WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **4577/19**
Applicant: **Kristjan Daniel Von Erland**
Respondent: **Deluxwood Pty Ltd (in liquidation)**
Date of Determination: **13 December 2019**
Citation: **[2019] NSWWCC 405**

The Commission determines:

1. Award for the respondent.

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

Rachel Homan
Arbitrator

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

A Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr Kristjan Daniel Von Erlund (the applicant) was employed by Deluxwood Pty Ltd (the respondent) as a full-time blind installer between late 2015 and 23 May 2016. The applicant claims that he sustained an injury to his left shoulder and arm as a result of the nature and conditions of his employment with the respondent, which involved stacking, loading, lifting and carrying heavy items and performing strenuous manual work above shoulder height.

2. The applicant made a claim for compensation and, on 24 August 2016, the respondent's insurer issued a notice pursuant to former s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) declining liability. The insurer disputed that the applicant had sustained a work-related injury and had an entitlement to weekly compensation or medical expenses. Further dispute notices were issued on 20 April 2017 and 6 August 2019, the latter of which additionally raised a dispute as to whether the applicant was barred from recovering compensation owing to non-compliance with ss 254 and 261 of the 1998 Act.

3. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) filed in the Commission on 4 September 2019. The applicant seeks weekly benefits from 23 May 2016 to 7 February 2018 and incurred medical expenses pursuant to s 60 of the *Workers Compensation Act 1987* (the 1987 Act), including the costs of and incidental to a left shoulder surgery performed on 18 July 2017.

PROCEDURE BEFORE THE COMMISSION

4. The parties appeared for conciliation conference and arbitration hearing on 18 November 2019. The applicant was represented by Mr Larry Brazel of counsel, instructed by Mr Nathan Job. The respondent was represented by Mr Tom Grimes of counsel.

5. During the conciliation conference, leave was granted to the applicant to amend the date of injury pleaded in the ARD to a deemed date of 23 May 2016 (previously 1 December 2015). The parties agreed that the applicable Pre-Injury Average Weekly Earnings (PIAWE) figure was $1,192.30.

6. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

ISSUES FOR DETERMINATION

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

    (a) whether applicant sustained injury to his left shoulder as a result of the nature and conditions of his employment with the respondent pursuant to s 4 of the 1987 Act;

    (b) whether employment was a substantial contributing factor to the applicant's injury pursuant to s 9A of the 1987 Act;

    (c) whether the applicant is barred from recovering compensation due to a failure to make a claim in accordance with ss 254 and 261;

(d) quantification of any entitlement to weekly benefits, and

(e) Entitlement to the s 60 expenses claimed.

EVIDENCE

8. The following documents were in evidence before the Commission and taken into account in making this determination:

(a) ARD and attached documents, and
(b) Reply and all attachments.

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

Applicant's evidence

10. The applicant's evidence is set out in written statements made by him on 15 July 2016, 27 August 2018 and 12 April 2019.

11. The applicant's first statement was prepared for the purposes of a factual investigation report procured by the respondent. The applicant said he arrived in Australia from Estonia in July 2012. Previously, the applicant had worked as a staging carpenter in London from 2000 to 2012. On arrival in Australia, the applicant worked as a blind installer for several employers prior to commencing work for the respondent.

12. The applicant said his duties for the respondent were to install products such as internal blinds, external shutters, aluminium shutters and awnings. This involved picking up products from a supplier and loading them into or on top of a company van. The applicant worked alone and the product was quite heavy. If the applicant was required to install a heavy product, the respondent sometimes provided other men to help. In these situations, the applicant took the leadership role and the helpers would mainly help hold the product in position. Often there was no one available to help the applicant and he had to do the work alone in order to keep his job.

13. In the week beginning 8 February 2016, the applicant was working on the home of the owner of the business. The applicant needed to fix internal shutters which were in a box and very heavy. The applicant was required to move the boxes from the ground floor to the first floor. The applicant did this work himself and estimated the boxes to weigh about 40 kg. The applicant would lift the box onto his shoulder in order to move them about.

14. On 18 February 2016, the applicant consulted a general practitioner, Dr Leo Van Den Huevel as he was experiencing pain in his left shoulder. The applicant had suffered this pain for around two months. The pain got stronger and the applicant's hand started to lose strength. The applicant's injury came on over a period of time. The applicant was lifting heavy stuff every day and felt his pain was becoming worse. Prior to consulting Dr Van Den Heuvel, the applicant had self-medicated with painkillers like Panadol. The doctor gave the applicant a prescription for painkillers.

15. The applicant said he had first mentioned pain in his left shoulder to his manager in around the first week of January 2016. The applicant asked for someone to give him a hand but was told there were no more staff available.

16. After taking the painkillers prescribed to him, the applicant's pain reduced but would return when the painkillers wore off. The applicant worked through to May 2016 taking the painkillers and avoiding using his left hand. The applicant did not know the reason for his pain and thought it would go away.

17. The applicant resigned in May 2016 and moved to Queensland. The applicant said that when he moved, he did not move anything himself.
18. The applicant intended to look for work or start his own business as an installer. The applicant went to the Blinds and Awnings exhibition on the Gold Coast with a view to getting in touch with businesses making awnings. The applicant hoped to get contacts to start his own business as an installer. The applicant was also looking on SEEK for positions as an installer. The applicant settled in Hervey Bay and had not found any work.

19. The pain in the applicant's left shoulder did not cease and kept him awake at night. The applicant consulted a local doctor who referred him for an MRI, ultrasound and x-ray. When he received the results, the applicant was given a worker's compensation certificate.

20. The applicant denied any previous injury or similar condition. The applicant denied having performed any activity outside of work which would have added to his symptoms.

