CITATION: *Jason Bannister Green v Porosus Pty Ltd* [2013] NTMC 005

PARTIES:	JASON BANNISTER GREEN v POROSUS PTY LTD
TITLE OF COURT:	WORK HEALTH COURT
JURISDICTION:	WORK HEALTH
FILE NO(s):	21128829
DELIVERED ON:	15 March 2013
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JUDGMENT OF:	Dr John Allan Lowndes

CATCHWORDS:

WORK HEALTH – DISCRETION TO MAKE DECLARATORY ORDERS – BURDEN AND STANDARD OF PROOF IN RELATION TO CONSEQUENTIAL INJURIES – RESOLVING CONFLICTS OF EVIDENCE IN MENTAL INJURY CASES INVOLVING THE APPLICATION OF DSM IV

Aussie Airlines Pty Ltd v Australian Airlines Ltd (1996) 68 FCR 406 applied
March v Stamere Pty Ltd (1991) 171 CLR 506 applied
Newton v Masonic Homes [2009] NTSC 51 applied
Adelaide Stevedoring Co Ltd v Forst (1940) 64 CLR 538 applied
McLean v Commonwealth (unreported) NSW Court of Appeal 31 December 1996 considered

REPRESENTATION:

Counsel:	
Worker:	Mr B O'Loughlin
Employer:	Mr D McConnel
Solicitors:	
Worker:	Priestleys
Employer:	Hunt and Hunt

Judgment category classification:	A
Judgment ID number:	[2013] NTMC 005
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IN THE WORK HEALTH COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 21128829

BETWEEN:

JASON BANNISTER GREEN
Worker

AND:

POROSUS PTY LTD
Employer

REASONS FOR DECISION

(Delivered 15 March 2013)

Dr JOHN LOWNDES SM:

BACKGROUND TO THE PROCEEDINGS

1. On or about 22 January 2008 the worker was collecting crocodile eggs during the course of his employment with the employer and was attacked by a 3.5 metre crocodile. He was bitten on his right arm by the crocodile. At the same he was accidentally shot by a colleague who was attempting to defend the worker from the attack.

2. As a result of the work related incident the worker commenced proceedings in the Work Health Court under the *Workers Rehabilitation and Compensation Act*. In these proceedings the worker alleges that he suffered the following injuries as a result of the incident:

- Fractured right arm (requiring multiple surgeries and total elbow replacement;
- Crocodile bite;
- Gunshot wound

3. As a consequence of those injuries the worker alleges that he suffered the following conditions, each of which is said to be a sequela, or medical condition attributable to the alleged injuries:

- Various infections;
- Left shoulder pain
- Neck and back pain;
- Scarring to right arm and both hips;
- Bone graft from hip;
- Hip pain;
- Loss of motion and strength to right arm;
- Mental injury; and
- Nerve damage and loss of sensation to right arm and hand.

4. The employer having declined to accept the alleged injuries and sequelae, the worker seeks a declaration that the worker suffered the disputed injuries and sequelae.

5. In these proceedings the employer admits the injuries – that is the fractured right arm (requiring multiple surgeries and total elbow replacement), the crocodile bite and the gunshot wound. However, with respect to the alleged sequela, or medical conditions attributable to the injuries, the employer:

1. admits the infections described in the worker's particulars of infections dated 10 December 2012; and further admits that these infections are attributable to the injuries (however, the worker does not currently suffer from any infection);

2. denies any alleged left shoulder pain and denies that any alleged left shoulder pain is attributable to, or a sequelae of the injuries;

3. denies any alleged neck and back pain and denies that any alleged neck and back pain is attributable to, or a sequelae of the injuries;

4. admits that the scarring to the right arm is attributable to the injuries.

5. admits the scarring to the hips as a consequence of the bone graft procedures.

6. denies any alleged hip pain and denies that any alleged hip pain is attributable to the injuries;

7. admits that the worker has sustained the loss of motion and strength to the right arm determined by the Consolidated Panel who assessed the worker's degree of permanent impairment as reported on 31 January 2012 and admits that such loss of motion and strength to the right arm is attributable to the injuries;

8. denies any alleged mental injury and denies that any alleged mental injury is attributable to, or a sequelae of the injuries;

9. denies any alleged nerve damage and loss of sensation to the right arm and hand and denies that any alleged nerve damage and loss of sensation to the hand is attributable to the injuries.

6. The employer denies that the worker is entitled to the declaratory relief sought in the Amended Statement of Claim.

7. By way of further background, it should be noted that following receipt of a workers compensation form lodged by the worker the employer initially accepted liability for the claim, and commenced making payments to the worker under the Act. However, those payments were subsequently

cancelled by the employer by a Notice of Decision pursuant to s 85 of the Act.

8. Prior to the commencement of proceedings, the worker and employer attempted to mediate the disputed injuries and sequelae. The worker says that prior to mediation he asked the employer to accept the injuries and sequelae. However, the employer denies a request having been made in those terms, and says that the worker asked the employer to accept the alleged conditions attributed to the injuries as injuries in their own right.

9. As is apparent from the pleadings, the sole focus in these proceedings is on whether the worker is entitled to a declaration that he suffered the disputed injuries and sequelae. The parties do not seek to ventilate any other aspect of the worker's claim for compensation at this stage.

THE NATURE OF DECLARATORY RELIEF IN WORKERS COMPENSATION PROCEEDINGS

10. The following explanation of a declaration of liability or declaratory award is set out in Boulter *Workers Compensation Practice* (Law Book Company Ltd 1966 at [326]:

> If a worker sustains injury which does not incapacitate him for work, he will not be entitled to an award of weekly compensation, but if it is probable that at a future date he will suffer incapacity, then he is entitled to a declaratory award, which is some safeguard or protection for him when such incapacity does occur.

11. As pointed out by the learned author, the House of Lords in *King v Port of London Authority* [1920] AC 1 recognised a claimant's right to a declaratory award under certain circumstances:

> It is hereby declared that the claimant has received an injury arising out of and in the course of his employment; but inasmuch as the evidence has not established that up to the date hereof the applicant has, as a result of such injury, been incapacitated for work for any period, but on the other hand established that there is a reasonable possibility that such incapacity may ensue, it is ordered that this arbitration stand adjourned, reserving to each

> of the parties hereto liberty to make such further application in the matter as he or she may be advised.[1]

12. As made clear in *Marshall v Clayton & Shuttleworth* [1991] 1 KB 509, whether there is a probability of any future development of the injury is a question of fact in each particular case.[2]

13. It is also important to consider the type of cases in which it may be appropriate to bring an application for a declaratory award. This is a topic also covered by Boulter:

> There has been some criticism of the bringing of applications for a declaratory award eg; *Devine v Brown's Wharf Ltd* [1949] WCR 70, in which case the origin and history of such declarations were traced, and whilst it is clear that there is no legal necessity to have such an award in order to protect future rights, nevertheless from the practical point of view there a number of cases in which it is important to the worker to have such an award. This is particularly so where the medical opinion depends upon the description of the symptoms by the patient. It is not difficult to recall cases in which the applicant has had the greatest difficulty in describing and recalling symptoms with any degree of accuracy. Probably the most common class of case in which awards are made is in respect of hernias. Similar criticism of the introduction into New South Wales of the declaration of liability to that in *Devine Case* (supra) was made in *Waters Trading Co v Eade* [1950] WCR 140. It is submitted, however, that these decisions tend to underestimate the difficulties of proof in a limited class of case, but in any case the power to make such an award is not challenged.[3]

14. A further commentary on declaratory awards is to be found in Hill and Bingeman *Principles of Workers Compensation* (Law Book Company Ltd 1981 at 79):

> Although declarations of liability are not common, they are sometimes necessary because as Lord Birkenhead pointed out, witnesses in such cases are often fugitive and the just claim of the worker might easily be destroyed by the indefinite postponement of a hearing (*King v Port of London Authority* (supra).

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[1] See Boulter *Workers Compensation Practice* at [326]. However , in light of developments in the law since 1920, modifications have been made to the precise form of order dealt with in *King v Port of London Authority*: see Hill and Bingeman *Principles of Workers Compensation* (Law Book Company 1981 at 79).
[2] See Boulter, n 1 at [326].
[3] Boulter n 1 at [326].

15. What must firmly be kept in mind is that the granting of declaratory relief is a discretionary matter. In *Aussie Airlines Pty Ltd v Australian Airlines Ltd* (1996) 68 FCR 406 at 414 Lockhart J conveniently summarised the principles guiding the exercise of the discretion to grant declaratory relief:

> For a party to have sufficient standing to seek and obtain the grant of declaratory relief it must satisfy a number of tests which have been formulated by the courts, some in the alternative and some cumulative. I shall formulate them in summary form as follows:
>
> - The proceeding must involve the determination of a question that is not abstract or hypothetical. There must be a real question involved, and the declaratory relief must be directed to the determination of legal controversies: *Re Judiciary and Navigation Acts* (1921) 29 CLR 257. The answer to the question must produce some real consequences for the parties.
>
> - The applicant for declaratory relief will not have sufficient status if relief is "claimed in relation to circumstances that [have] not occurred and might never happen": *University of New South Wales v Moorhouse* (1975) 133 CLR 1 at 10 per Gibbs J; or if the Court's declaration will produce no foreseeable consequences for the parties: *Gardner v Dairy Industry Authority (NSW)* (1977) 52 ALJR 180 at 180 per Mason J and at 189 per Aickin J.
>
> - The party seeking declaratory relief must have a real interest to raise it*: Forster v Jododex Australia Pty Ltd* (1972) 127 CLR 421 at 437 per Gibbs J and *Russian Commercial & Industrial Bank v British Bank for Foreign Trade Ltd* at 448 per Lord Dunedin.
>
> - Generally there must be a proper contradictor: *Russian Commercial & Industrial Bank* at 448; and *Ainsworth* at 596 per Brennan J. [4]

16. In *Declaratory Orders* PW Young AO[5] points out that a declaration should only be made if the dispute is "real", that is:

> A dispute will be held to be unreal "if the declaration sought had been granted it could not have been immediately and effectively available to resolve the dispute between the parties". For the purposes of this formula:

[4] See [9] of the workers further submissions dated 11 January 2013.
[5] The author was a judge of the Equity Division of the Supreme Court of NSW from 2001 to 2009 and since 2009 has been a judge of the NSW Court of Appeal.

> A declaration may be "immediately available" when it determines the rights of the parties at the time of the decision with necessary implications and consequences of these rights, known as "future rights". These "future rights" are to be contrasted with "hypothetical rights", which can only come into existence upon the happening of some contingency which may or may not occur after the decision and which cannot be the subject matter of a declaration.[6]

17. As pointed out in the employer's further written submissions dated 15 February 2013 this overarching principle has been applied by Australian Courts*: See the Dairy Farmers Co-Operative Milk Company Limited v Commonwealth* (1946) 73 CLR 381; *Coles v Wood* [1981] 1 NSWLR 723; *Re: Ainsworth* (1992) 175 CLR 564.[7]

18. The worker submits that it is entirely appropriate for the Court to entertain the declaratory relief as sought in the Amended Statement of Claim. The worker refutes the suggestion made by the employer that the declaration sought is of negligible significance, and that even if the worker established his case the Court should, in the exercise of its discretion, decline to make a declaratory order.[8]

19. At paragraph 8 of his further submissions dated 11 January 2013 the worker points out the issues in the present case are "real and will have legal consequences between the parties":

    (a) The proposed assessment of whole person impairment (WPI) failed to include reference to the psychiatric injury. A declaration that the worker does suffer from PTSD will very likely affect the WPI assessment. At the moment the extent of that effect is not quantified (the employer raised this issue in closing) and the Court has no evidence to support the employer's contention that the effect will be negligible. Without this evidence the employer's submission should simply be rejected.

