WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **3335/20**
Applicant: **William Jenkins**
Respondent: **Coastwide Steel & Metalwork Pty Limited**
Date of Determination: **10 September 2020**
Citation: **[2020] NSWWCC 315**

The Commission determines:

1. The applicant sustained an injury to his lumbar spine in the course of his employment with the respondent in the nature of an aggravation, acceleration, exacerbation or deterioration of a disease process to which the nature and conditions of employment with the respondent were the main contributing factor pursuant to s 4(b)(ii) of the *Workers Compensation Act 1987*.

The Commission orders:

1. The matter is remitted to the Registrar to be referred to an Approved Medical Specialist for assessment as follows:

Date of injury:	15 August 2014 (deemed)
Body parts:	Thoracic spine
	Lumbar spine
Method:	Whole Person Impairment

2. The materials to be referred to the Approved Medical Specialist are to include the Application to Resolve a Dispute and all attachments and the Reply and all attachments.

3. The matter to be placed on the Medical Assessment Pending List.

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.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr William Jenkins (the applicant) was employed as a welder by Coastwide Steel & Metalwork Pty Limited (the respondent). The applicant claims that as a result of the nature and conditions of his employment with the respondent he sustained an injury to his thoracic and lumbar spine.

2. The applicant made a claim for compensation which was initially declined. Following the commencement of proceedings in the Commission (5299/15), liability for an injury to the thoracic spine was accepted by the respondent's insurer.

3. By letter dated 11 December 2019, the applicant made a claim for lump sum compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act) in reliance on a report by Dr James Bodel. Dr Bodel assessed the applicant has having 12% whole person impairment (WPI) of the thoracic and lumbar spine.

4. On 30 March 2020, the insurer disputed liability for the lumbar spine injury and the claim for lump sum compensation by a notice issued pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act).

5. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) lodged in the Commission on 17 June 2020. The applicant seeks lump sum compensation pursuant to s 66 of the 1987 Act.

ISSUES FOR DETERMINATION

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

    (a) whether the applicant sustained an injury to the lumbar spine as alleged, and
    (b) the degree of permanent impairment resulting from injury.

PROCEDURE BEFORE THE COMMISSION

7. The parties appeared for conciliation conference and arbitration hearing by telephone on 11 August 2020. The applicant was represented by Mr William Carney of counsel, instructed by Ms Reichelle Jackson. The respondent was represented by Mr Paul Barnes of counsel, instructed by Mr Darran Russell.

8. 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.

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 written statements made by him on 3 June 2015 and 2 June 2020

12. In the first statement, the applicant set out his employment history. The applicant initially worked as a carpet layer then assisted his stepfather in an earthmoving business. The applicant also worked in a factory, timber mill and did some commercial cleaning.

13. In his early twenties, the applicant commenced work as a labourer then progressed to become a welder for the respondent. The applicant worked for the respondent for around five or six years before moving to Queensland and working in his father's fencing business.

14. During the time the applicant was employed by his father's business, he sustained an injury to his lumbar spine in the nature of a prolapsed disc at L5/S1. The applicant made a workers compensation claim which was accepted. After approximately 12 months off work, he returned to employment.

15. In 2001, the applicant returned to New South Wales and recommenced employment with the respondent as a welder. The applicant remained in that employment for two years before returning again to Queensland.

16. The applicant returned again to employment with the respondent in 2010. Other than six months off work in 2011 during his wife's pregnancy, the applicant continued to work for the respondent up until August 2014.

17. The applicant described his duties for the respondent as follows:

> "The materials which we had to work on were sent to us from the front of the shop. An overhead crane was there to assist us to move the materials onto our workbench. Sometimes though, I had to push my workbench under the crane, and I estimate the workbench weighed approximately 100kg. It was on wheels, however, it was stiII quite heavy.
>
> At one point in time, the crane broke. Consequently, I had to lift the materials from the ground up to my workbench on my own.
>
> Sometimes, the materials were not placed on my work bench. I had to work on the materials from the ground, and thus had to bend over to reach them.
>
> I regularly lifted heavy items, such as hand rails and bollards. I often had to carry these across the workplace.
>
> As part of my role, I also had to unload trucks on a daily basis."

18. The applicant said he noticed pain in his back in 2014:

> "Initially, I thought it was related to my previous lumbar spine injury. There was a particular incident in August 2014, where I was leaning over my workbench to conduct my duties. I found that I could not straighten properly, so I decided to go to the doctor. I then found out the issue was my thoracic spine, not my lumbar spine as previously thought."

19. The applicant described experiencing constant dull ache in his thoracic spine, difficulty standing for too long, bending or twisting. The applicant had disturbed sleep and could not drive for longer than an hour.

20. In his subsequent statement, the applicant described the previous injury to his lumbar spine in more detail:

> "I sustained injury to my lower back in or around 2008 while working as a fencer with my father. I was off work for approximately 12 months and during this time consumed pain relieving medication and attended physiotherapy before returning to my preinjury hours and duties. I was able to work as a welder for a number of years following this injury. I may have experienced some intermittent back pain every now and then which resolved shortly afterwards. I would have consumed over the counter pain relieving medication when the temporary flare ups in back pain occurred.
>
> On 27 June 2013, I felt a twinge of pain in my lower back with radiation of symptoms into my buttocks while at work. I attended the emergency department at Wyong Hospital. I advised the doctor that I had a previous injury to my lower back, however, had not experienced lower back pain for approximately 3 or 4 years. I was advised to follow up with my treating general practitioner if the pain continued. The doctor recommended I consume Panadol Osteo, anti-inflammatory medication, krill oil and glucosamine.
>
> I believe the pain in my lower back resolved shortly after this and I was able to make a return to my pre-injury duties and hours without any ongoing difficulties or restrictions."