21. In his second statement, dated 27 August 2018, the applicant noted that the clinical notes of Dr Leo Van Den Heuvel did not refer to a left shoulder injury. The applicant said he could clearly recall telling the doctor that he had a left shoulder problem and being advised to take painkillers. The doctor seemed more interested in a fungal toenail condition the applicant was suffering from.

22. The applicant next reported shoulder problems to Dr Kao after his move to Queensland. Dr Kao referred the applicant to an orthopaedic surgeon, Dr McGee. The applicant gave Dr McGee a history of the work he performed with the respondent. Dr McGee recommended a left shoulder arthroscopy surgery which took place on 18 July 2017.

23. The applicant said that since the surgery he had continued to suffer ongoing pain in the left shoulder, could not lift objects over 5 kg and had difficulty moving items and driving. The applicant was taking pain relief including ibuprofen and Tramadol.

24. In his final statement, the applicant said he specifically recalled informing his manager, Mr Mick Kaddour about his shoulder pain on several occasions. The applicant specifically recalled informing Mr Kaddour that he needed time off to consult with a doctor about the pain in February 2016.

25. The applicant denied being aware of any requirement to complete an injury form and said at no stage was he advised by his employer to complete such a form.

26. The applicant estimated the respondent provided him with an assistant on around 30% of jobs. In the remainder, the applicant was required to organise help by himself by finding an assistant or asking customers to assist. Otherwise, the applicant had to perform his duties alone. The applicant estimated that he was provided with assistance to load items into the van around 50% of time.

27. The applicant said he was often required to install awnings without any assistance including lifting, loading and unloading items above shoulder height weighing up to 150 kg.

Evidence from the applicant's treating practitioners

28. Clinical records from Myhealth Medical Centre Top Ryde include a consultation on 18 February 2016 recorded as follows:

> "**Surgery consultation recorded by Dr Leo van den Heuvel on 18/02/2016**
> sudden onset nil trauma R toe pain at rest
> also, extensive nail fungal infection R toes 1

Diagnosis:
Mild, Acute Gout
Moderate, Chronic Bilateral Onychomycos
Reason for visit:
Mild, Acute Gout Moderate. Chronic Bilateral Onychomycos

Actions:
Request printed to Douglas Pathology Fre all: M8A20; FBC; ESR; CRP; BSL; CHOL-H-L-T; TFTs. (? UA levels R toe pain)
Alcohol history updated.
Prescription printed: Indocid 25mg Capsul 1 Three times a day with meals
Letter printed.
Request printed to Douglas Pathology Fre call: nail clippings for fungal elements. (both feet extensive infection)
Prescription printed: Lamisil 250mg Tablet Daily."

29. Clinical notes from Dr Frank Wei-Fan Kao are also in evidence. The first consultation recorded reads as follows:

"**Surgery consultation recorded by Dr Frank Wei-Fan Kao on 06/06/2016**
Non specific L upper arm pain for 1 month
Persistent and worse at night time
Nil systematic features
Nil recent injuries
? shoulder pathology
? vascular"

30. The applicant consulted Dr Kao again on 15 June 2016 where the results of shoulder x-rays and ultrasounds were given to the applicant.

31. The report of an MRI of the applicant's left shoulder dated 21 June 2016 indicated that the referral was made due to "new onset of left shoulder upper arm pain exacerbated with movement, worse at night ? posterior or labrum ? Labral tear". The findings revealed:

"Inflammation of the AC joint on background degenerative changes with prominent marrow oedema.
Severe subacromial bursitis.
Severe supraspinatus and infraspinatus tendinopathy without distracted tearing.
Chronic labral fraying and tearing, minimally distracted, with some subtle superior chondral fissuring at the glenoid.
Capsular scarring but no acute capsulitis."

32. On 27 June 2016, Dr Kao appears to have issued a Queensland workers compensation medical certificate.

33. The first NSW WorkCover certificate in evidence issued by Dr Kao is dated 4 July 2016. The diagnosis given was "severe subacromial bursitis of L shoulder". From 6 June 2016 to 6 September 2016, the applicant was certified as having no current work capacity. However, on 14 July 2016, the applicant was certified as having capacity for some type of employment for four hours a day, five days a week with no lifting/carrying capacity or pushing/pulling ability and a 10-minute driving ability.

34. A letter from physiotherapist, Ms Alannah Grimm, to Dr Kao, dated 5 July 2016, set out a history as follows:

> "Kristjan presented to me with a 6-month history of worsening shoulder pain, He describes a dull pain felt over the superior and lateral shoulder into his upper arm. He experiences pain in lifting movements such as carrying groceries as well as driving. Kristjan reports that the injection he received last week has helped reduce the pain, however is now more diffuse over the shoulder, He reports that pain killers can help pain subside, however has had no relief with pain gels. Kristjan reports he avoids sleeping on his left side as it is too painful, and the pain often wakes him early in the morning."

35. An initial assessment report prepared by Interact Injury Management on 22 July 2016 includes a report prepared by Ms Grimm of the same date. Ms Grimm said the applicant was unable to work his pre-injury duties, had a lifting capacity of 1 to 2 kg on limited occasions, nil pulling, pushing up to 5 kg and a driving ability limited to 5 minutes. Ms Grimm said,

> "Patient presents with a six-month Hx of L shoulder pain, worsening. No particular incident described however is an installer for work, lifting of heavy sheeting to 150 kg (between workers). …Degenerative wear and tear consistent with previous occupation of chronic repetitive movements in heavy lifting. Likely underlying pathology due to years of work, aggravated by overuse."