    (b) The worker has also claimed shoulder and neck pain as a consequence of the injury and the employer has denied this aspect of the injury. These conditions will also be likely to affect the WPI. Further, the worker's evidence was that these were ongoing and

[6] See the text at p 59, referring to Hudson "Declaratory Judgments in Theoretical Cases: The Reality of Dispute" (1977) Dalhousie Law Journal 706-725.
[7] See [20] – [24] of the submissions.
[8] See [7] of the submissions.

regular complaints. The worker is entitled and prudent to obtain declarations. If the worker failed to act until later, he would have been criticised for delay. Declarations will also allow the worker to receive reasonable treatment and rehabilitation for these conditions.

(c) Scarring, nerve damage, hip pain will also be likely to have WPI consequences and also allow the worker to receive reasonable treatment.

(d) In addition, all of the alleged consequences attributable to the injury will affect the earning capacity of the worker.

(e) The psychiatric condition is of particular relevance as a favourable declaration will allow the worker to compel the employer to fund reasonable treatment. Not only will this have direct health benefits to the worker, Dr Frost (in her reports) stated that this may allow him to return to work and reinstate his earning capacity.

20. The worker submits that in this case the making of a declaratory order will have "real consequences for the parties"; [9] and "there will be real benefits to the worker in that (if the Court so orders) he will receive reasonable treatment for his psychiatric injury, increase his WPI assessment and give the parties greater certainty as to the compensation for the treatment of ongoing injuries".[10]

21. The employer made the following submissions with respect to the declaratory relief sought by the worker:

> The employer's submission as to the utility of a declaration did not apply to the issue of a psychiatric sequelae injury. It was confined to the issue of the worker's claim for a sequelae injury of left shoulder pain. In relation to the claim for shoulder pain, the evidence disclosed that:
>
> (a) The worker suffered an episode of shoulder pain from May to November 2011;
>
> (b) The worker does not claim to be owed compensation in respect of the period covering that episode.

[9] See [10] of the submissions.
[10] See [11] of the submissions.

> Even if the worker's episode of shoulder pain was attributable to the injury, that would make no difference to the worker's claim or to any question of his eligibility for compensation at the present time or any future time. It would be a different matter if, for example, the worker asserted that as a consequence of the injury (a) he has a tendency to over use of his left arm and shoulder; and (b) such tendency limits the worker's capacity for work and therefore constitutes an injury for the purposes of the Act.
>
> There is utility in finding that an injury has occurred where there is a likelihood of future compensation being payable in respect of that injury. In the present case however, the injury in question had resolved by November 2011. Given it is not the primary injury for which liability has been accepted, then any future episode of left shoulder pain must be assessed on the facts relevant to the onset of that future injury at that time. The circumstances of the worker having sustained an injury in May 2011 that had resolved by November 2011is, at best, of historical interest to any future diagnosis by a medical expert. The Court does not need to make a finding of fact in order for any future medical expert to take that matter into account. For now, there is no utility at all in making that finding, because no relief flows from that finding at all – no relief flows from any historical aspect of such a finding, and no future relief can flow from such a finding, either.
>
> The point is apposite in relation to an assessment for permanent impairment. The worker cannot seek to include a complaint of left shoulder pain for the purposes of an assessment of this degree of permanent impairment under the Act, unless that complaint is ongoing (or at least, intermittent but continuing). Otherwise, it is no more than an historical circumstance of pain that may or may not have occurred in connection with the injury. By virtue of it being an historical episode only, it can in no way be regarded as a permanent impairment within the meaning of the Act….
>
> The employer accepts that if the Court finds that any of the remainder of the alleged injuries is a continuing injury, then it is reasonable for the Court to make a finding by way of declaration as to those injuries because they may be taken into account for the purposes of a permanent impairment assessment.[11]

22. Having considered the law regarding declaratory orders and the submissions made by both parties I am satisfied there is a sufficient basis for the Court entertaining the worker's application for declaratory relief. Although the employer disputes the alleged consequential injuries and their continuing

[11] See [15] – [18] and [25] of the employer's further written submissions dated 15 February 2013.

nature (particularly in relation to the complaint of left shoulder pain) the worker claims that all the injuries or their effects are ongoing. If any of the claimed injuries are shown to be consequential injuries and ongoing they may, at least, be taken into account for the purposes of permanent impairment assessment.

23. It is of course one thing to entertain an application for declaratory orders – whether or not a court is prepared to make such orders is an entirely different matter.

THE SEQUELAE OR MEDICAL CONDITIONS ATTRIBUTABLE TO THE INJURIES

The Burden of Proof and Related Matters

24. The parties are in agreement that it is the worker who bears the onus of establishing a basis for the declaratory order or orders.

25. That concurrence is in accordance with the decision in *Newton v Masonic Homes* [2009] NTSC 51 per Mildren J, although the pleadings in that case were not the same as those in the present case. In that case the worker did not confine the issues to an appeal, but sought to claim inter alia for a consequential injury to her left hand, arm and shoulder and a second consequential injury, namely, a psychiatric or psychological condition. His Honour concluded that as the worker had specifically pleaded that the injury to the left hand and the psychological injury were sequelae to the injury to the right hand, and sought declarations accordingly, the worker bore both the legal and evidentiary onus of proof.[12]

26. In discharging that burden, the worker must:

> (a) prove the sequalae or medical conditions alleged in the Amended Statement of Claim;

[12] [2009] NTSC 51 at [24]. See also *Spellman v RSL* [2004] NTMC 087 at [22] –[26] where the Work Health Court also concluded that the onus is on the worker to establish that a particular consequence is in fact a sequela of an injury.

(b) prove a causal connection between the sequelae and medical conditions on the one hand and the physical injuries (which are admitted and in respect of which the employer has admitted liability) on the other hand;[13] and

(c) prove both (a) and (b) in accordance with the civil standard of proof, namely the balance of probabilities.

27. With respect to the issue of causation, the High Court in *March v Stamere Pty Ltd* (1991) 171 CLR 506 made it clear that the legal test of causation does not merely involve the application of the "but for" test, but is ultimately a question of commonsense determination of fact.

28. Subsequently in *Medlin v State Government Insurance Commission* (1995) 182 CLR 1 at 6-7 Deane, Dawson, Toohey and Gaudron JJ affirmed that the question whether a causal connection exists is essentially one of fact to be resolved, on the balance of probabilities, as a matter of commonsense and experience. At the same time the Court acknowledged that while the "but for" test retained "an important role as a negative criterion which will commonly (but not always) exclude causation if not satisfied, it is inadequate as a comprehensive positive test".

The Alleged Sequelae or Medical Conditions

(a) Left Shoulder Pain

29. The first issue that falls for consideration is whether the worker in fact sustained the alleged injury – namely left shoulder pain.

30. The worker gave evidence of having sustained an injury to his left shoulder at work in May 2011. Following the injury he saw a general practitioner and

[13] See *Newton v Masonic Homes* [2009] NTSC 51 at [25] where Milden J stated:
"If the worker is asserting that an injury is a consequence of another injury, the worker must prove what he or she asserts. Plainly, a physical injury may have consequences beyond the actual injury to the specific part of the body originally injured and, if so, they are part of the original injury. But whether or not such sequelae are part of the original injury requires proof of a causal connection".

went for an ultrasound. The ultrasound disclosed a tear in the rotator cuff muscle.[14] He subsequently received physiotherapy. His shoulder eventually came good. Mr Green could not recall any pain in his left shoulder prior to either the 2011 incident or prior to the crocodile attack.

31. The worker's evidence is that prior to the 2011 incident he was using his left arm at work because of the previous injury to his right arm and consequential disability.

32. It seems fairly clear that the worker experienced an episode of left shoulder in May 2011. So much appears to be conceded by the employer.[15] The worker's account of that injury is corroborated by clinical records as well as physiotherapy records; although Dr Bain, who was Mr Green's treating surgeon over the course of 3 or 4 years, reported having no recollection of any complaint of left shoulder pain. It is noted that in her report Dr Frost recounted the history given by the worker as to the nature of the injury, which he referred to as a torn rotator cuff. Dr Frost noted that the reported injury was in the nature of a tear in the supraspinatus muscle, which was able to be treated by a short course of physiotherapy. Dr Frost further noted that the left shoulder problem resolved.

33. Although the evidence supports the worker's account of an injury to his left shoulder, that is not the end of the matter. The worker must also establish to the satisfaction of the Court that the injury was causally related to the primary injury to his right arm.

34. The worker has attributed the left shoulder pain to the overuse of his left arm because of his right arm disability, thereby providing the requisite causal nexus between the two injuries.

[14] See Exhibit W1 p 39 where it is recorded that the left shoulder pain was caused by a tear in the supraspinatus muscle and bursitis.
[15] See [8] of the employer's written submissions dated 14 December 2012.

35. The worker also relies upon "intuitive inference" – as discussed in *Adelaide Stevedoring Co Ltd V Forst* (1940) 64 CLR 538[16] - as a basis for establishing the causal nexus. Intuitive inference is concerned with an examination of the sequence of events in a particular case, and then asking whether that sequence of events would intuitively "inspire in the mind of any common sense person" a causal connection between the events. The worker made the following submission:

> According to *Adelaide Stevedoring*, the principle allows a court to rely on its commonsense to form an "intuitive inference" or "presumptive inference" or a "preliminary assumption". In that case the medical witnesses could not state that the injury (heart attack) was caused by the difficult work. Rich ACJ thought that the sequence of events was enough to raise a presumption. Although in that case the "current medical views" were that there was insufficient basis to connect the work to the injury, this medical doubt was not sufficient to overturn or rebut the presumption.
>
> This reasoning may be open to the current matter….[17]

36. Dealing first with the matter of intuitive inference, the employer submits that such a process of reasoning cannot, in the present case, provide a sufficient basis for establishing a causal connection between the two injuries.[18]

37. In my opinion, in the present case, there is absolutely no scope for drawing an intuitive or presumption inference concerning the causal connection between the left shoulder condition and the primary injury. Unlike the facts or circumstances in *Adelaide Stevedoring* the sequence of events - that is to say the primary injury followed by the left shoulder condition – are not such as to intuitively inspire in the mind of any commonsense person a causal nexus between the two injuries.

38. Turning to the hypothesis that the worker's left shoulder pain was caused by using his left arm in substitution for his right arm, the Court cannot be

[16] See also *Hand v Alcan Gove Pty Ltd* [2007] NTMC 041.
[17] See [4] and [5] of the worker's further written submissions dated 11 January 2013.
[18] See [5] – [9] of the employer's further written submissions dated 15 February 2013.

satisfied on the balance of probabilities that there is such a causal connection between the left should pain and the worker's injured right arm and consequential disability.

39. In order to be reasonably satisfied as to the existence of such a causal nexus the Court would require medical evidence – or sufficiently cogent medical evidence – connecting the condition of bursitis in the left shoulder, or the supraspinatus tear in the left shoulder to overuse occasioned by compensating for the worker's injured right arm.[19]

40. There is a conspicuous absence of supporting medical evidence making the requisite connection.

41. The worker's general practitioner's evidence regarding the connection between the worker's right arm condition and the onset of left shoulder pain in May 2011 did not extend beyond a mere generalisation – namely "increased use can cause pain in other parts of the body that are compensating for the primary injury".[20] That evidence falls far short of establishing the requisite connection.[21]

42. The evidence given by Dr Bain falls into the same category. Dr Bain merely commented that "it is possible to have pain in other parts of the body that are compensating for the primary injury". This again is a generalisation – and one made in the context of no complaint of left shoulder pain having been made to Dr Bain. Again, the evidence falls far short of establishing the requisite connection.

