Kim, prepared a report for the applicant's solicitors, dated 27 August 2010.

61. Dr Kim noted that the applicant presented to her for the first time on 13 March 2009 with vertigo, tinnitus and severe pain in his left jaw and the muscles following the accident at work in September 2008. He also had pain in his left ear. The applicant was under the care of Dr Burne and undergoing physiotherapy.

62. When the applicant returned on 16 September 2009, he was developing Bell's palsy and was initiated on prednisone. An MRI scan confirmed seventh nerve neuritis. In the meantime, the applicant continued to experience tinnitus, vertigo, hiccups, a sensation of fullness in his ears and persistent pain in his head, neck and upper back area. The applicant was working suitable duties but frequently presented at the emergency department with fear of fainting and losing control of his balance.

63. Dr Kim made referrals to a neurosurgeon, Dr Ralph Mobbs, who in turn referred the applicant to a pain specialist, Dr Ray Garrick. The applicant also saw vertigo specialist, Dr Ross Black, neurologists, Dr Watson and Dr Darveniza and ENT specialist, Dr Thomas Kertesz. The applicant was commenced on Dothep for sleep and tricyclic antidepressants. The applicant had also commenced seeing a chiropractor with good results. Dr Kim noted,

> "Fernando's frequent days off and presenting to casualty at SVH and poor performance at work as a result resulted in a loss of his position at SVH. Because of a lack of a firm diagnosis he was diagnosed as having anxiety disorder or even labelled Somatiform disorder, rather than real physical condition by his workplace at SVH. During these times Fernando has seen psychologists Yolanda Waldman and Tony Ovadia and psychiatrist Dr Synnott with gradual improvement."

64. Dr Kim gave the opinion,

> "In my opinion patient has suffered from neurological condition stemming from stimulation and injuries to his cervical spine and occipital nerves."

65. Dr Kim considered the applicant was fit for part-time work, starting gradually, in nursing.

Dr Shaun R D Watson

66. On 29 October 2010, consultant neurologist, Dr Shaun Watson, reported to the applicant's solicitors. Dr Watson saw the applicant at the Dizziness and Balance Clinic at Prince of Wales Hospital on 23 September 2009, 24 February 2010 and 7 July 2010.

67. Dr Watson recorded a history of the applicant being fit and well prior to what appeared to be a relatively minor accident on 1 September 2008. Dr Watson's history of the applicant's physical injury and symptoms that followed was consistent with the other evidence.

68. Dr Watson gave the opinion,

> "I consider it highly likely that your client's complex and somewhat unusual symptoms are a direct consequence of the workplace injury as stated. Some of the symptoms (such as hiccupping and burping) are obviously unusual, they seem reproducible and are not likely to be symptoms that a registered nurse would "invent" to strengthen his case.
>
> My interpretation of the injury is that he suffered relatively modest musculoskeletal injury to his upper cervical spine, somewhat similar to the type of injury that occurs in a "whiplash" cervical injury. I consider that this initial injury has resulted in his complex symptoms through secondary effects within the central nervous symptom. This is a process which is well recognised in the context of chronic pain and is often referred to as central sensitisation. The predominant symptoms that I have been concerned with are dizziness and headache (as outlined above). The headache and dizziness that he experiences are clinically similar to migraine headache and migrainous vertigo. I reiterate that I consider that this symptom complex is a consequence of initial injury to the upper cervical spine, probably resulting in abnormal input to brain stem nuclei through activated nociceptive (pain) and proprioceptive pathways."

69. With regard to the applicant's capacity for work, Dr Watson said,

> "I do now consider that your client is fit to return to work, initially on restricted duties and limited hours (as referred to above). I have certainly gained the impression that he is highly motivated to both recover from his physical injuries and return to the workplace and most specifically to nursing."

WorkCover Certificates

70. WorkCover certificates in evidence show that at the commencement of the period of weekly benefits claimed, the applicant was certified unfit to work by Dr Kim in respect of a "soft tissue of neck and back/Left TMJ dysfunction/Bells palsy". The applicant's previous general practitioner had certified him fit for full hours in suitable duties.

71. A diagnosis of "occipital neuralgia" was added to the certificates from 23 March 2009.

72. From 31 March 2009, the applicant was certified fit for work at 12 hours per week. The applicant's capacity was increased to 14 hours per week from 11 May 2009, but returned to unfit for work from 18 May 2009.

73. On 29 May 2009, he was once again certified as fit for 16 hours per week.

74. The diagnosis on the certificates changed to "cervical disc lesions C5/6, C6/7, occipital nerve" on 26 June 2009.

75. The applicant's capacity was increased to 20 hours on 21 August 2009. A diagnosis of "secondary depression" was added to the certificates from 30 November 2009.

76. On 3 May 2010, Dr Kim issued a non-WorkCover medical certificate suggesting the applicant has capacity with restricted hours and a lifting limit of 10 kg. The certificate stated,

> "…patient is currently receiving psychologist [sic] but he needs to return to work to help his self-esteem and to have a goal in life as he is keen to work. He is also receiving physical treatment (acupuncture for his physical pain and anxiety) with good progress -paid for by Medicare as wc for this treatment has been declined."

77. After 30 June 2010, there are Centrelink certificates in evidence, certifying the applicant as unfit for work.

Medicolegal evidence

Dr James G Bodel

78. The applicant has filed a medicolegal report prepared by orthopaedic surgeon, Dr James G Bodel, dated 4 March 2011.

79. The applicant at that time complained of constant pain at the base of his neck and occipital headache on both sides. The applicant also had pain radiating down both arms with some numbness and tingling in his hands.

80. Dr Bodel diagnosed soft tissue injury to the cervical spine and the upper back as a consequence of the injury at work as well as aggravation of some underlying degenerative change.

