CITATION:	*Alireza Lajivadi v Performance Services Pty Ltd (ACN: 162 049 443)* [2025] NTWHC 5
PARTIES:	Alireza Lajevardi Worker v Performance Services Pty Ltd (ACN: 162 049 443) Employer
TITLE OF COURT:	WORK HEALTH COURT
JURISDICTION:	CIVIL
FILE NO(s):	2021-03411-LC
DELIVERED ON:	1 July 2025
DELIVERED AT:	Darwin
HEARING DATE(s):	Hearing from 4 to 8 March 2024, oral submissions 21 May 2024 and 7 June 2024, written submissions received 15 July, 30 August and 4 October 2024
DECISION OF:	Judge Woodcock

CATCHWORDS:

WORK HEALTH – appeal of notice – assault – physical and mental injuries – notices invalid

Return to Work Act 1986 s 73(4)

REPRESENTATION:

Counsel:

Worker:	Duncan McConnel SC
	Caroline Heske
Employer:	Trevor Moses

Solicitors:

Worker:	Sparke Helmore Lawyers
Employer:	Piper Grimster Jones Lawyers

Decision category classification:	B
Decision ID number:	[2025] NTWHC 5
Number of paragraphs:	36

IN THE WORK HEALTH COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 2021-03411-LC

BETWEEN:

Alireza Lajevardi

AND:

Performance Services Pty Ltd (ACN: 162 049 443)

REASONS FOR DECISION

(Delivered 1 July 2025)

JUDGE Alan Woodcock

1. During the night of 9 September 2017, the Worker was performing his duties as a security guard, in the employ of the Employer at The Opium Nightclub on Mitchel Street, Darwin. The Worker was assaulted by patrons. The Worker claimed compensation from the employer in the form of a declaration dated the 11 September 2017. Under the heading of "About the injury or disease – body part effected", the Worker wrote "head, neck, shoulder, hip, left knee". The Employer accepted liability on 4 October 2017 and commenced paying compensation.

2. On 17 November 2017, the Worker was diagnosed with Ramsay Varicella Zoster Virus, causing Ramsay Hunt syndrome, a serious and life-threatening form of shingles encephalitis. The Worker contends that on 8 March 2018 he was diagnosed with features of anxiety and depression consistent with post-traumatic stress disorder. The Employer says no such diagnosis was made and that none of these injuries arise out of the course of the Worker's employment as they do not arise from the assault.

3. The Worker relies on a letter from Professor John Olver, Medical Director of Rehabilitation Medicine at Epworth Healthcare dated 8 March 2018. Professor Olver notes the initial assault and admission to hospital, the subsequent readmission to hospital with Ramsay Hunt syndrome two weeks prior, writing

   "*My opinion is that he has more than a concussion injury. He really has a mild traumatic brain injury with persisting symptoms as outlined. In addition to these he is getting flashbacks to the incident with his anxiety and depressive symptoms, I believe therefore he also has some post-traumatic stress disorder on top of the organic symptoms. I am writing to you at QBE to ask for funding for a two-week inpatient admission to Traumatic Brain Injury Unit…*"

Professor Olver was not subsequently called in evidence. Strictly speaking of course, the Employer is correct that an opinion is something less than a diagnosis.

4. The Worker pleads that the Employer accepted liability for "all known injuries" arising from the assault, including physical injuries, as well as the secondary injuries and mental injuries on 12 June 2018. The Employer pleads that on 11 January 2018 the Worker was advised that the secondary injuries were not accepted.

5. The Employer served the Worker with notices on 29 November 2019 and 1 July 2021, disputing the reasonableness of costs incurred by the Worker for medical treatment of injuries. The Worker appeals these notices.

6. The Employer served the Worker with A Notice of Decision cancelling the payments of weekly benefits to the Worker on 20 April 2022. The notice referred to and attached the opinions of Professor Jonathan Foster, Dr LJ du Plessis, and Dr Samson Roberts. The Worker appeals the Notice of Decision.

7. The Worker gave evidence of the assault on him during his employment on 17 September 2017. He described in brief terms the event, attendance by police and paramedics, and subsequent treatment in hospital. His account was vague and at times he appeared to be making no legitimate effort to recall events or answer questions from counsel. He was argumentative with and dismissive of counsel. He was unmoved in cross examination.