43. The case for the worker suffers from some fundamental deficiencies. As pointed out by the employer, the worker has not obtained any medical report

[19] See [10] of the employer's written submissions dated 14 December 2102
[20] See Exhibit W1 page 1.
[21] The employer correctly characterised this evidence as falling within the domain of speculative opinion rather than evidence of a likely cause: see page 98 of the transcript.

that connects the condition of bursitis in the left shoulder, or the supraspinatus muscle tear in the left shoulder, to overuse occasioned by compensating for the injured right arm.[22] I agree with the employer's submission that "in the absence of any medical evidence connecting the left shoulder pain to overuse to compensate for the worker's injured right arm, the Court cannot be satisfied that this is the cause of the worker's left shoulder pain".[23]

44. Even the worker's evidence in relation to the consequential nature of the injury is not without problems.

45. Mr Green could not recall if he had reported to his doctor pain in his left shoulder at all during the period 2008 – 2011. The absence of such reports weakens rather that supports the worker's contention that the left shoulder pain was a consequential injury. Indeed, the absence of such reports is consistent with the episode of left shoulder pain being a distinct work related injury.

46. The employer made the following submission

> Moreover, the Court cannot be satisfied that the worker's allegation of left shoulder pain is a condition that can be attributed to his right arm injury, given the clear evidence that such pain arose from and/or was related to duties that the worker performed at work after the right arm injury, namely use of trucks, forklifts, opening of gates and the like with his left arm.[24]

47. This submission suggests an alternative hypothesis (in relation to the genesis of the left shoulder pain) to that advanced on behalf of the worker – namely that the injury to the left shoulder was related to duties the worker was performing at the time, and was a distinct injury of short duration, and

[22] See [10] of the employer's written submissions dated 14 December 2012 and [9] of the employer's written submissions dated 15 February 2013.
[23] See [11] of the employer's written submissions dated 14 December 2012.
[24] See [11] of the submissions.

not a consequential injury caused by overuse of the left arm occasioned by compensating for the primary injury. The fact that the injury was of limited duration and has resolved [25] increases the probability of that alternative scenario.

(b) Neck and Back Pain

48. Again the primary issue is whether the worker suffered neck and back pain. If Mr Green in fact suffered such an injury the question that then needs to be answered is whether that injury is a consequential injury in the sense that there is a causal connection between that injury and the primary injury.

49. The worker complained of pains running down the back of his head (on the left side). He described and demonstrated the pain as running down to his neck muscles and shoulder level. He said that he had the exact pain on the right side, "like a mirror image of the other pain". The worker said the pain was sharp and restricted head movement both to the left and right. He did not have such pain prior to the crocodile attack. He said the pain started after using his left arm all the time at work. He went on to say that one day while at work he felt pain in the back of his head on the left side, which felt like a pinched nerve. He said that after the torn rotator muscle on the left side he had to use his right arm to do certain things. From that point on he started to get pain down the right side of the back of his head and down his neck. He also stated that had pains between his shoulder blades on his back.

50. The worker said that the pain on the right side occurred after the torn rotator cuff, while the pain on the left side occurred much earlier, in about 2010. The worker said that he had told his doctors about the pain.

[25] The fact that the injury had resolved is supported by the fact that when Dr Martins, the workers' general practitioner, saw the worker in November 2011 and was told by the worker that he was using his left arm due his to right elbow, there was no complaint of left shoulder pain, and an absence of any investigation of a continuing left shoulder condition.

51. Mr Green said that the neck pain affected his mobility and sleep. He mentioned the fact that his partner used to grab him by the left arm and help him off the lounge where he slept. He assessed his pain level at 5/10. He went on to say that sometimes he would have the pain for a day, and it occurs about every couple of weeks. He said that the pain was occurring less frequently than it did.

52. The worker said that he currently has pain between his shoulder blades "in his spine". The pain occurs once every 2 weeks but sometimes more, depending on the activity. He described the pain as a dull ache. He rated the pain at 5 or 6/10.

53. Mr Green told the Court that he had experienced back pain prior to the crocodile attack; however it was a different type of pain, and it seemed to come good.

54. The worker's evidence needs to be considered along with the evidence given by Dr Martins, of the Arafura Medical Centre, who saw the worker on several occasions.

55. Dr Martins first saw Mr Green on 30 April 2010, when he told her that he was unable to sleep because of pain in his right elbow. Dr Martins saw the worker again on 10 May 2010. On that occasion he reported experiencing pain in the neck.

56. In June 2011 the worker complained of neck pain. However, this was the first occasion that Mr Green had complained of pain to the right side of his neck.

57. The worker complained of neck pain on 4 July 2011, the morning he was due to start a work placement at Middy's Electrical as part of a return to work plan.

58. The Arafura Medical Centre's records for 2 November 2011 recorded:

> Reports left side of neck pain and that he cannot sleep on his right side due to his right shoulder/arm pain… he has been …using his left arm due to his right arm pain...complains of that, not being able to sleep on his right side because of his elbow and arm pain and having shoulder and neck pain.

59. The only report of back pain by Mr Green to his doctor on any occasion was a reference to neck pain associated with upper back pain, which he claimed made him unable to work on 4 July 2011.

60. The worker gave evidence that he had experienced an episode of back pain when he undertook a computer course provided by the employer, which he attributed to sitting with his arm at a keyboard. Mr Green also told the Court about an episode or episodes of a dull ache in his back while sitting on the couch.

61. Although the Court is prepared to accept that the worker suffered the alleged neck and back pain, the evidence adduced at the trial is insufficient to establish the neck and back pain as a consequential injury for the following reasons:

1. It is apparent from the evidence that the worker did not mention neck pain to his general practitioner for about 2 years after the primary injury. Moreover, the worker's treating surgeon, Dr Bain, could not recall Mr Green ever having reported such pain.

2. The evidence discloses that on the first occasion that the worker complained of neck pain, Dr Martins noted that the worker gave a history that his boss had a similar problem. It is noteworthy that Dr Martins accepted that the significance of that note was that it was something to do with activity at work, as opposed to compensation for the disability caused by the right arm injury. The effect of Dr Martin's evidence is that the pain complained of was related to work duties being performed by Mr Green at the time. Rather than supporting a consequential injury, Dr Martin's evidence supports the neck pain as being a distinct injury - an injury in its own right.

3. The evidence discloses that the worker attended his general practitioner on numerous occasions between April 2010 and June 2011 and during that period it appears that Mr Green did not report ongoing frequent neck pain.[26] The absence of such reporting tends to militate against the existence of a causal nexus between the neck and back pain and the primary injuries.

4. The evidence shows that on 22 March 2010 and 20 September 2010 when the worker was reviewed by Dr Bain – who it must be remembered was Mr Green's treating surgeon – he did not complain of neck pain. Due to the lack of complaint of such pain there is no expert opinion evidence from Dr Bain regarding the causal connection between the neck and back pain and the primary injuries.

5. The evidence further shows that the worker's complaints of neck pain did not occur with any frequency until after the worker had ceased employment. The employer, in its submissions, pointed out the significance of this evidence.[27]

6. As submitted by the employer, the worker's evidence as to the existence of back pain does not go beyond establishing occasional back pain that one might expect to occur through posture or to be occasioned by a particular kind of activity.[28]

62. The worker bears the burden of proving the requisite connection between his complaints of neck and back pain and the primary injuries. That onus has not been discharged.

63. First, there is no medical evidence – or sufficiently cogent medical evidence – to establish to the satisfaction of the Court a causal nexus between the neck and back pain and the primary injuries. The present case is an instance where the absence of supportive expert evidence so weakens the worker's

[26] It should be noted that the first occasion on which the worker complained of pain to the right side of his neck was in June 2011.

[27] At [24] of its written submissions dated 14 December 2012 the employer submitted:

> If, as the worker asserts, the neck pain is caused by overuse of his left side to compensate for his right arm injury, then it would be natural to expect such complaints to arise when the worker was physically active in work. In the course of his evidence, the worker gave some examples of the type of work he was doing including dragging crocodile carcasses and assisting in removing their skins, using his left arm.

[28] See [29] of the submissions.

case that a finding in his favour would be against the weight of the evidence".[29]

64. Secondly, as submitted by the employer, the Court has only the worker's assertion that the occurrence of neck and back pain is due to compensation for the injury to his right arm.[30]

65. Thirdly, the absence of reporting of complaints of neck and back pain to his doctors during a significant part of the post accident period does not assist the worker in discharging the requisite burden.

66. Fourthly, the reported (and substantiated) complaints of neck and back pain do not go beyond proving the occurrence of such pain.

67. Fifthly, the reasoning process of "intuitive inference" does not assist the worker in establishing the requisite causal nexus. The mere fact that the worker did not have neck and back pain before the crocodile attack and accidental shooting, but had it afterwards, does not give rise to an intuitive or presumptive inference that the primary injury caused the neck and back pain.

68. For all of those reasons the Court cannot be reasonably satisfied on the balance of probabilities that the neck and back pain complained of by the worker is attributable to the primary injuries.

(c) Hip Pain

69. It should be noted at the outset that the employer admits the worker has sustained scarring to both hips as a result of hip graft surgeries.

70. Mr Green gave evidence as to the operations he had undertaken in relation to his hip. Dr Bain performed a bone graft from the right side of his hip which was put into his right elbow. As that graft was not successful, Dr Bain did a

[29] See Selby and Freckleton *Expert Evidence* (The Law Book Company Ltd), p 213.
[30] See [25] of the employer's written submissions dated 14 December 2012.

bone graft from the left side of his hip. As a result the worker had scarring to both the right and left side of his hip.

71. The worker complains of pain in both the right and left side of his hip. The worker says that the pain is more regular on the right side, but when pain occurs on the left side the pain is of greater severity. Mr Green says the pain is located in the hip joint – where his leg connects to his hip, behind the scarring, and not actually on the scars. Mr Green says that when the pain occurs on the right side it causes him to limp 2 or 3 times a week.

72. The worker said that he had undergone 30 hip operations. Prior to the crocodile attack he did not have any hip pain.

73. Again the Court cannot be reasonably satisfied on the balance of probabilities that the hip pain complained of by the worker is attributable to the primary injuries, and therefore a consequential injury for the purposes of the *Workers Rehabilitation and Compensation Act*.

74. There are a number of aspects of the evidence that tell against a finding in favour of the worker.

75. The worker has never reported an episode of hip pain to any of his treating doctors.[31] In my opinion, that is particularly telling against the worker, unless there is some expert evidence tending to lend credence to the worker's complaint of hip pain

76. However, there is no medical evidence as to the likely cause of his alleged hip pain. Therefore there is no expert evidence connecting the alleged hip pain with his primary injuries. Again the absence of supportive expert evidence weakens the worker's case in such a manner as to render a finding in favour of the worker to be against the weight of the evidence.

77. The employer made the following submission:

[31] See [31] of the submissions.

> The bone graft from the worker's hips was performed by Dr Bain. The worker has produced numerous reports from Dr Bain for the purposes of this proceeding. It would have been no difficulty for the worker to obtain a report as to the likelihood that a hip bone graft operation would cause episodes of hip pain such as the worker described.
>
> In circumstances where such evidence could have been easily obtained, the Court is entitled to draw an inference that the worker did not do so because that evidence would not have assisted his case (a *Jones v Dunkel* inference). [32]

78. It is surprising to say the least that such evidence was not forthcoming and presented at the trial. As Dr Bain was the surgeon who performed the bone graft he was in a prime position to provide an expert opinion as to the relationship between the bone graft and the hip pain complained of by the worker. The adduction of that evidence was within the absolute control of the worker. In my opinion the unexplained failure, on the part of the worker, to call evidence that was readily available entitles the Court to draw a Jones and Dunkel inference as submitted by the employer.

79. The worker rests his case solely on the basis that he did not have hip pain before the crocodile attack, or indeed after the attack; but it was only after the bone graft that he experienced hip pain. Once again the worker relies upon the Court drawing an intuitive or presumptive inference that the hip pain is attributable to the primary injuries on the basis that the bone graft is a surgical procedure considered to be part of the primary injury, [33] and as matter common sense the hip pain is attributable to the bone graft.