81. With regard to the applicant's capacity for work, Dr Bodel stated,

> "This gentleman is I understand certified as being fit for suitable duties four hours a day, five days a week with a 15kg lifting limit and hopefully some meaningful lighter duty work can be offered within those clinical capabilities."

Associate Professor Matthew Kiernan

82. The respondent relies on a medicolegal report prepared by neurologist, Associate Prof Matthew Kiernan, dated 18 April 2009.

83. Dr Kiernan took a history of the applicant's injury consistent with the other evidence. Dr Kiernan diagnosed mechanical, musculoskeletal type pain arising from the neck region. In addition, he diagnosed a left facial nerve palsy (Bell's palsy) which was healing. Dr Kiernan said,

> "The history of injury is minor, and one would have expected that given the nature of this injury, which occurred in September 2008, that any problem would have resolved by now. In terms of the structural changes reported on the MRI scan of the cervical spine, these would be regarded as constitutional in nature."

84. Whilst Dr Kiernan accepted that the work injury aggravated a constitutional degenerative condition involving the applicant's cervical spine, he considered the aggravation had ceased. Dr Kiernan did not consider employment with the respondent to be a contributing factor to the applicant's ongoing problems.

85. Dr Kiernan and did not consider the applicant's Bell's palsy or TMJ dysfunction to be as a result of his neck or shoulder injury.

86. From a neurological perspective, Dr Kiernan considered the applicant would be free to undertake normal duties. Dr Kiernan noted that the applicant was expected to return to work the following week and said this seemed appropriate.

Dr John Douglass

87. The respondent also relies on a medicolegal report prepared by orthopaedic surgeon, Dr John Douglass dated 23 June 2009. Dr Douglass agreed with Dr Kiernan's diagnosis:

> "I do agree with Professor Kiernan that Mr Gorostiza has not developed left Bells Palsy and/or temporomandibular joint dysfunction as a result of his neck or shoulder injury which had occurred on 1 September 2008 - the earliest onset of symptoms was three months later in December, and the Bells Palsy was not confirmed until mid-March 2009.
> …
> I also agree with Professor Kiernan's statement that the injury sustained on 1 September 2008 at St Vincent's Hospital, would no longer be a contributing factor to his ongoing problems. That injury was a soft tissue strain which occurred more than six months ago, and would have resolved spontaneously."

88. With regard to the applicant's capacity for work, Dr Douglass said,

> "If he has recovered from the musculoskeletal injuries to some extent, then he should be fit to resume light duties, initially doing six hours a day for four days a week with a lifting limit of 10kgs, whilst undertaking core strengthening exercises of the cervicothoracic spine, and also the lumbar spine which was surprisingly stiff when I examined him. If he undertook the physiotherapy exercises twice weekly for a month, he could gradually increase his hours by an hour per day, per week, and could increase his lifting limit by 2kgs a week so that after five weeks he would have a 15kg limit, and should be able to resume pre-injury duties by late June 2009. If he is not fit to do so, then he should reconsider his fitness to continue working on all activities

> as a nurse - this was suggested on Page 6 of my report dated 12 March 2009. If he is unable to resume full duties as a nurse, he may be able to find a lighter job as an occupational nurse in a factory, or in an out-patient clinic where the physical duties would be less demanding than in a day care surgery centre."

Medical Assessment Certificate

89. A MAC was issued by Approved Medical Specialist, Dr Peter Holman on 26 February 2013.

90. Dr Holman summarised the applicant's injury and diagnosis as follows:

> "As a result of an injury at work on 1 September 2008 as described, Mr Gorostiza sustained a musculoligamentous strain of his cervical spine and aggravated pre-existing degenerative changes principally at the C6/7 level. Despite ongoing conservative treatment, Mr Gorostiza continued to suffer from neck pain with pain radiating to the posterior aspect of both shoulders. He developed occipital and frontal headaches. He developed tinnitus and dizziness. He developed unusual symptoms including difficulty swallowing and repetitive burping.
> …
> Mr Gorostiza did not show any evidence of significant inconsistency during the presentation, however I was unable to relate some of the physical findings to a specific organic injury. Such findings included gulping and recurrent burping."

91. Dr Holman certified the applicant as having 6% whole person impairment of his cervical spine.

Applicant's submissions

92. Counsel for the applicant, Mr Tanner, noted that it had been accepted that the applicant sustained a compensable injury to the cervical spine. As a consequence, lump sum compensation pursuant to s 66 of the 1987 Act should be paid in accordance with Dr Holman's MAC. Given the acceptance of the cervical spine injury, a general order for s 60 expenses should follow in relation to that injury.

93. What remained to be determined was to whether there was a consequential psychological condition and whether there was an entitlement to s 60 expenses in respect of that condition. There was also a dispute as to the applicant's capacity for work.

94. Mr Tanner said the claim for weekly benefits was to be determined in accordance with the pre-June 2012 provisions in ss 37 and 40 of the 1987 Act. Mr Tanner noted that the applicant had been in receipt of WorkCover certificates issued by his general practitioner. From 14 March 2009 until November 2009 the applicant was certified as having limited capacity at times and total incapacity at other times. During that period, the applicant worked according to his restrictions with the respondent.

95. Mr Tanner referred me to the notes of the formal meeting between the respondent and the applicant on 13 November 2009. The identified purpose of the meeting was to discuss Dr Howe Synnott's assessment of the applicant's ability to return to work. Dr Howe Synnott had given the opinion that the applicant was not fit for the inherent requirements of a registered nurse and not psychiatrically capable of participating on a full-time or part-time basis in his role. Furthermore, based on the history and presentation at the consultation on 22 September 2009, the applicant had no capacity for any employment. The applicant was stood down from work on sick leave. Mr Tanner submitted that from that point onwards the applicant ceased to perform any duties for the respondent until the conclusion of the period of weekly benefits claimed on 10 April 2011.