8. Dr du Plessis a consultant neurologist and rehabilitation physician, gave evidence on behalf of the Employer. In his first report of 10 April and in evidence he expressed significant concern that the reported symptomology of the Worker was not organic in nature. He observed the Worker's behaviour during consultation to be inappropriate. The Worker's initial injury upon being assaulted is described as a very mild concussive brain injury. Dr du Plessis found no evidence of post-traumatic amnesia in the days following the assault and stated that ordinarily recovery from such an event should be complete within 14 days.

9. Dr du Plessis prepared a second report on 15 May 2018. During the period between the first and second report the Worker had been hospitalised with Ramsay Hunt Syndrome. Dr du Plessis considered this to be a far more significant medical event than the initial concussion and a possible explanation for the Worker's ongoing symptoms.

10. The diagnosis of post-concussion syndrome and functional neurological symptom disorder were considered resulting from psychological and psychosocial factors triggered by the initial mild traumatic brain injury. The significant effect of the unrelated but recent encephalitis was also considered significant. Malingering was also considered.

11. Psychometric testing by Dr Huntley, a report by Professor Foster were referred to, along with a report by Professor Olver. The Worker performed poorly in the psychometric testing. Dr Marty Ewer also performed psychometric testing on the Worker and was not called by the Employer.

12. Dr du Plessis was asked in cross examination why he has moved towards a diagnosis of Malingering: *"mainly atypical presentation that is totally never found… progressing from a bump to the head, possible… brief loss of consciousness, no pre-traumatic amnesia, minimal if any post traumatic amnesia… slowly progressing towards walking stick, more symptoms… needing a support*

dog…" The doctor's opinion was that the symptoms described by the Worker were nonorganic and therefore contrived.

13. Dr du Plessis agreed with the proposition that in a significant percentage of cases where a serious or mild concussion was sustained that people go onto have post-concussion syndrome. When asked if he agreed that it may take weeks or months to emerge after the injury he disagreed and said the symptoms must be ongoing. He was cross examined at length of symptoms of concussion complained of contemporaneous to the assault as indicative of ongoing concussion symptoms, and he remained unmoved in his diagnosis.

14. Professor Roberts, a consultant forensic psychiatrist authored a medicolegal report on the Worker dated 5 October 2021 and a supplementary medical report dated 16 May 2023 at the Employers request, was not called in evidence. He observed that the Worker was prone to intentionally presenting misleading impressions of his medical condition. He was also satisfied that the Worker had endeavoured to wilfully mislead the authors of the psychometric testing. He agreed with Dr du Plessis that (by the same rational), malingering is the most appropriate diagnosis.

15. Professor Johnathan Foster, consultant neuropsychologist prepared a report on the Worker at the Employers request, did not give evidence. He was unable to offer an evidence-based opinion.

16. Dr Lucas, a clinical neuro psychologist prepared a report on the Worker, at the request of the Employer dated 26 April 2023. She gave evidence that she administered a TOMM test – a test of malingering and memory – over a four-hour period. She observed the Worker's effort to be below normal limits on both the initial and back up test during that period. She observed inconsistencies on the Worker's presentation. The Worker was said to have made statements inconsistent with contemporaneous evidence.

17. The Worker was observed to have written off his prospects for recovery very early in the process. Misattribution of all his ongoing complaints to the initial mild traumatic brain injury was described. Dr Lucas observed compelling inconsistencies indicative of feigning and exaggeration. She agreed these symptoms could also be consistent with functional neurological disorder. Dr Lucas agreed that, in order to determine if the Worker was malingering, a multidimensional malingering criterion would need to be met.

18. During the process of cross examination and re-examination Dr Lucas referred to a continuum with functional neurological disorder at one end and conscious malingering at the other. Ultimately Dr Lucas conceded that this is a complex case with observed elements consistent with both ends of the spectrum, observing that it is not clear cut.

19. The Worker called Dr Geoffrey Herkes, a consultant Neurologist, in evidence. A review of the Worker's hospital records was undertaken. A history of headache, nausea and foggy vision and diagnosis of post-concussion subsequent to the assault was observed. Dr Herkes observed this to be "*reasonable at the time*".