80. Even if the Court were satisfied that the worker suffers from hip pain (which is not the case) then it could not, in my opinion, be intuitively inferred that the hip pain was occasioned by the bone graft.

[32] See [33] and [34] of the submissions.
[33] See *Hand v Alcan Gove Pty Ltd* [2008] NTSC 25.

81. The circumstances of the present case are quite different to the facts in *Adelaide Stevedoring Co Ltd v Forst* (supra). In the latter case the deceased worker had engaged in strenuous activity and within a very short period of time after that activity he collapsed and died. Clearly, that sequence of events gave rise to a prima facie inference that the strenuous activity had caused the collapse and subsequent death. However, the circumstances of the present case do not as readily give rise to a presumptive inference that the hip pain was occasioned by the bone graft. First there is not the temporal connection between the bone graft and the complaint of hip pain as there was between the strenuous activity and the workers' collapse and death in *Adelaide Stevedoring Co Ltd v Forst*. Secondly, the hip pain might have occurred independently of the bone graft, and been occasioned by other factors.

82. However, even if the circumstances of the present case could be considered to give rise to a presumptive inference that the hip pain was causally connected to the bone graft, that prima facie inference would be countered by the Jones and Dunkel inference, which is open to be drawn by the worker's failure to call available evidence on the topic.

(d) Nerve Damage and Loss of Sensation to Right Arm

83. Although the worker gave evidence of the buzzing sensation in his right little finger and a complete absence of feeling along the large scar running from above his elbow and down half way of his forearm, I am unable, in the absence of expert medical evidence, to be reasonably satisfied that the complaint of nerve damage and loss of sensation to the right arm is attributable to the worker's primary injuries.

(e) General Observations in relation to Proof of the Alleged Physical Injuries

84. The worker sought to have each of the alleged physical injuries included in his claim without adequate medical evidence to support them.[34]

85. There was a conspicuous absence of medical evidence connecting Mr Green's complaints of left shoulder pain, neck and back pain and hip pain to his primary injuries; and such expert evidence that was adduced was clearly insufficient to establish the causal nexus.

86. Although in some cases a worker's evidence and other lay evidence may be sufficient to prove a consequential injury, as a general rule, expert medical evidence is needed to persuade a court as to the connection between a subsequent injury and a primary injury. The present case called for such medical evidence. In the absence of such evidence, the Court is unable to be reasonably satisfied on the balance of probabilities that the worker's various complaints of pain were attributable to his primary injuries.

(f) The Mental Injury: Post Traumatic Stress Disorder

87. The worker alleges that he suffers from a consequential mental injury which has been diagnosed as post traumatic stress disorder (PTSD)

88. In support of his case the worker relied upon the evidence of Dr Mary Frost, psychiatrist. In support of its case, the employer relied upon the evidence of Dr Andrew Roberts, psychiatrist. The evidence of the two psychiatrists was conflicting, and the two expert witnesses reached diametrically opposed opinions about whether the worker suffers from PTSD. Whilst Dr Frost was of the opinion that the worker suffers from the condition, Dr Roberts opined that the worker does not suffer from PTSD.

[34] See [7] of the employer's written submissions dated 14 December 2012.

- **General Observations Regarding Disputed Expert Evidence in Mental Injury Cases**

89. The evidence relating to the alleged mental injury presents very real difficulties for the Court in terms of discharging its fact finding function.

90. Those difficulties arose from the fact that the Court has been presented with two diametrically opposed expert opinions as to whether the worker suffers from PTSD as a result of the crocodile attack in June 2008. The conflicting nature of the expert evidence is not the only problem. Evidence concerning the incidence of PTSD in a given case invariably has it own peculiar problems because of the inherent difficulties in establishing the diagnostic criteria for PTSD (in accordance with DSM –IV). In many instances proof of the diagnostic criteria is dependant not upon objective and independent evidence, but upon the self –reporting of the matters that pertain to the criteria by the person who claims to suffer from PTSD.[35] This necessitates not only a painstaking and rigorous examination by the court of the accuracy, completeness and reliability of the self reports, but an equally thorough scrutiny of the ability of the expert witnesses (who have proferred conflicting opinions) to make clinical judgments based on the history (self reports) they have received,[36] including their ability to assess the genuineness and, therefore, reliability of the self reporting process.[37] As pointed out by Freckleton and Selby:

> Much depends in terms of accuracy of diagnosis upon the reliability of patient self-report. If this is flawed, any diagnosis consequent upon it will be flawed – for instance, see *Alagic v Callvar* [1999] NTSC 90.[38]

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[35] See Shea *Psychiatry in Court* (Hawkins Press 1996, p 82). As also pointed out by Freckleton and Selby *Expert Evidence* (The Law Book Company Ltd at [13A-110] some of the symptoms are matters of "personal psychic experience and not readily susceptible of independent verification or corroboration".

[36] As stated by Broodbanks and Simpson *Psychiatry and the Law* (Lexis Nexis 2007 at [9.16]:
"…a crucial aspect of the psychiatrist's role is to evaluate on the basis of clinical interviews and other available material …whether the psychiatric condition exists…"

[37] See Freckleton and Selby n 35 at [13A-110].

[38] See Freckleton and Selby n 35 at [13A-100].

91. A further difficultly with PTSD is the ease with which its symptoms may be feigned, due to its very nature and definition.[39] Indeed, DSM IV itself acknowledges this characteristic of the condition, and counsels mental health practitioners to consider the prospect of malingering, when applying the diagnostic criteria and reaching a diagnosis.

92. As the fact finder, the Court must determine whether on the whole of the evidence the PTSD diagnostic criteria have been satisfied such as to warrant a diagnosis that the worker suffers from PTSD.[40]

93. However, in carrying out that function it is important to keep firmly in mind the comment in the introduction to DSM IV that "the specific diagnostic criteria included in the DSM IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion." This means that the diagnostic criteria are no more than guidelines, which are not to be applied in a rigid or "cookbook" fashion. The specific criteria are meant to serve as guidelines concurrently with clinical judgment. As pointed out by Brookbanks and Simpson:

> The Courts have tended to accept the proposition that the DSM should not be regarded as a "cookbook" and have extended a measure of latitude when psychiatrists have opined that a plaintiff suffers from PTSD in spite of not meeting all of the DSM criteria.[41]

94. In that regard Santow JA said in *McLean v Commonwealth* (unreported NSW Court of Appeal 31 December 1996):

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[39] See Shea n 35 p 82:
" …[a] diagnosis can be made entirely on what the patient tells the psychiatrist, which makes feigning the symptoms a relatively simple process. The psychiatrist can check some of the symptoms with friends and relatives but there is no guarantee that the friends and relatives will be entirely objective and truthful in what they report".
See also Freckleton and Selby, n 35 at [13A -110) where the learned authors refer to the defining characteristics of PTSD as being particularly prone of exaggeration or fabrication because of their being subjective and easy to simulate.
See also Freckleton and Selby, n 35 at [13A-110) where the learned authors say:
"The need for reliance by the psychologist or psychiatrist upon what the patient says creates a potential for erroneous diagnosis by dint of unrecognised fabrication or exaggeration of symptoms".

[40] See Brookbanks and Simpson n 36 at [9.16] where the authors observe:
"…Australian Courts in particular expect diagnoses to be proferred in terms of DSM taxonomies. A tendency toward increasingly rigorous analysis of whether a plaintiff's symptoms fully conform to the criteria for disorders such as PTSD can be discerned from decisions commencing in 1997: see for example *McLean v Commonwealth* (NSW Supreme Court 28 January 1997)".

[41] See Brookbanks and Simpson, n 36 at [9.16].

> The specific diagnostic criteria included in DSM IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion. For example, the exercise of clinical judgment may justify giving a certain diagnosis to an individual, even though the clinical presentation falls just short of meeting the full criteria for the diagnosis, so long as the symptoms that are present, are persistent and severe.

95. However, Santow JA went on to note:

> What is meant by a clinical presentation falling "just short" of meeting the full criteria for diagnosis is not explained in the document. The authors of the text do acknowledge, however, by that statement, that there must be some flexibility in the application of the criteria for particular witnesses.

96. As pointed out by Freckleton and Selby, the Court of Appeal's decision in *McLean v Commonwealth* "liberates diagnosis somewhat from the strait jacket of the "tick a box" criteria of DSM IV and ICD -10, and evinces reservation about the extent to which the courts will regard themselves as bound by the strict terms of the two main international manuals of psychiatric diagnosis".[42]

97. As mentioned earlier, the difficulties associated with the fact finding process in the present case are compounded by the conflicting nature of the expert medical evidence. However, it is clear that disagreement between expert witnesses in a civil case does not preclude proof of a party's case;[43] and it is the function of the tribunal of fact to resolve conflicts of expert evidence, and as a general rule that entails the Court preferring the evidence of one expert over another.

98. The subject of resolving conflicts of expert evidence was touched upon by Lord Bingham in *Eckersley v Binnie* (1988) 18 Con LR 1 at 77-78:

> In resolving conflicts of expert evidence, the judge remains the judge; he is not obliged to accept evidence simply because it comes from an illustrious source; he can take account of demonstrated partisanship and lack of objectivity. But, save where an expert is guilty of a deliberate

[42] See Freckleton and Selby n 35 at [13A-200].
[43] See Selby and Freckleton n 29 p 213.

> attempt to mislead (as happens only very rarely) a coherent reasoned opinion expressed by a suitably qualified expert should be the subject of a coherent reasoned rebuttal, unless it can be discounted for other reasons.

99. The court has the task of carefully examining the nature and quality of the expert evidence adduced during the course of a civil trial and to do so in a broad and commonsense manner: see *Taylor v The Queen* (1978) 45 FLR 343; *R V Weise* [1969] VR 953.[44] In discharging that function, the tribunal of fact is entitled to decide an issue in accordance with evidence which conflicts with expert opinion and which outweighs it.[45]

- **Analysis and evaluation of the whole of the evidence relating to the alleged mental injury**

100. A fundamental difficulty in the present case is that neither Dr Frost nor Dr Roberts saw Mr Green until a few years after the crocodile attack. Between the time of the attack and the psychiatric examinations conducted by Dr Frost and Dr Roberts the worker had returned to work, involving continuing contact with crocodiles – the real nature and extent of that contact not having been disclosed to either psychiatrist. In those circumstances, both psychiatrists have come to a diagnosis based on a retrospective reconstruction, primarily based on the history provided by Mr Green and his self – reported symptoms. Subject to one exception,[46] there is no contemporaneous medical evidence – in particular from a treating general practitioner or psychiatrist - during the intervening period, capable of providing a psychological or psychiatric profile of the worker, which traces and tracks the deterioration of his mental health following the crocodile attack.

101. Against that backdrop the task that befalls the Court is to examine the extent to which the diagnostic criteria contained in DSM IV have been satisfied on

[44] See Selby and Freckleton, n 29 p 213.
[45] See Selby and Freckleton n 29 p 213.
[46] The exception is Dr Erhlick's observation in 2009 that the worker may be suffering from PTSD.

the basis of both the expert evidence given by the two psychiatrists and the lay evidence of the worker and his partner.

102. The diagnostic components of PTSD are contained in Exhibit W 9 in these proceedings.

Criterion A

103. One of the critical components of a PTSD diagnosis is that the individual has been exposed to a traumatic event in which both of the following were present:

1. the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

2. The person's response involved fear, helplessness or horror.

104. There appears to be agreement between Dr Frost and Dr Roberts as to satisfaction of this first diagnostic criterion.[47] Indeed, Dr Roberts accepted that the worker had gone through a traumatic life threatening event and stated that he would not have been surprised if the worker had suffered PTSD as a result of the crocodile attack.

