IN THE MAGISTRATES COURT OF VICTORIA
AT MELBOURNE

F12228666

DAVID LENEHAN Plaintiff

V

SARGEANT TRANSPORT SERVICES PTY LTD Defendant

MAGISTRATE:	Magistrate B R Wright
WHERE HELD:	Melbourne
DATE OF HEARING:	28, 29 and 30 June 2016
DATE OF DECISION:	15 July 2016
CASE MAY BE CITED AS:	Lenehan v Sargeant Transport Services

REASONS FOR DECISION

Catchwords:

Workers Compensation – Bilateral Elbow Injury - Termination of Weekly Payments and Medical and Like Expenses – Whether Injury Still Work-Related - Aggravation of Pre-Existing PTSD – Relevance of Contribution by Delay and Associated Issues in Litigation – Workplace Injury Rehabilitation and Compensation Act 2013

APPEARANCES:	Counsel	Solicitors
For the Plaintiff	Mr L Allan	Arnold Thomas Becker
For the Defendant	Mr C Miles	IDP Lawyers

HIS HONOUR:

1 Mr Lenehan is a 62 year former truck driver who injured both elbows on 8 July 2014 after working for the Defendant (“Sargeant’s”) for just over one week. Liability was accepted for his claim and weekly payments commenced in accordance with the Workplace Injury Rehabilitation and Compensation Act 2013 (“the Act”). Liability for s211/212 lump sum impairment purposes was also accepted in about January 2016 for the bilateral elbow injury and "psychiatric condition" (“the lump sum claim”).

2 Eventually his entitlements to weekly payments and reasonable medical and like expenses were terminated by a Notice dated 12 June 2015, substantially on the basis there was no continuing work related incapacity for work and/or need for medical treatment.

3 Mr Lenehan seeks continuing reasonable medical and like expenses and weekly payments on a “current work capacity” basis on the basis he has continuing work-related bilateral elbow injury and a consequential psychiatric condition including post-traumatic stress disorder (“PTSD”).

4 He has had a very interesting and varied employment history. He said he was in the Australian Navy and served in North Vietnam in 1973 to 1974 doing covert work after most of the troops had been repatriated back to Australia.

5 He was in the United States of America as part of his navy service. He said he had a PhD in Linguistics. He also obtained a Masters in Architecture at the University of California at Berkeley. He also completed two maths degrees in the US. He said he was a deputy director of military intelligence in Australia and helped design Darling Harbour in NSW. He also worked at Kodak for four years. Later, he lectured in Linguistics and English around the world including various Persian Gulf countries, Eastern Europe and France.

6 He said he speaks Russian. He also had been a tourist administrator and a financial broker in the past as well. He had a rural property in the Darling

Downs area for about three years and went to France where he sustained a pulmonary embolism. He finally returned to Australia in 2013.

7 He said he was first diagnosed with PTSD in 2007, though he believes he had the condition since being in Vietnam. He was treated by Dr Lamont, a psychologist, in Toowoomba. Until about 2010 he had flashbacks and nightmares, but had no time off work. After about 2010 there was no real treatment except for occasional telephone calls to the psychologist.

8 As stated, he had returned to Australia in about 2013. He said his educational qualifications were largely not recognised in Australia. Thus, he began working as a truck driver with Alvaro Transport in about October 2013. He was working 40 to 60 hours per week. There was no manual handling and all goods were handled by forklift. He had a semi-trailer and heavy rigid vehicle licence. He had no problem with his elbows before or while being employed there.

9 He changed jobs to work for Sargeant's as at 30 June 2014. This was supposed to be casual, and on a probationary basis, for three months. He worked full time until 8 July 2014 with only one day off, driving both articulated and heavy rigid vehicles around the metropolitan areas. Vehicles again would be loaded and unloaded by forklift. He would mainly supervise the loading.

10 Some of the vehicles had folding material curtain walls. The curtain walls would have to be manually handled and tightened using a manual ratchet fitting. This required tightening both horizontally and vertically.

11 There were a number of vertical clips on each side to tighten, about 12 to 15 on a rigid vehicle and 18 to 25 per side on a semi. Thus, he would have to undo one or more clips on one or both sides depending on the load, or the extent of the load, for each delivery. Of course, at the start the curtains would require pulling horizontally over the whole distance after the truck was loaded. The longer the vehicle the more force was required to pull the curtain into a

closed position. He said he used his left arm on the driver's side and his right dominant arm on the passenger side.

12 On 8 July 2014 he had a pick-up in Mulgrave. He attempted to open up the side of the vehicle by lifting the clip out of the spindle, but was unable to do so. He then shifted the truck as sometimes if it was on an angle this could put extra strain on the clips. He shifted it twice and was still unable to open it. The other side was fixed as well. The client told him the delivery was urgent. After about 20 minutes he was able to undo the curtain after using a lot of force with both arms and legs.

13 He developed strong pain to the inside of both elbows. The pain was so bad he "sat under the trailer for 15 minutes and cried". The pain subsided and he was able to close up the curtains and go to the next delivery site. Again, he had pain while driving and opening and closing the curtains. He went back to the depot and got another driver to undo them.

14 He went into the office and tried to report the incident but there were no incident report forms. He came back the next day and filled in a form and was directed to go to a general practitioner, Dr Tan, to be assessed.

15 Dr Tan arranged some tests and referred him to a physiotherapist, Mr Du, at the same practice. On Dr Tan's suggestion, he returned to work on light duties but had difficulty with some tasks such as sweeping. On about 21 July 2014 he was told to go home and rest. He has not worked since then for the defendant.