21. The applicant also provided further detail with regard to the subject injury:

> "Prior to sustaining my injury, the overhead crane broke and I was required to manually lift the items I was working on from the ground onto the workbench. I would lift the materials on my own and was not provided with any assistance from my employer. In the weeks leading up to my injury, we were very busy and I had been performing a lot of overtime and working longer hours.
>
> On or around 15 August 2014, while at work I experienced pain in my upper and lower back. At first I did not think it was anything serious and I had pulled a muscle. It was a Friday, I finished work for the day and went home. I tried to take it easy and rested over the weekend. I may have consumed Panadol and Nurofen for pain relief.
>
> The following week the pain in my upper and lower back did not improve, I believe I went to work on Monday and during the course of the day, the pain gradually got worse.
>
> On 20 August 2014, the pain in my upper and lower back became unbearable and I was having difficulty walking and standing. I reported the pain to my employer and made an appointment to see the general practitioner and left work for the day."

22. The applicant said that on 26 August 2014 he attended his usual general practitioner advising that he had been performing repetitive heavy lifting at work and had developed pain and stiffness in his lower back and shooting pains in the middle of his back. The applicant was given a referral for physiotherapy and an MRI scan of the thoracic and lumbar spine. The MRI scan was performed on 5 September 2014.

23. After reviewing the MRI, the applicant's general practitioner, Dr Varsani, referred the applicant to see neurosurgeon, Dr Raul Pope. The applicant first consulted Dr Pope on 14 October 2014 and was advised to undergo a cortisone injection. The applicant continued to attend regular appointments with his general practitioner and physiotherapy, was prescribed Lyrica and performed home-based exercises as well as walking and swimming. The applicant continued with conservative treatment taking Fenac, Panadol and Nurofen as required. The applicant was off work for approximately two years, during which time he received income protection through his superannuation.

24. The applicant said he had experienced ongoing pain in his upper and lower back since August 2014 with flareups and exacerbations from time to time. The applicant never completely recovered and tried to limit his activities in order to avoid aggravating the pain.

25. The applicant experienced pain in his lower back with radiation into the right leg, difficulty sitting, standing and walking for long periods as well as difficulty lifting heavy items, bending, twisting, pushing and pulling.

26. The applicant had returned to work as a forklift driver but continued to experience pain due to sitting for long periods of time. The applicant avoided heavy lifting and sought assistance from co-workers as required.

Notification of injury

27. A notification of injury/illness form completed by the applicant's employer on 27 August 2014 described an injury in the nature of:

> "Lower and mid back pain.
>
> Possibly related to pre-existing injury to L4/5 S1. Was sore on Wednesday morning. No specific incident."

Treating medical evidence

28. The applicant presented to Wyong Hospital on 27 June 2013. The triage notes recorded:

> "felt twinge while at work in lower back same now radiating to buttocks
> Hx prolapse"

29. The discharge referral stated:

> "Mr Jenkins noted a twinge in his left lower back today. This is on a background of a previous back injury 8 years ago with a disc prolapse of L4 & L5. This was a work-related injury. Mr Jenkins received rehabilitation at the Wesley Hospital in Brisbane, though no surgery. He had a repeat episode of back pain 3-4 years ago. Today he is unsure what initiated the pain. He reports left paravertebral pain with some radiation down into the buttocks. He does not attend regular physiotherapy or hydrotherapy. Mr Jenkins reports he is usually well. He is on no regular medications and has no known drug allergies.
>
> O/E: Mild left paravertebral tenderness with some radiation to the left buttock. No spasm. Able to move through a normal range of motion though uncomfortable. Remainder of examination normal."

30. The applicant consulted general practitioner, Dr Vijay Varsani, on 19 August 2013. Dr Varsani made a clinical record as follows:

> "Previous work injury 8y ago to Lspine and has prolapse L5S1, since then is managing to get but 3m ago had flare up of back pain, not improving with analgesia, using celebrex and tramadol, no bowel/bladder dysfunction, no fever, pain now shooting Into Rt leg 0/e - limited forward flexion Lspine Plan - MRI Lspine, review with results"

31. On 15 April 2014, the applicant saw general practitioner, Dr Philip Cook, who recorded:

> "Ran out of Micardis tabs 3-4 weeks ago. Suffering head cold last few days. Flare in back pain after bracing to sit down. No red flags. Had voltarin PRN in past. does not affect asthma."