105. In any event, I have independently formed the opinion that the crocodile attack on the worker and the concomitant accidental shooting clearly qualify as a relevant traumatic event and stressor for the purposes of a diagnosis of PTSD. In other words, Criteria A has been satisfied on the evidence.

106. The reason for coming to that conclusion is that a PTSD diagnosis is by definition incident -specific – that is to say it is linked to a specific incident.[48] Invariably, there is objective evidence of the triggering incident or event. That is plainly the case here. Upon proof of the incident or event

[47] See for example page 2 of the worker's outline of closing submissions.
[48] It should also be noted that as PTSD diagnosis is incident specific it clearly determines causation for legal purposes.

all that remains is to make some assessment of the character of that incident or event and decide whether it meets the definition of a traumatic event. That exercise largely requires the application of commonsense. Although the person's response to the event may in part depend upon self reporting from the individual (with respect to emotions of fear, helplessness or horror), the application of common sense will ultimately determine whether the event was a traumatic event.

107. The point that is sought to be made is that, unlike the first diagnostic criteria for PTSD, the remaining criteria for PTSD are, to the most part, not as readily susceptible to objective testing

Criterion B

108. The second diagnostic component of PTSD (Criteria B) requires the traumatic event to be persistently re-experienced in one (or more) of the following ways:

1. recurrent and intrusive distressing recollections of the event;
2. recurrent distressing dreams of the event;
3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated);
4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event;
5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

109. It is clear from the wording of the Criteria B that at least one of the five symptoms must be present. It would seem to follow that if more than one of the symptoms were manifest then that would strengthen a diagnosis of

PTSD, provided the other diagnostic criteria were satisfied. However, the difficulty with the application of Criteria B is that, with the possible exception of the fifth symptom, the listed symptoms are largely reliant upon self reporting and are not readily susceptible to objective testing.[49]

110. In her first report dated 28 May 2012 Dr Frost seemed to rely upon the following symptomatology (as reported by Mr Green) as satisfying Criterion B:

- Continuing experience of vivid dreams and flashbacks to the incident, along with some "black holes" in his recollection and predominant anxiety symptoms;

- Sleep disturbance caused by pain and occasional nightmares – it being noted that for the first 12-18 months following the attack he had almost nightly nightmares of crocodiles; [50]

111. It can probably be inferred from the contents of her first report that Dr Frost also relied upon the symptomatology of "intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event", as meeting Criterion B.

112. Dr Frost does not appear to have relied upon any of the other symptoms listed under Criterion B, though she recorded a history of the worker sweating and thrashing around in sleep, which arguably might be considered to be a "physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event".

113. In her second report dated 22 October 2012 Dr Frost stated:

> Mr Green noted that since meeting with me in May and being diagnosed with post traumatic stress disorder he had become more acutely aware of his symptoms. He often felt anxious and experienced chest tightness and feeling itchy. He noted that his heart was, on occasion, "beating really loudly" when he was driving. Each time Mr Green had exposure to

[49] See Shea n 35, p82.
[50] Dr Frost stated that these nightmares were exacerbated by the birth of his daughter when he started to have nightmares of his daughter being attacked by crocodiles. Dr Frost stated that his partner noted that he is restless, sweating and thrashes around in his sleep.

> crocodiles such as through the newspapers or on TV, he would think about the potential for disaster. When such a trigger occurred he would have dreams that night in which his daughter was being attacked by a crocodile.

114. In that report, Dr Frost also relied upon Mr Green's experience and history of chest pain as indicative of panic attacks – and therefore supportive of a diagnosis of panic.

115. It is apparent that in her second report Dr Frost drew upon the worker's physiological responses as meeting Criterion B – and ultimately contributing to the diagnosis of PTSD.

116. If one of the above symptoms were found to exist, then the symptomatology would fulfil Criteria B. However, as stated earlier, the actual existence of those symptoms is largely dependent upon the accuracy and reliability of the worker's reporting of those symptoms to Dr Frost.

117. The starting point is an examination of the evidence given by the worker at the trial regarding his symptoms.

118. The worker stated that since the crocodile attack he did not sleep very much. He gave evidence that he has nightmares, waking up in the middle of the night. His said that his most recent nightmare was the night before he gave evidence at the trial. He said that he dreamt that he was being attacked by a crocodile. He said that he was grabbed by the crocodile, just like he was in the attack. The worker went on to say that sometimes he would have a nightmare once every 3 weeks and at other times once a month. He stated:

> I notice that if I see things or see documentaries on TV about crocodiles and I – or I start to think about them or when – I've noticed when I've seen kids, like the kids that have been taken lately in the newspaper I start to think about it or dwell on it a bit I seem to have nightmares.

119. Mr Green said that when he first starting having nightmares it was he who was being attacked – reliving the attack in his dreams. However, after the birth of his daughter he started to dream about her being taken by a crocodile, being the same dream every time.

120. The evidence given by the worker generally accords with the symptoms he reported to Dr Frost.

121. The worker gave a broadly similar account of his symptoms to Dr Roberts.

122. As regards the worker's psychiatric/psychological status, Dr Roberts stated that the worker had described "things popping into his head, of his daughter being taken by a crocodile". He also commented on "dreaming or experiencing nightmares in regard to his daughter". Dr Roberts stated that the worker referred to this dream as being of him camping with his daughter, of a crocodile looking at her and of him being unable to get to her. The worker added that he used to dream about himself but now he does not - that the dreams are about his daughter.

123. The symptoms Mr Green reported to Dr Roberts are consistent with the history given to Dr Frost and the evidence given by the worker as to his symptoms at the trial.

124. The high degree of consistency in the reporting of symptoms by the worker to both psychiatrists and the consistency of those self reports with the evidence given at trial is a factor to be weighed in considering the genuineness of the symptomatology.

125. Another factor to be weighed is that Dr Roberts acknowledged that the worker may have had nightmares, and would be unsurprised to hear that he did; although Dr Roberts did not consider that alone to be sufficient to ground a diagnosis of PTSD.

126. Against those factors there are other aspects of the case that militate against the genuineness of the symptoms reported by the worker.

127. The employer made these submissions:

> The worker at no time reported having nightmares to any of his treating doctors, even though he had significant sleep disturbance and frequently reported it to his doctors. When challenged at trial, the worker said that he had no reason to report the nightmares to his doctor. He thought they were just nightmares. The worker made no mention of having discussed it with his partner and of her concern that he should see his doctor about it. The worker's evidence in that regard is inconsistent with such a conversation with his partner ever having happened.[51]

128. The employer also submitted

> If he had really had the nightmares, and if Ms Crouch had really asked him to speak to his doctor about them, he would not have given that answer.[52]

129. It is curious that Mr Green did not report the incidence of nightmares to his doctors, particularly when he had ample opportunity to do so on the various occasions that he complained of sleep disturbance. This failure to report a significant symptom reflects adversely upon the genuineness of his complaint of suffering from nightmares. The worker's belated reporting of his symptoms to Dr Frost and Dr Roberts suggests that he was not, in fact, experiencing the nightmares; and that the incidence of nightmares is a recent invention or fabrication.

130. One needs to ask why Mr Green did not report the nightmares to his doctors at an earlier time and in closer proximity to the crocodile attack.

131. Mr Green does provide an explanation for that failure, which is couched in terms of him not having a reason to report the nightmares to his doctors and his thinking that they were "just nightmares". This explanation suggests that Mr Green did not appreciate the significance of the nightmares – and presumably their connection with a possible psychiatric condition.

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[51] See [58] of the employer's written submissions dated 14 December 2012. It is noted that the worker's partner, Ms Crouch,, gave evidence at the trial that she was aware of his nightmares, and because they were of concern to her, she had discussed the nightmares with Mr Green and suggested he see a doctor about them.
[52] See [90] of the submissions.

132. As the incidence of nightmares is largely dependent upon self –reporting one naturally looks for collateral evidence – ideally of an objective nature – to corroborate the nightmares.

133. In that regard, reliance is placed upon the evidence of Ms Crouch as corroborative evidence. However, as pointed out by the employer, there is a very significant inconsistency between the evidence given by Ms Crouch and the worker's evidence.

134. The fact that the worker made no mention of the conversation said to have taken place between himself and Ms Crouch is surprising. One would expect that, if the conversation had occurred, Mr Green would have mentioned it as it is corroborative evidence of not only the incidence of nightmares, but also their content – evidence that assists in establishing the genuineness of his symptoms.

135. Moreover, it is extremely difficult to understand why the worker would have given the explanation he did for failing to tell his doctors about the nightmares, if in fact he had discussed the nightmares with this partner. The two are difficult to reconcile.

136. Given that Mr Green made no mention of the subject conversation, coupled with the difficulty of reconciling the workers' explanation with the fact of the conversation or discussion, I am unable to be reasonably satisfied on the balance of probabilities that the conversation between Ms Crouch and the worker took place.

137. However, although I cannot be satisfied that the subject conversation took place, that still leaves Ms Couch's evidence in relation to her observations concerning the worker's sleep disturbance and groaning and moaning, and thrashing about in bed. Although her observations are consistent with the incidence of nightmares, they say nothing about the nature and content of those nightmares. Nor do her observations address the frequency of the

nightmares. Essentially, the Court is left with the worker's evidence of his symptomatology, and his self reporting of those symptoms to Dr Frost and Dr Roberts.

138. An aspect that impacts upon the genuineness of the symptoms reported by the worker is that it was only after the first consultation with Dr Frost, and during the second consultation with her, that he reported that each time he had exposure to crocodiles such as through the newspapers or on TV, he would think about the potential for disaster, and when such a trigger occurred he would have dreams that night in which his daughter was being attacked by a crocodile.[53]

139. The timing of this reporting is significant because in her report of 22 October 2012 Dr Frost stated that since her first meeting with Mr Green in May 2012, and after being diagnosed with PTSD, he had become more acutely aware of his symptoms. One of those symptoms was the occasioning of nightmares by newspaper and TV reports about crocodiles.

140. The worker himself agreed that after the first consultation with Dr Frost he had sought out additional information about PTSD. The worker also gave evidence that at the end of the first consultation Dr Frost printed off a list of PTSD symptoms and gave them to him.

141. The sequence of events strongly suggests that after seeking additional information about PTSD Mr Green provided Dr Frost with additional instances of symptoms, including the connection between media reports of crocodile incidents and nightmares.

142. In my opinion, the circumstances under which the worker reported psychological difficulties in the form of recurrent nightmares raises significant concerns over the reliability of the reported symptomatology –

[53] See Dr Frost's report dated 22 October 2012 p 3 under the heading "Recent Psychological Difficulties".

and in turn the reliability of the diagnosis insofar as it is based on satisfaction of Criterion B.

143. But assuming the reliability of the reported connection between media reports and nightmares, what remains unexplained by either the worker or Dr Frost is how the worker coped with working with crocodiles for some three years following the crocodile attack (to the full extent that he admitted under cross examination, and involving many of the features of his pre – injury employment) and exposing himself to a significant risk of injury, but TV and newspapers reports of crocodile attacks were enough to trigger nightmares.[54] It seems extraordinary that the latter would trigger nightmares and not the former. The extraordinary has not been explained. The lack of an explanation weighs heavily against the accuracy and reliability of the symptoms reported by the worker. I agree with the following submission made by the employer:

> …the suggestion that newspaper or television articles about crocodiles has triggered intrusive distressing dreams, when the worker spent the three years after the accident engaged in day to day close contact with crocodiles lacks credibility.[55]

144. Finally, but not least, the worker did not provide either Dr Frost or Dr Roberts with a complete description of the work he undertook at the crocodile farm following the attack.[56] The worker substantially downplayed his exposure to crocodiles after the crocodile attack. One must ask why. The rational and dominant inference is that Mr Green was attempting to "tailor his evidence to support a diagnosis of PTSD".[57]

145. This very significant non – disclosure and concomitant inference inevitably weighs heavily against the accuracy and reliability of the Criterion B symptomatology reported by the worker. The fact that Mr Green has been a

[54] See [62] of the employer's written submissions dated 14 December 2012.
[55] See [66] of the submissions.
[56] See [63] of the submissions. The further significance of this non-disclosure is discussed later in these reasons for decision.
[57] See [68] of the submissions.

less than open and frank historian in relation to his post –injury work history, and significant involvement with crocodiles, is such a fundamental defect in the self reporting process as to contaminate and impugn the validity of other related aspects of that process – that is to say the reporting of symptomatology.