20. Dr Herkes was asked of his experience in assessing diagnosing post concussive symptoms;

"It's an area fraught with difficulty… but essentially post-concussion syndrome is a constellation of symptoms occurring after a concussive injury. And the symptoms do consist of headache,

unsteadiness, visual disturbance and blurring, and cognitive change… In the literature there's a varied percentage of people after concussion who would suffer such symptoms… 50 percent would be an average. The vast majority would improve within 12 weeks… There's an entity of post-concussion syndrome which goes on after that period of time. But I think Mr Lajevardi would fill the criteria for post-concussion syndrome when he represented and also later in October… when he still had those ongoing symptoms."

21. Dr Herkes recommends a multidisciplinary approach for persons with persisting post-concussion syndrome, requiring timely intervention. He observed that there is often depression and anxiety, and usually sleep disturbance concurrent with post-concussion syndrome. Absent such timely intervention outcomes symptoms may be ongoing. This approach was recommended by Dr Herkes and not acted on.

22. Dr Herkes diagnosed the Worker with post-concussive syndrome complicated by Varicella Zoster Virus, encephalitis and Ramsay Hunt Syndrome in November 2017 with a subsequent development of functional neurological disorder and psychiatric injury.

23. Reports of Dr du Plessis were provided to Dr Herkes. When asked about the expectation of a full recovery from a mild concussion, Dr Herkes regarded this as the usual outcome, although in the order of 5 percent of people endure ongoing symptoms, including prolonged post-concussion symptoms and potentially functional neurological disorder.

24. Dr Herkes diagnosed the Worker with functional neurological disorder and does not agree with a diagnosis of malingering.

25. In cross examination, Dr Herkes agreed that the recorded history of the initial assault and treatment shortly thereafter indicated that the head injury suffered by the Worker should be assessed as mild. A tiny percentage of people, certainly less than five percent, have persisting post-concussion syndrome symptoms that persist over seven years.

26. Dr Herkes reiterated a need for a multidisciplinary approach in cross examination, agreeing that a broad approach considering psychosocial factors that may affect the client's reaction to the initial injury. Having been taken through much of the psychometric testing undertaken on the Worker, he conceded that he would defer to neuropsychologists in the difficult area of administering and interpreting such tests. However, his opinion remained that the Worker was not malingering and in fact continues to suffer from functional neurological disorder. Psychometric testing is influenced by amongst other things, pain, fatigue, stress, anxiety and historic illness. A diagnosis of where on the continuum the patient sits between malingering and functional neurological disorder should not be determined by psychometric testing alone and should be examined holistically in the context of the overall picture. This is the process and setting in which Dr Herkes rejects the diagnosis of the Worker as a malinger and makes a diagnosis of functional neurological disorder.

27. Dr Herkes agreed it was difficult to attribute the Worker's current symptoms as being caused by the initial assault or subsequent encephalitis, though in cross examination placed weight on continuity of initial consistent symptoms suffered post-assault and pre-encephalitis and the ongoing symptomology.

28. The Worker called Dr Kanaan, a Professor and practicing consultant psychiatrist in evidence. Dr Kanaan in his evidence and reports supports a previous diagnosis of major depressive disorder, post-traumatic disorder and meeting the criteria for functional neurological disorder. Functional neurological disorder was described as a condition where people present with a great variety of neurological symptoms which arise from the patient's psychopathology. Functional neurological disorder was said to be strongly supported by a history of trauma, often workplace trauma. Having been briefed with the material commented on by Dr du Plessis, Dr Kanaan acknowledged discrepancies in the history previously provided by the Worker. He concluded that *"the extent of the discrepancy was not sufficient to indicate any clear intent or purpose and they were the kind of discrepancies which I felt I encountered in my normal practice, where there was no, if you like, potential for malingering."*

29. Dr Kanaan noted the Worker's history of challenging and aggressive behaviour prior to the index event and subsequent hostility to examiners, unusually so. A sustained personality type that is likely to enter into conflict and is inherently argumentative was said to be the most likely explanation. Such a personality tends to make a diagnosis of malingering more likely.

30. Dr Kanaan was asked to comment on the poor performance of the Worker during psychometric testing. His opinion is that there is an inherent problem in psychometric testing capturing the unusual features of functional neurological syndrome in circumstances where it would appear to be caused by malingering. Having watched and listened to the Worker give evidence and considered the extensive medical history, he is at times an argumentative and difficult person. I accept the view of Dr Kanaan that the various critiques of his behaviour and history are likely to have arisen as a result of his personality and ordinary run of the mill misunderstandings that regularly arise when people who are not medically trained are endeavouring to understand those who are.

