# WORKERS COMPENSATION COMMISSION

## CERTIFICATE OF DETERMINATION

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

**Matter Number:** **6359/20**
**Applicant:** **Mohammed Javed Iqbal**
**Respondent:** **Hotel Operations Solutions Pty Ltd**
**Date of Determination:** **24 February 2021**
**Citation No:** **[2021] NSWWCC 61**

The Commission determines:

1. The applicant sustained injury to his cervical spine as a result of the nature and conditions of his employment with the respondent pursuant to s 4(b)(ii) of the *Workers Compensation Act 1987*.

2. The deemed date of injury is 7 October 2010.

3. The applicant has not discharged the onus of establishing injury to his lumbar spine as a result of the nature and conditions of his employment with the respondent. There is an award for the respondent in respect of the lumbar spine.

4. The applicant sustained a consequential upper gastrointestinal condition as a result of the injury to his cervical spine.

The Commission orders:

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

    Date of injury: 7 October 2010 (deemed)

    Body parts: Cervical spine
    Skin (scarring)
    Digestive system (upper gastrointestinal tract)

    Method: Whole Person Impairment

2. The materials to be referred to the Approved Medical Specialist are to include all documents admitted in these proceedings together with this Certificate of Determination and accompanying statement of reasons.

3. The matter to be listed for further teleconference upon receipt of the Medical Assessment Certificate.

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

Rachel Homan
**Arbitrator**

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

A Sufian

Abu Sufian
Disputes Officer
**As delegate of the Registrar**

# STATEMENT OF REASONS

## BACKGROUND

1. Mr Mohammed Javed Iqbal (the applicant) was employed as a room attendant by Hotel Operations Solutions Pty Ltd (the respondent) between October 2008 and March 2009 and again between August 2009 and October 2010. The applicant claims that he sustained an injury to his cervical spine and lumbar spine as a result of the nature and conditions of his employment with the respondent.

2. A claim for compensation for the alleged injury was made on 25 June 2012. On 21 September 2012, the respondent's insurer notified the applicant that liability was disputed under a notice issued pursuant to s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act). A review pursuant to s 287A of the 1998 Act was requested and the decision to dispute liability was maintained under a notice issued on 8 November 2012.

3. A further application for review was made on 14 December 2017 and a further dispute notice issued pursuant to s 74 of the 1998 Act on 6 April 2018.

4. On 10 December 2018, the applicant's former solicitors made a claim for lump sum compensation pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act) relying on assessments of whole person impairment (WPI) made by orthopaedic surgeon Dr Medhat Guirgis and gastrointestinal surgeon, Dr Anthony Greenberg.

5. Liability was declined for the injury, an alleged consequential gastrointestinal condition and the claim for lump sum compensation under a notice issued pursuant to s 78 of the 1998 Act on 5 February 2019.

6. The applicant commenced and later discontinued proceedings in the Commission in relation to the claim in 2014 and 2019.

7. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) lodged in the Commission on 2 November 2020. The applicant seeks:

    (a) weekly compensation on an ongoing basis from 7 October 2010;

    (b) incurred medical and related treatment expenses pursuant to s 60 of the 1987 Act;

    (c) lump sum compensation pursuant to s 66 of the 1987 Act in respect of 36% WPI of the cervical spine, lumbar spine, skin and digestive system; and

    (d) lump sum compensation pursuant to s 67 of the 1987 Act for pain and suffering.

## PROCEDURE BEFORE THE COMMISSION

8. The parties appeared for a teleconference on 30 November 2020. The applicant was unrepresented. On that occasion, an offer of settlement was put to the applicant but not accepted. Some considerable time was spent explaining the Commission's processes and the issues in dispute to the applicant. The applicant was strongly encouraged to obtain legal representation funded through WIRO.

9. The matter proceeded to conciliation conference and arbitration hearing conducted by telephone on 5 January 2021. The applicant again appeared unrepresented. The respondent was represented by Mr Tom Grimes of counsel, instructed by Ms Casey Bray. A representative from the insurer was also present.

10. During the conciliation conference, offers of settlement were again made by the respondent and rejected. The issues in dispute and the risks in proceeding to a determination of the claim on the current evidence were explained to the applicant. Again, the applicant was advised of his ability to obtain funded legal representation. The applicant indicated that he understood but wished to proceed to have the dispute determined.

11. It was noted that the applicant had also been offered but had declined the assistance of an interpreter during the proceedings. I was, however, satisfied that the applicant's English language skills were sufficient to allow him to meaningfully participate in the hearing and that it was appropriate in all the circumstances for the matter to proceed to arbitration.

12. Both the initial teleconference and the conciliation conference were recorded.

13. At the conclusion of the arbitration hearing, the applicant was granted leave to supplement his submissions in writing by 12 January 2021, should he wish to do so. A timetable was set to allow the respondent to reply to any written submissions also.

14. 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

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

    (a) whether the applicant has sustained an injury pursuant to s 4 of the 1987 Act to his cervical spine and lumbar spine as alleged;

    (b) whether employment was a substantial contributing factor to the alleged injury;

    (c) whether the applicant has sustained a consequential gastrointestinal condition as a result of the alleged injury;

    (d) the date of injury;

    (e) the extent and quantification of any incapacity resulting from injury;

    (f) the entitlement to s 60 expenses;

    (g) the degree of permanent impairment resulting from injury; and

    (h) the entitlement to lump sum compensation under ss 66 and 67 of the 1987 Act.

16. Given that the applicant was unrepresented and having regard to the large number of issues in dispute, I proposed that the parties focus their submissions at arbitration on 5 January 2021 on the following matters only:

    (a) whether the applicant has sustained an injury pursuant to s 4 of the 1987 Act to his cervical spine and lumbar spine as alleged;

    (b) whether employment was a substantial contributing factor to the alleged injury;

    (c) whether the applicant has sustained a consequential gastrointestinal condition as a result of the alleged injury; and

    (d) the date of injury.

17. I indicated that in the event of a favourable determination of the question of injury for the applicant, there would be a referral to an Approved Medical Specialist for an assessment of the degree of permanent impairment. The matter would then be listed for further teleconference to deal with the claims for weekly compensation and orders in relation to the claimed compensation under ss 60, 66 and 67 of the 1987 Act.

18. The parties agreed to this course.

## EVIDENCE

### Documentary Evidence

19. 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;

    (c) Written submissions and documents attached to Applications to Admit Late Documents lodged by the applicant on:

        (i) 3 November 2020;
        (ii) 17 November 2020;
        (iii) 8 December 2020;
        (iv) 5 January 2021; and
        (v) 6 January 2021; and

    (d) Written submissions lodged by the respondent on 19 January 2021.

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

### Applicant's evidence

21. The applicant provided a written statement to an investigator from ProCare on 31 July 2012.

22. The applicant said he migrated to Australia in February 2006. From May 2006 to May 2008 the applicant worked as a room attendant with a different employer.

23. The applicant commenced work for the respondent in October 2008. The applicant would work at different hotels and receive a roster each week telling him where he was to go. The applicant normally worked on his own and occasionally in a pair if there was an extremely dirty room or several rooms which needed cleaning. The number of rooms requiring cleaning varied depending on the hotel. The applicant was paid by the room. Approximately 30 minutes was allowed per room but this varied from hotel to hotel.

24. The applicant said there was a lot of pressure to get a room done as quickly as possible. The applicant would turn on the light and pick up the rubbish. Then the applicant pulled the bed from the wall and split the linen. The bed would be made layer by layer and pushed back against the wall. The furniture would need to be moved back into its original position. Tea, coffee and sugar sachets would be refilled. The toilet was cleaned. The applicant would then vacuum and dust. The applicant would then push a trolley to the next room or level. Sometimes the applicant would have to make up twin bedrooms which placed more pressure on him with no extra time allowed.

25. The applicant said he had attended a one-hour induction session when he commenced employment with the respondent. The applicant was shown how to lift, push and pull correctly and the correct way to dress a bed. The applicant said it could be difficult to stick to the rules of how to push and dress a bed properly as there was a lot of pressure to get the work done as quickly as possible.

26. In March 2009, the applicant returned to Bangladesh for three months. The applicant returned to employment with the respondent on 24 August 2009. Again, the applicant received induction training.

27. The applicant recalled an incident one day at the Ibis Hotel in Darling Harbour. The applicant and a colleague got in a lift on the fifth or sixth floor to go up, however, the lift quickly dropped to the basement level. The applicant was stuck in the lift for about an hour. After the lift mechanic came, the applicant went home as he was feeling very stressed. Although the applicant felt okay the next day, in retrospect, he felt the incident may have contributed to his current medical condition.

28. A few days later, the applicant had to clean a three-bedroom suite and felt very unusual. At the time the applicant thought it might be an allergic reaction to smoke or dust in the room. In retrospect, the applicant felt that this may have been a symptom of sensory impairment due to his injury.

29. In May 2010, the applicant noted stiffness in his ring finger and index finger on the right. The applicant consulted his doctor. The applicant experienced the stiffness whilst pushing a trolley at work. The applicant was advised to take paracetamol and rest his right hand as much as possible.

30. On 7 October 2010, the applicant recalled experiencing pain radiating up his hand from his fingertips. The applicant described the pain as being 10 out of 10. The applicant also experienced pins and needles from the right side of his neck down to his fingers. The applicant's hand was swollen up to his elbow and felt heavy. The applicant consulted his general practitioner the next day and was prescribed Mobic.

31. On 11 October 2010, the applicant explained the difficulties he was having with his hand as a result of work to his supervisor Asoka. The applicant said his general practitioner had advised that he get rest and find a more suitable job and so the applicant resigned. The applicant was not asked to fill in an incident form but was simply asked to write a letter of resignation. The applicant said he did not go into detail in the resignation letter as he was in pain.

32. The applicant was a qualified doctor in Bangladesh and wished to work as a general practitioner. For the next 1.5 years the applicant studied for the Australian Medical Council clinical examination and applied to hospitals for positions without success. The applicant sat the exam in March 2011 but was unsuccessful.

33. During this period, the applicant was receiving Centrelink payments. In April 2012, Centrelink required the applicant to go for a medical assessment as his injury was not improving. The applicant was referred to Dr Vijay Maniam by his general practitioner. The applicant was also referred for an x-ray of his right hand, which was reported to be normal.

34. After receiving the x-ray results, the applicant's general practitioner felt that the problem may involve the spine. The applicant was referred for an x-ray of his cervical spine. Although the radiologist thought the x-ray was normal, the applicant's doctor referred him for a CT scan which showed multi-cervical disc protrusions with spinal cord compression. The applicant was referred for physiotherapy. The applicant attended physiotherapy but would feel stiff in his right fingers and have pain in his back afterwards.

35. The applicant consulted Dr Maniam on 12 June 2012. Dr Maniam gave the applicant a WorkCover certificate on 22 June 2012 stating that the applicant was unfit for work from 24 May 2012 until 30 July 2012.

36. The applicant said that he had not gone on WorkCover as he thought he had a temporary problem and it would affect his chances of getting a job as a general practitioner in Australia. Since the CT scan showed a serious long-term problem, the applicant changed his mind.

37. The applicant's general practitioner gave the applicant a WorkCover certificate backdated to 7 October 2010.

38. Approximately one week after receiving the WorkCover certificate, the applicant gave it to his former supervisor, Asoka. A claim form was later faxed.

39. The applicant described ongoing symptoms of dizziness. The applicant's fingers became stiff and his hand swollen when doing household chores. The applicant said that prior to 2010 he never had any difficulty with his hand or spine.

40. The applicant provided additional written statements on 1 September 2015, 29 October 2015 and 27 September 2018.

41. In the statement dated 1 September 2015, the applicant confirmed the evidence in his previous statement and said he had not been working or able to find employment in his injured state.

42. In the statement of 29 October 2015, the applicant said he began taking NSAIDs occasionally in January 2010 after developing right foot pain. The applicant began to notice problems and changes in his gastric system.

43. In October 2010, the applicant began taking NSAIDs more regularly in the context of developing pain and restriction in his right hand. The applicant developed more serious gastric symptoms with pain and discomfort.

44. Around June or July 2012, after developing problems with his neck and back, the applicant began taking Ibuprofen for months at a time for pain management. The applicant developed more serious symptoms again including vomiting. The applicant stopped taking NSAIDs continuously but continued to have gastric pain, discomfort and vomited blood off and on as he needed to take NSAID painkillers for pain management.