146. In my opinion, the symptomatology reported to Dr Frost during the first meeting with Mr Green and relied upon by Dr Frost in her first report was not sufficient to satisfy Criterion B. There was an insufficient basis for Dr Frost concluding that the worker had persistently re-experienced the traumatic event in one (or more) of the ways specified under Criterion B.

147. In my opinion, there was also an insufficient basis for Dr Frost concluding that criterion B had been fulfilled following her second examination of the worker.

148. It is only after her first meeting with Mr Green - and after making a diagnosis of PTSD on the basis of the symptomatology reported by the worker during that first consultation- that Dr Frost sought to rely upon various physiological responses to the traumatic event (reported by the worker during the second mental examination) to bolster Mr Green's fulfilment of criterion B – and ultimately her diagnosis of PTSD.

149. In my opinion, Dr Frost's subsequent reliance upon the worker's reported physiological symptoms is problematic for the following reasons:

    1. In her first report , Dr Frost did not record Mr Green as having provided a history of racing heartbeat or shortness of breath as possible symptoms of PTSD, despite the fact that Dr Frost claimed to have made a record of having interrogated the worker in that respect. One must ask why Dr Frost did not record these very significant physiological symptoms in her first report - but relegated them to "note" status – when diagnostic Criterion B makes it patently clear that physiological reactivity to a traumatic event is an important marker for a diagnosis of PTSD. Moreover, there was a lack of detail as to any occasion on which the worker

claimed to have suffered shortness of breath.[58] It should also be noted that when the worker saw Dr Roberts in August 2012 Mr Green denied respiratory symptomatology (i.e. a sensation of air hunger or a tendency towards hyperventilation). The history given to Dr Roberts undermines the credibility of Mr Green's assertion of experiencing shortness of breath.

2. It was only on the subsequent consultation with Dr Frost that Mr Green reported that his heart was, on occasion, "beating really beating loudly" when he was driving. He does not appear to have reported to Dr Frost any other specific instances of such occasions.[59] However, as submitted by the employer, this limited history given to Dr Frost was at odds with the extended account given by the worker at the trial.[60]

3. There was no mention of chest tightness and pain (indicative of panic attacks) in Dr Frost's first report. That symptomatology only appeared in her second report after seeing Mr Green for the second time. The genuineness of the reported symptoms is called into question because of the worker's own evidence that after his first meeting with Dr Frost he sought additional information concerning PTSD[61] and in light of Dr Frost's evidence that after her diagnosing Mr Green with PTSD, she observed that he had become more acutely aware of his symptoms. It is particularly noteworthy that Mr Green actually thought that his heart or chest pain problems were occasioned by his medication and multiple surgical procedures. It is equally noteworthy that Dr Frost stated that on a number of occasions the worker informed her that he believed that he suffered from a heart condition until she gave him an alternative explanation – namely that of anxiety.

4. It is noted that when the worker first saw Dr Roberts he described having chest pain and tightness or discomfort, and reported that central chest pain had been present for about six months, and that he had experienced a few pains on the left and right side of his chest. However, Mr Green saw Dr Roberts on 7 August 2012 – a few months after the worker's first consultation with Dr Frost. The genuineness of the reported symptoms and history are again called into question for the reasons mentioned earlier. However, that aside, Dr Roberts did not regard the asserted heart and chest pains as a marker for PTSD because the complaint of pain or discomfort was of an infrequent nature, and, in the case of "heightened level of

[58] See [75] the employer written submissions dated 14 December 2012
[59] See [76] of the submissions.
[60] See [77] of the submissions. Mr Green gave evidence that his heart races a lot. By way of example he said that when lying on the lounge his heart was liable to "beat through his chest". The worker also recounted one incident where he had boarded a bus and experienced his heart beating very hard. On that occasion, Mr Green and his partner went to the Arafura Clinic immediately. The clinic records for 29 December 2011 disclosed no pain or palpitation at the time of examination.
[61] This was after Dr Frost had provided Mr Green with a list of symptoms for PTSD.

anxiety" – in the context of PTSD - such pain is a frequent symptom, and not an isolated symptom. Dr Roberts' impression was that although the worker reported that the chest pains had been present for some period of time, the infrequency of the pain coupled with the absence of other symptomatology, made it improbable, in "the context of an overall evaluation", that the chest pains were anxiety related. Even when it was put to Dr Roberts that the worker's evidence was that over the past two years he had experienced 50-60 episodes of chest pain[62] Dr Roberts did not accept that such frequency of reported pain would be a marker for PTSD.

5. As submitted by the employer, "importantly, the worker did not recount any instances where the shortness of breath or racing heart was triggered by something connected with the crocodile attack". [63] This deficiency is significant because one of the symptoms listed under Criterion B is "physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event". I agree with the submission made by the employer – "the fact that the worker was in fact exposed to significant cues resembling the crocodile attack, for years after the incident, suggest that his racing heart and shortness of breath, if they occurred at all, are not related to any condition of PTSD".[64]

6. Even accepting the genuineness of the various physiological symptoms reported by the worker, the evidence falls far short of showing that those symptoms conformed to the symptomatology described in DSM IV as "physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event". There needs to be a nexus between physiological symptoms and the traumatic event in order to satisfy symptom 5 listed under Criterion B. The requisite nexus is not established on the whole of the evidence.

150. On the whole of the evidence, I am not reasonably satisfied on the balance of probabilities that Criterion B has been fulfilled.

Criteria C

151. The third diagnostic Criteria for PTSD is avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

[62] It should be noted that this evidence was somewhat at odds with the history that Mr Green gave to Dr Roberts in August 2012.
[63] See [80] of the employer's written submissions dated 14 December 2012.
[64] See [80] of the submissions.

- efforts to avoid thoughts, feelings or conversations associated with the trauma;
- efforts to avoid activities, places or people that arouse recollections of the trauma;
- inability to recall an important aspect of the trauma;
- markedly diminished interest or participation in significant activities;
- feeling of detachment or estrangement from others;
- restricted range of affect (eg unable to have loving feelings);
- sense of foreshortened future (eg does not expect to have a career, marriage, children or a normal life span)

152. It is in relation to this third diagnostic component of PTSD that Dr Frost and Dr Roberts are most vigorously in disagreement.

153. The starting point is Dr Frost's first report dated 28 May 2012.

154. Dr Frost's first report in diagnostic terms is conspicuously scant. Under the heading of "Diagnosis" Dr Frost simply says:

> Using DSM IV criteria, Mr Green's symptoms fulfil each domain of a diagnosis of Post Traumatic Stress Disorder.

155. That diagnosis is not supported by any detailed analysis of the various DSM –IV criteria in light of the symptoms reported by Mr Green and her mental state examination of the worker. In particular, Dr Frost does not identify which of the three or more listed symptoms in Criteria C were found by her to be present to satisfy the third diagnostic component of PTSD.

156. The second report of Dr Frost dated 22 October 2012 suffers from the same diagnostic deficiency. Dr Frost simply affirms that Mr Green continues to suffer from "untreated Post –Traumatic Stress Disorder".

157. A fundamental difficulty with the evidence given by Dr Frost is that Dr Frost has, in each of her reports which were tendered in evidence (Exhibit W5), failed to explain the basis upon which she formed the opinion that the worker fulfilled the requirements of Criteria C.

158. The oral evidence given by Dr Frost concerning the basis upon which she considered the worker satisfied Criterion C was also problematic in that it was foremost difficult to follow the doctor's reasoning, and the doctor's explanation was less than convincing.

159. Initially during cross examination, Dr Frost pointed out that "avoidance" (as referred to in Criterion C) was one of the diagnostic criteria in DSMIV, and that the general category of "avoidance" also includes numbing responses. However, she never explained what she meant by that. Dr Frost then proceeded to say that did she not rest her diagnosis on "avoidance". She stated that she based her diagnosis on "numbing".

160. Dr Frost's evidence is somewhat confusing. However, it may be that what Dr Frost was attempting to convey was that her diagnosis was not based on symptoms (1) and (2) – efforts to avoid thoughts feelings, conversations associated with the trauma and efforts to avoid activities, places and people associated with the trauma – but on the numbing symptoms listed under Criterion C,[65] which might be considered to be another way of avoiding a traumatic event. It is noted that at this stage of cross examination Dr Frost was not specific as to the numbing symptoms she considered were present in order to satisfy Criterion C.

161. Later in cross examination, Dr Frost stated that during her second meeting with Mr Green he had reported efforts to avoid talking with others about what happened to him during the crocodile attack. She said that she had

[65] Namely symptoms (3) – (7) inclusive.

ticked this as one of the symptoms satisfying Criterion C. My understanding of Dr Frost's evidence is that she also found present numbing symptoms in terms of an inability to recall an important aspect of the trauma [66] and a sense of foreshortened future.

162. The final effect of Dr Frost's seems to be that she considered Criterion C to have been fulfilled on the basis of those two numbing symptoms and the worker's efforts to avoid talking about the trauma.

163. What Criterion C requires is that avoidance of stimuli associated with the trauma and numbing of general responsiveness is to be indicated by three or more of the listed symptoms. What the diagnostic criteria requires is some evidence of both avoidance of stimuli associated with the trauma and emotional numbing. It is noted that the first two symptoms are related to avoidance of stimuli associated with the trauma, whereas the remaining five symptoms are related to numbing of general responsiveness. Criteria C seems to require that there be present, at least, one of the symptoms referable to avoidance of stimuli.

164. Dr Roberts' evidence looms large in that regard.

165. In his second report dated 6 September 2012, Dr Roberts stated:

> I note specifically that PTSD is precluded in Mr Green by his comments in regard to his working with crocodiles and I have commented on page (10) of my report of 30 August 2012 that Mr Green's attitude towards crocodiles is inconsistent with PTSD.

166. At pages of 74 and 75 of the transcript the following facts and circumstances were put to Dr Roberts by counsel for the employer:

> The facts that I wish you to accept and assume are these, that the worker returned to work at the crocodile farm in July 2008, that is, about six months after the crocodile attack. The work that the worker undertook at the crocodile farm included working with other workers inside the crocodile pens at close quarters with newly arrived crocodiles from the

[66] In that regard Dr Frost made specific reference to "black holes", which was mentioned in her first report.

> wild, where the crocodiles were to be sorted according to their size and sex as to whether they would be kept for breeding, be culled or moved to the farm and continue to grow until they were to be harvested. The work also included going into large enclosures at the crocodile farm up to an acre in size, in order to locate crocodile nests, and with a team of people to act as a watcher, that is a lookout, sometimes from the back of a vehicle but sometimes on the ground and at close quarters to the other workers while eggs were harvested from those nests. Also that on occasion there was a cull of 30-40 very large, that is four metres or larger crocodiles, where a number of those crocodiles were shot, with the same gun as the worker was shot with in his accident; that the worker was present …..with the same type of gun – that the worker was present at least some of the time during the killing of those crocodiles, that at least some of the 30 to 40 crocodiles were killed with the gun while others were anaesthetised with drugs; that the worker was involved in the work included dragging with a vehicle crocodile corpses to an areas where they could be skinned and their heads removed; that the worker was involved in a process of cooking the heads in a large steamer in order for the flesh and meat to be removed from the heads so that the heads could be processed for sale as souvenirs. The worker continued to work at the crocodile farm from 2008 until May or June of last year….my question is do those facts have any bearing on your opinion as to whether or not the worker suffers from post traumatic stress disorder or not.