36. A report from specialist orthopaedic surgeon, Dr Andrew McGee, dated 13 October 2016, noted that the applicant commenced work for the respondent in 2015 and was performing a much heavier job than he had done previously. The applicant had to lift up heavy boxes and go through the installation process on his own without help. The applicant found the boxes very heavy. In December 2015, he had pain in his left shoulder which failed to settle. From February 2016 onwards, the applicant had a heavier job to do than normal. The applicant developed significant pain in the left shoulder and was struggling to elevate the shoulder above chest level or behind his back.

37. Dr McGee noted that the applicant had been given four subacromial injections which gave him good relief before wearing off. The applicant had been taking Brufin and Targin. Dr McGee concluded,

> "Kristjan-Daniel is suffering with significant subacromial bursitis along with biceps tendinopathy and an inflamed acromioclavicular joint. From the history given I would support a WorkCover claim. He is at present thinking of appealing the decision.
>
> I today have discussed with him that I think he would benefit from a left shoulder arthroscopy, subacromial decompression, biceps tenodesis and excision of the AC joint. I have said to him that hopefully the surgery will improve his symptoms and pain."

38. On 16 December 2016, Dr Kao issued a WorkCover certificate indicating that the applicant had no current capacity for any employment from 15 December 2016 to 15 March 2017. The applicant continued to be certified as having no current work capacity until 10 June 2018. An additional diagnosis of "severe supraspinatus/infraspinatus tendinopathy" was added to the diagnosis of "severe subacromial bursitis of L shoulder" from 2017 onwards.

39. On 5 June 2017, Dr McGee prepared a report for Dr Kao indicating that the applicant's shoulder had failed to settle down. The applicant had pain and was struggling to do things above shoulder height or behind his back. Examination revealed movement restricted by pain and marked positive impingement signs. Dr McGee said,

> "Kristjan's pain is now more in keeping with underlying rotator cuff tendinopathy and bursitis. Today I have discussed the option of doing a left shoulder arthroscopy, subacromial decompression +/ pair of the ACJ +/- biceps tenodesis. I feel that the acromioclavicular joint is now recovering and can be left alone.

> I have been through the risks and benefits of surgery and have highlighted the risks of infection, injury to the nerves and vessels, chronic pain, chronic stiffness 1:20 developing a frozen shoulder, incomplete resolution of the symptoms in the long rehabilitation phase. … He would like to proceed with surgery and today signed his consent form."

40. On 28 August 2017, Dr McGee prepared a report for the applicant's legal representatives. Dr McGee recited the same history and diagnosis as in his reports above. Dr McGee said the diagnosis was "in keeping with a Workcover related injury given the history".

Dr Machart

41. The applicant relies on a medicolegal report prepared by orthopaedic surgeon, Dr Frank Machart, dated 9 February 2018.

42. Dr Machart took a history of the applicant commencing work for the respondent in September 2015. The applicant was asked to work on his own, handling heavy awnings and materials. Around November or December 2015, he started to experience pain in the left shoulder but kept working. Pain became more severe on 18 February 2016 after lifting heavy material. The applicant saw a doctor and was treated with analgesics but the pain did not improve. The applicant ceased work on 23 May 2016. Dr McGee performed an arthroscopy and biceps tenodesis and subacromial decompression on 18 July 2017. Recovery was slow and complicated by stiffness. The pain gradually eased.

43. Dr Machart said there was no relevant past history. The applicant was now experiencing virtually constant pain in the left shoulder. The applicant has been treated with home exercises, Tramadol, Mobic and Lyrica.

44. Dr Machart considered an MRI of the right shoulder dated 21 June 2016 and x-ray of the right shoulder dated 10 June 2016.

45. Dr Machart gave the opinion that the applicant's painful left shoulder developed in relation to physical activities at work and his symptoms were consistent with biceps tendonitis and subacromial bursitis. These features were confirmed on MRI. The applicant's recovery from surgery had been complicated by adhesive capsulitis. Dr Machart said the description of injury, symptom pattern and clinical findings of Dr McGee were indicative of an inflammatory condition in the subacromial region including the biceps. The medical evidence indicated that the applicant did not suffer from frozen shoulder before the operation. The frozen shoulder pathology was secondary to the operation.

46. Dr Machart said the surgery performed by Dr McGee was appropriate for the pathology demonstrated given that the symptoms had not settled with conservative measures. The surgery was cost-effective and accepted by the medical profession as being a reasonably necessary step in the treatment of the worker. Dr Machart said the treatment was necessary as a direct result of the injury sustained in the course of employment.

47. Dr Machart considered that the applicant was incapacitated for conducting his usual work, however, as the condition affected the left shoulder and the applicant was right-handed he was not totally incapacitated. Dr Machart said,

> "Within the realm of his education and experience, he would have to be considered unfit for work because he has been used to doing manual work all his life. Technically, he could do administrative or desk work, that is, work which does not involve lifting anything heavy with the left arm or lifting his arm overhead."

48. Dr Machart said there was no evidence of a pre-existing condition.

Respondent's evidence

49. The respondent's evidence includes an Early Investigation Report prepared for the insurer by Verifact, dated 28 July 2016.

50. Attached to the report is a written statement prepared by Mr Mick Kaddour, dated 22 July 2016. Mr Kaddour indicated that he was a sales representative and supervisor of the applicant.

51. Mr Kaddour indicated that the applicant commenced employment in November 2015 and resigned from employment on 21 May 2016. Mr Kaddour said that sometime in May 2016, the applicant informed him that he was going to leave as he had purchased property in Queensland which he intended to subdivide. Mr Kaddour advised the applicant that the business had customers in Queensland and if he wanted to do some installations, if and when they became available, this could be done on a subcontract basis. Mr Kaddour said he was aware that the applicant hired a 10-tonne truck to move to Queensland and he made two trips to Queensland alone moving his furniture.