31. I accept the opinion of Dr Herkes that the Worker suffered post-concussion syndrome as a result of being assaulted at work and continued to do so for some time thereafter, this diagnosis complicated by infection with Varicella Zoster Virus. Consequently, he suffered from and continues to suffer from functional neurological disorder which incapacitated him from working. I accept the opinion that this diagnosis is consistent with the recorded medical history of the Worker, including the fact that the initial work-related head injury was mild, that the usual prognosis would be a full recovery in a matter of weeks, but that he is within a small, but known, cohort who continue to suffer post-concussion syndrome over a longer period.

32. Having had the benefit of days of evidence, exhaustive medical histories and learned submissions I do not accept the opinions of Dr du Plessis, Dr Lucas and Professor Foster that the Worker is malingering. I premise this finding in this way to make clear this is not a criticism, or casting doubt on the professional expertise of these expert Doctors who day after day are asked to provide opinions without the benefit of these factors. Having viewed firsthand the personality traits of the Worker previously described, which are consistently made out in the medical history, and considered the nature of the criticisms of the Worker's inconsistencies as a historian of medical events and a man of peculiar habits, previously discussed, I accept the opinion of Dr Kanaan and Dr Herkes that malingering by the Worker is unlikely. Rather, the Worker has performed poorly in psychometric testing and been an indifferent historian of medical events as a result of his personality type and misunderstanding of medical terminology in the context of ongoing functional neurological disorder.

33. I am therefore satisfied the Worker has successfully appealed the Notice of Decision served by the Employer on 20 April 2022. The diagnosis of the Worker with Ramsay Hunt Syndrome does not arise from the initial workplace assault, but does complicate his condition going forward. The history of claiming workplace injuries and acceptance or denial of the same have been taken into account in the course of my deliberations. However, given my ultimate finding that the Worker continues to have an injury resulting from an assault in the course of his employment, the pleaded history of diagnosis, acceptance and or rejection need not be individually ruled on. Similarly, the issue of so-called secondary injuries need not be ruled on individually given the findings on the evidence and ruling. The counterclaim of the Employer must necessarily fail and be dismissed given the successful appeal by the Worker.

34. It is pleaded that on or about the 29 November 2019 and 1 July 2021 the Employer issued the Worker a notice disputing the reasonableness of costs incurred by the Worker for medical treatment. It is pleaded by the Worker that these notices are invalid, this is rejected as the notice complies with the requirements of section 73(4) of the *Return to Work Act 1986*. No evidence was called to prove the costs were unreasonable, therefore, the notice of dispute is not made out and the appeal of this notice by the Worker must succeed.

35. The Employer pleads that the Worker has attempted to mediate 20 April 2022. It is further pleaded that the Worker has mischaracterised the 20 April 2022 notice, and as such has frustrated mediation. This pleading is not proven on the evidence. I am satisfied that there has been an attempt by the Worker to resolve the dispute by mediation and the attempt has been unsuccessful and refer in part to the affidavit of Miss Grimster that was received into evidence. Section 103J(1) of the *Return to Work Act 1986* has been complied with and the proceeding properly commenced.

36. I am therefore satisfied the Worker is entitled to the relief as sought.

Orders

1. The following orders are made:

2. The Worker has successfully appealed The Notice of 29 November 2019, therefore, The Notice is invalid.

3. The Worker has successfully appealed The Notice of 1 July 2021, therefore, The Notice is invalid.

4. The Employer is to pay arrears for reasonable medical and rehabilitation costs from the time of the notice to the present and ongoing until lawfully reduced or ceased in accordance with the *Return to Work Act 1986.*

5. The Worker has successfully appealed The Notice of 20 April 2022, therefore, The Notice is invalid.

6. The Employer is to pay The Worker arears of weekly benefits from the time of the notice to the present and ongoing until lawfully reduced or ceased in accordance with the *Return to Work Act 1986.*

7. The matter is certified fit for counsel.

8. The Employer is to pay The Workers costs at 100% of The Supreme Court Scale.