96. Mr Tanner took me to Dr Howe Synnott's report as well as the reports of Ms Waldman and Ms Xavier in support of the secondary psychological condition. Mr Tanner submitted that the evidence demonstrated quite clearly that the applicant's psychological condition was pain related and the pain could be traced to the undisputed injury to his cervical spine.

97. With regard to the applicant's physical incapacity, Mr Tanner referred to the report of Dr Bodel of 4 March 2011. Mr Tanner noted that Dr Bodel in effect endorsed the WorkCover certificates, finding the applicant fit for suitable duties four hours per day for five days per week with a 15kg lifting limit.

98. Mr Tanner noted the various reports by Dr Burne and his opinion that the applicant's pain was of cervical origin. In his report of 12 January 2009, Dr Burne noted the pain to be increasing and the onset of headache symptoms. Mr Tanner said Dr Burne's reports demonstrated a clear pattern of persisting pain. Dr Burne also considered the applicant would strongly benefit from psychological treatment to assist with relaxation techniques.

99. Mr Tanner referred to the report of the applicant's general practitioner, Dr Kim to the applicant's solicitors dated 27 August 2010. Mr Tanner noted it was Dr Kim's opinion that the workplace injury was responsible for all of the applicant's symptoms.

100. Mr Tanner referred to the report from Dr Watson to the applicant's solicitors. Mr Tanner noted that Dr Watson recorded that the applicant generally looked quite sad during the consultation. Mr Tanner said Dr Watson reached the same conclusion as Dr Kim with regard to the work injury being the cause of the applicant's symptoms. As at 29 October 2010, Dr Watson recommended a graded return to work with restrictions as guided by his general practitioner and occupational therapist. Mr Tanner noted that this was towards the latter stage of the period of weekly benefits claimed. However, Dr Watson's opinion was given without reference to the applicant's psychological condition and importantly, Dr Watson's report did not indicate there was immediate capacity.

101. Mr Tanner noted that the respondent had not elicited any evidence with regard to the applicant's psychiatric condition other than the report of Dr Howe Synnott. Mr Tanner submitted that I would accept in those circumstances, that the applicant sustained a secondary psychological condition and continued to suffer incapacity as a result of that condition throughout the period of weekly benefits claimed.

102. Mr Tanner noted the report of Dr Sutton with regard to the applicant's Bell's palsy but submitted that the applicant did not rely on the Bell's palsy condition as a basis for any incapacity for work.

103. Mr Tanner noted that the respondent relied on the report of neurologist, Dr Kiernan. Mr Tanner noted that Dr Kiernan considered the initial injury was not significant. There was, however, clear evidence that notwithstanding the relatively minor initial incident, the applicant had persistent symptoms. Although Dr Kiernan expected that any problem associated with the initial injury would have resolved, the evidence showed that in fact the symptoms did not resolve.

104. Mr Tanner noted that the MAC from Dr Holman confirmed there was residual pathology warranting an assessment under AMA 5. As result, the opinion of Dr Kiernan was unable to be accepted.

105. Mr Tanner noted that only a supplementary report from Dr Douglass had been filed. The original report was not in evidence. Mr Tanner submitted that Dr Douglass' opinion was also misconceived in light of the MAC being predicated on the applicant having recovered from his injury.

106. Mr Tanner submitted that the applicant's general practitioner was in a reliable position to comment on the applicant's capacity and her certifications should be accepted. There was also a significant psychological component to the injury and the respondent's own evidence indicated total incapacity as a result of the psychological condition.

107. Mr Tanner submitted that there were ongoing physical and psychological incapacities. To the extent that there was any capacity for work it was of such a limited nature to leave a sufficient shortfall to give rise to an entitlement to an award at the weekly statutory rate.

Respondent's submissions

108. Mr Parker said that the respondent only accepted that the applicant sustained an injury to the cervical spine. The applicant's cervical injury was not very significant. The applicant was assessed as having only 6% whole person impairment in the MAC.

109. Noting that this was a s 40 case, Mr Parker said that if the applicant was found to have partial incapacity, there were a number of factors that should be taken into account in the exercise of the Commission's discretion.

110. Mr Parker submitted that there were a number of conditions arising in the early part of 2009 when the applicant went off work, that were not pleaded in the proceedings including, the applicant's Bell's palsy and TMJ symptoms. Mr Parker submitted that Dr Watson, Dr Burne and Dr Kim had all addressed the applicant's Bell's palsy and TMJ symptoms in their reports. The WorkCover certificates issued to the applicant around that time included reference to the Bell's palsy and TMJ symptoms.

111. Mr Parker submitted that Dr Kiernan and Dr Douglass looked at the part of the claim that was within their area of specialty and gave a consistent opinion. Mr Parker conceded that the respondent had not qualified a medicolegal expert in respect of the secondary psychological condition but noted that the report of Dr Howe Synnott was commissioned by the employer. Mr Parker submitted that Dr Howe Synnott's report should be read as indicating only that, at the date of his assessment, on the basis of the applicant's presentation, he was not fit to do the work of a registered nurse.

112. Mr Parker referred to a chronology of events set out in a Return to Work Placement Report dated July 2009 attached to the Reply. Mr Parker said there were a number of issues arising from that chronology relevant to the exercise of the discretion in s 40. Mr Parker submitted that the applicant had gone on holidays to the Philippines for a period of time and that no weekly benefits were payable pursuant to s 53 of the 1987 Act during that period. Mr Parker said it was apparent that the TMJ and Bell's palsy symptoms were the catalyst for the applicant going off work. Mr Parker said the applicant first presented to the hospital emergency department with Bell's palsy symptoms on 10 March 2009. Mr Parker said the headaches the applicant was experiencing were related to the Bell's palsy and TMJ symptoms. Mr Parker said there were also work performance issues which were not addressed in the applicant's evidence. The applicant had not denied having performance issues at work in his own statement, and it could be inferred that any evidence the applicant would give on that matter, would not assist his case. In this regard, Mr Parker referred to the decision in *Russo v Aiello*[1].