16 Dr Tan gave him medical certificates on a monthly basis. He made a worker's compensation claim form which was accepted. However, he was initially underpaid weekly payments at the rate of about 40% of pre-injury average weekly earnings.

17 He tried unsuccessfully to sort out that issue himself. After some months it

was eventually resolved at the Accident Compensation Conciliation Service ("ACCS"). This had put him under considerable financial and stress and strain and he was very resentful. He began to get nightmares increasing in frequency and severity. He was angry that he had no further offer of work from Sargeant's, despite the fact that he was able to drive a fully enclosed vehicle, that is, without side curtains. He said Sargeant's had plenty of these trucks. They refused to give him such work despite him telephoning them.

18 He was assessed for rehabilitation and a Certificate IV course in workplace training at Kangan Institute in about late 2014/early 2015. He was not able to use this training further as his PTSD symptoms flared up. He had an ultrasound in 2014 and was seeing Dr Tan monthly and Mr Du weekly, which he found helpful.

19 During 2014 he continued to have trouble using both elbows on such tasks as lifting items and even doing up shoe laces. He was only taking non-prescription Nurofen. He said he was desperate for work in late 2014 as he was under great financial strain. He obtained a forklift licence and contacted Foodbank, driving a forklift for them on a voluntary basis for one to three days per week. He coped okay with the forklift as the controls were on the handle and there was no lifting, twisting or horizontal arm movement required.

20 As stated, he began getting nightmares again in about October 2014. He said the stress of it all began to flare up his PTSD. He began getting day time flashbacks again. He had not had these PTSD symptoms since about September 2010. He said he was less functional over time.

21 He was referred to a number of doctors for assessment by the VWA. After seeing a Dr Snyman his weekly payments were eventually terminated by Notice dated 6 February 2015. The alleged basis for termination was the initial ultrasound request set out a wrong date of injury being prior to the actual date of injury. This was a typographical error by the GP. It took some

time for this to be resolved at the ACCS and the Termination Notice was eventually withdrawn in April 2015.

22 This put even further stress on him. Payment for cortisone injections and autologous blood injections were refused by the VWA despite his doctor's suggestion for same. He was happy to have the autologous blood injection. He saw this as another knockback and felt he was under threat. His nightmares were increasing and he saw himself as at war with the authorised agent. He was not able to control his PTSD with his usual self-management techniques. He said he would be "out of it" for days at a time. The ACCS processes were very stressful.

23 He had difficulty in getting to and remaining asleep. He spoke to his GP and looked around for a psychologist in Melbourne who could treat PTSD. He found a Mr Ken Holland to whom his GP referred him in early 2015. He received another Termination Notice (which is the relevant one before this court) alleging that he had recovered and did not need treatment. He thought this was unfair. He felt outraged and offended.

24 He began getting one or more nightmares each night. He said he would shake for days afterwards. He wrote letters of complaint to his MP, the Ombudsman and the Fair Work Commission. He complained about how his case was handled, the unfair use of reports and “unlawful treatment”, all of which he believed he could document. He stopped getting medical treatment in July 2015 as his entitlement to medical and like expenses was terminated.

25 He was unable to pay for treatment. The lack of treatment, such as physiotherapy, made him feel vulnerable. He had little money, using a small superannuation payment and also social security. He said he was under stress physically, mentally and financially.

26 He said that all this made his PTSD worse with increasing mood swings, extreme depression and social isolation. He said he stopped eating for days

at a time. He cried inexplicably at times and felt completely dysfunctional all the time. One day in February 2015 he was in a bottle shop when a bottle smashed and he cringed in a corner for three hours.

27 He had been married twice. His first marriage broke up in about 1980 after 18 months with his PTSD being a factor. He married a second time in 1984, had three children but did not have a happy marriage. He said his wife could not cope with his PTSD, but that there were also other factors involved. They separated in about September 2010. He allowed her to stay on their farm but later found out that she had sold it in about October 2014 and kept 70% of the proceeds for herself.

28 There was a bitter Family Court dispute until May 2015 when the divorce was finalised. He was frank in admitting the dispute "exacerbated" his PTSD which was already worse because of the situation involving his work injury. He had another setback with a diagnosis of prostate cancer in September 2015 and later a failed prostatectomy. He had hormone therapy and 39 sessions of radiotherapy.

29 His PSA antigens are now back to zero. He said his strong Christian beliefs helped him cope with the cancer which was not as bad an experience as he had thought. His PTSD flared up after the diagnosis. When his PSA antigens levels improved, his PTSD improved as well.

30 On 29 April 2016 he had to move to Queensland for financial reasons to live on a yacht about 50 kilometres north-east of Gympie. It is a 37 foot boat which sits at anchor. He had to sand and paint the boat over some time but did this in patches. He said it took him three weeks to do a five day job.

31 He says he is very comfortable on the boat and his financial outgoings have markedly decreased. He said that generally his left arm had improved more than his dominant right arm. Over Easter this year he had woken up with severe right arm pain one morning for no apparent reason. His new GP, Dr

Mikhail, had referred him to a rheumatologist, Dr Karlov, who advised rest and physiotherapy after arranging an MRI.

32 He said overall his left arm had improved considerably with pain to the inner elbow on activities such as lifting. There had been less improvement in his right arm. He gets sharp pain in the right arm at times. He can lift the arm to shoulder level. Activities such as household chores cause pain and he limits them to about 20 minutes at a time. He finds activities such as sweeping, reaching and twisting bring on the pain and he tries to do more with the left arm. He only takes Nurofen twice a week, one tablet at a time when the pain is very bad.