52. Mr Kaddour said the first time he became aware that the applicant had allegedly injured himself was when he received a call from the insurer. At no time during his employment had the applicant informed him that he had injured himself nor did he ever mention that he had a sore shoulder. Mr Kaddour said all staff were aware that if they injured themselves, they were to complete an injury form. No incident forms were completed by the applicant.

53. The applicant generally worked alone but if he required assistance, he was provided with another worker. The applicant had a friend who had assisted the applicant on occasions and was paid cash by the employer. When loading stock into a work van, assistance was provided by staff employed in the warehouse.

Dr English

54. The respondent relies on medicolegal reports prepared by orthopaedic surgeon, Dr Hugh English dated 5 August 2016 and 26 November 2018.

55. In his first report, Dr English took a history consistent with the other medical evidence although he recorded that the applicant had experienced "gradually increasing pain and stiffness" since moving to Queensland. Under the heading, "current situation", Dr English said the applicant was reporting ongoing pain and difficulty lifting his arm away from his side, difficulty driving a car with his left hand and difficulty sleeping. The applicant felt his shoulder was becoming stiffer and stiffer. Dr English said no specialist referral had yet been made.

56. Dr English reviewed the x-ray films, ultrasound report and MRI report and expressed the opinion that the applicant had a developing adhesive capsulitis or frozen shoulder affecting his left shoulder. This condition was of spontaneous onset and unrelated to work. Dr English said,

> "No clear work-related injury is diagnosed. Mr Von Erlund has spontaneous adhesive capsulitis affecting his left shoulder. Whilst work may have exacerbated this for a few hours following a day at work, the underlying condition is spontaneous.
> …
> I would disagree with the diagnosis of severe subacromial bursitis left shoulder. Diagnosis is one of adhesive capsulitis.
> …
> This is a spontaneous condition occurring in the fourth and fifth decade of life of unknown cause.
> …
> There is no clinical evidence of subacromial bursitis."

57. Dr English considered the applicant was unfit for pre-injury employment but this was not due to any work-related injury.

58. In his supplementary report dated 26 November 2018, Dr English noted that he had been given the report of Dr McGee dated 13 October 2016 but it was only partially legible. Dr English also had the operation report by Dr McGee dated 18 July 2017 and Dr Machart's report of 9 February 2018.

59. Dr English maintained his opinion that the history was in keeping with adhesive capsulitis and his findings on examination on 4 August 2016 were in keeping with this pathology.

Applicant's submissions

60. Mr Brazel handed up written submissions at the arbitration hearing which were supplemented by oral submissions.

61. Mr Brazel submitted that the main issue in this case related to the nature of the condition from which the applicant was suffering. That is, whether the applicant had a frozen shoulder or bursitis/tendonitis.

62. Mr Brazel took me through the evidence as outlined above. With regard to the absence of any record of complaint with respect to the left shoulder in the clinical notes of Myhealth Medical Centre, Mr Brazel noted that the applicant had been prescribed "Indocid". The applicant had given evidence that he believed he had told the doctor of the injury to his shoulder at the time of that consultation. Mr Brazel submitted that care should be taken in considering the medical notes consistent with observations made in *Simbana v ISS Facility Services (Australia)*[1].

63. Mr Brazel submitted that Dr English's opinion was inconsistent with the evidence from the applicant's general practitioner, the treating orthopaedic surgeon, the scans and the opinion of Dr Machart. Dr English's examination revealed wasting but he diagnosed a spontaneous condition rather than something consistent with the history given to him.

64. Mr Brazel submitted that having regard to the history, the general petitioner certificates, the opinions of Dr McGee, the scans and operation report as well as the expert opinion of Dr Machart, there should be little doubt that the correct diagnosis was one of bursitis/tendonitis. It was submitted that Dr English's reports should be discounted.

65. Mr Brazel submitted that a common sense test of causation consistent with *Koorangang Cement v Bates*[2] should be applied. The causal connection must be real and of substance but employment need not be the only contributing factor or even the most significant contributing factor referring to *Super Retail Group Services v Uelese*[3] and *Badawi v Nexon Asia Pacific Pty Ltd t/as Commander Australia Pty Ltd*[4].

66. It was submitted that as the applicant's injury appeared to have occurred over a period of time it might be considered an aggravation, acceleration or exacerbation of an underlying condition. Mr Brazel submitted that the applicant initially experienced symptoms in December 2015 when he felt pain but that really set in in February 2016 after he was involved in moving heavy boxes.

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[1] [2015] NSWWCC 306 at [85].
[2] (1994) 10 NSWCCR 796.
[3] [2016] NSWWCCPD 4.
[4] (2009) 75 NSWLR 503; (2009) 7 DDCR 75; [2009] NSWCA 324,

67. The applicant was involved in heavy duties, lifting blinds and awnings by himself. It was noted that the employer had gone into liquidation and that might give rise to an inference that it might not have been able to pay for assistance as often as required.

68. There was nothing to indicate that the applicant would have suffered the condition in any event, aside from Dr English's report, which conceded an aggravation was possible.

69. The applicant was in good health prior to the injury and otherwise able to carry out his duties. No treatment had been received in relation to the shoulder previously. There was nothing in the applicant's lifestyle or activities which would predispose him to the injury.

70. There was no evidence from the respondent to contradict the applicant's account of events in the week of 8 February 2016. In particular, the respondent did not deny the weights of the various components or that they may have been awkward to install. Mr Brazel noted that photographs on some of the products the applicant was required to install were attached to the ARD.