113. Mr Parker noted that the applicant placed significant weight on the report of Dr Howe Synnott. Mr Parker submitted, however, that Dr Howe Synnott's conclusion was based solely on the applicant's presentation on the day of examination. By 3 May 2010, Dr Kim had indicated that the applicant was fit to work restricted hours with a lifting limit of 10 kg. Dr Kim said the applicant needed to return to work to help his self-esteem. Mr Parker submitted that it could not be said that the applicant was totally incapacitated throughout the period of the claim.

[1] *Russo v Aiello* (2003) 215 CLR 643; (2003) 201 ALR 231; [2003] HCA 53.

114. Mr Parker noted that with respect to the applicant's physical condition, Dr Watson had indicated that at the time of his last review with the applicant on 7 July 2010, the applicant was making excellent progress and could commence a graded return to work with restrictions.

115. In view of this evidence, Mr Parker submitted that any inability for the applicant to return to work was due to his discipline and performance issues or other factors unrelated to the injury or consequential psychological condition.

116. Mr Parker noted that the applicant returned to the Philippines on holidays on two occasions in 2010. This travel was noted by Dr Watson and Dr Bodel who indicated that the applicant had travelled overseas for three months. Mr Parker noted that the applicant had not given any explanation as to his travel to the Philippines.

117. Mr Parker submitted that the Commission should only find a neck injury. The respondent denied that there was a secondary psychological condition but said if there was, it was limited in scope. Mr Parker submitted that the true cause of the applicant's incapacity was the symptoms associated with Bell's palsy or TMJ or other non-pleaded conditions. Combined with the applicant's holidaying to the Philippines and discipline, competency and performance issues at work, any award of compensation should be reduced pursuant to the Commission's discretion. Mr Parker submitted that there was no incapacity for which compensation should be payable whilst the applicant was overseas, having taken himself out of the labour market.

118. Mr Parker submitted that the applicant was fit for eight hours per day five days per week as at February 2009, which was equivalent to what the applicant was earning. The calculation under s 40(2) should therefore be $ nil. Mr Parker submitted that if the applicant was found to have a lesser capacity to earn, the discretion should be exercised to reduce the payments by a significant amount or at least $200 - $300. During the period the applicant was away overseas, only a nominal amount should be payable. In this regard, Mr Parker referred to *North Coast Area Health Service v McDonald (No 2)*[2].

119. Mr Parker conceded that if the Commission were to find a psychological condition, an entitlement to s 60 expenses for that condition would follow.

Applicant's submissions in reply

120. Mr Tanner submitted that for the purposes of s 53, the applicant did not cease to reside in Australia but simply went on holiday. Mr Tanner submitted that there would need to be evidence that the applicant's home had changed. Mr Tanner referred to dictionary definitions of the expression, "reside" and said there was no evidence that the applicant had changed his domicile for the purposes of s 53 of the 1987 Act.

121. Mr Tanner referred to the report of Dr Mobbs of 20 May 2009 in which it was recorded that the applicant's neck pain was his number one issue. It was noted at that stage that the applicant's pain was radiating into his shoulders, back and head. The compensable injury was a source of continuing pain and incapacity. The issues of Bell's palsy and TMJ did not detract from the core of the applicant's complaints.

122. Mr Tanner submitted that the suggestion that disciplinary and performance issues were the reason the applicant was not working was incorrect. The meeting minutes recorded that the applicant was stood down as a result of Dr Howe Synnott's report. Mr Tanner submitted that for the purposes of the s 40 discretion it was necessary to consider whether there was some supervening reason why the applicant was not working.

[2] [2009] NSWWCCPD 156.

123. Mr Tanner submitted that there was no countervailing evidence that, at a psychiatric level, the applicant's condition had improved to the extent that he was able to return to work. Ms Waldman and Ms Xavier's reports confirmed there were enduring psychiatric symptoms.

124. Mr Tanner submitted that it was not necessary for the applicant to explain his travel to the Philippines. It was identified in the evidence and did not bear on the assessment of the applicant's incapacity or the exercise of the discretion.

125. Mr Tanner noted that psychological issues were first raised with the applicant's general practitioner on 4 December 2008.

126. Mr Tanner submitted that there was undisputed pain as a result of the applicant's accepted work injury. As a matter of commonsense it was unsurprising that the applicant developed psychological symptoms in dealing with that pain and being out of the workforce.

127. Mr Tanner submitted that the performance and discipline matters were irrelevant to a determination as to the applicant's incapacity for work.

FINDINGS AND REASONS

Secondary psychological condition

128. It is accepted by the respondent that the applicant sustained "injury" to his cervical spine on 1 September 2008 pursuant to s 4 of the 1987 Act. The first issue requiring determination by me is whether the applicant sustained a consequential psychological condition as a result of that injury.

129. It is not necessary for the applicant to establish that the psychological condition alleged is in itself an 'injury' pursuant to s 4 of the 1987 Act. Deputy President Roche in *Moon v Conmah*[3] 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."

130. In *Bouchmouni v Bakhos Matta t/as Western Red Services*[4], Roche DP noted,

> "The Commission has considered and explained the difference between an 'injury' and a condition that has resulted from an injury in several recent decisions (*Moon v Conmah Pty Ltd* [2009] NSWWCCPD 134 at [43], [45] and [50] (*Moon*); *Superior Formwork Pty Ltd v Livaja* [2009] NSWWCCPD 158 at [122]; *Cadbury Schweppes Pty Ltd v Davis* [2011] NSWWCCPD 4 at [28]–[32] and [39]–[42] (*Davis*); *North Coast Area Health Service v Felstead* [2011] NSWWCCPD 51 at [84]; *Australian Traineeship System v Turner* [2012] NSWWCCPD 4 at [28] and [29] (*Turner*); *Kumar v Royal Comfort Bedding Pty Ltd* [2012] NSWWCCPD 8 at [35]–[49] and [61]).
>
> …

[3] [2009] NSWWCCPD 134.
[4] *Bouchmouni v Bakhos Matta t/as Western Red Services* [2013] NSWWCCPD 4; (2013) 14 DDCR 223; BC201319259.