45. In the statement of 27 September 2018, the applicant provided an overview of the subsequent treatment of his cervical spine and reiterated his earlier evidence with regard to his gastric issues. The applicant also described back symptoms:

> "I'd also suffered with lower back pain after working with Hotel Operations. I always had pain and discomfort in my back and I would feel pain radiating down my right limb. This was occurring after I had started working at Hotel Operations. I was performing heavy duties at Hotel Operations and at the end of every day I would always get back pain with a radiating pain into my right leg. I would get attacks of pain down my right lower limb including pain and numbness and foot drop. As I continued to work, it made it more difficult to perform my duties and it was one of the reasons why I resigned in 2010."

46. The applicant described the treatment he had received for his lumbar symptoms and his capacity for work.

**Asoka Hapuwinda**

47. The respondent's office manager, Mr Asoka Hapuwinda, provided a statement to the investigator on 3 August 2012.

48. Mr Hapuwinda confirmed the applicant's employment with the respondent. Mr Hapuwinda said the applicant underwent a three-hour orientation which covered policies and procedures including the reporting of injuries. The applicant also received three weeks of on-the-job training.

49. On average, the applicant would have been expected to clean between 9 and 12 rooms per day. On a very busy day he may have been responsible for doing 13 rooms. On average it would take 30 minutes to clean a suite.

50. Mr Hapuwinda described the applicant's duties in a similar fashion to the applicant:

> "Upon entering they are required to turn on lights, spray chemicals in the bathroom and collect rubbish in the bathroom. They are then to proceed to strip the bed, take the dirty linen out, bring new linen in and dress the bed. They are then to clean the bathroom and replenish all the items. The vacuuming and dusting are the last thing to be done.
> …
> Each employee is responsible for loading their own trolleys and therefore it is up to them how much they put on it. The suggested load would be to put enough linen etc for 4 rooms but as I said this is up to the individual."

51. Mr Hapuwinda said the applicant worked mainly at the Novotel in Sydney Olympic Park. Mr Hapuwinda said the beds at the Novotel were not heavy and had wheels on them:

> "I believe that one can push them with their leg, however if they have to pull/push a bed employees have been instructed that they are required to bend from the knees when doing so."

52. Mr Hapuwinda could not recall an incident involving a lift at the Ibis and the applicant being stuck in the lift for over an hour.

53. Mr Hapuwinda did recall the applicant having issues with cigarette smoke in the Ibis hotel. The applicant's concerns were accommodated and he returned to the Novotel at Olympic Park. Mr Hapuwinda did not recall the applicant complaining about heavy items at the Westin Hotel in the weeks leading up to 7 October 2010.

54. Mr Hapuwinda did recall that on 11 October 2010 the applicant came to his office and said he was having problems with his right hand and finger and that his general practitioner had advised him to find another job. Mr Hapuwinda advised the applicant to write a letter of resignation. Mr Hapuwinda denied that the applicant said the problem with his finger was related to work. If he had, he would have asked the applicant to fill in an incident sheet in accordance with normal procedure.

**Other factual material**

55. A job description, a document titled, "Flow Of Service For Cleaning A Guest Room" and a document titled "HRC 5 Steps to a perfect clean room" were attached to the factual investigation report prepared by ProCare and described the applicant's duties in similar terms to the evidence of the applicant and Mr Hapuwinda.

56. An email from the applicant to Mr Hapuwinda dated 22 November 2009 stated:

> "I am sending you this email because i think that as a employer you should be informed if i get any problem with my health & safety while working. Last week, I worked 4 days in Ibis Darling harbour. On each of these 4 days i got soor throat, running nose & sneezing while working, Something can be there in their environment which is allergen for me. Same problem i got while working in level 8 and some of the double bedder room of Novotel Darling harbour. Level 8 is smoking level. May be in ibis and in some of the double bedder of Novotel guest are doing smoking."

57. A handwritten letter of resignation from the applicant dated 11 October 2020 states that the applicant had been:

> "recently getting problem with my fingers of rt. hand. They are getting stiff as I am continue to work. My GP has suggested to take rest and look for something physically suitable for me. So, I need to stop the job with you. So, I want to resign."

58. A Centrelink employment separation certificate completed by Mr Hapuwinda on 13 October 2010, stated that the applicant ceased employment voluntarily as:

> "Employee says that he is not suitable for this type of work and resign from his position."

59. The applicant also relies on an article apparently sourced from the Canadian Centre for Occupational Health and Safety, which states:

> "What are the risk factors of housekeeping?
>
> The main risk factors for repetitive motion injuries (RMIs) in housekeeping are:
> - heavy physical workload and excessive bodily motions which are a high risk for back injuries
> - forceful upper limb motions in awkward positions which are a high risk for neck or shoulder and arm injuries

Space limitations require workers to use many uncomfortable postures. These are:

- standing or walking
- stooping
- squatting
- kneeling
- stretching
- reaching
- bending
- twisting
- crouching

A housekeeper changes body position every three seconds while cleaning a room. If we assume that the average cleaning time for each room is twenty-five minutes, we can estimate that a housekeeper assumes 8,000 different body postures every shift.

In addition, forceful movements while using awkward body positions include lifting mattresses, cleaning tiles, and vacuuming every shift. Housekeeping is a physically demanding and very tiring job. It can be classified as 'moderately heavy'."

**Medical Evidence**

60. The clinical records of the applicant's general practitioners at NAS Advanced Medical Centre show consultations in October 2009 in which the applicant complained of a blocked nose, sore throat and sneezing in the context of working as a housekeeper and needing to do dusting. Later the same month the applicant described a skin rash and referred to dusting to rooms and using chemicals for cleaning.

61. On 8 January 2010, the applicant reported pains in his right foot in the context of his work. An x-ray of the right foot was requested.

62. On 6 August 2010, Dr Mahmoud Abdalla recorded consultation as follows:

> "pains right hand and fingers
> painful movements
> S/R work labour uses hand a lot
> O/E some tenderness right hand and fingers no signs painful movements
> left hand nad
> ? Strai"

63. On 13 August 2010, the applicant reported that the pains in his right hand were better when resting and not working. Blood tests requested on the previous occasion were reported to be normal. The applicant was advised to use heat and rest.

64. On 8 October 2010, Dr Abdullah recorded:

> "pains fingers, hands
> difficulty in moving and in holding objects
> cant sleep from pains
> O/E tender hands and fingers
> painful restricted movements"

65. The applicant was given a Centrelink medical certificate.

66. A Centrelink Job Capacity Assessment Report dated 20 October 2010 reported a diagnosis of:

> "Pains and stiffness, strained hand (client reported onset May 2010). Current Treatment: Anti-inflammatory medication (mobic). Future Treatment: Client reported he has been advised to take medication and rest his hand. His GP will review his condition in a few months; if his condition has not improved, he stated he will be referred to a specialist for further assessment, nerve conduction studies, or neck MRI."

67. The same report referred to an onset of anxiety and depression in the last few months. A temporary work capacity of 8-14 hours per week until 11 January 2011 was recommended with a baseline work capacity of 15-22 hours:

> "Rationale: The severity and chronicity of symptoms are anticipated to reduce baseline work capacity to 15-22 hours per week. The client reported pain and numbness in his right (dominant) hand/upper limb which significantly affects his lifting, carrying and manual dexterity. He stated he remains capable of typing however has difficulty doing up buttons, opening bottles/jars, using a razor to shave, and brushing his teeth. He reported reduced grip strength and difficulty with vacuuming. Suitable work: Light skilled (W01) Examples: Doctor."

68. The report stated:

> "Mr Iqbal reported his most recent employment experience was on 07/10/2010, when he was working as a housekeeper and hotel room attendant. He stated he has approximately 3-4 year experience in this style of work, working casually, part time and more recently full time. He reported he ceased due to exacerbation of his hand and finger sprain. He reported he is currently voluntarily working as an observing G.P. when he can, with local doctor's in his area. He expressed a keen motivation to find full time work as a doctor."

69. Symptoms including right-hand and finger stiffness and swelling, being unable to form a fist and painful restricted movement were reported to Dr Abdalla again on 11 October 2010, 6 December 2010 and 11 April 2011.

70. A further Job Capacity Assessment Report was completed for Centrelink on 31 January 2011. In that report, the applicant was said to have a baseline work capacity of 30+ hours per week in light skilled work:

> "Client's current capacity remains at 30+ hpw as permanent medical condition right hand sprain does not significantly impact on client's functioning if in suitable employment."

71. On 12 August 2011, the applicant reported symptoms of dizziness with change of body and head position to Dr Abdalla.

72. A consultation in relation to skin lesions at the back of the neck and upper back was recorded on 14 October 2011.

73. On 29 November 2011, Dr Abdalla recorded:

> "pains both hands, wrists and arms esp right hand
> difficulty in moving at times
> H/O of injury/ strain
> O/E tender all painful sl restricted movements
> R/ deep heat panadol nurofen"

74. On 3 January 2012, Dr Abdalla recorded:

> "pain right hand right forearm
> numbness
> stiffness of 3 middle fingers
> H/O work injury
> O/E Tender right hand and forearm
> painful restricted movements"

75. On 3 April 2012, the applicant reported pain in his hands, difficulty moving and holding things and difficulty sleeping at night due to pain. Similar symptoms were reported again on 10 April 2012, on which occasion Dr Abdalla requested an x-ray of the right hand.

76. A Job Capacity Assessment Report dated 11 April 2012 described a "Shoulder and Upper Arm Disorder":

> "[Pains and stiffness right hand and forearm strained right hand and forearm]
> as noted in MC (3/4/12). Treatment: NSAIDs. Has been referred to a specialist."

77. It was reported that the applicant would benefit from a reduced work capacity of 0-7 hours per week until 3 July 2012.

78. On 13 April 2012, Dr Abdalla recorded a consultation as follows:

> "pain right hand difficulty in moving the hand, numbnes
> Neck pains
> Difficulty in moving neck
> check X-Ray hand- nad—
> O/E tender cervical spine and right hand
> painful restricted movement"

79. On this occasion, the applicant was referred for an x-ray of the cervical spine and a letter of referral prepared to Dr Vijay Maniam.

80. Right hand and finger pains, neck pains and difficulty moving neck and hand were reported again on 16 April 2012. On 7 May 2012 the applicant was recorded to have complained of neck pains, difficulty moving the neck and being dizzy at times. The applicant was observed to have a tender cervical spine and painful restricted movements. A CT scan of the cervical spine was requested.

81. The CT scan of the cervical spine performed at the request of Dr Abdalla on 8 May 2012 was reported to show:

> "Left paracentral broad-based disc protrusion at C3/4 and a more foraminal left broadbased small disc protrusion at C4/5 with mild left, bony foraminal narrowing. Marked bony left paracentral and left foraminal C6/7 narrowing. Right bony foraminal narrowing at C5/6. Mild facet joint arthropathy at lower levels."

82. On 9 May 2012, Dr Abdalla recorded:

> "neck pains to the hands, more in the right
> used to lift beds and clean when was working in a hotel
> check CT C spine
> O/E tender Cervical spine painful sl restricted movements
> CT: disc lesions"

83. The applicant was referred to the physiotherapy department at Auburn Hospital. Records from the Auburn Hospital dated 16 May 2012 indicate that the applicant reported neck pain radiating into the right arm with a history of:

> "Used to be a hotel worker. Heavy manual work. Began feeling hand pain
> and stiffness in May 2010 progressed to numbness in arm. Insidious onset."

84. Similar symptoms were recorded by Dr Abdalla on 1 June 2012. Symptoms were said to be better with physiotherapy but returning afterwards. It was noted that a letter from Dr Maniam and MRI results were being awaited.

85. An MRI of the cervical spine performed at the request of Dr Maniam on 13 June 2012 was reported to show:

> "At C3/4 level, a mild posterior disc protrusion is present. A mild right paramedian posterior protrusion of the C5/6 disc is noted. At the C6/7 level, a moderate broad-based left paramedian posterior disc protrusion has occurred. At these levels, mild cervical disc arthrosis has developed. There is narrowing of the right C5/6 and left C6/7 intervertebral foramina. At these levels, the cervical cord is flattened indicating the presence of degenerative canal stenosis."