71. It was submitted that the diagnosis of Dr Machart, Dr McGee and the general practitioner should be preferred to that of Dr English. The injury was substantially caused by or mainly due to the applicant's employment. The applicant should have an award for weekly payments and past medical expenses.

72. Mr Brazel noted that although the applicant had been certified for certain periods as only partially incapacitated, in fact there was no suitable employment available to him having regard to his restrictions and his employment history which had always been as a carpenter or installer. Mr Brazel said the first 13-week period ran from 23 May 2016 to 22 August 2016. The second period ran from 23 August 2016 to 7 February 2018 which was the date on which the applicant departed Australia.

73. It was submitted that the treatment provided by McGee was reasonable and necessary. The applicant underwent physiotherapy and steroid injections before resorting to the surgery.

74. With regard to ss 254 and 261, Mr Brazel noted that the applicant made the claim within six months and well within three years of the injury. The applicant was out of the state when he made the claim. The applicant had relatively recently arrived in Australia and had never made a claim for workers compensation before. In the circumstances, it was open to find that any default was occasioned by ignorance.

Respondent's submissions

75. Mr Grimes took me to the general practitioner's notes from Myhealth and noted that there was no reference at all to left shoulder symptoms in the attendances on this Medical Centre during the period of employment with the respondent. Attendances in relation to sore throats, nail fungal infections and gout were recorded in this period.

76. Although conceding that the applicant had been prescribed Indocid on 18 February 2016, Mr Grimes said a simple search would reveal that this was a common treatment for gout which was referred to in the notes of the consultation on that date.

77. Mr Grimes said payslips in evidence suggested that the applicant in fact ceased work on 7 April 2016 and there was no evidence of any sick leave taken. Mr Grimes submitted that the evidence suggested that the applicant did not cease work due to alleged symptoms but because there was not enough work to do. There was evidence from the employer indicating that the applicant had moved himself to Queensland. Given there were no reported symptoms during the period of employment it was possible that the cause of the applicant's symptoms was moving his furniture.

78. Mr Grimes observed that the initial clinical notes from Dr Kao made no reference to work and suggested the applicant had been experiencing symptoms for only one month. This would be consistent with symptoms appearing after the cessation of work and the relocation to Queensland. The MRI report of 21 June 2016 suggested there had been a "new" onset of symptoms. A referral made by Dr Kao to physiotherapist Ms Grimm made no reference to work. Ms Grimm's first report back to Dr Kao of 5 July 2016 also made no mention of work causing injury. Mr Grimes said this was a detailed report, prepared two months after the cessation of work, and could not be discounted in the same way that clinical notes might be.

79. Mr Grimes said there were a number of inaccuracies or disputed facts in the applicant's evidence. Mr Grimes said it was disputed that the applicant commenced employment in September 2015. Mr Kaddour had disputed that the applicant had reported shoulder problems to him. The applicant's evidence that he had told his general practitioner about his left shoulder pain was not supported by the clinical records. The applicant's evidence indicated that he intended to perform the same work as an installer after moving to Queensland. This suggested that the applicant did not suffer pain during the period of his employment with the respondent or report pain during that time. The applicant's evidence did not suggest that he believed he would be prevented from doing the same work in Queensland due to any shoulder problem.

80. Mr Grimes submitted that the applicant had gone to Queensland thinking that he would be able to start a business doing the same type of employment as he did with the respondent. The applicant had never been required to perform suitable or light duties with the respondent. The applicant was able to move himself, driving a truck long distances twice to do so. These circumstances were entirely inconsistent with a history of injury due to employment.

81. Mr Grimes submitted that Mr Kaddour's statement was consistent with the clinical notes and the applicant's history as to why he ceased employment with the respondent. Mr Grimes noted that the applicant had the opportunity to respond to the evidence in Mr Kaddour's statement. Mr Grimes submitted that there was also a dispute as to the level of assistance provided to the applicant in the performance of his duties.

82. Mr Grimes noted that Dr English considered the condition one of spontaneous onset. Mr Grimes submitted that this was consistent with the contemporaneous evidence, the employer's evidence and the evidence with regard to the applicant's move to Queensland. Mr Grimes noted that Dr English had a correct and full history, having been given the Verifact report.

83. Mr Grimes submitted that Dr McGee's report did not set out an opinion consistent with the statutory tests. Rather, he simply noted that the diagnosis was consistent with a WorkCover injury. The history taken by Dr McGee was inconsistent with the contemporaneous evidence.

84. Mr Grimes submitted that the requirements of s 9A were not satisfied. Mr Grimes submitted that the need for surgery was not consequential upon a work injury. With respect to incapacity, Mr Grimes submitted that if injury was accepted there were indications that the applicant was not incapacitated during several of the periods claimed. Mr Grimes noted that weekly benefits were claimed from 23 May 2016 but there was no medical evidence of any incapacity from this date until 6 June 2016 when the applicant consulted Dr Kao.

85. Mr Grimes submitted that a number of the applicant's pre-injury duties as set out in the Interact Injury Management report were capable of being performed within the applicant's restrictions including, customer service by phone and face-to-face, supervising junior staff members and labourers, training junior staff, conducting and ordering logistical tasks, inspecting sites for job estimates, drawing preliminary installation plans, and completing administrative tasks and paperwork. The applicant was right hand dominant and would not be hampered in undertaking administrative roles.

86. The applicant's WorkCover certificates had certified him as fit to work 20 hours per week in the second half of 2016. Dr Machart also considered the applicant could perform suitable duties. Mr Grimes submitted that the applicant had transferable skills and experience in supervisory roles. Mr Grimes suggested that the applicant could perform sales duties, for example, at Bunnings, supervisory roles, work in a call centre or work as a carpark attendant.