> The injury to Mr Bouchmouni's right knee caused him to seek treatment in the form of surgery and physiotherapy. The evidence suggests that it was in the course of receiving that treatment, and/or as a result of an altered gait because of his knee symptoms, Mr Bouchmouni developed back symptoms. If that is accepted, and no reason has been advanced why it should not be, it is clear beyond doubt that his back condition has resulted from the treatment he received for his accepted knee injury and his altered gait. That does not, however, make the back condition an 'injury'."

131. A commonsense evaluation of the causal chain to determine whether any psychological condition resulted from the accepted injury to his cervical spine is required. In *Kooragang*, Kirby P said,

> "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 death or 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."[5]

132. The respondent has been granted leave to dispute the allegation of a secondary psychological condition. The evidence relevant to this issue does, however, uniformly point towards a finding in favour of the applicant.

133. There is nothing in the evidence before me to suggest any psychological symptoms or pre-existing psychological condition prior to the workplace injury on 1 September 2008.

134. The contemporaneous medical evidence indicates that complaints of psychological symptoms were reported relatively soon after the physical injury.

135. Reference to psychological symptoms appeared in the clinical notes of the applicant's general practitioner from 4 December 2008 onwards. In January 2009, Dr Burne reported that the applicant was experiencing tension in the workplace which appeared to increase the frequency and severity of headaches the applicant was experiencing. In this regard, Dr Burne noted that the applicant was having discussions with his general practitioner with regard to a psychological assessment to assist with relaxation techniques.

136. A psychological assessment was in fact performed by Ms Xavier on 9 January 2009. The history taken in Ms Xavier's report related primarily to the applicant's physical injury and the persisting pain the applicant was experiencing. The applicant described depression, anxiety, frustration, disturbed sleep and headaches. Ms Xavier did also note the applicant had been experiencing difficulties at work but her opinion suggested that difficulties at work were the result of the applicant's persisting pain in his back and neck and associated distress. Ms Xavier considered the applicant had moderate to severe symptoms of depression and anxiety. This view is consistent with the applicant's evidence and the minutes of the meetings at which the applicant's difficulties at work were discussed.

137. A psychiatric assessment was performed by Dr Howe Synnott on 22 September 2009. Dr Howe Synnott's history was consistent with the other evidence in referring to the applicant's physical injury and chronic physical symptoms. Dr Howe Synnott reported that the applicant developed psychological symptoms soon after the physical symptoms in 2008.

[5] (1994) 10 NSWCCR 796 at [810].

Dr Howe Synnott made a formal diagnosis of adjustment disorder but noted that a diagnosis of depressive disorder with prominent anxiety would also be appropriate. Dr Howe Synnott suggested that if there were no physical or medical cause for the applicant's physical symptoms a diagnosis of somatoform disorder would have to be considered. Dr Howe Synnott noted that the applicant's condition had deteriorated over the previous 12 months and said it would be prudent for the applicant to have follow-up by a psychiatrist.

138. On 2 February 2010, psychologist Yolanda Waldman reported that she had seen the applicant for four sessions. Ms Waldman reported that the applicant's severe psychological symptoms had developed after the workplace injury which had resulted in ongoing, chronic physical symptoms such as pain in the neck and back area.

139. An opinion that the applicant's depression arose as a consequence of being unable to work due to his physical injury was given by clinical psychologist, Ms Tony Ovadia. By the time of her last consultation with the applicant on 9 July 2010, Ms Ovadia did, however, note a significant improvement in the applicant's psychological condition associated with an improvement in the applicant's physical condition following chiropractic treatment.

140. A review of the evidence thus indicates a consistently expressed opinion that the applicant had developed symptoms of a psychological nature as a result of the work injury, in particular, the ongoing symptoms of pain of cervical origin. The applicant's psychological symptoms were sufficient to warrant a clinical diagnosis and appeared to deteriorate for a period of time before some improvement being recorded in late 2009 and early 2010, coinciding with improvement in the applicant's physical symptoms.

141. In the absence of any countervailing evidence, I accept that the applicant sustained a psychological condition as a result of the injury on 1 September 2008.

Extent and quantification of incapacity

142. Section 33 of the 1987 Act provides:

> "If total or partial incapacity for work results from an injury, the compensation payable by the employer under this Act to the injured worker shall include a weekly payment during the incapacity."

143. The applicant claims weekly payments due to incapacity resulting from injury from 14 March 2009 to 10 April 2011. The parties agree that the entitlement to weekly compensation is governed by the weekly payment provisions in force prior to the 2012 amendments to the 1987 Act. It also agreed that the applicant has received in excess of 26 weeks of weekly payments in respect of the present injury.