86. On 15 June 2012, Dr Abdalla recorded:

> "since was lifting, pushing in a hotel- cleaning job- 7th of october 2010
> Neck pains down to both sides of neck and down to the right arm hand
> pain and neck stiffness
> Difficulty in moving neck
> O/E tender cervical spine
> painful restricted movements
> R/ voltaren emulgel. panadol. nurofen
> X-Ray cervical spine
> MRI 13/6/2012 disc lesions"

87. On 22 June 2012, Dr Maniam issued a WorkCover Medical Certificate describing an injury "Due to lots of pulling and pushing of heavy beds, trolley, vacuum during cleaning of rooms". A date of injury of 7 October 2010 was given as well as a diagnosis of: "C3/4, C6/7 + C5/6 IVD protrusions". The applicant was certified unfit for work from 24 May 2012 to 30 July 2012.

88. Dr Abdalla issued the applicant with a work certificate describing an injury to the neck and shoulder pains radiating to his arms on 25 June 2012. The applicant was said to be unfit for work from 7 October 2010 to 30 July 2012.

89. Symptoms in the neck, arms and hands were again recorded by Dr Abdalla on 29 June 2012 and 6 July 2012. On 9 July 2012 the applicant also complained of recurrent dizziness. On 23 July 2012 the applicant was referred for occupational therapy at Auburn Hospital.

90. A further Job Capacity Assessment Report for Centrelink dated 3 July 2012 described the applicant's condition as a "Musculo-skeletal Disorder – Other":

> "C3/4 level mild posterior disc protrusion is present. A mild right paramedian posterior protrusion of the C5/6 is noted. At the C6/7 level a moderate broad-based left paramedian posterior disc protrusion has occurred. At these levels, mild cervical disc arthrosis has developed. There is narrowing of the right C5/6 and left C6/7 intervertebral foramina. At these levels, the cervical cord is flattened indicating the presence of degenerative canal stenosis.
> Onset: 2010.
> Diagnosed: 2012.
> Past treatment: NSAIDs.
> Current treatment: weekly physiotherapy since May 2012. Additional sessions if required. Specialist review. NSAIDs.
> Future treatment: is to go for specialist review on 20/07/2012. May undergo surgery.
> Functional impact: pain and stiffness, cannot perform activities such as doing up buttons or using a keyboard for prolonged periods, restricted range of movement.
> Although Mr. Iqbal may receive surgery, even with the surgery the condition is not expected to significantly improve within a two-year period, therefore this condition is considered fully diagnosed, treated and stabilised"

91. The applicant was said to have a temporary work capacity of 0-7 hours per week.

92. On 25 July 2012, Dr Maniam prepared a report to Dr Abdalla giving a history as follows:

> "Mohammed indicated that whilst working in hotels as a cleaner between May 2006 and October 2010 he developed pains in the neck and right shoulder. He has noticed recurring stiffness and a pain radiation into the shoulders. In January 2010 the symptoms worsened and he applied to seek Centrelink benefits.
>
> He has not suffered from any similar problems in the past and his general health has been satisfactory. He has ben receiving medication and exercises for his neck.
>
> Examination of the cervical spine exhibited spasmodic muscles and restricted movements, movements in all range were restricted and the Spurling's was positive. Sensations in the right C5 and C6 dermatomes were poorly appreciated and the right biceps was exaggerated."

93. Dr Maniam reviewed the CT scan and MRI of the cervical spine and recommended conservative treatment.

94. A Whole Body Scan with SPECT/CT was performed at Dr Maniam's request on 22 August 2012 due to "documented chronic disc disease / protrusion cervical spine" and "flexor tendinopathy right hand". The report concluded:

> "There are scan features suggestive of mild osteoarthritic change with low grade synovitis at the MCP and PIP joints left ring finger. There is no scan evidence for significant synovitis or inflammatory tendonitis in the right hand. Minor degenerative change is noted at several of the joints of the upper limbs as described above. There is no scan evidence for significant facet joint arthritis in the cervical spine, however, minor discovertebral degenerative change is noted at C5/C6 and C7/T1. There is no scintigraphic evidence for a reflex sympathetic dystrophy involving the right hand"

95. On 6 September 2012, Dr Maniam certified the applicant as fit for suitable duties from 7 September 2012 to 7 November 2012.

96. Injury Management Consultant, Dr Uthum Dias, prepared a report from the applicant's former solicitors on 13 September 2012. Dr Dias took a history as follows:

> "In December 2009, Mr Iqbal reported that as a result of his work duties, he started feeling stiffness around his left and right trapezial regions. The stiffness in the trapezial regions continued for the next 7 or 8 months until his resignation from work in October 2010. In May 2010, MR Iqbal noticed that the fingers of his right hand, particularly the index and ring finger, were becoming stiff. He saw his GP who did X-Rays, which were normal. He continued to work as a room attendant. By October 2010, he reported having felt the sensation of numbness and pins and needles in his right upper limb over a period of a couple of months prior to this; and he noted that it was specifically worse on 7 October 2010. This had been associated with mild to moderate neck discomfort. On the next day, 8 October 2010, he went to his GP and reported this. Mr Iqbal reports that his GP advised him to resign from his job as it was felt that his employment was causing these symptoms. He then went to Centrelink and commenced benefits but did not commence a Workers Compensation claim.
> …
> Mr Iqbal then was on Centrelink about a year and a half with ongoing symptoms when in about June 2012 when Centrelink encouraged him to get another assessment. As part of this, his GP sent him to a specialist who ordered a CAT scan. Upon receipt of the CAT scan findings, Mr Iqbal and his specialist decided to activate a WorkCover claim as they felt the symptoms were attributed to his work with Hotel Operations Solutions."

97. Dr Dias recorded a history of the applicant's work duties for the respondent that was broadly consistent with the other evidence. Dr Dias recorded the applicant's current symptoms as:

> "Mr Iqbal reports pain in several areas of the body, namely, the neck, the right upper limb, the left upper limb and the lower back. The pain in his right and left upper limbs are associated with pins and needles and numbness. He reports that his neck pain associated with dizziness which limits his functional and mental capacity. He reports that he has pain in the lumbar paraspinal regions which is also associated with difficulties with bladder control, erectile dysfunction and he also has symptoms of "transient bilateral foot drop" (in his own words). Mr Iqbal also reports stiffness and pain in his right index and ring finger and he reports a triggering sensation with these fingers. Mr Iqbal also reports a depressed mood and anxiety."

98. Dr Dias reviewed the radiological investigations and performed an examination before giving a diagnosis as follows:

> "Mr Iqbal has chronic pain relating to:
>
> • A C5/C6 disc protrusion on the right side, and C6/C7 left sided disc protrusion. Disc protrusions cause a clinical radiculopathy on the right C6 nerve root and the left C7 nerve root. There is a background of degenerative disc disease and facet joint arthrosis noted throughout the cervical spine which is indicative of moderate cervical spondylosis.
>
> • I will not comment on his lower back symptoms as these have not been investigated at this point in time. I will not comment on his mental health symptoms as this would fall outside my area of specialist expertise."

99. On the causal relationship between the diagnosis and employment with the respondent, Dr Dias stated:

> "it is reasonable to think that his employment with Hotel Operations Solutions was a contributing factor to his current compensable medical condition (relating to his neck) at this stage in time. In my opinion, there is a degree of constitutional degenerative osteoarthritis that is also contributing to his injuries."

100. On 17 September 2012 the applicant first reported back pains to Dr Abdalla who recorded:

> "Back pains with lifting and cleaning at home
> pain started at work years ago
> difficulty in moving back, and in walking
> O/E tender L/S spine
> painful restricted movements
> R/ voltaren emulgel, Panadol, nurofen
> Diagnostic Imaging requested: CT Lumbar spine"

101. A CT scan of the applicant's lumbar spine was performed at Dr Abdalla's request on 24 September 2012 and was reported to reveal:

> "At L4/5 level there is an annular disc bulge with mild bilateral foraminal narrowing. At L5/S1 level there is an annular disc bulge which lies in close proximity to the origin of the right 1st sacral nerve root. Clinical correlation for possible impingement is suggested. There is also mild right sided foraminal narrowing."

102. Back pains were reported at consultations with Dr Abdalla throughout September 2012.

103. On 30 September 2012, neurology consultant Dr M Dowla prepared a report for Dr Maniam which provided a history as follows:

> "Many thanks indeed for referring this 34-year-old right handed Doctor from Bangladesh who presents with two years history of intermittent paraesthesia and stiffness in his shoulders and hands. The stiffness affects his neck. He complained of pain radiating to the neck, the left arm and to the shoulders and elbows. He also complains of similar sensation in his right upper limb affecting his right wrist and right shoulder. There is a patch of numbness in his left outer arm."

104. Dr Dowla reported on the results of nerve conduction studies and recommended intensive physiotherapy and possible surgical assessment.

105. In November 2012 the applicant was referred to the neurosurgical department at Concord Hospital.

106. On 30 November 2012, Dr Dias prepared a supplementary report for the applicant's solicitors. On this occasion, Dr Dias reviewed additional documents including the CT scan of the lumbo-sacral spine dated 24 September 2012 and gave the opinion:

> "In my opinion based on the history and examination of the 13.09.2012 and as well as the available evidence I believe that Mr Iqbal's employment with Hotel Operations Solutions was a substantial contributing factor to his injury. This is as a result of repetitive manual handling, repetitive twisting of the lower back, repetitive overhead work inherent in the nature and conditions and task with his employment at Hotel Operations Solutions as a room attendant."

107. With regard to capacity for employment, Dr Dias stated:

> "Objectively based on history and examination on 13.09.2012 and the available evidence Mr Iqbal is functionally capable of performing full time duties with normal hours and normal days however he should be restricted from lifting more than approximately 5 Kg, he should be restricted from doing any repetitive manual work or overhead work or from driving a heavy commercial vehicle. He will be fit for mainly seated duties. He is not fit to return to his pre injury duties as a room attendant. The fields of employment that will be open to him include administrative and clerical duties. He may be able to find employment in health-related industries, for which he is qualified, if the duties are mainly sedentary or seated in nature."

108. The applicant continued to report symptoms relating to the neck and back as well as his shoulders in 2013 and 2014.

109. On 21 October 2013, Neurosurgeon, Dr Raoul Pope of the Neurosurgery Outpatient Clinic at Concord Hospital reported to Dr Abdalla that the applicant's symptoms could be summarised as:

> "Summarising his symptoms he has had bilateral upper limb paraesthesia and pain in the last two years affecting predominantly his right shoulder and right hand. In recent times it has been affecting his left upper limb with some pins and needles going down the triceps region into the posterior forearm but not affecting the fingers particularly. The main pain is into the lateral aspect of the arm consistent with C5. He has chronic subaxial neck pain which is daily and worse with movement than rest but has not had any myelopathic features such as clumsiness, bladder or bowel issues, gait disturbance."

110. Dr Pope gave the opinion "that Mr Iqbal is suffering from musculoskeletal and discogenic neck pain as well as a bilateral radicular component." It was noted that surgery had been discussed.

111. An MRI of the lumbar spine was performed on 25 August 2014 and was reported to show:

> "At L3/4 there is minor left foraminal disc bulging with low grade left foraminal narrowing, but no nerve root impingement. At L4/5 there is a shallow broad based posterior disc bulge with posterocentral annular fissuring with low grade foraminal narrowing, but no nerve root impingement. The spinal canal remains capacious throughout. There is no evidence of impingement of the L5 or S1 nerve roots."

112. On 12 September 2014, Dr Abdalla recorded:

> "W/C
> Back pains down to his legs
> Difficulty in moving and in walking also
> C/O epigastric pains following NSADS for his back pain
> O/E tender L/S spine
> painful restricted movements
> some tenderness over the epigastrium. not acute no masses
> R/ deep heat . panadol , nurofen.
> Stop NSAIDS
> mylanta somac 40 mg"

113. The applicant was referred to Dr Robert Woods.

114. On 29 September 2014, Dr Woods arranged a gastroscopy. In November 2014 the applicant was referred to Dr Ayaz Chowdhury.