Applicant's submissions in reply

87. Mr Brazel noted Mr Grimes' submissions with regard to the prescription of Indocid. Mr Brazel said it simply was not known for what purpose the medication had been prescribed.

88. Dr Kao consistently referred to employment with the respondent as being causative of the applicant's injury. Mr Brazel submitted that the claim for compensation was made relatively quickly after the first consultation with Dr Kao.

89. Mr Brazel noted that the physiotherapist had taken a six-month history of shoulder pain in about July 2016, which was consistent with the applicant's evidence.

90. Dr English did not consider there was an alternative explanation for the applicant's condition. Specifically, he did not consider the applicant's move to Queensland may have been causative. Rather, Dr English considered the applicant had a spontaneous onset of symptoms.

91. Mr Brazel conceded that Dr McGee did not express an opinion in the language of the statute but said it was significant that he considered the diagnosis to be consistent with the stated cause. Dr McGee supported a worker's compensation claim.

92. In terms of residual capacity, Mr Brazel submitted that the applicant had extensive experience as a carpenter and there was no evidence to suggest he was suited to supervisory or management roles or customer service work. The claim for weekly benefits was confined and the applicant had been forthright in providing evidence to the insurer.

FINDINGS AND REASONS

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

> **"4 Definition of 'injury'**
>
> In this Act:
> **injury:**
>
> (a) means personal injury arising out of or in the course of employment,
>
> (b) includes a disease injury, which means:
>
> (i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and
>
> (ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, and

(c) does not include (except in the case of a worker employed in or about a mine) a dust disease, as defined by the *Workers' Compensation (Dust Diseases) Act 1942*, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined."

94. A common sense evaluation of the causal chain is required. In *Kooragang* Kirby P said,

> "The result of the cases is that each case where causation is in issue in a workers compensation claim, must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from', is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent death or injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a common sense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation."[5]

95. The onus of proof rests upon the applicant and depends on examination of the evidence as a whole. The Court of Appeal in *Nguyen v Cosmopolitan Homes*[6] has found that a tribunal of fact must be actually persuaded of the occurrence or existence of a fact before it can be found, summarising the position as follows:

(1) a finding that a fact exists (or existed) requires that the evidence induce, in the mind of the fact-finder, an actual persuasion that the fact does (or at the relevant time did) exist;

(2) where on the whole of the evidence such a feeling of actual persuasion is induced, so that the fact-finder finds that the probabilities of the fact's existence are greater than the possibilities of its non-existence, the burden of proof on the balance of probabilities may be satisfied;

(3) where circumstantial evidence is relied upon, it is not in general necessary that all reasonable hypotheses consistent with the non-existence of a fact, or inconsistent with its existence, be excluded before the fact can be found, and

(4) a rational choice between competing hypotheses, informed by a sense of actual persuasion in favour of the choice made, will support a finding, on the balance of probabilities, as to the existence of the fact in issue.

96. There is, in this case, a number of disputed facts. As noted by Mr Grimes in submissions, there are disputes around the duration of the applicant's employment with the respondent; the nature of the assistance provided to the applicant in the performance of his duties; the timing of the onset of the applicant's shoulder symptoms, including whether the applicant reported shoulder symptoms to his manager and Dr Van Den Heuvel; and whether the applicant's relocation to Queensland provides an alternative explanation for the onset of the applicant's left shoulder symptoms. There is, in addition, a medical dispute as to the nature of the applicant's left shoulder condition.

97. It is convenient to deal with the medical dispute first. The respondent relies on Dr English, who first examined the applicant on 5 August 2016. This was before the applicant was first seen by his treating orthopaedic surgeon, Dr McGee. Dr English took a history that was broadly consistent with the applicant's evidence but noted in particular that there had been gradually increasing stiffness. Dr English was able to review an ultrasound report from

[5] (1994) 10 NSWCCR 796 at [810].
[6] [2008] NSWCA 246.

9 June 2016, x-ray films and report from 10 June 2016 and the MRI report dated 21 June 2016. Dr English formed the view that the applicant had a developing adhesive capsulitis or frozen shoulder which was unrelated to work and was a condition of spontaneous onset. Dr English maintained this opinion, after reviewing Dr McGee's reports and the expert opinion of Dr Machart, in his supplement report.

98. Dr Machart was in agreement with Dr English that the applicant now presented with adhesive capsulitis. His opinion differed from that of Dr English with regard to the onset of that condition. Dr Machart expressed the view that the adhesive capsulitis was secondary to the surgery performed by Dr McGee. Prior to the surgery, the applicant presented with symptoms consistent with biceps tendonitis and subacromial bursitis, which Dr Machart said developed in relation to the physical activities at the applicant's work.

99. Dr Machart's expert opinion is consistent with the opinions expressed by Dr McGee in his report for the applicant's representatives and his contemporaneous reports to Dr Kao. It is also consistent with the diagnoses identified by Dr Kao in the WorkCover certificates, the pathology identified on a plain reading of the MRI report of 21 June 2016 and the observations of the applicant's physiotherapist, Ms Grimm. The weight of evidence therefore indicates, and I accept, that Dr Machart's opinion as to the nature of the medical condition is to be preferred over that of Dr English. It follows from this finding that I also do not accept Dr English's opinions with regard to the timing of the onset of the condition and causation.

100. It is, however, for the applicant to establish on the balance of probabilities that he sustained an injury the purposes of s 4 of the 1987. The evidence suggests that the injury in this case is a disease injury for the purposes of s 4(b)(i) or (ii). It is necessary, therefore, for the applicant to establish that employment with the respondent was the main contributing factor to the disease or any aggravation, acceleration, exacerbation or deterioration of the disease.