144. Sections 37 and 40 of the 1987 Act as they apply to this case provided as follows:

> "**37. Weekly payment during total incapacity—after first 26 weeks**
>
> (1) The weekly payment of compensation to an injured worker in respect of any period of total incapacity for work (not being a period during the first 26 weeks of incapacity) shall be:
>
> (a) 90 per cent of the worker's average weekly earnings, except that:
>
> (i) the payment shall not exceed $235.20 per week,

(ii) in the case of a worker who is over 21 years of age at the time of payment—the payment shall not be less than $187.10 per week, and

(iii) in the case of a worker whose average weekly earnings do not exceed $170 per week—the payment shall be 100 per cent of those earnings or $153, whichever is the lesser amount,

(b) in addition, $62 per week in respect of:

(i) a dependent wife or dependent husband of the worker, or

(ii) if there is no dependent wife or dependent husband at any time during which weekly payments are payable—any one dependent de facto spouse or other family member of the worker, and

(c) in addition:

(i) in respect of the dependent children of the worker, the following amounts per week:

No of dependent children	**Additional amount per week**
1 dependent child	$44.30
2 dependent children	$99.10
3 dependent children	$164.16
4 dependent children	$230.90
5 or more dependent children	$230.90 plus $66.60 for each child in excess of 4

(ii) if there are no dependent children at any time during which weekly payments are payable—in respect of the dependent brothers and sisters of the worker, the same amounts per week as are payable under subparagraph (i) in respect of dependent children of the worker."

And

"**40. Weekly payments during partial incapacity—general**

(1) **Entitlement**

The weekly payment of compensation to an injured worker in respect of any period of partial incapacity for work is to be an amount not exceeding the reduction in the worker's weekly earnings, but is to bear such relation to the amount of that reduction as may appear proper in the circumstances of the case.

Note. Section 35 limits the maximum weekly payment of compensation under this section.

(2) **Calculation of reduction in earnings of worker—general**

The reduction in the worker's weekly earnings is (except as provided by this section) the difference between:

(a) the weekly amount which the worker would probably have been earning as a worker but for the injury and had the worker continued to be employed in the same or some comparable employment, and

(b) the average weekly amount that the worker is earning, or would be able to earn in some suitable employment, from time to time after the injury.

Note. The difference between (a) and (b) is the maximum amount of compensation payable to the worker. It is not a limit on the combined total of compensation and earnings.

…

(3) **Ability to earn in suitable employment**

The determination of the amount that an injured worker would be able to earn in some suitable employment is subject to the following:

(a) the determination is to be based on the worker's ability to earn in the general labour market reasonably accessible to the worker,

(b) the determination is to be made having regard to suitable employment for the worker within the meaning of section 43A.

…

(5) **Maximum rate of compensation**

The weekly payment of compensation to an injured worker in respect of any period of partial incapacity for work is not to exceed the weekly payment that would be payable to the worker if it were a period of total incapacity for work."

145. The expression "suitable employment" was relevantly defined in s 43A as follows:

"43A Suitable employment

(1) For the purposes of sections 38, 38A and 40:

suitable employment, in relation to a worker, means employment in work for which the worker is suited, having regard to the following:

(a) the nature of the worker's incapacity and pre-injury employment,
(b) the worker's age, education, skills and work experience,
(c) the worker's place of residence,
(d) the details given in the medical certificate supplied by the worker,
(e) the provisions of any injury management plan for the worker,
(f) any suitable employment for which the worker has received rehabilitation training,
(g) the length of time the worker has been seeking suitable employment,
(h) any other relevant circumstances."

146. In view of my findings above, an assessment is required to be made of the extent of any incapacity resulting from the applicant's accepted cervical spine injury as well as the secondary psychological condition.

147. A difficulty arises in completing this task due to a degree of uncertainty as to nature and cause of some of the symptoms described by the applicant following the incident on 1 September 2008. The applicant does not rely on the Bell's palsy condition diagnosed in March 2009. Nor was the temporomandibular joint dysfunction included in the description of injury in the ARD or the subject of specific submissions on behalf of the applicant at the arbitration hearing. I have excluded those conditions from my consideration of the extent of the applicant's incapacity resulting from the injury.

148. It has been accepted by the applicant and there is a consistent view in the medicolegal evidence that the incident on 1 September 2008 caused an injury to the applicant's neck.

149. Dr Kiernan indicated that there was an injury in the nature of an aggravation of constitutional degenerative changes as revealed on the MRI scan of the applicant's cervical spine. Dr Douglass took the view that there was a soft tissue strain. Dr Bodel considered that there was both a soft tissue injury to the cervical spine as well as aggravation of underlying degenerative change. Dr Holman in his MAC expressed an opinion consistent with that of Dr Bodel. Dr Holman indicated that the applicant sustained a musculoligamentous strain of his cervical spine and aggravated pre-existing degenerative changes, principally at the C6/7 level.

150. There is, however, a material difference of opinion in the medicolegal evidence as to the ongoing effects of the applicant's neck injury. Both Dr Kiernan in April 2009 and Dr Douglass in June 2009 expressed the view that the effects of the applicant's injury would have ceased.

151. Dr Bodel and Dr Holman reached a different view. Dr Holman stated in his MAC that despite ongoing conservative treatment, the applicant continued, at the time of the MAC in February 2013, to suffer from neck pain with pain radiating to the posterior aspect of both shoulders. The applicant was noted to have developed occipital and frontal headaches, tinnitus and dizziness. Although Dr Holman did not attribute all of the applicant's symptoms to the injury including, gulping and recurrent burping, Dr Holman considered that the applicant had 6% whole person impairment of the cervical spine as a result of injury.

152. The evidence from the applicant's treating practitioners is consistent with Dr Bodel's opinion and Dr Holman's MAC in indicating that the applicant continued to suffer symptoms, principally pain, in relation to his cervical spine throughout the period of weekly benefits claimed. On 20 May 2009, Dr Mobbs's reported that the applicant's neck pain was his number one issue. The pain was radiating into both shoulders, more on the left than the right and into the back of his head into the distribution of the occipital nerves. In October 2010, Dr Watson expressed the view that the applicant continued to experience a symptom complex consequential to the initial injury to the upper cervical spine.

153. In view of the evidence of ongoing pain and other symptoms of cervical origin from the applicant's treating practitioners, I prefer the opinions of Dr Bodel and Dr Holman over the opinions given by Dr Kiernan and Dr Douglass. Whilst a resolution of the applicant's injury might have been expected, I am satisfied that this is not what actually transpired in the applicant's case. I am satisfied on the evidence before me that the applicant's physical injury continued to result in partial incapacity for work.