115. The applicant continued to regularly consult Dr Abdalla in relation to the same symptoms in 2015.

116. Neurological symptoms including urgency and incontinence were reported to Dr Abdalla in March 2015.

117. A CT-guided injection at L4/5 was performed on 28 April 2015 at the request of Dr Pope.

118. An endoscopy was performed on 24 April 2015. On 25 May 2015, Dr M Ayaz Chowdhury, a consultant gastroenterologist reported that the applicant had undergone gastroscopy which amongst other things showed "active chronic gastritis associated with large number of helicobacter pylori organism" and evidence of a previous duodenal ulcer. Dr Chowdhury recommended that the applicant avoid anti-inflammatory agents and use Panadol for pain. Dr Chowdhury said it was "possible that his duodenal ulcer is due to a combination of helicobacter pylori infection and taking anti-inflammatory agent."

119. On 10 September 2015, the applicant was referred to the pain clinic at Westmead Hospital.

120. Gastrointestinal symptoms continued to be reported throughout 2015 and early 2016. On 9 February 2016 it was recorded that the applicant had vomited blood after taking Panadol for his neck pain. The applicant was again referred to Dr Ayaz Chowdhury.

121. On 18 April 2016, the applicant consulted a new general practitioner at Mount Druitt Medical Centre, Dr Ahmed Taher who recorded:

> "New pt to practice
> Long standing issue with lower back and neck pain following injury at work
> Had multiple steroid injections in past for same
> Requesting to fill up referral for westmead pain clinic"

122. On 27 June 2016, the applicant underwent a C5/6 and C6/7 anterior cervical discectomy and fusion under Dr Pope.

123. An MRI of the cervical spine performed on 20 September 2016 showed:

> "Status post interval C5/6 and C6/7 ACDF, with mild improvement of canal stenosis at these two levels. There is persistent subtle cord flattening particularly on the right at C5/6 level and on the left at C6/7 level. No myelomalacic change is seen."

124. An MRI of the lumbar spine on the same occasion was reported to show:

> "There are mild spondylotic changes seen in the lumbar spine as described without significant central canal or foraminal stenosis. No nerve root impingement is seen to account for patient's symptoms."

125. On 27 February 2017, a Registrar at the Chronic Pain Outpatient Clinic at Westmead Hospital prepared a report for Dr Taher describing:

> "Chronic right lower limb weakness and pain of a neuropathic nature. He has potentially related bladder incontinence, Medication management limited as he is reluctant to try pregabalin or gabapentin which may assist neuropathic pain. I cautioned him on the long-term effects of diazepam, His request is to pursue a further neurosurgical opinion of his lower limb weakness and pain."

126. A CT-guided injection at L4 was performed on 7 March 2017.

127. On 14 March 2018, Dr Pope reported to Dr Taher that the applicant had presented essentially requesting a medicolegal assessment which Dr Pope did not normally provide. Dr Pope agreed to see him on a clinical basis. Dr Pope noted that the applicant presently complained of bilateral upper limb pain, numbness and weakness, neck pain, lower back pain, and bilateral lower limb pain for nine years. Dr Pope recorded a history as follows:

> "He states that he had some insidious onset of workplace injury working in the Ibis hotel between March 2009 and October 2010 with repetitive labour, resulting in the above fore mentioned symptoms. I became involved with him in 2013 for mainly his neck for which he ended up failing nonsurgical measures and we had correspondence from his neurologist that there were nerve compressions at C7 and C6 and spinal stenosis requiring an operation. I agreed and we performed a 2-level anterior cervical discectomy and fusion C5/6 C6/7 on the 27/06/2016. This was after failed nonsurgical measures."

128. Dr Pope performed an examination which he described as follows:

> "He walked with a walking stick with a stooped posture. There was definitely a change in his demeanour with grossly exaggerated fear avoidant behaviour. I was not able to perform a physical examination to any degree because he was unable to do any of the requested movements due to pain. There was virtually no movement of his neck. No movement of his lower back and all movements were excessively slow. I am not denying that he was in pain but it made a physical examination extremely difficult. Objective signs such as clonus were absent. There was no Hoffmann's reflex bilaterally. No crossed adductor reflex. I could not elicit knee jerks or ankle jerks bilaterally. Hip examination normal. Sensory examination impossible to interpret."

129. Dr Pope gave the opinion:

> "My opinion is that Mr. Iqbal has whole body pain and physical signs that exaggerate the symptoms. I would like to have an MRI of the neck and the lower back to make further assessments and comments. It is quite clear that he is debilitated but to the exact extent I am not entirely sure. I will make factual comments about the scan results but I cannot correlate them to the physical examination. I will be happy to review him after these investigations, in the meantime I would like him to continue his current medications. Perhaps it would be reasonable for him to find another pain specialist to help him through his symptoms."

130. Further MRIs of the cervical spine and lumbar spine were performed on 4 April 2018.

131. Dr Pope reviewed the applicant again on 24 July 2018 and reported:

> "My opinion is that Mr. Iqbal does not have any worsening myelopathic features. The lower back pain is due to musculoskeletal lower back pain potentially discogenic. He came to me also with forms to access the superannuation as he states he is unable to work given that he has not worked for almost a decade. I think that is reasonable to suggest that entering the work force again would be extremely difficult for him."

132. The applicant did not consult Dr Abdalla again until 24 July 2018 in which the applicant reported that he was awaiting back surgery.

133. Dr Pope prepared a report for the applicant's former solicitors on 17 June 2019 in which he recorded the history of complaints and treatment and gave the following opinion:

> "6. The diagnosis for Mr. Iqbal was C3/4, C5/6 and C6/7 disc narrowing, disc herniations causing bilateral foraminal stenosis, discogenic neck pain and bilateral upper limb radicular symptoms.
>
> 7. There was also a diagnosis of lumbar spondylosis. My opinion is that the lumbar condition is most likely degenerate and I do not feel that this was significantly caused by the patient's employment. The neck symptoms however are more likely to be due to the repetitive heavy lifting and twisting.
>
> 8. Mr. Iqbal's major complaint was neck pain, upper limb altered sensation and pain due to foraminal stenosis due to disc herniations at multiple levels of the subaxial spine. My opinion is that Mr. Iqbal 's work was a substantial contributing factor to the cervical spine injury however I did not take detailed aspects of his job at the time when he was reviewed in the clinic by my registrar.
>
> 9. The incident mentioned in your correspondence where he dropped 6 levels when the lift mechanism failed at the Ibis Hotel in Darling Harbour was not mentioned to me. It is difficult for me to comment without knowing further details whether this may have caused lumbar or cervical spine injury. It may well be that Dr. Guirgis's opinion that this was the trigger of accumulative traumatic disorder such as disc bulging, annular tearing and nerve compression and it may well be a main contributing factor to the genesis of his condition. I cannot say medically/legally that the incident is the substantial contributing injury or factor to his symptoms."

**Dr Medhat Guirgis**

134. The applicant relies on medicolegal reports prepared by orthopaedic surgeon, Dr Medhat Guirgis on 25 October 2017 and 29 October 2020. Dr Guirgis has indicated that he prepared an earlier report on 29 July 2014, however, that report is not in evidence before me.

135. In his 2017 report, Dr Guirgis took a history as follows:

> "He gave me the history of being involved in an accident at sometimes during his duties as a Room Attendant which he did between 10-2008 and 10-2010. On that day he was working in Ibis, Darling Harbour and he went into the lift from the 5th or 6th floor to go up. Instead the lift mechanisms failed and the lift dropped quickly all the way down to basement where he was stuck in the lift for an hour until help arrived.
>
> He indicated to me that his duties with Hotel Operations Solutions were described to be demanding on his neck, arms, and back. They included a lot of heavy manual handling activities, fast repetitive movements with the hands and fingers, adopting awkward postures to be able to reach for difficult to clean areas etc."

136. With regard to the prior history, Dr Guirgis recorded:

> "There was no history of any pain felt in the neck prior to the elevator incident. Prior to that incident he only complained of episodic ache in his lower back at the end of a hard-working shift which would settle down completely after a night sleep. The problems of worsening pain in his right back that was causing right L4/5 sciatic syndrome started after the elevator incident."

137. Dr Guirgis performed an examination and reviewed the radiological investigations and made a diagnosis of:

> "Post-traumatic mechanical derangement of the cervical area of the spine. This was caused by musculo-ligamentous sprain\ strain with intervertebral disc involvement. This had also triggered & aggravated the effects of underlying multilevel age appropriate degenerative changes.
> …
> Post-traumatic mechanical derangement of the lumbar area of the spine. This was caused by musculo-ligamentous sprain\ strain with intervertebral disc involvement. This had also triggered & aggravated the effects of underlying spondylotic changes.
> …
> On top of the organic basis of this patient's complaints, the whole picture became complicated by the development of a chronic pain syndrome. Chronic pain, the onset of which was triggered by tissue damage, represented here a neuro-psychological event lying in the same category as anxiety and depression, with each emotional state having its own neurochemical correlates."

138. With regard to causation, Dr Guirgis gave the opinion:

> "I must admit that I found it rather difficult to distinguish between the effects of the nature and conditions of his employment and the described lift incident of unknown date. On the balance of probabilities, the described lift incident in the course of his employment was the triggering factor to the symptoms and signs of the developing cumulative traumatic disorder caused by the nature and conditions of his employment. He was specific indicating that he did not feel any pain in the neck prior to the elevator incident. The right cervicobrachial symptoms and the right L4/5 sciatic symptoms developed and continued to progress since the lift incident being caused by exposing the spine to the overloading stresses associated with the nature and conditions of his employment. As such, I would consider that the nature and conditions of his employment was and remained to be a substantial contributing factor to the injuries described above and these injuries were a substantial contributing factor to the symptoms, signs, incapacities and disabilities as described above."

139. In his 2020 report, Dr Guirgis recorded a history as follows:

> "As stated in my earlier reports this 43 years old gentleman indicated that he performed duties with Hotel Operations Solutions described to be demanding on his neck, arms, and back since October 2008. Off work from March 2009 to August 2009. They included a lot of heavy manual handling activities, fast repetitive movements with the hands and fingers, adopting awkward postures to be able to reach for difficult to clean areas etc. The duties in the Westin Hotel were far more demanding because the furniture was heavier than the Ibis. He stressed the point that the stated undated lift incident in Ibis Hotel was minor and did not even required registering."

140. Dr Guirgis gave the same diagnoses with respect to the cervical spine and lumbar spine and expressed the following opinion with regard to causation:

> "On the balance of probabilities, I am of the opinion that the nature and conditions of his employment was and remained to be a substantial contributing factor to the injuries described above and these injuries were a substantial contributing factor to the symptoms, signs, incapacities and disabilities as described above."

141. Dr Guirgis commented on a medicolegal report prepared for the respondent by Dr Lloyd Hughes:

> "I read with interest the report of Dr Hughes and he was talking about 'Factual' supporting evidence and I am not aware of other factors in the history provided by Mr Javed that would make me alter my opinion.
>
> In regards of 'Medical' supporting evidence I beg to disagree with his conclusions. I must note here that when addressing causation and impairment issues, we are addressing what is known as 'Envelop of Function'. Despite the biological abnormalities demonstrated in his radiological investigations, his performance and daily living activities remained within the normal range of tissue homeostasis encompassing the more complex phenomena of asymptomatic normal biological physiologic and often supraphysiological loading processes. We are dealing here with BIOLOGY as being distinct from PATHOLOGY encompassing the clinical stages of structural failure when the collagen-based tissues fail to accommodate the extra-loading and in time even the normal loading leading to symptoms."

142. Dr Guirgis commented further:

> "In answering my questioning, he indicated that before joining HRC he used to do same job under Empire Hospitality. As he used to do heavy manual job, he used to get some mild backache at the end of the day. After coming back home and having some rest it used to be gone. In October 2008, when he joined hotel operations solution, they sent him to Pullman Olympic park. Their beds were too heavy to push and make up and his back pain started to increase as time passed. By 2010 the pain in his back was felt all the time and was shooting down his right leg to the foot and often down his left leg but not as much. By that time he also developed the right C6 cervicobrachial symptoms which eventuated into the surgical treatment to be performed by Dr Pope on 27-6-2016 in the form of ACDF (anterior cervical discectomy and interbody fusion). The immediate postoperative period passed uneventfully. In this case he might have felt mild axial low back pain after a hard working day that would disappear after a good night sleep. This is quite different from the severe persistent right cervicobrachial syndrome including right C6 and 7 radiculopathy, and the severe persistent right > left L5 radiculopathic lumbosciatic syndrome that necessitated CT guided injections."