32. On 20 August 2014, the applicant consulted general practitioner, Dr Alison Charnock, who recorded a clinical note as follows:

> **"History:**
> chronic lower back pain, known prolapsed lower lumbar discs, has seen spinal surgeons who don't want to operate. End of last week has injured 'higher up' somehow. No red flags or Sx of nerve root compression. Has had to come home from work today. Voltaren normally helps - has tried OTC strength today plus panadiene with no result
> **Examination:**
> tender upper lumbar/lower thoracic spine, reduced flexion, ext ok
> **Reason for contact:**
> Back pain"

33. Dr Varsani saw the applicant on 26 August 2014:

> "Works as welder, was doing alot of heavy lifting last week, end of day stiff lower back and shooting mid back pain, no fevers, no bowel bladder symptoms, had 4d rest and went to work today and symptoms flared again, had work-related injury 8y ago and has prolpase L4/5/S1
> Taking analgesia, which helps
> No light duties available et work
> O/e - neuro NAD Tender midline
> T8-12, stiff Plan- for wee, MRI TLspine, Physio, cont analgesia, 1 week off work and review"

34. The report of an MRI of the thoracolumbar spine performed on 5 September 2014 noted that the applicant was referred with "low and mid back pain". The report found:

> "Small protrusions of multiple mid-thoracic intervertebral discs with mild spinal cord contact and focal deviation at T7. These findings would require further consideration if neurological signs were to develop in the legs. L5/S1 disc degeneration with an annular tear."

35. Records from Wyong Hospital showed that the applicant attended the Emergency Department on 10 October 2014, complaining of thoracic spine pain for the last eight weeks exacerbated over the last two days and previous lower back pain that was treated conservatively. The applicant was discharged home on Lyrica and was to attend a review of the neurosurgeon on the following Tuesday.

36. Neurosurgeon Dr Raul Pope prepared a report for Dr Varsani dated 14 October 2014. Dr Pope took a history of injury as follows:

> "Mr. Jenkins had a fairly sudden onset of symptoms with no trauma. Often he is bending forward welding but then noticed some interscapular pain at the lower end and a radicular component towards the right anterior chest wall daily, constant, mechanical more than non-mechanical and also sleeping difficulties. No pins and needles or numbness. Symptoms got so severe a few weeks ago he had to go to the emergency department locally and have a non-steroidal injection which did help. His symptoms have been relentless and has forced him to stop work for the past 2 months. They are well localised with no symptoms in the lower limbs with no myelopathic symptoms although he does have a lower back issue with occasional leg pains."

37. Dr Pope performed an examination predominantly involving the thoracic spine and commented on the MRI of the thoracic spine. Dr Pope diagnosed T6/7 disc herniation with T7 radiculopathy. Dr Pope suggested a cortisone injection of T7 may help and asked the applicant to see a pain specialist if symptoms persisted in the next 4 to 6 weeks.

38. Clinical notes from Dr Varsani's practice in the period that followed during 2014 and 2015 record ongoing issues with "back" pain with specific reference to the thoracic spine and "upper back" on some occasions and specific reference to the "lower back" on other occasions.

Dr Bodel

39. The applicant relies on medicolegal reports prepared by Dr James Bodel, dated 7 January 2015, 5 February 2015 and 14 October 2019.

40. In his first report, Dr Bodel took a history of injury as follows:

> "This gentleman suffered an injury to the lower part of the back on 15 August 2014. He was working in a bent over position for a period of time when he developed increasing lower back pain, particularly in the lower rib margin. He informed the foreman and he went home early that day. He subsequently went to his local doctor and was put onto anti-inflammatory and analgesic medication such as Voltaren and Panadeine Forte. He was off work for about four or five days and he seemed to settle and returned to work on the following Monday. He had been to the doctor on about the Wednesday of the week before.
>
> He worked that day but on the Tuesday he was again in pain and he had to go back to the local doctor. He then had an MRI scan done of the thoracolumbar spine and that showed evidence of disc pathology at the thoracolumbar junction and also old pathology at the L5/S1 level. He was referred to Dr Raoul Pope, a neurosurgeon, and he discussed various treatments including the possibility of surgery but it was not strongly recommended at that time. He had to go off work and was treated conservatively with rest and analgesic medication and physiotherapy."

41. Dr Bodel noted the previous injury and workers compensation claim in respect of the lower back at the L5/S1 level 8 to 10 years earlier. That settled within about 12 to 18 months and allowed the applicant to return to his pre-injury level of work activity.

42. The applicant complained of pain at the thoracolumbar junction as well as pain in the lower part of the back radiating into the buttocks and thighs down to the knees. The leg pain was intermittent.

43. Dr Bodel performed an examination and considered the MRI scan of the thoracolumbar spine of 5 September 2014. Dr Bodel expressed the opinion that the applicant had no capacity for work and permanent impairment although he had not yet reached maximum medical improvement.

44. In his second report, Dr Bodel confirmed that employment with the respondent was a substantial contributing factor to the injury.

45. In the most recent report, Dr Bodel recorded that the applicant had been employed as a steel fabricator and welder for about two years prior to the injury in work that involved heavy welding and metal fabrication work.

46. Dr Bodel described injury to the lower part of the back and the interscapular region of the thoracic spine:

> "This gentleman suffered an injury to the lower part of the back on 15 August 2014. When I originally saw him he confined the area of injury mainly to the lower part of the back, but today he indicates that in fact it did spread to the interscapular region of the thoracic spine and into the thoracolumbar junction soon after the onset of symptoms in the lower part of the back. He referenced that by saying that it spread to involve 'the lower rib margin', which he had mentioned when I saw him previously."