167. Dr Roberts' response was as follows:

> The thing is this was not in terms of those details but it was referred to generally in my report of 13 August, where I noted that Mr Green in fact disclosed no animosity to crocodiles and worked with crocodiles prior to him ceasing work, and that the reason for his cessation of work was physical not psychiatric. Post – traumatic stress disorder associated with avoidance of circumstances which give rise to recollections of the traumatic event and exposure to circumstance that give rise to recollections or associations with the traumatic event. If post traumatic stress disorder is present, it will give rise to any severe levels of anxiety. That is characteristic of a condition. Mr Green doesn't, in my view, have post traumatic stress disorder and one of the factors against that diagnosis is the fact that he has no animosity towards crocodiles. He was quite happy to work with crocodiles. The information indicates that he has done so. That is supportive of my view but PTSD is not present because if it was present he wouldn't do, in effect, what he's been doing.[67]

168. The effect of Dr Roberts's evidence is that the continued association by the worker with his former work with crocodiles ruled out PTSD because of the significance of the requirement for persistent avoidance of stimuli, in

[67] See p 75 of the transcript.

particular, the presence of heightened anxiety of an inappropriate degree where such stimuli occur.[68]

169. If, on a proper construction of Criterion C, the criteria requires an indication of an avoidance with stimuli, then Dr Frost's initial diagnosis of PTSD following the first consultation and examination was based on a failure of the symptomatology reported by the worker to fully conform to the diagnostic criteria. At that stage her diagnosis did not rest on either symptom 1 or 2 listed under the Criterion C. At that stage Mr Green had not reported efforts to avoid talking to others about the trauma.

170. However, even if Criterion C does not require an indication of avoidance with stimuli, the fact is that ultimately Dr Frost sought to justify her diagnosis, in part, on the presence of efforts to avoid talking about the trauma.

171. One must ponder why during the first consultation and mental examination such a significant symptom as efforts on the part of the worker to avoid talking with others about the trauma was neither reported by the worker nor elicited from the worker during the course of a normal psychiatric interview.

172. It is a matter of concern that after the first consultation with Dr Frost – and after being diagnosed as having PTSD – Mr Green sought to obtain additional information concerning his diagnosed condition, having been previously provided with a list of symptoms associated with PTSD. It goes without saying that there has to be very serious doubts about the genuineness of the symptomatology (including that relating to avoidance of stimuli) reported to Dr Frost during the second consultation and mental examination.

[68] See [54] of the employer's written submissions dated 14 December 2012. The employer put Dr Roberts' evidence in this way:
"Dr Roberts' primary point is that you cannot have PTSD if you go back working with the animal that caused the horror".

173. The fact that Mr Green did not provide a complete history of the nature and extent of his contact with crocodiles following the attack in 2008 bears heavily against the validity of the diagnosis proferred by Dr Frost.

174. When Dr Frost was provided with the actual specifics of the work undertaken by the worker following the crocodile attack, she responded by saying that the changed history did not undermine her diagnosis. Dr Frost stated that the altered history put her diagnosis "on a different slant". Dr Frost said that it was not necessary for there to be actual avoidance of the activities or type of activities that the worker was engaged in prior to the attack. She gave the example of a person involved in a serious motor vehicle accident not necessarily avoiding driving altogether: the person may only avoid some aspects of driving, for example driving in the locale where the accident occurred.

175. Dr Frost went on to say that Mr Green's return to the very activities that caused his trauma did not rule out a diagnosis of PTSD. Dr Frost said that there was evidence of the worker avoiding thoughts of and feelings about the attack. Dr Frost said that in that regard the avoidance/numbing criteria were met.[69] Dr Frost said that there were other markers of PTSD.

176. My concerns with the reliability of Dr Frost's diagnostic findings in relation to Criterion C should already be evident. At the outset Dr Frost diagnosed the worker with PTSD on the sole basis of reported "numbing symptoms". Subsequently Dr Frost affirmed her diagnosis, but this time on the basis of symptoms consistent with efforts to avoid talking about the trauma with others, under circumstances which would inevitably lead the Court to question the validity of those symptoms. It is apparent that the basis (in terms of satisfaction of Criterion C) for Dr Frost's diagnosis shifted between

[69] Incidentally, this evidence from Dr Frost is indicative of the need for there to be evidence of symptoms referable to the avoidance of stimuli associated with the trauma, in addition to evidence of symptoms indicating emotional numbing.

the first consultation and the second meeting with the worker; and it shifted because of the worker's change in the symptoms reported by him.

177. As Mr Green was not a forthcoming historian in relation to the nature and extent of his contact with crocodiles, how can the Court have any confidence in his belated reporting of efforts to avoid talking with others about what happened to him during the crocodile attack. Similarly, what confidence can the Court have in the genuineness of the "numbing" symptoms reported by Mr Green (upon which Dr Frost also relied in making her first and final diagnosis).

178. There is a further problem with Dr Frost's opinion that Mr Green met Criterion C. As stated above, Dr Frost based her final diagnosis, inter alia, on satisfaction of three of the symptoms listed under that criterion. However, most significantly, one of those symptoms related to Mr Green avoiding talking to others about the trauma. However, the genuineness of that symptom has been seriously questioned for the reasons given earlier. Therefore, that only leaves the two numbing symptoms (assuming their genuineness) to satisfy the criterion. As Criterion C requires the presence of at least 3 symptoms, the criterion has not been fulfilled to the satisfaction of the Court.

179. However, there are additional reasons which have led me to that conclusion.

180. I accept that in order to satisfy Criterion C it is not necessary for there to be avoidance of stimuli in terms of avoiding activities, places and people associated with the trauma. I also accept that there are cases where individuals do not avoid the trauma, and yet still meet the diagnostic criteria for PTSD. This point was made by Dr Frost. She mentioned that she had a small cohort of patients who had survived a crocodile attack and who had continued to work in the crocodile industry. Dr Frost stated that all of these individuals had been diagnosed with PTSD.

181. However, in the particular circumstances of this case, the absence of avoidance of activities associated with the trauma assumes special significance.

182. The present case presents as almost the antithesis of avoidance of stimuli associated with the crocodile attack in 2008. When Mr Green made full disclosure of the nature and extent of his post-injury work at the crocodile farm, it became immediately obvious that for some 3 years since the accident Mr Green had very close contact with crocodiles on a day to day basis, and engaged in work that shared some of the aspects of his pre-injury employment. The work that Mr Green was consistently involved in entailed a risk of further crocodile attacks. Indeed, he was treated for a crocodile bite to the left hand in March 2011 – although it is conceded that this was a relevantly minor incident according to the scale of severity of crocodile attacks.

183. In my opinion, the worker's close continuing contact with crocodiles is inconsistent with a number of symptoms reported by the worker. As already stated it is inconsistent with Mr Green's claim that nightmares were triggered by media reports of crocodile attacks. It is inconsistent with Mr Green's reported symptom of avoiding talking with others about the trauma. The coexistence of the two was never explained or adequately explained. It is also inconsistent with the various "numbing" symptoms reported by the worker. DSM IV Criteria C appears to treat the listed avoidance and numbing symptoms as not discrete diagnostic features but as related symptoms. Indeed the "numbing" symptoms might be viewed as another way of avoiding trauma. Given that connection it is difficult, in the absence of a rational explanation, to reconcile the worker's non avoidant conduct (constituted by his persistent and close contact with crocodiles over a lengthy period) with his avoidant behaviour indicated by the numbing symptoms he reported to Dr Frost.

184. In my opinion, these inconsistencies in the worker's psychiatric profile were tacitly, if not expressly, identified in Dr Roberts' evidence.

185. The fact that Dr Frost relied upon her own experience as a psychiatrist treating other crocodile attack victims who she claimed have suffered PTSD, and yet returned to working with crocodiles in the same manner as the worker[70] does not assist in explaining the identified inconsistencies. The unsatisfactory nature and unhelpfulness of that part of Dr Frost's evidence is captured in the following submissions made by the employer:

> That evidence was unsatisfactory. Dr Frost provided no evidence to support her assertions in respect of those cases. No information about the particular circumstance of those cases has been made available for consideration by the parties. Dr Frost did not mention it in her reports, despite knowing that Dr Roberts considered the worker's return to work history, and his continued affection for crocodiles, were significant factors telling against a diagnosis of PTSD. Her resort to the fact that Dr Roberts was not from the Northern Territory and did not know crocodile cases in the way she did, was a shallow and unconvincing ground of distinction to draw in the circumstances.[71]

186. In my opinion, the submission is very much to the point, and it is accepted by the Court.

187. Finally, but not least, the basis upon which Dr Frost was satisfied that Mr Green was suffering from the numbing symptom of a sense of a foreshortened future is unconvincing.

188. The employer made the following submission in relation to the asserted symptom:

> Dr Frost included a "marker" of the worker's sense of compromised future as a basis for her diagnosis of PTSD. Yet she was unable to draw on any particular history given to support that conclusion. The fact the worker and his partner had gone on to have their first child and were expecting another and his statement that he wanted to get on with his life, were factors plainly contrary to such a marker, particularly having regard to the clear description of what such a marker entails, within the DSM IV

[70] See [55] of the employers' written submissions dated 14 December 2012.
[71] See [55] of the submissions.

> diagnostic criteria. Dr Frost's explanation for maintaining that such a marker was relevant in the worker's case was unconvincing.[72]

189. In my opinion, the sequence of events in the worker's life following the crocodile attack is very much at odds with the PTSD marker of "sense of a foreshortened future" – especially in relation to his marriage and children. Furthermore, I am not persuaded by Dr Frost's opinion that there is no inconsistency between Mr Green's issues with moving forward with his relationship with his wife and his eagerness to move on; and that the two attitudes can co-exist. In my opinion, on the evidence, Mr Green does not fulfil symptom (5) listed under Criterion C.

190. For all of the reasons set out above, I am unable to be reasonably satisfied on the balance of probabilities that Mr Green meets the diagnostic features of Criteria C.

Criterion D

191. The fourth diagnostic criteria for PTSD is persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- difficulty falling asleep or staying asleep;
- irritability or outbursts of anger;
- difficulty concentrating;
- hypervigilance;
- exaggerated startle response;

192. Although there may be sufficient evidence before the Court to substantiate the symptom of difficulty with falling asleep or staying asleep, the same

[72] See [74] of the submissions.

cannot, in my opinion, be said of the remaining symptoms listed under Criterion D.

193. In her first report dated 28 May 2012 – following the first examination of the worker – Dr Frost noted that the worker had reported the following symptoms:

1. Irritability, leading to problems between him and his partner;
2. An exaggerated startle response at the sound of guns, fireworks or thunderclaps and
3. Vigilance

194. In her second report dated 22 October 2012, Dr Frost stated:

> On a number of occasions, Mr Green had experienced an exaggerated startle response, e.g. when cars backfired or when gunshots occurred. Recently a mate had shown him his new hunting gun, suggesting that he and Mr Green fire it together. But when Mr Green went outside with his mate, he found that he was instantly "on alert" sweaty and clammy because of the impending gunshot and had to ask his friend to stop. He remained vigilant, especially around his daughter and was avoidant of crowds…
>
> His partner was aware of his irritability and edginess, commenting on Mr Green's "change in personality". Mr Green reported that friends had noticed he was "more revvd up, like I've got ADD.

195. In my opinion, the nature and extent of the worker's irritability – including specifics instances of irritability – was not sufficiently demonstrated to satisfy the actual presence of symptom (2) listed under Criterion D. The genuineness of this marker for PTSD was entirely reliant upon the reliability of what Mr Green had told Dr Frost. Furthermore, there is no guarantee as to the objectivity and truthfulness of the observations made by the worker's partner. It is quite significant that Mr Green does not appear to have reported the symptom of irritability to Dr Roberts.