143. Dr Guirgis concluded:

> "He had contracted the aggravation, acceleration, exacerbation or deterioration in the course of employment of the underlying asymptomatic biological age related changes in his lumbar spine and cervical spine to which his employment was the main contributing factor within the meaning of section 4(b) of the 1987 Act."

**Dr Anthony Greenberg**

144. The applicant relies on a medicolegal report prepared by General and Gastrointestinal Surgeon, Dr Anthony Greenberg, dated 9 November 2017. Dr Greenberg indicated in that report that he had previously seen the applicant on 24 November 2015.

145. Dr Greenberg said the applicant's current medications included:

> "two Paracetamol, one to three tablets per week, Antenex (diazepam) 5 mg one daily, Duloxetine 30 mg one tablet a month and Endep which he takes occasionally when he feels that the Duloxetine is not adequate, Omeprazole two to three tablets per week, Atenolol when he seems to have blood pressure problems and Methyl Salicylate cream as required"

146. The applicant had stopped taking Nurofen and switched to Maxigesic. The applicant described epigastric pain and nausea and throwing up on occasions particularly after taking paracetamol. The applicant's epigastric pain seemed to relate to particular food. Dr Greenberg noted that the applicant's last endoscopy and gastrointestinal consultation was with Dr Chowdhury in 2015. On that occasion, Dr Chowdhury did comment there was some active chronic gastritis.

147. Dr Greenberg commented:

> "It is hard to explain why Mr Iqbal has ongoing epigastric pain.
>
> Mr Iqbal has chronic ongoing epigastric pain, the reason for this is not clear.
>
> When Mr Iqbal was last assessed, he was taking Nurofen and then switched to Maxigesic. Both of these medications are NSAIDS which are known to cause analgesic gastropathy and GORD. He stopped taking Nurofen and Maxigesic in 2015.
>
> It is recognised that long term use of NSAIDS can cause acute epigastric pain.
>
> However, it would be expected that with withdrawal of the NSAIDS the upper gastrointestinal tract symptoms would settle."

148. Dr Greenberg gave the opinion:

> "Mr Iqbal's persisting abdominal pain appears to be related to the period when he started taking NSAIDs. Furthermore he is adamant that his pain has persisted and not resolved. Mr Iqbal has been prescribed Cymbalta and intermittent Endep, both medication SSRI and used for depression and neuropathic pain. It is possible that Cymbalta may be contributing to his symptoms."

**Dr George Kalnis**

149. The applicant was examined at the request of the insurer by orthopaedic surgeon, Dr George Kalnis, on 10 August 2012.

150. The applicant reported a history of feeling funny and unusual commencing in 2009. In April 2010, the applicant first noted stiffness in his right ring finger. In October 2010 the applicant noticed swelling in his right hand and forearm and numbness and paraesthesia in the whole of the right arm up to the shoulder. The applicant resigned due to the hand condition. In April 2012 the applicant was referred to Dr Maniam and underwent an x-ray, CT scan and MRI. Dr Maniam told the applicant that the right upper limb symptoms were related to his neck.

151. The applicant complained of stiffness and discomfort in his cervical spine but was not sure when the symptoms commenced. The applicant reported undergoing physiotherapy to his neck including traction at Auburn Hospital.

152. Dr Kalnis reviewed the x-ray of the applicant's right hand, the CT scan of his cervical spine performed on 8 May 2012 and the MRI of the cervical spine performed on 13 June 2012.

153. Dr Kalnis' examination of the cervical spine revealed no deformity. Forward flexion extension rotations to each side were full. There was a complaint of right neck discomfort in extremes of movements and slight discomfort to palpation on the right side.

154. Dr Kalnis gave the following opinion:

> "There is no specific work injury except a gradual onset of stiffness in his fingers in the right hand, swelling in his right wrist and forearm, all of which have been investigated with no abnormality found. After having investigations of his cervical spine by Dr Maniam, he at some stage has developed symptoms in his cervical spine and is getting treatment for these. These do not relate to his right upper limb symptoms."

155. Dr Kalnis prepared a further report on 21 August 2012 in which he reiterated his view that the symptoms in the applicant's right hand, wrist and forearm had no relationship to the cervical spine pathology.

**Dr Lloyd Hughes**

156. The applicant was examined for the insurer by another orthopaedic surgeon, Dr Lloyd Hughes on 16 January 2019 in relation to the claim for whole person impairment of the cervical spine and lumbar spine.

157. The history recorded by Dr Hughes suggested the applicant had noticed some stiffness in his neck as well as pain in the fingers of his right hand during his employment with the respondent. Prior to this, the applicant had been suffering from pain in his lower back on and off for several years:

> "Mr Iqbal confirms that he has had a varying degree of low back pain since about 2008 without any specific incident/injury occurring. However, he said that his work as a room cleaner involves a lot of lifting and bending over and he suggested this might have caused the pain in his back."

158. Dr Hughes noted the subsequent history of treatment and investigation including the cervical discectomy performed by Dr Pope in 2015. The applicant reported no improvement after receiving epidural injections by Dr Pope for his lower back pain.

159. After performing an examination and reviewing the investigations, Dr Hughes gave the following opinion:

> "This man gives a history of spontaneous onset of symptoms in relation to his neck and back unrelated to any specific incident at work and in particular he gave no history of the specific incident referred to in your letter regarding the incident where a lift he was in dropped suddenly while he was performing his work duties as a room attendant. Therefore, I do not consider he is suffering from any work-related injury in his back or neck, rather he is suffering from generalised disc disease in his cervical spine and lumbar spine as evidenced from the investigations carried out. The symptoms in his upper limbs and right lower limb are related to the degenerative conditions in his neck and back. He presents as a grossly disabled man exhibiting illness behaviour and he is not fit for any type of physical work."

160. In response to questions from the insurer, Dr Hughes confirmed that the degenerative disc disease of the cervical spine and lumbar spine were not due to employment nor had there been an aggravation, acceleration, deterioration or exacerbation of the disease by employment.

**Dr Siddharth Sethi**

161. Gastroenterologist, Dr Siddarth Sethi examined the applicant for the insurer and provided a medicolegal report on 29 January 2019.

162. Dr Sethi recorded a history of gastrointestinal symptoms as follows:

> "Mr. Iqbal reports that his abdominal symptoms began in 2010. He began to experience epigastric discomfort particularly after eating. There was nausea and vomiting. He would feel "hunger pains" relieved by eating. He would find that his pain would worsen on taking nurofen and ibuprofen and improve after taking paracetamol. There were no symptoms of gastro-oesaphageal reflux described as retrosternal burning sensation. There was no change in bowel habit or rectal bleeding. He received somac for relief of abdominal pain on an intermittent basis.
>
> In 2015, Mr. Iqbal underwent gastroscopy/colonoscopy with Dr. Chowdhury showing mild oesophageal reflux and helicobacter pylori. This was treated with antibiotics and successfully cleared. In 2015, he ceased non-steroidal agents completely and took Paracetemol for pain relief. His epigastric pain is still persisting."

163. Dr Sethi reviewed the gastroscopy/colonoscopy performed in 2015 and examined the applicant. Dr Sethi gave an opinion as follows:

> "Mr. Iqbal has irritable bowel syndrome to account for his symptoms. This has developed entirely independently of his accident and the medications he took afterwards. It would almost certainly have occurred regardless of his employment. The symptom of abdominal pain in the setting of a normal endoscopy is diagnostic of irritable bowel syndrome. Pathological conditions have been excluded and the endoscopy has confirmed the diagnosis of irritable bowel syndrome beyond all doubt. Nurofen and ibuprofen can cause peptic ulceration. This was not seen in Mr. Iqbal's case and was essentially excluded by normal endoscopy. The persistence of pain after ceasing nurofen and Mobic conclusively proves that they were not responsible. Paracetamol does not cause abdominal pain at all and cannot reasonably be held responsible for his abdominal pain. In summary, Mr. Iqbal's medication did not play any role in his symptoms. His alleged injury while working for Hotel Operations Solutions did not cause any direct gastrointestinal injury."

**Respondent's submissions**

164. The respondent submitted that the applicant bore the onus of establishing injury on the balance of probabilities and referred to the authority in *Nguyen v Cosmopolitan Homes*[1].

165. Referring to the applicant's evidence as to the nature of his duties, the respondent submitted that the only task potentially of a heavy nature would be the movement of beds. The respondent submitted that the applicant's duties would not be considered heavy, fast or repetitive. The respondent noted Mr Hapuwinda's evidence as to the applicant receiving training in how to perform his duties safely. The duties were varied in nature and included many duties that were light. On Mr Hapuwinda's evidence the movement of beds and other furniture was not heavy or repetitive. The applicant was not under time pressure.

[1] [2008] NSWCA 246.

166. The respondent referred to the clinical notes of Dr Abdalla and noted that only symptoms in the right hand were reported initially. The first mention of neck symptoms appeared on 13 April 2012, some 18 months after the applicant ceased employment with the respondent. No symptoms involving the neck or lumbar spine were reported during the period of employment with the respondent.

167. The respondent referred to *Department of Education and Training v Ireland*[2] and submitted that the delay in reporting neck and lumbar symptoms was not addressed in the applicant's statement evidence. No reports from the applicant's general practitioner or evidence from witnesses, including family members or colleagues had been provided to corroborate the applicant's claim to have been suffering neck and lumbar pain prior to 2012. The applicant's letter of resignation referred to finger and hand symptoms but made no mention whatsoever of cervical and lumbar symptoms.

168. The respondent noted that a Centrelink Job Capacity Assessment Report dated 20 October 2010 mentioned the possibility of a neck MRI but submitted that there was no mention in this report of any neck symptoms.

169. The respondent submitted that there was an "extreme" delay in reporting neck and lumbar symptoms and a lack of contemporaneous evidence of injury.

170. The respondent noted that Dr Maniam and Dr Abdalla had issued WorkCover certificates of capacity which were backdated to certify incapacity from 7 October 2010, however even these made no mention of lumbar symptoms.

171. Dr Kalnis' examination of the applicant in 2012 was not supportive of injury to the cervical spine. The examination was essentially normal. Dr Kalnis considered there was no work injury except to the fingers and hand and the symptoms reported in the applicant's cervical spine were unrelated to this.

172. The respondent noted that a Whole Body Scan with SPECT/CT was performed at Dr Maniam's request on 22 August 2012 but no mention was made in the accompanying report of lumbar symptoms or pathology.

173. The respondent noted that Dr Dias did not find an injury to the lumbar spine in his first report. Although he did in the second report, the respondent submitted that the opinion was based on an inaccurate history of repetitive twisting of the lower back and repetitive overhead work.

174. The respondent noted that Dr Pope's initial treating reports lacked reference to the lumbar spine.

175. Referring to Dr Guirgis' first report, the respondent submitted that the opinions on causation were not founded upon an accurate representation of the applicant's work. The applicant's work did not involve a lot of fast repetitive movement or heavy manual handling. The tasks were extremely varied and done in an order or manner to avoid being heavy or repetitive. Dr Guirgis also took into account the effect of an elevator incident which was not relied upon in these proceedings. Referring to *Makita (Aust) Pty Limited v Sprowles*[3] the respondent submitted that Dr Guirgis' opinion would not be accepted as it was based upon an inaccurate history.

[2] [2008] WCCPD 134.
[3] [2001] NSWCA 305.

176. The respondent observed that Dr Hughes took a history of pre-existing back symptoms which was not taken into account by Dr Guirgis. Dr Hughes' report was based upon an accurate history and the respondent submitted that it would be given more weight than the reports of Dr Guirgis.

177. The respondent also submitted that Dr Guirgis had not taken into account the unexplained delay in reporting neck and lumbar symptoms.

178. Dr Pope in his report for the applicant's former solicitors said the lumbar condition was most likely degenerative. The respondent submitted that the Commission would comfortably give an award for the respondent in respect of the allegation of injury to the lumbar spine.

179. With regard to the cervical spine, the respondent reiterated that there was a delay in reporting neck symptoms which was unexplained. The delay in reporting symptoms was not taken into account by Dr Guirgis. There was no medical opinion to explain the right hand symptoms by reference to the cervical spine. The respondent submitted that the applicant had not discharged the relevant onus.

180. With regard to the consequential gastrointestinal condition, the respondent submitted that Dr Sethi's report was far more considered than Dr Greenberg and would be preferred.