33 Interestingly, he says that since he had meningitis some years ago he is not susceptible to pain normally. He wears a type of elastic brace on both elbows, more frequently on the right elbow. He has had to give up previous activities such as sailing and horse riding because of his elbow injuries. He is frank in admitting that physically he could drive a truck full time if it had no side curtains. He could possibly pull back the curtain walls once, but this would cause his arm pain to flare up.

34 His PTSD is now what he refers to as “bad” with nightmares every night which wake him up and he is unable to return to sleep. He gets flashbacks during the day every day which cause him to be depressed. He avoids shops and social contact if possible. He has severe mood swings and is dysfunctional at times. Consequently, he is unable to maintain relationships.

35 He sometimes gets several flashbacks per day which makes him unable to function for minutes, hours or even days at a time. He tries to see Mr Holland weekly and contacts him by phone at times. He does not believe he could do a job for psychiatric reasons. He believes his nightmares would make his driving dangerous. He has difficulty in concentrating and performing activities of daily living (“ADL”) after having had nightmares. He believes he would be

unsafe to others particularly using, or being near, machinery.

36 In cross-examination, he denied telling Dr Tan and Mr Du on their respective first consultations that he had a twinge in the arm on the previous Friday before the relevant incident. I do not see that issue as being of great relevance anyway as he was employed by Sargeant's at the time. He admitted having instances after July 2014 when his arm pain would flare up for no apparent reason and had told a number of the doctors in this case about that.

37 He agreed that up until seeing Dr Karlov he had been told he could do light duties. He did not believe that his academic qualifications would help him return to work as he could not hold a job with PTSD. For example, he would have trouble making appointments.

38 As stated, he had applied for and obtained a forklift driver's licence by himself with state government funding after being injured. He drove voluntarily at the Foodbank for two to three days per week. He was trying to re-skill himself. However, his PTSD "played havoc" in October 2014. His nightmares were worse and he found that he was attending irregularly at the Foodbank. His PTSD meant that he could not work reliably and would not be a regular attendee.

39 The nightmares affected his concentration. He was concerned about getting flashbacks during the day and this meant that he would be unsafe to work with. Previously, he was able to self-manage his PTSD. It had no effect on his employability for four years until he was employed by the Sargeant's.

40 He agreed that his matrimonial financial dispute had occupied his time for a while and had upset him. It was complicated by the fact that he and his wife lived in different states. She had a solicitor in a different state. He said that she had made untruthful allegations against him. She had disregarded Family Court Orders and refused to return to Australia at one time.

41 He had also received a number of traffic fines prior to February 2015 and agreed that he had asked Dr Lamont to prepare a brief report for his application to revoke those fines. He said that rather than concern about his fines made his PTSD worse, that he was trying to show that the PTSD was to blame for the traffic infringements. He had not discussed return to work recently with Mr Holland, though he had in the past. As for work, he had looked round for "just about everything" in the past.

42 He denied being fixated on this case and using it for financial advantage, for example, to buy a yacht and sail around. He had been interested in buying a yacht in the United States and sailing it to Australia in the past. He did the Certificate IV workplace training course in about February 2015 with Dr Tan's agreement. It had theoretical and practical requirements. He tried unsuccessfully to get a job with it for one month, but his nightmares and flashbacks became worse. He had two flashbacks while doing the course.

43 His usual GP, Dr Conway, only wanted to treat him for general health issues and not for his work injuries or psychological problems. He agreed that a number of issues such as marital problems and the traffic fines may have played a part in his PTSD, but his arm injury was the main one. He had not seen Dr Tan since June 2015. He had seen Dr Mikhail for his arms on a couple of occasions. He was the doctor who referred him to Dr Karlov.

44 He agreed that he had told Mr Holland that the dealings with his wife as part of his divorce had upset and frustrated him. He agreed there was little chance of getting suitable employment while he lives in Queensland on his yacht, but he had to shift there for financial reasons.

45 Some surveillance DVD's were then shown to the court. On 2 March 2016 he drives to a house, talks to somebody and carries some folders in his left arm to the car. He is shown at a supermarket carrying four boxes of tea in the left arm to a checkout. He also carries a large three litre milk carton again in his

left arm. He said he uses such a container to exercise his arm as advised by the therapist.

46 That completes my summary of his evidence.

47 Dr Tan and Mr Holland were called to give viva voce evidence on his behalf. I will set out the medical and other treatment evidence in roughly chronological order with the treating evidence first.

48 Dr Tan had supplied three medical reports setting out that he first saw Mr Lenehan on 9 July 2014 complaining of bilateral severe medial elbow pain as a result of lifting the post or curtains on his truck. An ultrasound five months later confirmed the diagnosis of bilateral medial epicondylitis. He thought that Mr Lenehan could do light duties, subject to pain restriction. He referred him for physio.

49 Later, he had good strength in his hands but had discomfort with forceful grip. In October 2015 he thought that Mr Lenehan was fit for modified hours and was able to drive trucks without repetitive lifting or lifting more than 15 kilos. He needed physiotherapy and steroid or autologous blood injections. In his evidence before me he said that he had not seen Mr Lenehan since 17 June 2015, providing medical certificates over the whole of his period of treatment. He confirmed the history of a prior niggle on the Friday previous to the relevant injury.

50 In his last medical certificates he had certified that various aspects of Mr Lenehan's mental health function had not been affected. However, he told me that that he believed Mr Lenehan had been seeing a psychologist separately and had focused on the physical aspects of the injury. There had been some referral to psychiatric issues in his notes. On 23 March 2015 Mr Lenehan felt depressed when talking about the way the incorrect date of his ultrasound referral had been used as a basis for termination of his entitlements. On 8 December 2014 Mr Lenehan had spoken of his previous history of nightmares

and flashbacks, referring specifically to PTSD.