101. A significant challenge for the applicant in discharging the burden of proof lies in the absence of contemporaneous corroborating evidence as to the onset of symptoms. The value of contemporaneous evidence has been repeatedly endorsed by the courts: *Watson v Foxman*[7] and *Onassis v Vergottis*[8].

102. The applicant's evidence is that he first began to experience symptoms in his left shoulder in December 2015. The applicant says he first mentioned this pain to his manager, Mr Kaddour, in around the first week of January when he asked for someone to give him a hand but was told there were no staff available. This evidence is contradicted by the evidence given by Mr Kaddour, who said that at no time during the applicant's employment did he inform him that he had injured himself nor did the applicant ever mention that he had a sore shoulder.

103. Mr Kaddour did corroborate the applicant's evidence that he was working on an installation at the business owner's residence in the week of 8 February 2016, however Mr Kaddour said that the work took a couple days and there was a total of four staff, including himself, assisting. The applicant's evidence makes no mention of any assistance provided to him on this project. The applicant said he needed to fix internal shutters to large floor-to-ceiling windows. The panels were in very heavy boxes which he was required to move from the ground floor to the first floor. The applicant said he did this work himself.

104. Mr Kaddour also corroborated the applicant's evidence with regard to the identification of his duties and the claim that he generally worked alone. Mr Kaddour did, however, suggest that on any heavy jobs, including the installation of awnings, assistance would be provided to the applicant. Whilst Mr Kaddour's evidence suggests the applicant may have understated the level of assistance provided to him, I accept generally that the applicant's work involved some heavy lifting and regular manual work above shoulder height.

[7] (1995) 49 NSWLR 315.
[8] (1968) 2 Lloyds Report 403.

105. It has been accepted by the applicant's treating practitioners and Dr Machart that the nature and conditions of the applicant's work were of a type capable of causing the condition found in the applicant's shoulder. There is, however, no contemporaneous medical evidence to corroborate that this is in fact what occurred.

106. The applicant claims that he first reported symptoms in his shoulder to Dr Van Den Heuvel on 18 February 2016. The applicant's evidence is that by the time he consulted Dr Van Den Heuvel he had been experiencing pain in his left shoulder for around two months, which was getting stronger and his hand had started to lose strength. There is a clinical record of a consultation with the doctor on 18 February 2016 but there is nothing in that record to suggest any complaint of shoulder pain.

107. It is well-established that consideration of clinical notes must be approached with caution, consistently with the observations of Basten JA in *Mason v Demasi*[9]:

> "First, the trial judge was invited to discount the appellant's oral testimony on the basis of accounts given to various health professionals, which appeared inconsistent either with each other, or with her oral testimony, or both. The difficulties attending this kind of exercise should be well-understood; as explained in the *Container Terminals Australia Ltd v Huseyin* [2008] NSWCA 320 at [8], such apparent inconsistencies may, and often should, be approached with caution for the following reasons, amongst others:
>
> (a) the health professional who took the history has not been cross-examined about:
> (i) the circumstances of the consultation;
> (ii) the manner in which the history was obtained;
> (iii) the period of time devoted to that exercise, and
> (iv) the accuracy of the recording;
>
> (b) the fact that the history was probably taken in furtherance of a purpose which differed from the forensic exercise in the course of which it was being deployed in the proceedings;
>
> (c) the record did not identify any questions which may have elucidated replies;
>
> (d) the record is likely to be a summary prepared by the health professional, rather than a verbatim recording, and
>
> (e) a range of factors, including fluency in English, the professional's knowledge of the background circumstances of the incident and the patient's understanding of the purpose of the questioning, which will each affect the content of the history."

108. I have approached the clinical records from Myhealth Medical Centre with caution consistently with the observations above. I accept that the omission of any reference to shoulder symptoms in the record for 18 February 2016 does not necessarily leads to the conclusion that the applicant did not make any such complaint to the doctor. The duration and severity of the symptoms the applicant said he was experiencing at the time do, however, render the omission, in contrast to the detailed reference to other symptoms and actions, for example, with regard to a fungal toenail infection, surprising. I am also not satisfied that the prescription for Indocid can be attributed to shoulder pain, when other types of pain were noted in the record.

109. Clinical notes from that practice show three consultations in February and March 2016, none of which refer to any shoulder symptoms.

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[9] [2009] NSWCCA 227 at [2].

110. I have approached the clinical records from Dr Kao's practice with the same caution. As noted by Mr Grimes, the record of the initial consultation with Dr Kao made no mention of work in relation to the shoulder symptoms reported to him. The pain was reported to have been present for one month, which would suggest an onset in early May 2016 rather than December 2015 or February 2016 as suggested by the applicant's evidence. Similarly, the MRI report from 21 June 2016 indicates the applicant had a "new" onset of shoulder and upper arm pain.

111. I accept it is possible that Dr Kao's initial notes contain an error as to the timing of the onset of pain. The omission of reference to work is also not determinative. I have additionally taken into account the later references to work and a history consistent with the onset of symptoms during employment with the respondent. Whilst these records alone would not be sufficient for me to find that the applicant did not experience any shoulder symptoms during the period of his employment with the respondent, I am not satisfied that they support that claim either.

112. The first evidence of the applicant's shoulder symptoms being related to his work appeared on 27 June 2016 when Dr Kao issued a Queensland workers compensation certificate after receiving the results of the investigations. The applicant has said that Dr Kao first issued a Queensland certificate of capacity on 6 June 2016 but that is not in evidence before me or referred to in Dr Kao's clinical records on that date. The clinical records first refer to a certificate being issued on 27 June 2016, and one bearing that date is in evidence. This was the third consultation with Dr Kao.