181. The respondent submitted that there would be two deemed dates of injury in the event of a finding favourable to the applicant being 25 June 2012 for the claim for weekly compensation and medical expenses and 10 December 2018 for the claim for lump sum compensation.

**Applicant's submissions**

182. The applicant relies on written submissions as well as his oral submissions at arbitration hearing.

*Pre-hearing written submissions*

183. In a document titled "Responses to Liability Issues" lodged as a late document before the arbitration, the applicant identified the parts of Dr Guirgis' supplementary report in which opinions were expressed in favour the of the applicant's case in the language of s 4 of the 1987 Act.

184. The applicant submitted that Dr Guirgis found he had had an "underlying asymptotic biological process" which was aggravated, accelerated, exacerbated or deteriorated in the course of his employment where the nature and conditions of his employment were the main contributing factors.

185. The applicant submitted that he had undergone a whole body scan in 2012 and multiple CT scans and MRIs which had excluded any significant degeneration in the cervical and lumbar spine. Blood tests had also been taken which were essentially normal.

186. The applicant noted that Dr Guirgis had given the opinion that employment was a substantial contributing factor to his cervical spine and lumbar spine injuries. Dr Maniam and Dr Pope had also given opinions consistent with s 9A in relation to the cervical spine. The applicant submitted that if, as noted by Dr Pope, repetitive heavy lifting and twisting could cause injury to his cervical spine then the same conditions of employment would have contributed to the injury of his lumbar spine also.

187. The applicant noted that Dr Chowdhury had performed an endoscopy in 2015 which suggested a previous healed duodenal ulcer. Dr Chowdhury considered that the duodenal ulcer was partly due to taking anti inflammatory agents (NSAIDs). The endoscopy was not normal and the applicant's pain was not due to Irritable Bowel Syndrome.

188. In further written submissions, dated 7 December 2020, the applicant stated that he had cervical and lumbar disc protrusions due to repetitive heavy lifting and twisting during his employment with the respondent. The radiological investigations had excluded any significant degeneration in his spine. So, the disc protrusions were not due to degeneration but rather the nature and conditions of employment. Although the applicant stopped working on 7 October 2010, he did not get any proper treatment until 2016 as the respondent continued to decline his claim.

*Oral submissions*

189. In his oral submissions at the arbitration hearing the applicant referred to the Centrelink Job Capacity Assessment Report dated 20 October 2010 as containing an early reference to the need for an MRI of the neck. This report was prepared two weeks after the applicant stopped work for the respondent and was evidence of neck symptoms being reported.

190. The applicant submitted that he had mentioned neck symptoms to his general practitioner at the time but he did not know what was being typed in the clinical notes. The applicant's general practitioner later realised the connection between the neck and the applicant's hand symptoms and certified the applicant as unfit for work due to neck injury from 7 October 2010. The applicant submitted that the absence of reference to the neck in the early clinical notes did not mean that he did not have the problem. The applicant submitted that a busy general practitioner could easily miss something and this would explain the omissions in the clinical notes.

191. The applicant noted that the lumbar spine injury was diagnosed in 2012 but in January 2010 he had reported severe right foot pain in the context of his heavy manual job to his general practitioner. The applicant was later referred for CT scan of lumbar spine.

192. The applicant noted that he had been referred to Dr Maniam who had referred him for nerve conduction studies. Dr Maniam considered there was a work injury to the cervical spine and issued a WorkCover certificate.

193. The applicant submitted that Dr Guirgis had given the opinion that employment with the respondent was the main contributing factor to injury both to the cervical and lumbar spine.

194. The applicant noted the respondent's submissions with regard to the nature of his work duties. The applicant submitted that housekeeping was a heavy manual job. The applicant had to pull the beds from the wall, make them layer by layer and push them back. The applicant submitted that if the nature of his duties was sufficient to cause an injury to his cervical spine then it followed that it could cause injury to his lumbar spine also. The applicant suggested that lumbar spine injuries particularly at L4/5 were more common than cervical spine injuries in housekeeping.

195. The applicant submitted that the CT scan of his lumbar spine showed no evidence of degeneration only disc bulging. The whole body scan in 2012 also showed no degenerative changes in the lumbar spine. The MRI of the lumbar spine performed in 2014 also showed discogenic changes rather than degenerative changes. The applicant said his young age was relevant. Although Dr Hughes and Dr Kalnis considered the applicant had degenerative changes, they had not considered his relatively young age.

196. Similarly, at his cervical spine, the applicant submitted that Dr Dowla had said the MRI performed in June 2012 showed disc protrusion at C6/7.

197. The applicant noted that blood tests had been performed which were normal. There was no history of any non-work injury or accident. There was no degeneration. There was no other cause for the disc bulges and the applicant's symptoms. Employment with the respondent in a heavy manual job was the only factor.

198. The applicant said he definitely had an injury both to his cervical spine and lumbar spine. The applicant noted that Dr Dias had also given an opinion that there was a lumbar spine injury.

199. With regard to the consequential gastrointestinal condition, the applicant noted the opinion of Dr Greenberg and the report of Dr Chowdhury indicating that his duodenal ulcer was caused by anti-inflammatories.

*Post-hearing written submissions*

200. Following the hearing, the applicant updated his earlier document titled "Responses to Liability Issues". The applicant noted that Dr Dias had given an opinion in favour of there being both a cervical spine and lumbar spine work injury for the purposes of ss 4 and 9A.

201. The applicant referred to the nerve conduction studies and report of Dr Dowla.

202. The applicant submitted that his employment with the respondent had been classified as a "heavy manual (unskilled) job" for the purposes of his superannuation fund TPD insurance.

203. In further written submissions lodged on 7 January 2021, the applicant submitted that he had told Dr Abdalla about his neck problem before 2012 but he did not note it down. The applicant said he recalled showing Dr Abdalla his area of pain from his neck to his right shoulder and arm. The applicant said he also mentioned this to the Centrelink job capacity assessor (who was an Accredited Exercise Physiologist) which was why there was mention of a neck MRI in the job capacity assessment report of 20 October 2010.

204. The applicant said that the WorkCover certificate issued by Dr Abdalla in 2012, backdated to 7 October 2010 was evidence that he knew the applicant had neck pain on 7 October 2010.

205. In further written submissions, served and lodged after the expiry of the timetable allowed for written submissions, the applicant submitted that he had a huge number of tasks to complete within a 20-30 period in order to clean a hotel suite. Those tasks including heavy manual jobs such as pulling and pushing beds, pushing loaded trollies, vacuuming and pushing other furniture back in place.

206. The applicant said he was not paid per hour but paid per suite which was expected to take 20-30 minutes. There was indirect economic pressure to do the job quickly.

**Respondent's oral and written submissions in reply**

207. The respondent submitted that the applicant had purported to give expert medical evidence. Despite his Bangladeshi medical training, such evidence was inadmissible.

208. The respondent submitted that the article apparently sourced from the Canadian Centre for Occupational Health and Safety would be given little weight as it was not an expert report, was unsigned and did not pertain to the applicant's actual duties for the respondent.

209. The respondent reiterated that it relied upon the evidence of Mr Hapuwinda and that contained in the ProCare report to dispute that the applicant's duties were heavy. In particular:

    (a) The applicant was on average expected to do between 9 to 12 rooms per day;

    (b) There were many light duties such as spraying chemicals, collecting rubbish, replenishing items, dusting that were interspersed with the slightly heavier duties such as stripping the bed and vacuuming;

(c) There was no pressure put on the applicant to work quickly;

(d) Trolleys were provided to the applicant; and

(e) The beds had wheels on them making them easy to manoeuvre.

## FINDINGS AND REASONS

### Injury

210. 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."

211. It is the applicant who bears the onus of establishing on the balance of probabilities that he has sustained an injury for the purposes of s 4. In *Nguyen v Cosmopolitan Homes (NSW) Pty Limited*[4] McDougall J stated at [44]:

> "A number of cases, of high authority, insist that for a tribunal of fact to be satisfied, on the balance of probabilities, of the existence of a fact, it must feel an actual persuasion of the existence of that fact. See Dixon J in *Briginshaw v Briginshaw* [1938] HCA 34; (1938) 60 CLR 336. His Honour's statement was approved by the majority (Dixon, Evatt and McTiernan JJ) in *Helton v Allen* [1940] HCA 20; (1940) 63 CLR 691 at 712.

212. One of the primary challenges for the applicant in discharging his onus is the lack of contemporaneous evidence of cervical and lumbar symptoms.

[4] [2008] NSWCA 246.

213. The respondent referred in this regard to the decision in *Department of Education and Training v Ireland* [91] where the President, Keating J found:

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

214. As noted by the respondent there is no contemporaneous account of the applicant complaining of neck or lower back symptoms during the period of his employment with the respondent or for a significant period of time after he ceased work. There is no documentary evidence, no witness evidence and no record in the clinical notes which directly corroborates the applicant's claims to have been experiencing such symptoms at that time.

215. There is evidence of the applicant complaining of other symptoms. There is an email dated 22 November 2009 from the applicant to Mr Hapuwinda complaining of respiratory symptoms. This complaint was recalled by Mr Hapuwinda and is reflected in the clinical records of Dr Abdalla. Although the applicant has, in hindsight, characterised this as a sensory symptom of his neck or back condition there is no corroboration of this assertion in any of the medical evidence before me.

216. I accept that on 8 January 2010 the applicant reported pains in his right foot to Dr Abdalla. Examination revealed a tender dorsum and the applicant was referred for an x-ray of the foot. There is, however, no evidence of further investigations or treatment of those symptoms other than deep heat and Nurofen. The symptoms were not reported again during the period of the applicant's employment. Although the applicant has more recently reported symptoms of lower limb radiculopathy and foot drop in association with his lumbar spine condition, there is no opinion in the medical evidence that the symptoms reported on 8 January 2010 were associated with a lumbar spine condition as opposed to some other condition.

217. The factual and medical evidence before me does consistently record that the applicant experienced symptoms in his right hand and fingers during the period of his employment with the respondent. These symptoms were first reported to Dr Abdalla on 6 August 2010, and Dr Abdalla appears to have associated them with a strain initially.

218. On 13 August 2010, the applicant reported that the symptoms were better with rest and worse with work, suggesting a connection between the symptoms and the applicant's employment.

219. The symptoms persisted and were reported again to Dr Abdalla on 8 October 2010. The applicant's letter of resignation confirmed that the applicant was experiencing worsening right hand symptoms with work and that he was resigning as the work was unsuitable for him. Mr Hapuwinda also recalled the applicant complaining of symptoms of this nature.

220. The medical evidence suggests that the hand symptoms were initially attributed to a strain and treated with Mobic and rest, although the Centrelink Job Capacity Assessment Report dated 20 October 2010 does suggest some uncertainty over the diagnosis. The possibility of nerve conduction studies and cervical spine MRI if symptoms did not subside was recorded in that document although not in Dr Abdalla's notes.

221. The evidence indicates that the symptoms did not subside but persisted over the next 18 months. In this period, symptoms such as dizziness with change or body and head position, left handed symptoms, numbness and difficulty holding objects were also reported. Despite these symptoms, Dr Abdalla did not refer the applicant for cervical spine investigation or specialist review until neck pains were specifically reported on 13 April 2012.

222. The applicant was then referred for a CT scan which revealed pathology at multiple levels of the cervical spine. On 9 May 2012, Dr Abdalla's records suggested a relationship between the symptoms and the applicant's work lifting beds and cleaning in hotels. A similar history was reported to Auburn Hospital's physiotherapy department on 16 May 2012.

223. Dr Maniam referred the applicant for an MRI which showed multiple disc protrusions and degenerative canal stenosis.

224. On 15 June 2012, Dr Abdalla's clinical records again suggested a connection between the applicant's employment with the respondent and the reported neck pains down both sides of neck and into the right arm and hand.

225. Dr Maniam appears to have made the same connection, as he issued a Work Cover Certificate on 22 June 2012 describing an injury to the cervical spine due to "lots of pulling and pushing of heavy beds, trolley, vacuum during cleaning of rooms".

226. Dr Abdalla also issued a WorkCover certificate describing an injury to the cervical spine with pain radiating to the arms on 25 June 2012. The applicant was certified to have been incapacitated as a result of that injury from 7 October 2010 onwards.