47. Dr Bodel noted that it had been five years since he last saw the applicant. The applicant reported flareups of pain from time to time which never completely recovered. There were the days when the applicant could not move and other days when he was capable of reasonable activity.

48. The applicant experienced pain in the interscapular region of the thoracic spine and at the thoracolumbar junction as well as the lower part of the back. The applicant had injections which helped for about a month or two but never cured his symptoms.

49. Dr Bodel expressed the opinion that the applicant had sustained a work-related injury during the course of his employment:

> "This gentleman has interscapular pain, thoracolumbar back pain and lumbosacral pain caused by the injury that occurred at work on 15 August 2014. At the very least he has an aggravation, acceleration, exacerbation and deterioration of an underlying disease process at these three levels.
> …
> Work is the main substantial contributing factor at least by the way of aggravation, acceleration, exacerbation and deterioration. It is probable that the T6/7 disc injury did occur as a result of the specific event at work"

50. Dr Bodel considered the applicant had undergone appropriate treatment, including medication and physiotherapy.

51. Dr Bodel assessed the applicant as having 12% WPI of the thoracic spine and lumbar spine.

Dr Panjratan

52. The respondent relies on medicolegal reports prepared by orthopaedic surgeon, Dr Vijay Panjratan, dated 10 November 2015 and 9 March 2020.

53. In his first report, Dr Panjratan took a history of injury as follows:

> "He said that he developed massive pain in between the shoulder blades due to the nature and conditions of his work as a welder. As a welder he was constantly bent over while welding and he did this all the time. That was his job other than when he had to load / unload the truck. The problem gradually built up over 3-4 days and he could not straighten up."

54. Dr Panjratan noted that Dr Varsani had referred the applicant for an MRI of the thoracolumbar spine for low and mid back pain on 5 September 2014. Dr Panjratan noted the pathology at the lumbar spine and said:

> "He pointed out to me that the L5/S1 disc degeneration was 10 years old.
>
> The L5/S1 disc degeneration was a work related injury while lifting a welder out of a utility In Queensland in 2005. He went to ground while they were lifting that welder. He did not get up til helped. The doctors treated him with physiotherapy and needles. He has still ongoing pain but it is not related to the current injury. At the time he joined Southcoast Welding he had intermittent low back pain but not severe enough to prevent him from working."

55. Dr Panjratan noted that the applicant had been referred by Dr Varsani for physiotherapy at Total Physio Centre:

> "His GP Dr Vijay Varsani had referred William to the Centre for continued treatment of his old injury to his lower back sustained around 2005 namely a prolapsed disc at LS/S1 with annular tear, in addition to treatment of a new injury sustained to his thoracic spine at T6/T7 in August 2014.
>
> The physio told him that they could not treat the new injury without treating the old injury. He had two visits a week for 10 weeks and he also had 4 hydrotherapy sessions towards the end of those visits. However in spite of all the treatment he says the condition failed to improve."

56. Dr Panjratan took a history of the applicant's employment duties with the respondent:

> "Between the ages of 18 to 25 he was a labourer more than a welder. Now he is a welder more than a labourer. On this occasion the pain just came one day but did not develop over a period of time. Pointing to the LS/S1 region, he said it was bad but he had learnt to deal with that. He had done back rehabilitation courses where he was taught to lift properly and deal with it.
>
> About his work bench were he worked there was a 500kg lifting crane which was used if he was welding a handrail to flip it over the other side so that it was not so manual but that had not worked for the past 18 months. This was after reminding his boss at least half a dozen times that it needed to be fixed. He has been told it has still not been fixed. He said he had to manually flip the handrails. Sometimes he would try not to lift too much but when it had to be done he would do it."

57. Dr Panjratan's examination revealed tenderness at L5/S1 and pain in both the thoracic region and lumbosacral region on bending forward.

58. Dr Panjratan said he did not consider the injury to be a disease but said it would have developed over a period of time. Dr Panjratan did consider the applicant was partially incapacitated for work at the time.

59. In the more recent report, Dr Panjratan took a history of injury as follows:

> "Mr Jenkins considers the nature and conditions at work responsible for the thoracic and lumbar back pain. The nature of his work involved a lot of bending and lifting. The overhead crane at work had been broken for the past 12 months. The load was hand lifted including steel beams and other heavy loads."

60. Dr Panjratan noted the previous lower back injury whilst working for his father at L5/S1 and noted that that injury was not part of the present claim.

61. Dr Panjratan's examination of the lumbar spine revealed:

> "At the time of examination there was no pain in the lumbar region. Gentle palpation in that area did not cause pain. He said forward flexion was good and he could bend down further, but tries to avoid that because it irritates. This was not always the case but that did not improve so he is careful. He does not like back extension at all."

62. Dr Panjratan diagnosed a T6/7 disc injury. Asked to advise whether employment and specifically the injury of 20 August 2014 was a substantial contributing factor to the lumbar spine injury, Dr Panjaratan responded:

> "Employment, specifically the injury of 20 August 2014 is a substantial contributing factor to the thoracic spine as he had no thoracic pain before. The relevant reports at the time indicate a thoracic injury at T6/7 but no mention of a lumbar spine injury although there was a pre-existing lumbar spine injury which is not related to the current claim."