51 Mr Du, a physiotherapist, provided a report dated 12 August 2015 setting out treatment from 9 July 2014 to 20 July 2015 when his entitlement to reasonable medical and like expenses was terminated. Mr Lenehan had persisting symptoms at the end of that period. He thought that Mr Lenehan needed autologous blood injections. He also noted a history of first noticing symptoms on 4 July 2014 while driving for Sargeant's and again later aggravated "on the next day".

52 Dr Victor Karlov, rheumatologist, provided a medical report dated 23 April 2016 referring to his one attendance with Mr Lenehan on 22 April 2016. Dr Karlov had access to a recent MRI for the purposes of his report. He noted the history of injury on 8 July 2014 as a result of using extreme force to move a truck curtain. On examination he found "extensive elbow injuries including medial and lateral epicondylitis, tendinosis and internal derangement of the right elbow".

53 He also thought that there was exacerbation of the PTSD. He thought there was no work capacity and there was a clear relationship between the employment and his injury. He noted little improvement over the two years. Mr Lenehan needed ongoing physiotherapy and maybe even pain clinic treatment. As there had been an exacerbation (probably referring to the Easter 2016 episode when Mr Lenehan had woken up with a painful right elbow), he thought that Mr Lenehan could not be regarded as having stabilised.

54 He was examined by Alex Stockman, a rheumatologist, for independent medical examination purposes for Mr Lenehan's solicitors on 1 March 2016. Dr Stockman had two ultrasound reports from Dr Tan's practice. He also took a history of the 8 July 2014 injury and later history consistent with the evidence given by Mr Lenehan before me. He also noted the flare up in

PTSD. After his examination, he diagnosed chronic bilateral medial epicondylitis and exacerbation of PTSD. He said that the 8 July incident "caused" bilateral medial epicondylitis.

55 He was unfit for prior employment as a truck driver but could perform modified duties. He thought he only needed future treatment by way of regular stretching exercises.

56 Mr Lenehan was also examined for independent medical examination purposes on behalf of his solicitors by Dr Joseph Slesinger, an occupational physician, on 6 April 2016. Dr Slesinger also had one ultrasound report and reports from Dr Tan and Mr Du amongst others. Again, he took a history of the specific work episode on 8 July 2014, continuing elbow pain, worse on the right side, as well as deterioration of previous PTSD.

57 He noted some restrictions in ADL and also his prostate cancer. He diagnosed bilateral chronic medial epicondylitis and psychological impairment. He implicated the repetitive nature of the job task and single incident as "proximal causes" of the impairment. He said that Mr Lenehan needed steroid and/or autologous injections. He did not think that Mr Lenehan could return to his truck driving, noting manual handling and postural requirements. However, there was a capacity for light work with no sustained or forceful flexion of wrists or elbows and no pushing, pulling, carrying or lifting over five kilograms bilaterally.

58 Counsel for Sargeant's tendered a report from Dr Lamont, the psychologist, dated February 2015. Dr Lamont had treated Mr Lenehan for PTSD between January 2009 and July 2010. This was the report used for the traffic offences application. She referred to a history of severe trauma in childhood and service in Vietnam. She found moderate to severe PTSD. His PTSD had been confirmed by a psychiatrist.

59 He also had recurrent and moderate ongoing depression. She noted the

recent "considerable workplace related stress after a workplace injury contributed to his current difficulties and again aggravating his PTSD symptoms".

60 Dr Ken Holland, the psychologist, also gave evidence and had reports tendered as well. He said that he does work for Veterans Affairs (“DVA”) and has specialist PTSD psychological training.

61 He treated Mr Lenehan after he came to see him initially on a mental health care plan. Later, his treatment expenses were paid by the DVA. He noted Dr Lamont's previous treatment for PTSD and confirmed chronic and severe PTSD which had been caused by Mr Lenehan’s war experience. He thought that Mr Lenehan's overall control of PTSD was good. The symptoms would intensify under moderate to severe stress from other life events.

62 In this case, he believed that Mr Lenehan's PTSD had been "exacerbated" by the protracted nature of his worker's compensation claim, the adversarial attitude of his employer and tactics employed by the employer and insurer, such as the non-payment of worker's compensation entitlements. This was the major reason for the exacerbation. He saw the marital dispute as being the secondary cause.

63 In August 2015 he thought that Mr Lenehan was capable of part-time employment but later in April and May 2016 thought that he was not fit for work at that time. He had impaired concentration, impaired mood, disability and energy due to increased sleep disturbances, depression and trauma “re-experiencing” that had occurred with the exacerbation of his PTSD. His exacerbation had made him more vulnerable than usual to deterioration from other stresses, for example, the recent ending of a relationship as compared to the breakdown of his two previous marriages.

64 In his evidence before me, Mr Holland said that he first saw Mr Lenehan from April 2015 until 28 April 2016, though he had spoken to him by phone since,

about once or twice a week. He believes that Mr Lenehan is still severely impaired for sustained full time or regular employment, though he could do part time which he said was “less than half time” employment. He said that he uses the word “exacerbation” in the sense of an aggravation which lasts until the stressor is removed.

65 He acknowledged that Mr Lenehan conveyed four main problems, namely the marriage dispute, stress associated with his worker's compensation claim, the cancer diagnosis and the traffic fines, though the worker's compensation stressor was the more significant factor. He agreed that all or any could stir up the PTSD. Interestingly, he did not associate the aggravation of PTSD directly to the physical injury as such.

66 He agreed that Mr Lenehan told him he wanted to purchase a boat and sail it from the USA and needed a substantial settlement from the marriage or his worker's compensation claim to do so. He thought that Mr Lenehan did not need a psychiatric referral. He said that Mr Lenehan had not expressed a reluctance to work.