227. I accept the respondent's submission that there was a delay in neck symptoms being recorded in the evidence and a lack of contemporaneous evidence of neck injury. The foregoing analysis of the treating medical evidence does, however, suggest an onset of symptoms during the period of employment with the respondent which whilst initially attributed to a hand sprain, did not settle and were on, further investigation, considered to be originating from the cervical spine by both the general practitioner and treating specialist at the time. I accept that both Dr Abdalla and Dr Maniam considered the symptoms to be causally related to the applicant's work for the respondent and, in particular, the activities of lifting, pulling and pushing beds, pushing a trolley and vacuuming whilst cleaning. The contemporaneous material also suggests that the symptoms increased with work and deceased with rest and were what caused the applicant to resign.

228. Medicolegal opinions in favour of a causal relationship between the condition at the applicant's cervical spine and the applicant's employment for the respondent have been given by Dr Dias and Dr Guirgis. The respondent has submitted that little weight would be given to those opinions as they were founded upon an inaccurate history as to the nature of the applicant's work duties. The respondent has submitted that the duties were not heavy or repetitive but varied and the heavier tasks were interspersed with duties of a light nature. Mr Hapuwinda has given evidence that beds were on wheels and easy to manoeuvre and the furniture was not heavy. Mr Hapuwinda also suggested that the applicant was not required to work under time pressure.

229. The tasks required to be performed by the applicant are set out in detail in the witness evidence and other factual material before me including the job description, a document titled, "Flow Of Service For Cleaning A Guest Room" and a document titled "HRC 5 Steps to a perfect clean room". The duties are described in broadly consistent terms. I accept that there was a particular order in which tasks were to be performed. I accept that there was a variety of tasks, many of which would be considered light. I accept Mr Hapuwinda's uncontradicted evidence that beds were on wheels and easy to manoeuvre. I accept that the applicant underwent induction training which including training on how to safely perform his work.

230. I do, however, accept that the work involved tasks including pushing and pulling beds and other furniture, pulling linen off beds, lifting the sides of mattresses in order to make up beds, lifting linen and towels, pushing trolleys, vacuuming, cleaning bathrooms and dusting. These tasks could be described as moderately heavy and involving awkward positions, overhead work and reaching. Whilst there was no overt time pressure, I accept the applicant's evidence that there was indirect pressure to work quickly as he was paid by the room.

231. Dr Dias, indicated in his first report that he understood the applicant's work to involve cleaning 10 to 15 rooms per day, changing beds, stripping trolleys and moving heavy furniture in an efficacious way. Although there is a dispute as to whether the furniture was appropriately described as "heavy", and the number of rooms cleaned was estimated at 9 to 12 by Mr Hapuwinda, Dr Dias appears to have had a reasonably sound understanding of the nature of the applicant's duties. Whilst accepting that the history may not have been entirely accurate, it accords sufficiently with the remainder of the evidence as to provide a sound factual foundation for the opinion that employment with the respondent was a contributing factor to the neck condition.

232. The history recorded by Dr Guirgis in his first report was problematic in that it relied heavily on an incident involving a lift which does not form part of the current claim. The history was corrected in Dr Guirgis' second report. On that occasion, Dr Guirgis indicated that it was his understanding that the duties involved a lot of heavy manual handling activities, fast repetitive movements with the hands and fingers and adopting awkward postures to be able to reach for difficult to clean areas.

233. The respondent has taken issue with Dr Guirgis' reliance on there being "a lot of heavy" manual handling and "fast repetitive movements". I accept that this characterisation puts a factually inaccurate gloss on the nature of the applicant's duties and lacks precision. Were Dr Guirgis' opinion the only opinion on causation favourable to the applicant's case I would have some hesitation in accepting it. Dr Guirgis' opinion is, however, one of a number of qualified medical opinions in evidence before me supportive of a causal relationship between the symptoms ultimately found to originate in the applicant's cervical spine and employment with the respondent.

234. The applicant's treating surgeon, Dr Pope has also expressed the opinion that the applicant's work was a substantial contributing factor to the cervical spine injury although he did not take a detailed history of the applicant's duties. Despite the lack of detailed history, Dr Pope was aware that the applicant worked as a hotel housekeeper and I accept he would have a general or broad understanding of the tasks required to be performed in that role.

235. Weighing against the opinions of Dr Abdalla, Dr Maniam, Dr Dias, Dr Pope and Dr Guirgis are the opinions of Dr Kalnis and Dr Hughes.

236. Dr Kalnis took a broadly accurate history of the onset of symptoms and subsequent treatment and investigation. Dr Kalnis found no "specific work injury", suggesting that he was looking for a specific injurious event in the workplace. The evidence of the applicant is, however, of a gradual onset and worsening of symptoms. Dr Kalnis noted that symptoms in the fingers and arm were investigated and no abnormality found. Dr Kalnis did not find a relationship between the symptoms in the cervical spine and the right upper limb symptoms.

237. In making this finding, Dr Kalnis did not engage with the opinions of Dr Maniam and Dr Abdalla who had by that time opined that the upper limb symptoms were related to the neck. Nor did Dr Kalnis provide any explanation as to why those opinions may be wrong. Dr Kalnis appears to have been under a misapprehension that neck symptoms were only reported after investigation of the cervical spine by Dr Maniam. In this regard, Dr Kalnis does not appear to have appreciated that neck symptoms were reported first to Dr Abdalla who ordered an x-ray, then a CT scan before referring the applicant to Dr Maniam who ordered a MRI.

238. Dr Hughes has also provided an opinion that the condition in the applicant's cervical spine was unrelated to work in response to the claim for lump sum compensation. Like Dr Kalnis, Dr Hughes' attention also appears to have been focused on whether there was a specific injurious event at work. Dr Hughes may have been distracted by the reference to the lift incident in Dr Guirgis' earlier report as he noted that the applicant gave no history of such an event. Dr Hughes did not engage with the evidence of a gradual onset of symptoms originally experienced in the right hand and arm during the course of employment with the respondent. Dr Hughes did not engage with the nature and conditions of the applicant's employment duties. Although he said there was not a work-related aggravation of the degenerative disc disease in the applicant's cervical spine, Dr Hughes did not explain why the applicant's duties would not have caused such an aggravation.

239. Importantly Dr Hughes did, unlike Dr Kalnis, and consistently with the applicant's treating doctors and medical experts, give an opinion that the symptoms in the applicant's upper limbs were related to the condition in his cervical spine.

240. Weighing all the evidence, I am satisfied on the balance of probabilities that the applicant did sustain an injury to his cervical spine in the course of his employment with the respondent. The weight of medical evidence favours the view that the hand and upper limb symptoms experienced by the applicant during the course of his employment were related to the condition at his cervical spine. There is no evidence that these symptoms were experienced prior to the commencement of employment with the respondent. There is contemporaneous evidence of the symptoms being worse with work and better with rest. The symptoms persisted despite the cessation of work and gradually deteriorated leading eventually to the surgery performed by Dr Pope.

241. Whilst the opinions given by Dr Dias and Dr Guirgis are problematic in some respects, in that they do not describe the work duties with precision, I accept that the histories on which their ultimate opinions were founded were sufficiently accurate as to provide a proper basis of the acceptance of those opinions.

242. Although the applicant's submissions suggested that he had no degenerative changes in the cervical spine, this is contrary to the medical evidence before me. Dr Guirgis specifically found that the applicant had an aggravation, acceleration, exacerbation or deterioration in the course of employment of underlying asymptomatic biological age related changes in his cervical spine to which his employment was the main contributing factor within the meaning of s 4(b)(ii) of the 1987 Act. This opinion is consistent with the evidence of Dr Dias and the treating doctors. For the reasons given above, I prefer and accept Dr Guirgis' opinion in relation to the cervical spine injury to the opinions of Dr Kalnis and Dr Hughes.

243. I am not satisfied, however, that there is a proper basis for the acceptance of Dr Guirgis' opinion in relation to the lumbar spine.

244. On my review of the medical evidence, lumbar symptoms were first reported to Dr Dias in his medicolegal examination in September 2012. This was several months after the claim for workers compensation was made and almost two years after the cessation of work for the respondent. Unlike the cervical spine, I can find no contemporaneous reporting of symptoms during the period of employment which were at the time, or have been subsequently, attributed to the applicant's lumbar spine.

245. I do accept that there was a single report of foot pain recorded by Dr Abdalla in January 2010. The applicant has, in hindsight, formed the view that this was a symptom of his lumbar condition. I accept that the applicant was medically trained in Bangladesh. I am not satisfied, however, that the isolated complaint of pain in the dorsum of the applicant's foot to Dr Abdalla in January 2010 has been found by any of the treating doctors or medicolegal experts to be attributable to lumbar symptoms such as radiculopathy.

246. Dr Dias initially refrained from expressing any opinion as to whether there was a compensable injury at the lumbar spine in the absence of investigations. The back symptoms were, however, reported shortly afterwards to Dr Abdalla for the first time on 17 September 2012. On that occasion, the applicant is recorded to have described lumbar symptoms occurring in the context of “lifting and cleaning at home”. The applicant is recorded to have told Dr Abdalla that back pain started “at work years ago”. It is not, however, clear what work this was in reference to.

247. The applicant was referred for a CT scan of the lumbosacral spine on 24 September 2012 and pathology including disc bulges and foraminal narrowing was reported to be shown. In November 2012, Dr Dias reviewed this investigation and based on the history given to him, his examination and the available evidence, expressed the opinion that employment was a substantial contributing factor to an injury of the lumbar spine due to repetitive manual handling and repetitive twisting.

248. In expressing this opinion, Dr Dias did not engage at all with the substantial delay in lumbar symptoms being reported.

249. In his statement of 27 September 2018, the applicant said he suffered lower back pain during his employment with the respondent. The applicant said that at the end of every day he would get back pain with a radiating pain into his right leg, numbness and foot drop. The applicant said this made it more difficult to perform his duties and it was one of the reasons why he resigned in 2010.

250. In considering this evidence, I am conscious of the observations in cases such as *Watson v Foxman*[5] and *Onassis v Vergottis*[6]. In the latter case, Lord Pearce commented upon what is often recollected and said by witnesses, many years after an event, as opposed to what is contemporaneously recorded in documents at the time of the event, in the following terms:

> "Witnesses, especially those who are emotional, who think that they are morally in the right, tend very easily and unconsciously to conjure up a legal right that did not exist. It is a truism, often used in accident cases, that with every day that passes the memory becomes fainter and the imagination becomes more active. For that reason, a witness, however honest, rarely persuades a Judge that his present recollection is preferable to that which was taken down in writing immediately after the accident occurred. Therefore, contemporary documents are always of the utmost importance. And lastly, although the honest witness believes he heard or saw this or that, is it so improbable that it is on the balance more likely that he was mistaken? On this point, it is essential that the balance of probability is put correctly into the scales in weighing the credibility of a witness. And motive is one aspect of probability. All these problems compendiously are entailed when a Judge assesses the credibility of a witness; they are all part of one judicial process. And in the process contemporary documents and admitted or incontrovertible facts and probabilities must play their proper part."

251. The evidence given by the applicant in his statement of 27 September 2018 is not corroborated by any of the contemporaneous evidence. The applicant is noted to have been pro-active in complaining of other health issues including respiratory symptoms, rashes and hand and upper limb symptoms to his employer and general practitioner. There is, in contrast, no documentary, witness or medical evidence of complaints of the significant lumbar symptoms he has later described. I have noted the applicant’s explanation that he did

[5] (1995) 49 NSWLR 315.
[6] (1968) 2 Lloyds Report 403.

not put everything in his resignation letter. I also accept that clinical records must be approached with caution consistently with the observations, for example, of Basten J in *Mason v Demasi*[7]. I do not, however, find it credible, in the context of the evidence as a whole that such debilitating and frequent symptoms would not have been recorded in any of the contemporaneous evidence until September 2012.

252. Dr Guirgis' first report attributed the onset of lumbar pain to the elevator incident at the Ibis Hotel as well as the nature and conditions of employment. In his supplementary report, a different history was given of mild back ache at the end of work during the applicant's previous employment. The applicant reported that after commencing employment with the respondent, by 2010 the pain in his back was felt all the time and was shooting down his right leg to the foot and often down his left leg. It was on the basis of this history that Dr Guirgis expressed the opinion that there was an aggravation, acceleration, exacerbation or deterioration in the course of employment of underlying asymptomatic biological age-related changes in the lumbar spine.