63. Dr Panjratan noted that the reports from Dr Pope made no mention of a lumbar problem and so concluded that there was no aggravation of a lumbar spine injury.

64. Dr Panjratan did not consider that the applicant qualified for lumbar spine impairment although he assessed 7% WPI of the thoracic spine.

Applicant's submissions

65. Mr Carney referred me to the applicant's statements and the employment history. It was noted that the applicant sustained a substantial injury to his lumbar spine in Queensland. The applicant later returned to employment with the respondent and had described his arduous, physical duties.

66. Mr Carney referred to the general practitioners' clinical notes and noted that the doctors were aware of a previous injury. Mr Carney submitted that the clinical notes were consistent with a recurrence of the previous injury. It was the applicant's own opinion initially that there was a recurrence of the old pain. Mr Carney submitted that this supported the view that the applicant had experienced an increase in his lumbar symptoms.

67. Mr Carney noted that the applicant had been referred to Dr Pope. Although Dr Pope focused on the thoracic injury he also identified lumbar symptoms including occasional leg pain.

68. Mr Carney submitted that the applicant gave a history to the treating doctors of both thoracic and lower back pain. The applicant initially put the site of pain at the lumbar spine although later this was more clearly identified as involving the thoracic spine also. Mr Carney observed that Dr Bodel's initial report identified only a lower back injury.

69. In his second report, Dr Bodel noted that the applicant had originally confined the area of injury mainly to the lower part of the back although he indicated that it spread to the interscapular region of the thoracic spine and into the thoracolumbar junction soon after the onset of symptoms in the lower part of the back.
70. Mr Carney noted that Dr Panjratan had recorded the nature and conditions of the applicant's work including being constantly bent over. The applicant attributed his injury to his heavy work for the respondent.

71. Although Dr Panjratan had answered a question indicating that he did not consider the injury to be a disease but one which developed over a period of time, Mr Carney submitted that this was consistent with the disease process. Pathology in the applicant's thoracic and lumbar spine was accelerated by the work the applicant was doing for the respondent. Mr Carney submitted that it was correct to categorise the injury as one falling within s 4(b)(ii).

72. Mr Carney noted that the reason why Dr Panjratan formed the view that there was no injury to the lumbar spine was because it was his view that no complaint of been made to the doctors at the time. Mr Carney submitted that this was not correct. The applicant clearly complained of problems although he originally attributed those to a manifestation of his earlier injury. Contrary to Dr Panjratan's report, the applicant did report pain in the lower back going into the buttocks to Dr Pope. Mr Carney submitted that this was consistent with an increase in symptomology and an injury in the nature of an aggravation of an earlier disease condition.

73. Mr Carney submitted that Dr Panjratan's second report did not take the matter further. Clearly Dr Panjratan had taken a wrong history and repeated his earlier error when asked whether there was an aggravation of a disease.
74. Mr Carney submitted that the Commission would find that there was an injury to the applicant's lumbar spine.

75. Mr Carney noted that a deemed date of injury of 15 August 2014 was agreed.

Respondent's submissions

76. Mr Barnes noted that Mr Carney's submissions characterised the injury as an aggravation of a disease although Dr Bodel appeared to take an "each way bet" suggesting on the one hand there was a frank incident on 15 August 2014 but then saying that at the very least there was an aggravation of a disease.

77. Mr Barnes referred to the applicant's evidence that he had a serious injury to his lumbar spine whilst working for his father, requiring a significant period of time off work. Mr Barnes submitted that contrary to what was recorded in Dr Bodel's first report, the original lower back injury never resolved, having regard to the general practitioner's records.

78. Mr Barnes noted that no opinion on causation was given in Dr Bodel's first report. Although an opinion was given that employment was a "substantial contributing factor" to the injury in Dr Bodel's second report, Mr Barnes submitted that this was the incorrect test. The issue of "main contributing factor" had been squarely raised by the insurer in the initial dispute notice.

79. In Dr Bodel's most recent report, Mr Barnes said the opinion on causation was unclear insofar as it suggested both a frank incident and an injury in the terms of s 4(b)(ii) of the 1987 Act. Dr Bodel described employment as the "main substantial contributing factor" and it was unclear what three levels of the spine Dr Bodel was referring to as this was not specified.

80. Mr Barnes noted also that Dr Bodel failed to consider whether there should have been a deduction under s 323 of the 1998 Act in making his assessment of WPI. Dr Bodel said there was no indication clinically of any pre-existing abnormality or condition and no basis for a deduction for pre-existing impairment. Mr Barnes described this as "absurd" given the history provided to the doctor. On this basis, Mr Barnes said the Commission would have no confidence in Dr Bodel's report and described it as "fatally flawed".

81. Mr Barnes referred to the report of Dr Pope and took issue with Mr Carney's suggestion that Dr Pope referred to lumbar spine pain or complaints connected with employment with the respondent. The complaint presented to Dr Pope was of symptoms in the thoracic spine. Although he referred to a lumbar problem it was not linked to employment with the respondent. Mr Barnes noted that there was no more recent update from Dr Pope.

82. Mr Barnes took me to the records of Wyong Hospital and noted that although the applicant was at work when he noticed a "twinge of pain" in his lower back on 27 June 2013, the applicant did not explicitly relate it to his work activities. The presentation on 10 October 2014 was only in relation to the thoracic injury eight weeks earlier.