67 He was not asked, and did not comment on, whether or not there was any adjustment disorder and/or anxiety, but he did mention depression in his evidence.

68 That completes the plaintiff's medical and other evidence.

69 Before discussing evidence called on behalf of Sargeant’s, I will refer to the lump sum claim Medical Panel Opinion and associated Reasons. Both Counsel agreed that the Opinion itself is of very little assistance in this case. They agreed I could look at the Reasons as setting out the basis for the Opinion as I would consider any other medical report before me.

70 Certainly, bearing in mind the principles discussed in Ansett v Taylor [2006] VSCA 171, the admission of liability should only be seen as an initial

admission as to the original injury and no more. As stated, there was only an admission of bilateral elbow injury and consequential psychiatric condition.

71 After the acceptance of liability Mr Lenehan was examined for the VWA by Associate Professor Buzzard, a general surgeon, on 12 October 2015. He noted the single work incident. He noted bilateral medial and lateral epicondylitis "caused by the nature of work at the time of onset of symptoms".

72 He was capable of work not involving rapid repetitive movement of wrists and forearms as in his former job pulling truck curtains. Mr Buzzard thought that he did not have any related whole person impairment based on the AMA tables.

73 He was also examined for impairment lump sum purposes for the VWA by Dr Matthew Tagkalidis, a psychiatrist, on 28 January 2016. He also took a similar history of the single work incident, later treatment and employment. He also noted PTSD after Vietnam involvement.

74 Mr Lenehan complained to him of a relapse in his PTSD because of frustration, financial distress and continued depression. Since his work injury he had war -related flashbacks two to three times per week and related nightmares most nights. He avoided war-related media and was hyper-vigilant in public, being easily startled. Dr Tagkalidis noted the prostate cancer treatment and marital separation, but did not refer to the marital property or traffic fines issues.

75 On examination, Dr Tagkalidis thought that the content was primarily occupied with frustration about his physical and emotional difficulties. He concluded Mr Lenehan was currently suffering an adjustment disorder with mixed anxiety and depressed mood in the context of PTSD relevant to the accepted injuries. He found there to be a psychiatric impairment under the AMA tables of 16% of which 5% was pre-existing and unrelated to the accepted injury, due to pre-existing PTSD. 3% was unrelated to the accepted injury because of the

prostate cancer and excluded as well. 8% was secondary and consequential to the physical injury. He did not say whether this included any aggravation of any PTSD by the work injury.

76 Obviously, he examined Mr Lenehan for lump sum claim purposes. However, there was no follow up report from him before me as to any link between the PTSD and work injury on the basis of his stated frustration about the physical and emotional difficulties after the work injury.

77 The Medical Panel included an orthopaedic surgeon, Mr John Bourke, and a psychiatrist, Dr David Weissman, who examined him for lump sum claim purposes. They examined him on 6 April 2016. The panel took a history of the single work related incident and examined him on that basis.

78 The Panel found he was suffering from the residual symptoms and dysfunction of the right elbow following the right flexor tendinopathy and persistent symptoms of the left elbow following a left flexor tendinopathy which had substantially resolved. It assessed a 1% whole person impairment under the AMA Tables.

79 The psychiatric component was separately assessed. Mr Lenehan gave a full history of previous PTSD because of war service, as well as psychological problems following his injury. He reported moderate mixed reactive depression/ anxiety symptoms, themes and features consequential to his work related pain, injuries, disabilities, limitation and restrictions, as well as grievances regarding the “WorkCover agent and his pre-injury employer”.

80 The Panel concluded he was suffering from a chronic adjustment disorder with depressed and anxious mood in part relevant to the accepted psychiatric condition injury. This was in part due to the worker's unrelated prostate condition and a moderate aggravation of the pre-existing mild chronic PTSD relevant in part to the accepted psychiatric condition injury and in part due to the worker's pre-existing and unrelated condition which was described as

being mild chronic PTSD.

81 Mr Lenehan has been examined on behalf of the VWA by a number of specialists, though not any psychiatrists or psychologists, for the purposes of this case.

82 He was examined by Mr Barclay Reid, a general surgeon on 4 August 2014, that is less than one month after the injury which Mr Reid related as occurring on 8 July 2014. He diagnosed bilateral medial epicondylitis at that stage and thought that Mr Lenehan was fit for modified duties.

83 Mr Lenehan was examined once by Dr Jurie Snyman, an occupational physician, on 10 December 2014. She later prepared three subsequent reports. Again, Mr Lenehan gave a history of the work related injury on 8 July 2014. She thought his biggest problem was the limitation imposed because of the inside elbow pain. Dr Snyman diagnosed bilateral golfer's elbow (i.e. medial epicondylitis), but thought that the primary diagnosis was severe right tennis elbow(i.e. lateral epicondylitis).

84 She thought that there had been a severe exacerbation of underlying tendinopathy which itself was a constitutional condition. She thought that he could return to driving without forceful pulling of items such as curtain walls.

85 The second report was prepared on the basis of the previously discussed typographical error by the GP in the request for radiology that he had "bilateral elbow pain since February 2014".

86 As I have pointed out, the VWA later acknowledged that this was a typographical error and withdrew its original Termination Notice. Thus, Dr Snyman's change of opinion that the injury was not work-related should be disregarded as well, though she still seemed to think he was still restricted in employment as previously outlined. The third report was also based on the same error.

87 The main doctor referred to by Sargeant's in this case was another occupational physician, Dr Barton, who examined Mr Lenehan twice on 5 June 2015 and 17 March 2016. He also gave viva voce evidence before me.