253. As indicated above, this history is not corroborated by the contemporaneous evidence and I do not find it credible that such persistent and serious symptoms would not have been recorded in the contemporaneous medical evidence until September 2012. Like Dr Dias, Dr Guirgis has not engaged at all with the delay in reporting symptoms.

254. I have taken into account the applicant's submissions that lumbar injuries are common for those performing housekeeping duties and I have considered the article from the Canadian Centre for Occupational Health and Safety which identifies the risk factors for repetitive motion back injuries in housekeeping. The applicant has submitted that if his duties were capable of causing a cervical spine injury, they were also capable of causing a lumbar injury. I also accept, having regard to the radiological investigations and medical evidence before me, that the applicant does currently have a symptomatic lumbar spine condition for which he has been receiving treatment. The question requiring determination is, however, whether there is a relevant causal relationship between the applicant's lumbar condition and the applicant's actual employment with the respondent.

255. The applicant also made submissions to the effect that there is no degenerative change revealed on the radiological investigations in his lumbar spine. The applicant submits that the pathology at his lumbar spine is in the nature of disc protrusions caused by heavy lifting and twisting inherent in his duties for the respondent. The applicant also referred to his relatively young age. I have taken all of these submissions into account but am not satisfied that they are consistent either with the opinions of the medicolegal experts or the treating doctors' evidence.

256. The applicant's surgeon, Dr Pope, has not given an opinion favourable to the applicant's case. Dr Pope expressed the view in June 2019 that the lumbar condition was most likely degenerative and not significantly caused by the applicant's employment.

257. Dr Hughes has expressed a similar view that there was no work-related injury but rather generalised, degenerative disc disease in the lumbar spine. Although Dr Hughes and Dr Popes' opinions lack detailed reasoning, ultimately it is for the applicant to establish on the balance of probabilities that there was an injury.

258. As indicated above, I am not satisfied that the history relied on by Dr Dias and Dr Guigis is supported by the other evidence before me. I am not satisfied that there is a fair climate for the acceptance of their opinions that the lumbar spine symptoms are causally related to the applicant's employment with the respondent. In *Paric v John Holland Constructions Pty Ltd* (at 846) the Court (Mason CJ, Wilson, Brennan, Deane and Dawson JJ) said:

[7] [2009] NSWCCA 227 at [2].

> "It is trite law that for an expert medical opinion to be of any value the facts upon which it is based must be proved by admissible evidence (*Ramsay v Watson* [1961] HCA 65; (1961) 108 CLR 642). But that does not mean that the facts so proved must correspond with complete precision to the proposition on which the opinion is based. The passages from Wigmore on Evidence ... to the effect that it is a question of fact whether the case supposed is sufficiently like the one under consideration to render the opinion of the expert of any value are in accordance with both principle and common sense.'[8]

259. For the reasons given above, I am not satisfied on the evidence before me that the applicant has discharged his onus in relation to the allegation of injury to his lumbar spine. There will be an award for the respondent in respect of the claim of injury to the lumbar spine.

**Consequential condition**

260. The applicant additionally claims that he has sustained a consequential upper gastrointestinal condition as a result of the consumption of anti-inflammatories due to his cervical spine and lumbar spine injuries.

261. It is not necessary for the applicant to establish that any gastrointestinal condition is itself an 'injury' pursuant to s 4 of the 1987 Act. Deputy President Roche in *Moon v Conmah*[9] 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."

**262.** A commonsense evaluation of the causal chain is required. The legal test of causation is that discussed by the Court of Appeal in *Kooragang Cement Pty Ltd v Bates*[10], where Kirby P said (at 461) (Sheller and Powell JJA agreeing):

> "From the earliest days of compensation legislation, it has been recognised that causation is not always direct and immediate…
>
> Since that time, it has been well recognised in this jurisdiction that an injury can set in train a series of events. If the chain is unbroken and provides the relevant causative explanation of the incapacity or death from which the claim comes, it will be open to the Compensation Court to award compensation under the Act."

263. His Honour said at 463–464:

> "The result of the cases is that each case where causation is in issue in a workers' compensation claim, must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from', is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a commonsense evaluation of the causal chain. As the

[8] *Paric v John Holland (Constructions) Pty Ltd* [1985] HCA 58.
[9] [2009] NSWWCCPD 134.
[10] (1994) 10 NSWCCR 796 at [810].

> early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation. In each case, the question whether the incapacity or death 'results from' the impugned work injury (or in the event of a disease, the relevant aggravation of the disease), is a question of fact to be determined on the basis of the evidence, including, where applicable, expert opinions. Applying the second principle which Hart and Honoré identify, a point will sometimes be reached where the link in the chain of causation becomes so attenuated that, for legal purposes, it will be held that the causative connection has been snapped. This may be explained in terms of the happening of a novus actus. Or it may be explained in terms of want of sufficient connection. But in each case, the judge deciding the matter, will do well to return, as McHugh JA advised, to the statutory formula and to ask the question whether the disputed incapacity or death 'resulted from' the work injury which is impugned."

264. I have accepted above that the applicant sustained an injury to his cervical spine in the course of his employment with the respondent. The medical evidence before me confirms that for a substantial period, the applicant's cervical symptoms were treated by NSAIDs such as Mobic and ibuprofen.

265. Epigatsric pains associated with the consumption of NSAIDs were first reported by Dr Abdalla in September 2014. The applicant was advised to stop taking NSAIDs and prescribed Mylanta and Somac. The clinical notes suggest that a gastroscopy may have been arranged by Dr Robert Woods in 2014. In 2015, Dr Chowdhury arranged a gastroscopy which showed active chronic gastritis associated with a large number of helicobacter pylori organisms and evidence of a previous duodenal ulcer. Dr Chowdhury recommended that the applicant avoid anti-inflammatory agents and use Panadol for pain. Dr Chowdhury said it was "possible" that the duodenal ulcer was due to a combination of helicobacter pylori infection and taking anti-inflammatory agents.

266. Dr Greenberg recognised that long term use of NSAIDs can cause acute epigastric pain. However, he expected that with the withdrawal of the NSAIDs the upper gastrointestinal tract symptoms would have settled. Notwithstanding this, Dr Greenberg gave the opinion that the applicant's persisting abdominal pain appeared to be related to the period when he started taking NSAIDs.

267. Dr Sethi took a history of the applicant reporting epigastric discomfort but did not engage with the evidence of prolonged consumption of NSAIDs other than to note that the applicant's pain would worsen on taking nurofen and ibuprofen. Dr Sethi acknowledged that nurofen and ibuprofen can cause peptic ulceration. Although Dr Sethi had the evidence of Dr Chowdhury's gastroscopy before him, he did not engage with the findings of gastritis and previous duodenal ulcer. Dr Sethi said that ulceration was not seen in the applicant's case and was essentially excluded by a "normal" endoscopy.

268. The evidence before me does not suggest that the consumption of NSAIDs alone would account for the epigastric symptoms in the applicant's case. The helicobacter pylori infection has also been described as a contributing factor. The consumption of NSAIDs appears to have occurred in response to both the lumbar symptoms, which I have not found to be work related, as well as the cervical symptoms. As noted by Roche DP in *Murphy v Allity Management Services Pty Ltd* [11], however, a condition can have multiple causes.

269. I am satisfied on the evidence before me that the consumption of NSAIDs due to the work injury found above materially contributed to the applicant's upper gastrointestinal tract symptoms. I am satisfied that there was a consequential upper gastrointestinal tract condition as a result of the injury to the applicant's cervical spine.

[11] [2015] NSWWCCPD 49.

270. The degree of permanent impairment now resulting from the work-related condition will be a matter for an Approved Medical Specialist to assess.

**Date of injury**

271. Having made the findings above, I consider it appropriate for the matter to be remitted to the Registrar for referral to an Approved Medical Specialist for an assessment of the degree of permanent impairment of the applicant's cervical spine and digestive system. There is no dispute from the respondent as to whether the surgical scarring of the skin at the cervical spine should also be referred for assessment.

272. For the purposes of the referral, it is necessary to make a determination as to the correct date of injury. The injury found by me is one falling within s 4(b)(ii) of the 1987 Act. As a result, s 16(1) of the 1987 Act deems a date of injury as follows:

> "(1) If an injury consists in the aggravation, acceleration, exacerbation or deterioration of a disease—
>
> (a) the injury shall, for the purposes of this Act, be deemed to have happened—
> (i) at the time of the worker's death or incapacity, or
> (ii) if death or incapacity has not resulted from the injury—at the time the worker makes a claim for compensation with respect to the injury, and
>
> (b) compensation is payable by the employer who last employed the worker in employment that was a substantial contributing factor to the aggravation, acceleration, exacerbation or deterioration."

273. The applicant relies on a deemed date of 7 October 2010 being the day on which Dr Abdalla first certified incapacity resulting from the cervical spine injury and the day on which the applicant ceased work.

274. The respondent submits that there should be two deemed dates, one in respect of the claim for lump sum compensation and one in respect of the claim for weekly compensation and medical expenses, being the respective dates of claim. In this regard the respondent refers to *Stone v Stannard Brothers Launch Services Pty Ltd*[12]. The submission is founded upon the respondent's view that there is no evidence of incapacity resulting from injury.

275. The issue of incapacity is not one on which detailed submissions have yet been given. Given the complexities and particular circumstances of this case, consideration of that issue has, with the agreement of the parties, been deferred until after a Medical Assessment Certificate has been received from the Approved Medical Specialist.

276. I have however accepted that there is an injury pursuant to s 4(b)(ii) to the cervical spine. There is also evidence of economic incapacity resulting from that injury from 7 October 2010 in the form of Dr Abdalla's WorkCover certificate, the clinical records, the letter of resignation and the Centrelink Job Capacity Assessments. Whilst I am not able, at the present time to make a finding on the extent and quantification of incapacity resulting from the injury, for the purpose of deeming a date for the medical assessment referral, I find that the injury did cause incapacity from 7 October 2010 pursuant to s 16(1)(a)(i).

[12] [2004] NSWCA 277.

277. While I accept that s 16(1) "may fix different dates for incapacity and impairment injuries" (per Handley JA in *Stone*), the section does "not dictate that there must be a separate deemed dates in all cases" (per Roche DP in *Collingridge v IAMA Agribusiness Pty Ltd*[13] at [70]). The crucial and determinative issue is whether the relevant injury identified by reference to s 4(b) has resulted in both incapacity and permanent impairment, in which case s 16(1)(a)(i) applies and prevails to deem the injury to have been suffered on the date of first relevant incapacity for all purposes, or whether such injury, or further injury, has not produced a relevant incapacity but has given rise to a claim, or further claim, for permanent impairment compensation, in which case the deemed date of injury for the permanent impairment claim would be the date on which that claim was made.

278. In the present case, I am satisfied that the injury found by me has produced both incapacity and has founded a claim for permanent impairment compensation. Both weekly compensation and lump sum compensation are sought in these proceedings. Applying *White v Sylvania Lighting Australasia Pty Ltd*[14] and *Collingridge v IAMA Agribusiness Pty Ltd*[15], for present purposes, I find the deemed date of injury for the purposes of the lump sum compensation claim to be 7 October 2010.

**SUMMARY**

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

280. The deemed date of injury is 7 October 2010.

281. The applicant has not discharged the onus of establishing injury to his lumbar spine. There is an award for the respondent in respect of the lumbar spine.

282. The applicant sustained a consequential upper gastrointestinal condition as a result of the injury to the applicant's cervical spine.

283. The matter is remitted to the Registrar for referral to an Approved Medical Specialist to provide an assessment as follows:

| | |
|---|---|
| Date of injury: | 7 October 2010 (deemed) |
| Body parts: | Cervical spine<br>Skin (scarring)<br>Digestive system (upper gastrointestinal tract) |
| Method: | Whole Person Impairment |

284. The materials to be referred to the Approved Medical Specialist are to include all documents admitted in these proceedings together with the Certificate of Determination and accompanying statement of reasons.

285. The matter is to be listed for further teleconference upon receipt of the Medical Assessment Certificate.


[13] [2011] NSWWCCPD 31.
[14] [2011] NSWWCCPD 7.
[15] [2011] NSWWCCPD 31.