83. Mr Barnes observed that the general practitioner's notes referred to ongoing lower back pain on 19 August 2013 but made no link to work with the respondent. The clinical notes after the subject injury made reference to thoracic or upper back pain only.

84. Taking me to Dr Panjratan's reports, Mr Barnes observed that the thoracic spine injury was viewed in isolation from the pre-existing lumbar injury.

85. Mr Barnes referred to the observations of Snell DP in *State Transit Authority of New South Wales v El-Achi*[1] (*El Achi*) at [80] with regard to expert reports and submitted that Dr Bodel's report was of no value to the Commission.

86. Referring to Snell DP's observations in relation to the "main contributing factor" test at [91] of *El Achi*, Mr Barnes submitted that it was incumbent upon the applicant to demonstrate that employment with the respondent was the main contributing factor to the aggravation of a disease in the lumbar spine. The applicant relied upon a report from Dr Bodel which did not comply with the principles governing expert evidence. As a result, the claim was fatally flawed and should be rejected.

Applicant's submissions in reply

87. Mr Carney submitted that the respondent's attack on Dr Bodel concerned his apparent failure to deal with s 323. On the tests set out in *Hancock v East Coast Timber Products Pty Ltd*[2] and *El Achi*, Mr Carney said the report was sufficient. The report set out the facts and evidence and an opinion was given. The issue of s 323 was not a matter relevant to the arbitrator's determination but would be a matter for an Approved Medical Specialist to determine if there was a finding of injury. An error in one part of the report would not render the report unreliable in its entirety.

88. Mr Carney submitted that Dr Pope's report did refer to the lumbar spine. Dr Pope was a treating specialist and was not providing a medicolegal report. It should be borne in mind that the report was prepared for the purpose of managing the injury.

89. In relation to the "main contributing factor" test, Mr Carney referred me to the more recent decision in *AV v AW*[3] *(AV v AW*). Mr Carney submitted that this was a matter for the arbitrator to determine on the whole of the evidence and the doctor's evidence simply formed part of the factual matrix.

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[1] [2015] NSWWCCPD 71.
[2] [2011] NSWCA 11; 80 NSWLR 43.
[3] [2020] NSWWCCPD 9.

FINDINGS AND REASONS

90. Section 9 of the 1987 Act provides that a worker who has received an "injury" shall receive compensation from the worker's employer. The term "injury" is defined in s 4 of the 1987 Act as follows:

> **"4 Definition of 'injury'**
>
> In this Act:
> **injury:**
>
> (a) means personal injury arising out of or in the course of employment,
>
> (b) includes a disease injury, which means:
>
> (i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and
>
> (ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, and
>
> (c) does not include (except in the case of a worker employed in or about a mine) a dust disease, as defined by the *Workers' Compensation (Dust Diseases) Act 1942*, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined."

91. In *AV v AW*, Snell DP considered the expression, "main contributing factor" in s 4(b)(ii) and observed:

> "The following may be taken from the above:
>
> (a) The test of 'main contributing factor' in s 4(b)(ii) is more stringent than that in s 4(b)(ii) in its previous form, which applied in conjunction with the test in s 9A. There will be one 'main contributing factor' to an alleged aggravation injury.
>
> (b) The test of 'main contributing factor' is one of causation. It involves consideration of the evidence overall, it is not purely a medical question. It involves an evaluative process, considering the causal factors to the aggravation, both work and non-work related. Medical evidence to address the ultimate question of whether the test of 'main contributing factor' is satisfied is both relevant and desirable. Its absence is not necessarily fatal, as satisfaction of the test is to be considered on the whole of the evidence.
>
> (c) In a matter involving s 4(b)(ii) it is necessary that the employment be the main contributing factor to the aggravation, not to the underlying disease process as a whole."

92. The expression, “aggravation, acceleration, exacerbation or deterioration” of a disease was considered by Windeyer J in *Federal Broom Co Pty Ltd v Semlitch*[4] (*Semlitch*):

> “The words have somewhat differing meanings: one may be more apt than another to describe the circumstances of a particular case: but their several meanings are not exclusive of one another. The question that each poses is, it seems to me, whether the disease has been made worse in the sense of more grave, more grievous or more serious in its effects upon the patient. To say that a man's sickness is worse or has deteriorated means in ordinary parlance, oddly enough, the same thing as saying that his health has deteriorated.”

93. Justice Kitto in the same case found:

> “Moffitt J. was right, I think, in saying: ‘There is an exacerbation of a disease where the experience of the disease by the patient is increased or intensified by an increase or intensifying of symptoms. The word is directed to the individual and the effect of the disease upon him rather than being concerned with the underlying mechanism’. Accordingly if salt be applied to an open wound, making the would no worse but causing it to smart as it had not smarted before, it is proper to say that there is an exacerbation of the wound.[5]”

94. In the present case, it is not disputed that the applicant sustained an injury to his thoracic spine in the course of his employment with the respondent as a result of the nature and conditions of that employment. The issue requiring determination is whether the applicant also sustained an injury to his lumbar spine in the same manner.