88 His first report does not state what documents he had for the purposes of his report and he was not able to take this any further in his viva voce evidence. He took a history of the single incident on 8 July 2014 as well. Mr Lenehan complained of continuing worsening pain to Dr Barton and told him the ultrasound diagnosed tears to the bilateral common flexor tendons.

89 Dr Barton thought it was medically naïve to state that this finding was due to the single incident, though he did not refer to actually seeing any ultrasound report in his report. He stated that "having ceased the alleged cause of activity, normally a recovery would be expected". He concluded the work activities led to the initial symptoms, but that his "mild soft tissue injury as a result of the work activities had resolved and he could work normally".

90 In his second examination Dr Barton took a history that the upper limb symptoms "had just about fully settled" until he lifted a pot from the stove with both hands. The main area of pain was around the inner elbows, more so on the right, made worse by reaching up or turning on difficult taps. Mr Lenehan said that he was unable to work because of the significant exacerbation of PTSD "by this problem".

91 In his conclusion, Dr Barton maintained his previous opinion on diagnosis, causation and capacity to perform normal work. Basically, he thought that the longer the period since cessation of employment went the less relevant any work was to his condition. Any incapacity was related to his psychological condition and prostate cancer.

92 In his viva voce evidence Dr Barton said he accepted Mr Lenehan did have arm symptoms. He did not know when any work causation had ceased but now estimated this was "maybe within a day of two".

93 He believed that Mr Lenehan could work with any activity related pain, though he should avoid pulling on the truck curtain as this had brought on the pain in the first place. However, he then said that Mr Lenehan could do this but with pain. He maintained this view in his second report that the arm problem had no impact on his domestic and leisure activities. He said that he could use both hands to undo taps. Mr Lenehan was “75% better” on his second examination. Later in his evidence he then said that the work aggravation had ceased "within a few weeks". Even accepting the history of continuing pain, Dr Barton said he would have expected that any work contribution "had ceased".

94 That completes my summation of the medical evidence. I will now summarise the submissions of both Counsel.

95 Counsel for Sargeant’s emphasised that despite the allegation of only one work incident, there is a reference to previous “niggles” in the initial reports. Mr Lenehan’s complaint of pain with ADL was consistent with fluctuating non work-related epicondylitis.

96 He accepted that if I found Mr Lenehan to be unable to draw truck curtains then there would be “current work capacity” as defined.

97 In any event, he submitted that initially all doctors said Mr Lenehan was fit for light work for which he was qualified by training and experience in view of his pre-injury employments and qualifications around the world. He submitted I should disregard PTSD as being work-related in any way. Mr Lenehan had ample other explanations for his PTSD and its flare-up including marital stress, prostate cancer and the traffic fines as related by Mr Holland.

98 He submitted that Mr Lenehan was not motivated to return to work and wants a large settlement in order to purchase a yacht. There was no evidence called from his other GP's, Dr Conway or Dr Mikhail. Dr Tan did not refer to any mental issues in his medical certificates. The Medical Panel had stated his elbow problems had "substantially resolved". At best, he submitted Mr

Lenehan's psychiatric symptoms or psychological symptoms were only partially the result of the authorised agent's handling of his claim.

99 However, he submitted this does not make the symptoms work related, referring to a decision of ATC v Tzikas, a 1985 AAT decision which gave some limited report in that regard. However, he was unable to find a copy of that report. He submitted that simple resentment as a result of delay was not a work related injury, as to which I agree. He submitted the alleged aggravation of the PTSD by the authorised agent was too remote and/or a "novus actus interveniens" in this case.

100 Counsel for Mr Lenehan submitted that the common diagnosis in this case was bilateral medial epicondylitis, save for Dr Barton who still accepted he had continuing elbow pain. He submitted I should disregard Dr Barton's views on capacity to do normal driving and a worker should not be expected to drive with pain. He agreed that the PTSD did not appear to be directly the result of the physical injuries. There was some support for a work-related adjustment disorder though from Dr Tagkalidis and Dr Weissman.

101 The PTSD had led to symptoms which further restricted Mr Lenehan's capacity for work. For example, his continuing nightmares and flashbacks leading to sleep difficulties, make it difficult for him to work on a regular or reliable basis in any event. The various aspects of the handling of the claim by the authorised agent and Sargeant's was an important factor in the worsening of the PTSD. There was his evidence of worsening of his PTSD in October 2014, well before he found out about the sale of the property by his wife.

102 He referred to my decision in Sheppard v Woolworths [2015] VMC 22 in which I discussed the decision in Grech v Orica [2006] 14 VR 682, amongst other cases. As to the failure to call the GPs to give evidence, the evidence of Dr Conway was irrelevant as the evidence was that he did not want to treat Mr

Lenehan for any worker's compensation injury. He said that Dr Mikhail had only treated him recently and for a limited number of times.

103 I now make my findings in this case. I will refer first to the physical aspects of the injuries and later to the psychiatric aspects.

104 The real issue in this case is whether Mr Lenehan has any, and if so what, continuing work-related injury. In this regard, the various elements to be considered in determining whether employment was a “significant contributing factor” as set out in cl. 25 of Schedule 1 of the Act must be taken into account.

105 The admission of liability for the lump sum claim purposes for both the physical and psychiatric components is of limited assistance to my determination of this case. As Ashley JA pointed out in Ansett v Taylor (supra) at para. 3 "such an acceptance has an evidentiary effect only as an admission by the Authority that such an injury was sustained. However, such an admission should ordinarily be regarded as very significant".

106 I agree with Counsel for Sargeant’s that such an admission should not be seen that there is a continuing work-related injury as at the date of the acceptance of the lump sum claim. Of much more importance is the actual lay and medical evidence before me.