113. After this point, the applicant appears to have provided a much longer history of worsening shoulder pain to his treating practitioners. Ms Grimm took a six-month history of worsening shoulder pain on 5 July 2016. Ms Grimm did not initially relate to the applicant's symptoms to work, referring only to difficulty carrying groceries and driving but chronologically a six-month history would be consistent with the onset of pain during employment with the respondent. By 22 July 2016, in the context of the initial assessment report prepared by Interact Injury Management, Ms Grimm had expressed an opinion that the history was consistent with the applicant's previous occupation. Ms Grimm did, however, say the likely underlying pathology was due to years of work, aggravated by overuse. The history given to Dr McGee was consistent with the applicant's claims, as was the history given to Dr Machart and Dr English.

114. The opinions subsequently given by the applicant's treating practitioners and Dr Machart, are consistent and supportive of the applicant's claims. As indicated above, I am satisfied on the basis of those opinions and having regard to the lay evidence that the nature of the applicant's duties was of a kind capable of causing the applicant's shoulder condition. The opinions are, however, all based upon an acceptance of the applicant's history as to the onset of symptoms during his employment with the respondent.

115. In weighing the evidence, I have taken into account the absence of any evidence to suggest that the applicant experienced shoulder symptoms or difficulties prior to his employment with the respondent. There is nothing to suggest that the applicant's shoulder was previously symptomatic. At the time he commenced employment with the respondent, the evidence suggests that the applicant had capacity to engage fully in what was relatively strenuous work involving regular work above shoulder height. I accept that the applicant's capacity for work is now vastly reduced.

116. There are, however, other aspects of the evidence that cause me difficulty in accepting the applicant's claims as to the onset of his symptoms. The applicant has given evidence that his pain was increasing, he was losing strength in his hand and his symptoms were sufficient to cause him to mention them to his supervisor and his general practitioner during his employment with the respondent. Despite this, the applicant continued in his pre-injury duties until he resigned. There is no suggestion that the applicant's resignation had anything to do with any shoulder difficulties or incapacity.

117. Both the applicant and Mr Kaddour have given evidence indicating that the applicant resigned due to a lack of work. The applicant moved to Queensland with the intention to look for similar work or start his own business as an installer. Although the applicant never undertook such work, he does not suggest that this was because of his left shoulder symptoms. Rather, the applicant's evidence indicates that he attempted to, but did not, find any work. This evidence does not suggest that the applicant was experiencing incapacitating symptoms at the time he stopped work for the respondent.

118. Mr Kaddour has also given evidence that the applicant moved himself to Queensland in May 2016, making two trips with his furniture in a 10-tonne truck he had hired. In his first statement the applicant said he had not moved anything himself during his relocation to Queensland. In his last statement, the applicant responded to several aspects of Mr Kaddour's statement but not this allegation. Mr Kaddour's evidence is in this regard uncontradicted.

119. It is a matter of common knowledge that the drive from Sydney to Queensland is long and arduous and would take well in excess of 10 hours. If, as suggested by Mr Kaddour, the applicant undertook this trip twice, the applicant drove that distance three times in May 2016 in order to relocate. In this regard, the evidence does suggest a possible alternative cause of the applicant's symptoms which would be broadly consistent, chronologically, with the clinical note recorded by Dr Kao soon after the relocation on 6 June 2016, Dr Kao recorded a one-month history of pain or "new" onset of pain as noted in the MRI report on 21 June 2016.

120. It is not apparent from the reports of Dr McGee, Ms Grimm, Dr Kao or Dr Machart, that they have considered the possible effect of the applicant's relocation to Queensland or the absence of contemporaneous medical evidence to corroborate the history provided to them, in reaching the conclusion that the history was consistent with the applicant's shoulder condition.

121. The evidence in this case is finely balanced. A careful analysis and weighing of all the evidence has, however, left me without a sense of actual persuasion that an injury occurred. The absence of corroborating contemporaneous medical evidence during the period of employment; inconsistent reporting as to the onset of symptoms to Dr Kao; Mr Kaddour's denial of the applicant reporting symptoms to him; discrepancies in the evidence as to the level of assistance provided to the applicant; the evidence that the applicant continued to work full duties up until the time he ceased work; the evidence that the applicant resigned with the intention of pursuing the same type of work in Queensland; and the event of the applicant's long distance relocation shortly prior to the first record of symptoms being reported to a medical practitioner, all weigh against the applicant's evidence. These considerations cumulatively leave me unsatisfied as to the reliability of the applicant's evidence as to the onset of his symptoms. As a result, I am not satisfied that the opinions on causation given by the applicant's treating practitioners and Dr Machart, which are based on the history provided to them by the applicant, are also reliable.

122. I am not satisfied on the balance of probabilities that the applicant's employment with the respondent was the main contributing factor to him contracting a left shoulder condition or that such employment was the main contributing factor to an aggravation, acceleration, exacerbation or deterioration of a disease condition in the applicant's left shoulder for the purposes of s 4(b) of the 1987 Act. The applicant has not claimed and the evidence does not suggest that the applicant sustained an acute or frank personal injury for the purposes of s 4(a) of the 1987 Act.

123. I am not satisfied that the applicant sustained an injury pursuant to s 4 of the 1987 Act. It follows that I am not satisfied that the surgery performed by Dr McGee was reasonably necessary as a result of an injury pursuant to s 60 of the 1987 Act or that the applicant has been incapacitated for work as a result of an injury pursuant to s 33 of the 1987 Act.

124. There will be an award for the respondent.