196. Similarly, it is my opinion that the evidence concerning vigilance does not fulfil symptom (4) listed under Criterion D. The evidence regarding

vigilance was generalised – and no specific instances of vigilance were provided to the Court. Furthermore, Mr Green did not report this symptom to Dr Roberts. Finally, symptom (4) requires something more than vigilance – it requires evidence of hyper –vigilance. Even if the Court were satisfied that the worker was vigilant, the evidence still falls far short of establishing the more elevated state of hyper –vigilance, which is required to fulfil the diagnostic sub-criterion.

197. It is noted that in neither of her reports did Dr Frost identify "difficulty concentrating" as a presenting symptom, and as a symptom upon which she relied as fulfilling Criterion D – and as ultimately supporting her diagnosis. However, during the course of the evidence given by her at the trial, Dr Frost opined that the various symptoms reported by the worker – including loss of concentration – could not necessarily be attributed to the worker's medication (Oxycontin). Dr Frost said that the side effects of Oxycontin were overly inclusive and overly cautious; and were designed to protect manufacturers from legal suits. Although Dr Frost conceded the possibility that the various symptoms reported by the worker could be connected with his medication, she considered it highly probable that the symptoms were the product of anxiety caused by the crocodile attack.

198. However, there is a body of evidence that points the other way.

199. Dr Roberts made reference to Mr Green commenting on feeling ill and sweating with the medication, and that "he didn't realise what it was, that he couldn't concentrate with his medication". Dr Roberts also noted in his first report that the worker reported that he had problems with memory and concentration since taking Oxycontin. However, Dr Roberts observed at the same time Mr Green was able to give a detailed chronological history without reference to notes. Dr Roberts' evidence not only challenges the worker's assertion of problems with memory and concentration, but

indicates that any difficulties with memory and concentration were related to his medication.

200. Later in his first report Dr Roberts noted Mr Green commenting that he had problems with thinking and blaming those problems "on the drugs". Dr Roberts noted the worker's statement that he felt better when he was off Oxycontin. Again this indicates a connection between cognitive difficulties and the worker's medication.

201. Mr Green himself told the Court that his taking of Oxycontin over the past 5 years[73] had adversely affected his memory – and he now had a really bad memory. Again, this is evidence connecting Oxycontin with memory problems.

202. In my opinion, the evidence does not support any difficulty concentrating (on the part of the worker) as being related to PTSD. It is probably for that reason that Dr Frost did not seek to rely upon that symptom as contributing to fulfilment of Criterion D.

203. The third symptom relied upon by Dr Frost in fulfilment of the criterion was "exaggerated startle response".

204. Fulfilment of this sub criterion is problematic for the following reasons:

1. Exaggerated startle response is one of the few symptoms for PTSD that can be tested objectively.[74] However, there is little, if no, objective evidence to support the rather vague and non specific instances of exaggerated startle response elicited by Dr Frost during the two consultations with Mr Green.

2. It is noted that although Mr Green reported, during the first consultation with Dr Frost, an exaggerated startle response at the sound of guns, fireworks or thunderclaps, he did not volunteer that information - rather it was elicited in response to questioning by Dr Frost. The significance of this is that the symptomatology of

[73] Mr Green's evidence was that he took Oxycontin twice a week, though he had been on the medication 3 times a week and sometimes he had taken it for a week or two weeks.
[74] Shea n 35 p 82.

exaggerated startle response was not spontaneously provided to Dr Frost, and it required some prompting.

3. It is noteworthy that by the time of the second consultation – at which time Mr Green had become more acutely aware of his symptoms and had acquired additional information regarding PTSD – Mr Green reported to Dr Frost having encountered exaggerated startle response in the context of cars backfiring. Mr Green also reported a recent instance of having been shown a new firearm by a friend and invited to join his friend in discharging the firearm. The worker's reaction was one of instantly going "on alert" and becoming sweaty and clammy due to the impending gunshot. That response prompted him to request his friend to desist. One really has to question the genuineness of this belated reported symptomatology.

4. It is also particularly noteworthy that in neither of his reports did Dr Roberts make any reference to instances of exaggerated startle response.

5. What particularly tells against the genuineness of the worker's reported symptomatology (in terms of exaggerated startle response) is the failure of the worker to volunteer his work history after the crocodile attack, where he had been present when a number of large crocodiles were shot.[75] One would expect that those circumstances would have elicited an exaggerated startle response. However, Mr Green said nothing about that to either Dr Frost or Dr Roberts. In re-examination, the worker attempted to downplay and minimise the significance of his interaction with crocodiles and exposure to circumstances that one would expect to elicit a paradigmatic exaggerated startle response.[76] It can be reasonably inferred that Mr Green did not experience an exaggerated startle response during the incident involving the shooting a number of large crocodiles.

6. If Mr Green did not encounter an exaggerated startle response in relation to the above incident, then it is very difficult to conceive of him experiencing an exaggerated startle response at the sound of guns, fireworks, thunderclaps and cars back firing – and even in the context of being invited by a friend to co – jointly discharge a new firearm.

[75] See [72] of the employer's written submissions dated 14 December 2012.
[76] See [72] of the submissions. For example Mr Green qualified the number of crocodiles being shot, saying that a number had been drugged and that he was personally preoccupied with other aspects of the culling of the crocodiles. Mr Green also sought to remove himself from proximity to the gunfire.

205. I am unable to be reasonably satisfied on the balance of probabilities that the worker has the symptomatology of exaggerated startle response, and fulfils that sub criterion of Criteria D. The Court has only vague and non specific – and uncorroborated - instances of exaggerated startle response. There are very real concerns as to the validity of the symptoms reported by the worker to Dr Frost. Finally, but not least, Mr Green's exposure to the culling of crocodiles by shooting severely undermines the presence of exaggerated startle response as a symptom contributing to fulfilment of Criterion D.

206. It follows from the preceding analysis that the Court is unable to be satisfied that Criterion D has been met.

- **The Significance of Dr Ehrlich's Foreshadowed Diagnosis of PTSD**

207. In her first report Dr Frost noted that Professor Ehrlich in his report dated 26 June 2011 had not only commented on the worker's orthopaedic disability, but noted that Mr Green is "most likely suffering from Post Traumatic Stress Disorder".

208. Dr Frost considered it highly relevant that an orthopaedic surgeon would express such an opinion, because it is uncommon for an orthopaedic surgeon to proffer the possibility of a psychiatric condition. However, Dr Frost told the Court that – consistent with her usual methodology – she saw Mr Green before reading Professor Ehrlich's report.

209. In his report Dr Roberts noted that Professor Ehrlich had raised the possibility of a degree of post traumatic stress disorder. Dr Roberts commented as follows:

> I agree with Professor Ehrlich that such a diagnosis is worthy of consideration – the diagnosis is however negated by the paucity of heightened anxiety symptoms described and by the ongoing affection for crocodiles described by Mr Green.

210. Dr Roberts stated that Professor Ehrlich did not assert that Mr Green is most likely suffering from PTSD. He stated that Professor Ehrlich said that there may be a degree of post traumatic stress disorder – "which is having regard to the stressor criteria a reasonable assessment in the context of his psychiatric experience to make".

211. At the trial, and during the course of her evidence, Dr Frost conceded that Dr Ehrlich had only raised the possibility of PTSD, despite the fact that in her first report she had inaccurately noted that the professor had opined that Mr Green was most likely suffering from PTSD.

212. It is important not to elevate the observations made by Professor Ehrlich to the status of a provisional diagnosis of PTSD. It is equally important not to attribute undue evidentiary or probative value to those observations, but to treat those observations as no more than, as suggested by Dr Roberts, a reasonable assessment that a medical practitioner with psychiatric experience might make in all the circumstances, contingent upon further investigations and the gathering of supporting evidence.

- **Comparing the Diagnostic Methodology of Dr Frost and Dr Roberts**

213. It is clear from the evidence before the Court that Dr Frost and Dr Roberts adopted different methodological approaches to the diagnosis of the worker's mental condition.

214. Dr Roberts was informed by Mr Green that Dr Frost had, during the first consultation, read a list of symptoms to him and told him that he had anxiety and PTSD. The worker informed Dr Roberts that Dr Frost had explained the condition to him. However, he told Dr Roberts that he still did not understand the condition that he had been diagnosed with.

215. The worker, in fact, gave evidence that when he saw Dr Frost she went through a list of symptoms with him, and his evidence was that she printed

off a list of PTSD symptoms. When asked what he did with that list he said he didn't keep it, but he did acknowledge that after his consultation with Dr Frost he sought additional information about PTSD.

216. Dr Roberts stated that the making of a diagnosis by reading a list of symptoms is a methodology that is open to criticism:

> I refer to the Text of Clinical Assessment of malingering and Deception edited by Richard Rogers, 3rd edition page 113 which comments "Even individuals naïve to the criteria of PTSD could qualify for the diagnosis on a check list when asked to do so 86% to 94% of the time (Burgess and McMillan, 2001; Lees -Haley and Dunn 1994; Slovenko 1994.

217. Relying upon the information given to him by the worker, Dr Roberts expressed concerns about his understanding of the methodology applied by Dr Frost in eliciting a history of symptoms from the worker.

218. Dr Roberts expressed the view that the provision of a list of symptoms to a patient was "a significant contaminant". He said that the problem is that even if you approach the initial part of the interview in what might be regarded as a traditional interview, by subsequently introducing a list of symptoms to the patient one runs a very great risk of creating a number of false positives in relation to the diagnosis. In that regard Dr Roberts relied upon a number of well recognised textbooks warning of that problem (as referred to above).

219. Despite Dr Frost's defence of her methodology, I cannot help but find that the provision of a list of symptoms to Mr Green after the first consultation was a significant contaminant in the terms described by Dr Roberts, and that it had a clear potential to infect the validity of the subsequent and significant symptoms reported to Dr Frost during the second consultation.

- **Resolution of the Diagnostic Divergence between Dr Frost and Dr Roberts**

220. In my opinion, Dr Robert's diagnostic opinion is to be preferred to the opinion proffered by Dr Frost on the basis of the preceding analysis of the evidence and concomitant findings.

221. On the whole of the evidence the worker has failed to fulfil Criteria B, C and D for the purposes of a diagnosis of PTSD. In my opinion, that completely undermines Dr Frost's diagnosis. Although courts may allow a measure of latitude where a claimant does not meet all of the DSM criteria, such latitude does not extend to a case where there is a wholesale failure to meet the diagnostic criteria.

222. Accordingly, I am unable to be reasonably satisfied on the balance of probabilities that the worker suffered a mental injury – namely PTSD.

223. It is noted that in his Statement of Claim the worker pleaded a mental injury per se – and did not confine himself to a specific mental condition such as PTSD. Although it is open on the pleadings for the Court to find an alternative mental injury, the evidence does not support a finding that the worker suffers from another psychiatric illness or condition recognised by DSM IV.

DETERMINATION

224. The Court declines to make orders that the following injuries are attributable to the primary injuries, and therefore consequential injuries for the purposes of compensation under the *Workers Rehabilitation and Compensation Act*:

- Left shoulder pain
- Neck and back pain
- Hip pain
- Nerve damage and loss of sensation to right arm and hand

- Mental injury.

225. As the alleged injuries of various infections, scarring to the right arm and scarring to both hips as a result of hip graft surgeries were admitted by the employer in its Notice of Defence to the Amended Statement of Claim the Court invites the parties to make submissions as to what, if any, declaratory orders should be made with respect to those admitted consequential injuries.

226. The Court will also hear the parties in relation to any ancillary orders, including those relating to the question of costs.

Dated this 15th day of March 2013.

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Dr John Allan Lowndes
STIPENDIARY MAGISTRATE