107 Mr Lenehan's credibility is very much in issue in this case, especially as to the acceptance of his continuing symptoms and motivation to work as submitted by Counsel.

108 Essentially, I found him to be an honest witness who may have unconsciously exaggerated some of his evidence before me. He was an articulate, obviously intelligent but emotionally demonstrative in his evidence. I found it hard to accept literally that he sat under a trailer and cried for 15 minutes with pain after the incident but then was able to get up, close the curtains and drive to the final job for the day.

109 Despite this, I thought that he gave a generally truthful account in his evidence. The doctors in this case have also largely accepted that he has genuine symptomatology in his elbows and that he has significant psychological issues.

110 He certainly has an interesting background in terms of employment and qualifications. His claimed qualifications were not questioned by Counsel despite there being some variation in the various histories taken by the doctors and in the evidence before me.

111 However, having regard to their detail, complexity and limited relevance for the purposes of their examination, it is possible there may have been mistakes in doctors taking that history, which is obviously not crucial in this case anyway. As to his claimed war experience, his treating psychologist gave evidence that the DVA is paying for his PTSD treatment.

112 I do not accept Mr Miles' submission as to Mr Lenehan's motivation to work. He went back to work on light duties with Sargeant's until after a few weeks he was sent home and not offered any further light duties. He believes that he is still formally employed by Sargeant's. Prima facie, it would appear Sargeant's did not comply with its obligations as to return to work under the Act rather than Mr Lenehan.

113 Further, Mr Lenehan arranged and applied for a forklift licence on his own initiative. He did voluntary work as a forklift driver for some months, hoping to advance his work experience. He stated he only ceased that work because of his concerns over increasing PTSD symptoms. Allegations that he did not want to work to increase his chances of a large settlement to buy a yacht is speculative at best and, I believe, incorrect.

114 Looking at the elbow claim, what is significant in this case is that all of the doctors in this case, including the VWA doctors except Dr Barton, accept Mr Lenehan had a continuing work injury, having at least bilateral medial

epicondylitis of varying severity, as at the dates of their examinations. Although Professor Buzzard in October 2015 thought the elbow had substantially resolved, he still considered the continuing symptoms were work-related, though not enough to give an AMA permanent impairment in the left elbow.

115 Of course, the sheer weight of numbers does not mean that Dr Barton is wrong in his opinion. However, I found that his evidence and opinion to be unsatisfactory in a number of ways. At times he appeared to be more concerned with maintaining his original opinion rather than considering the actual facts in this case. He took a very theoretical and dogmatic approach in his reports and in his evidence as to diagnosis, causation and recovery. Despite the radiological findings (which he referred to as being possibly false positives), his examination findings and acceptance of Mr Lenehan's symptoms, he was reluctant to diagnose bilateral medial epicondylitis and the likelihood of some aggravation or exacerbation of that condition by the incident on 8 July 2014.

116 His evidence varied as to what he referred to as the likely recovery time of any aggravation or exacerbation event. At one point in his evidence this was “a day or two” and at another “a few weeks”. I believe that he was simply pulling figures out of the air rather than giving a considered opinion, acknowledging that he had accepted Mr Lenehan had continuing symptoms at both of his examinations.

117 I accept the other medical evidence as outlined that Mr Lenehan has had and continues to have work-related bilateral medial epicondylitis. However, I do not accept that any lateral epicondylitis is related to his work. There may be radiological evidence as such, but there has been little complaint of relevant symptoms as such by Mr Lenehan. Further, there was no complaint of such until well after he had ceased his employment.

118 In making my finding, I make my finding in this regard having regard to the factors set out in cl.25 of Schedule 1. Hereditary risks, lifestyle and outside work activities do not appear relevant in this case. As this case only involves a single incident, the duration of his employment and the nature of the tasks are of little relevance as well.

119 More important aspects are the particular tasks of the employment and the probable development of the injury occurring if that employment had not taken place.

120 As to the former, Mr Lenehan has been consistent in describing the relevant incident to the various doctors in this case and liability was initially accepted anyway. As to the latter, I note that the relevant provision refers to “employment” and not a specific injury. It seems to be more relevant to a “throughout the course of employment” claim, rather than one based on a single incident.

121 Certainly, the changes shown on the first ultrasound were probably pre-existing. I accept they were asymptomatic prior to 8 July 2014 and prior to his employment with Sargeant’s.

122 I also accept that his condition has been rendered symptomatic on a continuing basis, though his symptoms vary in severity and can even flare up without apparent cause. I believe this is reflective of the nature of his injury in that his injury has made him more susceptible to symptomatic flare-ups from time to time, even if with little aggravation. Such symptomatic flare-ups should not be seen as new injuries in themselves.

123 The DVD surveillance did more to confirm, rather than contradict, Mr Lenehan's evidence of disability. He was shown carrying light items in his non-dominant left arm rather than utilising the more painful dominant right arm.

124 I now move on to the psychological psychiatric aspects of the claim. This has

two aspects. Firstly, there is the issue of an adjustment disorder with anxiety and depression, consequential upon the physical injury to the elbows.

125 This is referred to by the only two psychiatrists in this case, Dr Tagkalidis who examined Mr Lenehan for his impairment lump sum claim and Dr Weissman who examined him later as part of the medical panel assessment of the same claim. Some of the surgeons and physicians who have examined Mr Lenehan have referred to this in a roundabout way as well.

126 Secondly, there is the PTSD aspect, more particularly the alleged exacerbation or aggravation of that pre-existing, though largely dormant, PTSD condition which Mr Lenehan said he was able to self-manage prior to 8 July 2014.