95. It is agreed that the applicant had a pre-existing injury to his lumbar spine which he sustained during a period of employment with his father. There is unfortunately no contemporaneous medical evidence before me relating to that injury. As a result, there is a degree of ambiguity surrounding the timing of that injury, the levels of the lumbar spine involved, diagnosis and the treatment and investigations undertaken. Broadly speaking, however, the evidence places the injury in or around 2005. The affected levels of the lumbar spine are described as both L4/5 and L5/S1 in the subsequent medical evidence.

96. The applicant’s own evidence is that he spent a period of approximately 12 months off work and treated the lumbar injury with pain relieving medication and physiotherapy. The applicant was able to return to his pre-injury work as a welder although he experienced intermittent and quickly resolving back pain in the period thereafter. The applicant’s evidence, which is not contradicted by any evidence from the respondent, is that he returned to employment with the respondent in 2010. Other than a period of six months during his wife’s pregnancy in 2011, the applicant continued to work for the respondent as a welder until August 2014.

97. The clinical records confirm that the applicant did experience and report symptoms relating to the lumbar spine to both Wyong Hospital and his general practitioners during the most recent period of his employment with the respondent. There is, however, no evidence that the lumbar symptoms were incapacitating prior to 15 August 2014.

98. There was a presentation to Wyong Hospital on 27 June 2013. The discharge referral on that occasion described an onset of symptoms in the lower back radiating into the buttocks whilst at work. Mr Barnes has observed that this record did not indicate that the applicant was actually performing work duties at the time. The discharge referral noted a previous disc prolapse at L4/5 eight years earlier with a repeat episode three to four years earlier. The applicant was unsure what initiated the pain on the most recent occasion. The referral confirmed that the applicant was not taking any regular medications or receiving treatment.

[4] [1964] HCA 34; (1964) 110 CLR 626 at 640.
[5] At 635.

99. A clinical note of Dr Varsani on 19 August 2013 suggested that by that date the flare up from June 2013 had not improved despite analgesia, Celebrex and Panadol. The applicant reported symptoms shooting into the right leg. The clinical notes suggested that the applicant was advised to undergo MRI of the lumbar spine. There is nothing in the evidence to indicate, however, that this was in fact performed.

100. There was also mention of a flare up of back pain reported to Dr Cook on 15 April 2014.

101. The applicant's evidence is that each of these "flare ups" did settle and the applicant was able to perform pre-injury duties and hours without ongoing difficulties or restrictions until August 2014. In the absence of any evidence to the contrary I am prepared to accept that this was the case.

102. The contemporaneous evidence from August 2014 is also broadly consistent with the applicant's evidence that he experienced increased symptoms at his lumbar spine as well as new symptoms in his thoracic spine at that time. The history recorded in the clinical note of Dr Charnock on 20 August 2014 referred to chronic lower back pain and known prolapsed lower lumbar discs as well as symptoms higher up from the end of the previous week. Examination by the doctor revealed tender upper lumbar and lower thoracic spine as well as reduced flexion.

103. A more detailed history was recorded by Dr Varsani on 26 August 2014. Dr Varsani recorded that the applicant was doing a lot of heavy lifting the previous week and at the end of the day had a stiff lower back as well as shooting mid back pain. Symptoms had flared again on return to work. Dr Varsani referred the applicant for an MRI of the thoracolumbar spine which the applicant underwent on 5 September 2014. The MRI revealed pathology at both the thoracic and lumbar levels including L5/S1 disc degeneration with an annular tear.

104. An injury was notified by the respondent the next day on 27 August 2014. The notification form described both lower and mid back pain and said the injury was possibly related to pre-existing injury to "L4/5 S1".

105. Consistently with the employer's notification of injury, Dr Bodel's initial report dated 7 January 2015 focused on the claimed injury to the lower part of the back. The history recorded was of increasing lower back pain after working in a bent over position on 15 August 2014. After a few days off, the applicant returned to work but could not continue.

106. The treating medical evidence does suggest that the new thoracic pathology revealed on the MRI on 5 September 2014 subsequently received greater attention than the lumbar symptoms. There was a presentation to Wyong Hospital on 10 October 2014 the records of which, while referring to lower back pain focused predominantly on thoracic pain over the previous eight weeks which had been exacerbated two days earlier. Dr Pope's report on 14 October 2014 also dealt predominantly with the thoracic spine although reference was made to a lower back issue with occasional leg pains. The general practitioner's clinical notes also suggest that thoracic symptoms were more dominant than lumbar symptoms in late 2014 and early 2015.

107. The attention given to the new thoracic symptoms is not, however, inconsistent with an increase in lumbar symptoms also. The contemporaneous evidence is, I accept, broadly consistent with the applicant's own evidence that in August 2014, he experienced increased symptoms of pain and stiffness in both his upper and lower back which did not improve. The applicant said that by 20 August 2014 the pain in both his upper and lower back had become unbearable and he was having difficulty walking and standing.

108. The medicolegal evidence produced by the parties is problematic on both sides. I accept as correct, Mr Barnes' submission that in his first report, Dr Bodel failed to provide a clear opinion on causation beyond recording a history of increasing lower back pain on 15 August 2014 after working in a bent over position for a period of time. An attempt was made to remedy that situation in the supplementary report dated 5 February 2015 although on that occasion only a brief and unexplained opinion was given that employment was a "substantial contributing factor" to the injury.