154. Immediately prior to the period of weekly benefits now claimed, the applicant was working in accordance with restrictions certified by his general practitioner. Dr Burne noted on 3 February 2009, that the applicant had increased his work hours to eight hours per day and would be soon undertaking a trial of increasing intensity of work. This was reflected in WorkCover certificates issued by the applicant's previous general practitioner, which had certified the applicant as fit for full hours in suitable duties.

155. The applicant was certified as totally unfit for work by Dr Kim from the commencement of the period of weekly benefits claimed. Dr Kim's certificates at that time did, however, include the diagnoses of Bell's palsy and left TMJ dysfunction which do not form part of this claim. I am not satisfied, therefore, that Dr Kim's certificates in that period constitute reliable evidence as to the extent of incapacity resulting from the compensable injury.

156. Dr Kim's early WorkCover certificates also did not include reference to the secondary psychological condition. That condition was not added to the certificates until 30 November 2009.

157. I accept that the applicant was incapacitated as a result of the secondary psychological condition prior to 30 November 2009. This is consistent with Dr Howe Synott's assessment on 22 September 2009 that the applicant was totally unfit for work. As early as 9 January 2009, Ms Xavier had expressed the view that the applicant's moderate to severe symptoms of depression and anxiety were impacting on the applicant's ability to engage in everyday activities including work.

158. That the applicant's psychological and physical symptoms were significantly impacting on the applicant's ability to work is reflected in the minutes of the meetings held with the applicant during 2009. From March 2009, the applicant was described as being verbally aggressive, shouting at colleagues, appearing apathetic towards his learning contract and competencies. The applicant was noted to be highly anxious and to be complaining of headaches. The applicant related these difficulties to his injury according to those notes. Although the applicant was stood down on pay for a period of time as a result of these "performance or disciplinary matters", I am satisfied on the evidence before me that the applicant's difficulties at work were in fact the result of the physical and psychological symptoms caused by the injury. Both Dr Kim and Ms Xavier have expressed opinions consistent with this view.

159. Having regard to the lay and medical evidence before me, I am satisfied that the applicant was partially incapacitated for work as a result of the physical symptoms caused by the injury. In addition, I am satisfied that from 14 March 2009 onwards, the applicant's psychological symptoms were impacting negatively on his ability to engage in work, with the combined result that the applicant was in fact totally incapacitated for work.

160. From 30 November 2009, the WorkCover certificates issued by Dr Kim reflected both the applicant's physical injury and secondary depression. The applicant was certified as having capacity to work for 20 hours per week. On 2 February 2010, Ms Waldman reported that the applicant was willing to make changes in order to "face life again". On 3 May 2010, Dr Kim issued a non-WorkCover medical certificate confirming that the applicant had capacity for work with restricted hours and a lifting limit of 10 kg. The applicant was receiving psychological treatment but was keen to work. Dr Kim considered a return to work "necessary" to help the applicant's self-esteem. By July 2010, Ms Ovadia reported that the applicant's mood had lifted and the applicant appeared ready for work. Around the same time, Dr Watson considered that the applicant was fit to return to work from a physical perspective, initially on restricted duties and limited hours. Dr Bodel appeared to endorse the certification of capacity to work 20 hours per week with lifting restrictions on 4 March 2011.

161. In view of this evidence, I accept that the WorkCover certificates issued by Dr Kim accurately reflected the extent of the applicant's capacity for work from 30 November 2009 onwards until the end of the period of weekly benefits claimed.

162. Having regard to the findings above, the applicant's entitlement to weekly benefits in the period 14 March 2009 to 29 November 2009 is governed by s 37(1)(a) of the 1987 Act. It is undisputed that the applicant's average weekly earnings were $1011.20. As 90% of that figure exceeded the indexed statutory maximum, the applicant will be entitled to an award of weekly benefits in that period at the applicable indexed statutory rate for a worker with no dependents. That rate in the relevant periods was:

1 October 2008	to	31 March 2009	$381.40
1 April 2009	to	30 September 2009	$389.10
1 October 2009	to	31 March 2010	$396.10

163. From 30 November 2009 to 10 April 2011, the applicant's entitlement to weekly benefits is governed by s 40.

164. The steps to be followed for the calculation of an injured worker's entitlement to weekly payments pursuant to s 40 of the 1987 Act prior to amendment were set out by the Court of Appeal in *Mitchell v Central West Area Health Service*[6](*Mitchell)* as follows:

    (1) Determine the weekly amount the worker would probably have been earning but for the injury (s 40(2)(a));

    (2) Determine the average weekly amount that the worker is earning or would be able to earn in some suitable employment from time to time after the injury (s 40(2)(b)) based on the worker's ability to earn in the general labour market reasonably accessible to the worker (s 40(3)) and having regard to suitable employment for the worker within the meaning of section 43A;

    (3) Subtract the figure derived from (2) from the figure derived from (1) (s 40(2));

    (4) Decide whether and to what extent the reduction calculated above appears proper in the circumstances (s 40(1)), and

    (5) Make an award in the amount arrived at in step 4.

165. The respondent has not disputed that the weekly amount the applicant would probably have been earning as a worker but for the injury pursuant to s 40(2)(a) was $1011.20.

166. For the purposes of s 40(2)(b), the parties' wages schedules and payslips in evidence indicate that the applicant received no actual earnings in this period until 14 March 2011. From 14 March 2011 to 27 March 2011, the applicant appears to have received $305.74 per week in leave payments. In the period 28 March 2011 to 10 April 2011 the applicant earned $790.74 per week in leave payments.

167. In considering what the applicant would be able to earn in suitable employment I have determined above that the applicant had capacity to work 20 hours per week in suitable employment.