127 Certainly, Mr Lenehan believes that his PTSD has flared up and been made worse by a number of aspects of Sargeant's, and the authorised agent's, handling of his claim.

128 Firstly, he was sent home and not re-offered light or modified duties, despite his willingness to continue. Secondly, there was the delay in the proper calculation as to pre-injury average weekly earnings which placed him under financial strain for some time.

129 Thirdly, his weekly payments and reasonable medical and like expenses were wrongly terminated on the basis of a typographical error in a GP's request for an ultrasound. It took some time for this to be rectified and his benefits reinstated, if only for a period prior to being terminated again.

130 Fourthly, the later termination (the subject of these proceedings) has meant that he has been placed under further financial pressure, been unable to continue medical and physiotherapy treatment and get access to rehabilitation or vocational assistance programs.

131 Mr Holland, the psychologist, has only considered PTSD in his treatment in

this case. He considers the dealings by Sargeant's and the authorised agent as being the major reason for what he refers to as the "exacerbation" of the PTSD. Mr Holland was not asked, and did not offer any opinion, as to any adjustment disorder, anxiety and depression, or whether the physical injury itself had played a part itself in the exacerbation of that PTSD. Obviously, he is not a medical practitioner but is a psychologist trained in PTSD. He treats Mr Lenehan for PTSD with his treatment expenses being paid by the DVA. These aspects may explain him not addressing other possible mental disorders.

132 I have already pointed out the limitations on Dr Tagkalidis report as to any link between PTSD and his employment or injury. However, Dr Weissman on the medical panel concluded at p.11 of the Reasons "the worker is suffering from a chronic adjustment disorder with depressed and anxious mood and a moderate aggravation of a mild pre-existing PTSD". As I noted, Dr Weissman did take a history of the direct effects of the physical injuries such as pain and restriction, as well as what he referred to as "grievances regarding the WorkCover agent and his pre-injury employer".

133 Counsel referred to my decision in Sheppard v Wesfarmers [2015] VMC 22 in which I discussed a number of cases as to causation in workers compensation matters and consequential injury, in particular referring to March v Stramare Pty Ltd [1991] 171 CLR 506 at 524. I see no need to repeat the matters set out in my previous decision.

134 Despite the lack of reference by Mr Holland, I accept that Mr Lenehan does have an adjustment disorder and some anxiety and depression as a direct of his physical injury to both elbows. In particular, the resultant pain, limitation and restrictions arise therefrom. It is not separate to, but forms part of, the physical injury to both elbows.

135 Insofar as the PTSD is concerned, I need to consider the various elements in

cl. 25 of schedule 1 as well. The major aspects of that clause relevant to this case involve paras. (d) and (g) as to probable development otherwise and also other activities. There is no doubt that Mr Lenehan had previously diagnosed and treated PTSD for some time prior to 8 July 2014.

136 I accept his evidence that his coping techniques meant that the PTSD was relatively dormant prior to his elbow injury. I accept Mr Holland's view that various aspects of the conduct of Sargeant's and the authorised agent was the major cause of his later exacerbation. Applying the principles set out in March v Stramare (supra) and the other cases I referred to in Sheppard v Wesfarmers (supra), I find that his employment and its consequences were a significant contributing factor to that aggravated PTSD injury. Further, such injury arose out of his employment for the same reasons.

137 I do not see that the four elements that I have previously referred to are a "novus actus interveniens" separate to his employment or his physical injury. Clearly, as a matter of common sense, Mr Lenehan would not have been exposed to that conduct of Sargeant's and the authorised agent after 8 July 2014 unless he had suffered his physical injury.

138 To put it another way, I can take account of the effects of the termination of payment for his reasonable medical and like treatment as it affects his physical injury. For example, if he was unable to have physiotherapy because of an inability to pay, this may lead to increased pain and restriction in function. It is no different to take account of the effect of the authorised agent's decision to terminate his worker's compensation benefits as it affected his mental state.

139 I emphasise that I do not find that the employer or authorised agent had acted wrongly at any time, or more particularly, had tried consciously to cause any difficulty to Mr Lenehan. Unfortunately, this has been part and parcel of a worker's compensation claim and being involved in consequential litigation.

140 In this regard I refer to it a decision of Judge Just and members of the former Workers Compensation Board in Hruskar v Champion Meat Packing [1974] 4 WCBD 408.

141 In that case a worker had a relatively minor physical injury but developed what was diagnosed as “litigation neurosis” resulting in total incapacity. The causes of such were outlined by the Board in its Decision, including such factors as social isolation, various medical examinations, loss of money and the "delay and uncertainty which is unavoidable but part of the process of litigation".

142 In that case the Board accepted that the worker’s litigation neurosis stemmed from the original injury and was thus compensable under the Workers Compensation Act.

143 Similar considerations apply in this case. No doubt there were other factors such as the marital property dispute which played a limited role in the flare up of his PTSD. On the balance of probabilities for the reasons I have set out, I accept the aggravation of the PTSD did arise out of his employment which was a significant contributing factor.

144 As I pointed out, both parties agree that Mr Lenehan has a “current work capacity” in that on the medical material, apart from Dr Barton, he is unable to return to work driving vehicles with curtain walls. Even Dr Barton at one stage in his evidence stated that he would be better advised not to undertake such work in future anyway.

145 Thus, my final order in this case is that Mr Lenehan is entitled to weekly payments on the “current work capacity” basis from 3 July 2015 and continuing with reasonable medical and like expenses from 16 July 2015.

146 I determine that his continuing work-related injuries are the "aggravation and acceleration of bilateral epicondylitis, adjustment disorder with anxiety and

depression and post-traumatic stress disorder".

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