109. I also accept Mr Barnes' submission that there are ambiguities in the final report prepared by Dr Bodel including reference to an injury on 15 August 2014 and a "specific event". The use of the expression, "the main substantial contributing factor" conflates the tests in ss 9A and 4(b) of the Act. It is, in my view, however, tolerably clear that Dr Bodel had formed the opinion that there was at least an aggravation, acceleration, exacerbation and deterioration of an underlying disease process at the interscapular region of the thoracic spine, thoracolumbar junction and lumbar spine caused by employment with the respondent consistently with s 4(b)(ii) of the Act. That said, it is possible to read Dr Bodel's reports as expressing a view that there was an injury which would satisfy both ss 4(a) / 9A and 4(b)(ii) consistently with the observations of Kirby J in *Zickar v MGH Plastics Industries Pty Ltd*[6]

110. Dr Bodel's reports are more problematic when it comes to the assessment of WPI. The failure to address the pre-existing injury to the lumbar spine renders Dr Bodel's assessment of permanent impairment unreliable. I am not satisfied, however, that this omission renders the entirety of Dr Bodel's reports unreliable. An evaluation of all the evidence is still required.

111. In his first report, Dr Panjratan identified the old injury to the lumbar spine and took a history of "intermittent" lumbar symptoms at the time the applicant joined the respondent which were not severe enough to prevent him working. This history was therefore consistent with the applicant's evidence and the clinical records before me.

112. Dr Panjratan did note that the applicant now complained of "ongoing" pain and symptoms in the lumbar spine. Dr Panjratan's examination on the first occasion revealed symptoms in the lumbar spine. It was also noted that the applicant had been referred by Dr Varsani for treatment for his lumbar spine as well as thoracic spine by physiotherapist Reg Brunet and had undergone hydrotherapy. Dr Panjratan took a history of the applicant's duties for the respondent as involving a lot of bending and lifting, including hand lifting loads such as steel beams and other heavy items due to an overhead crane being broken. Despite these observations, Dr Panjratan failed to expressly address the possibility that the lumbar pathology had been aggravated in the course of employment with the respondent. In the circumstances, Dr Panjratan's assertion that the lumbar condition was unrelated required a clear explanation, which was not provided.

113. In his second report, Dr Panjratan noted that the applicant considered the nature and conditions of his work responsible for his lumbar back pain. Despite this, Dr Panjratan maintained that the lumbar condition was not part of the present claim. Dr Panjratan expressed the view that there was no aggravation of the previous lumbar injury. The only explanation given for this was Dr Panjratan's assertion that the relevant reports at the time, including that from Dr Pope, did not mention a lumbar spine injury.

114. The analysis of the evidence above suggests that Dr Panjratan's assertion was inaccurate. There was reference to a stiff lower back as well as shooting mid back pain after doing heavy work for the respondent in the clinical note of 26 August 2014. A referral was made for an MRI scan of the lumbar spine on that date. An injury to the lower back was reported by the employer on 27 August 2014. General references to "back" pain as well as specific lumbar symptoms do appear in the subsequent clinical notes as well as Dr Pope's report. In January 2015, Dr Bodel took a clear history of increased lumbar symptoms in August 2014.

[6] [1996] HCA 31; 187 CLR 310.

115. Considering the evidence as a whole, I do not find Dr Panjratan's opinions persuasive.

116. The applicant's evidence as to the nature and conditions of his employment with the respondent is not in dispute. That work involved bending and hand lifting heavy loads. It has not been disputed that this work was causative of an injury to the applicant's thoracic spine. As a matter of common sense and experience, it is not difficult to imagine that such work had potential to be causative of an aggravation of the pre-existing degenerative process in the applicant's lumbar spine.

117. There is no evidence before me of any other possible causative factor to an increase in the applicant's lumbar symptomology in August 2014.

118. 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."

119. This is not a case where the evidence is clear cut. The contemporaneous medical evidence of an increase in lumbar symptoms in August 2014 is sparse. There was a previous injury which was continuing to flare up intermittently. The medicolegal opinions are also problematic.

120. Having carefully considered the evidence as a whole and for the reasons given above I am, however, satisfied on the balance of probabilities that there was an increase in the applicant's lumbar symptomology in August 2014 in the course of employment. I am further satisfied, on all the evidence, including Dr Bodel's reports, that the nature and conditions of the applicant's employment with the respondent were the main contributing factor to an aggravation, acceleration, exacerbation or deterioration of the disease process in the applicant's lumbar spine. I am satisfied that the applicant sustained an injury to his lumbar spine pursuant to s 4(b)(ii) of the 1987 Act and that the deemed date of 15 August 2014 relied on by the applicant pursuant to s 16 of the 1987 Act is appropriate.

121. Having made this finding, the appropriate course is for the matter to be remitted to the Registrar to be referred to an Approved Medical Specialist for an assessment of WPI of the thoracic spine and lumbar spine resulting from the injury deemed to have occurred on 15 August 2014.

122. All of the materials admitted in the proceedings will be included in the referral.

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[7] [2008] NSWCA 246.

SUMMARY

123. The applicant sustained an injury to his lumbar spine pursuant to s 4(b)(ii) of the 1987 Act.

124. The matter is remitted to the Registrar to be referred to an Approved Medical Specialist for an assessment of WPI of the thoracic spine and lumbar spine resulting from the injury deemed to have occurred on 15 August 2014.