168. The payslips attached to the ARD indicate that prior to the period of incapacity, the applicant was being paid an hourly rate of approximately $26 per hour as a Registered Nurse under the Affiliated Health Organisations' Nurses Agreement 2009. I find, however, that the applicant remained subject to lifting restrictions which may not have been able to be readily accommodated on the open labour market for a Registered Nurse. I accept, however, having regard to the factors set out in s 40(3) and s 43A that lighter and less demanding work as an occupational nurse, a nurse in an outpatient clinic, or, for example, as a pathology collector would have constituted suitable employment in the applicant's particular circumstances. It is likely that such employment would have attracted a lower hourly rate. I consider a rate of $22 per hour to be an appropriate estimation of the amount the applicant would be able to earn in suitable employment.

169. For the period 30 November 2009 to 10 April 2011, therefore, I consider the applicant was able to earn $440 (20 hours @ $22 per hour) in suitable employment based on the worker's ability to earn in the general labour market reasonably accessible to the worker and having regard to suitable employment for the worker within the meaning of s 43A. The calculation required by s 40(2) therefore results in a figure of $571.20.

[6] (1997) 14 NSWCCR 526.

170. Submissions were made by Mr Parker in relation to a range of factors that he considered ought to be taken into account in determining whether the figure calculated above appeared proper in the circumstances (s 40(1)). Amongst other things, Mr Parker submitted that the applicant was incapacitated by non-compensable conditions including Bell's palsy and TMJ dysfunction, was stood down due to performance and disciplinary issues and had gone on holidays for periods of time.

171. The first two factors have been taken into account already in making the assessments of the nature of the applicant's incapacity as a result of the compensable injury above. With regard to applicant's absence from Australia, I am not satisfied that the applicant ceased to reside in Australia. The evidence before me suggests that the applicant travelled temporarily to the Philippines for the purposes of caring for an ill relative, to receive medical treatment and for a holiday. I have not considered that this travel affected the applicant's ability to earn in the general labour market reasonably accessible to him. I am also not satisfied that s 53(1) applied.

172. I am satisfied that the the reduction calculated above appears proper in the circumstances. Until 10 April 2011, that amount exceeded the indexed maximum statutory rate in s37(1)(a)(i):

1 October 2009	to	31 March 2010	$396.10
1 April 2010	to	30 September 2010	$403.70
1 October 2010	to	31 March 2011	$409.10
1 April 2011	to	30 September 2011	$417.40

173. Pursuant to s 40(5), the applicant will be entitled to an award from 30 November 2009 to 10 April 2011 at the indexed maximum statutory rates.

174. The evidence indicates that the applicant received payments from the respondent during parts of the period of weekly benefits claimed. The evidence suggests that at different times the applicant was paid annual leave and sick leave and at other times was paid wages. I am unable to determine from the wages schedules and payslips precisely what type of payments were made at all relevant times.

175. To the extent that the applicant received wages for sick leave, s 50(3) of the 1987 Act relevantly provides:

> "(3) If a worker, in respect of any period of incapacity for work in respect of which the employer is liable to pay compensation to the worker, is paid wages for sick leave by the employer and either an award is made afterwards for the payment of compensation to the worker in respect of that period or the employer agrees afterwards that compensation be paid to the worker in respect of that period:
>
> (a) the employer's liability to pay compensation in respect of that period shall, to the extent of the wages paid, be deemed to have been satisfied by that payment, and
>
> (b) the wages shall, to the extent of the compensation, be deemed for the purposes of subsections (4) and (5) to have been paid as compensation and not as wages."

176. To the extent that other forms of leave were paid, s 49 of the 1987 Act will apply.

177. For any other wages or benefits paid, the respondent will have credit pursuant to s 46 of the 1987 Act.

Entitlement to medical expenses

178. In view of my findings above, the applicant will be entitled to compensation pursuant to s 60 of the 1987 Act in respect of the accepted injury to his cervical spine as well as the secondary psychological condition. The parties have agreed that a general order to this effect is appropriate in this case.

179. I note that a substantial sum of medical expenses was particularised in the ARD and late documents. In the event of any dispute between the parties as to whether any particular expenses were "reasonably necessary as a result of" the injury found by me, the dispute may be referred to the Commission in separate proceedings.

SUMMARY

180. The applicant sustained a secondary psychological condition as a result of the injury on 1 September 2008.

181. The applicant was totally incapacitated as a result of the injury on 1 September 2008 between 14 March 2009 and 29 November 2009.

182. The applicant was partially incapacitated as a result of the injury on 1 September 2008 between 30 November 2009 and 10 April 2011.

183. The Commission orders:

(a) The respondent to pay the applicant weekly benefits as follows:

(i) From 14 March 2009 to 31 March 2009 at the rate of $381.40 per week;
(ii) From 1 April 2009 to 30 September 2009 at the rate of $389.10 per week;
(iii) From 1 October 2009 to 31 March 2010 at the rate of $396.10 per week;
(iv) From 1 April 2010 to 30 September 2010 at the rate of $403.70 per week;
(v) From 1 October 2010 to 31 March 20111 at the rate of $409.10 per week; and
(vi) From 1 April 2011 to 10 April 2011 at the rate of $417.40.

(b) The parties have liberty to apply on 3 days' notice in relation to the figures above.

(c) That the respondent to have credit for payments already made.

(d) The respondent to pay the applicant's reasonably necessary medical expenses in respect of the injury to the applicant's cervical spine and secondary psychological condition pursuant to s 60 of the 1987 Act on production of accounts, receipts and/or valid Medicare Notice of Charge.

(e) Pursuant to s 66 of the 1987 Act, the respondent to pay the applicant $8,250 in respect of 6% whole person impairment of the cervical spine as a result of injury on 1 September 2008 in accordance with the Medical Assessment Certificate of Dr Peter Holman dated 26 February 2013.