WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **222/20**
Applicant: **Gai Miller**
Respondent: **Blue Haven Pools South Pty Ltd**
Date of Determination: **26 March 2020**
Citation: **[2020] NSWWCC 90**

The Commission determines:

1. I remit the matter to the Registrar for referral to an Approved Medical Specialist to assess the applicant's permanent impairment as a result of injury on 6 April 2016 to her:

    (a) Cervical spine;
    (b) Left upper extremity (shoulder and brachial plexus), and
    (c) TEMSKI.

2. The following material is to be sent to the Approved Medical Specialist:

    (a) Application to Resolve a Dispute;
    (b) Reply;
    (c) Application to Admit Late Documents dated 11 February 2020;
    (d) Application to Admit Late Documents dated 25 February 2020, and
    (e) A copy of this Certificate of Determination and reasons.

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

Catherine McDonald
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 CATHERINE McDONALD, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A MacLeod

Ann MacLeod
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Gai Miller was employed by Blue Haven Pools South Pty Limited as its Preconstruction and Compliance Manager. On 6 April 2016 she was assembling a desk in her new office. The task was awkward and when she lifted the return of the desk it fell backwards onto her neck, chest and left shoulder, causing her to fall backwards to the floor. Her primary injury was identified as a left sternoclavicular joint and thoracic outlet injury.

2. Ms Miller claims permanent impairment compensation in respect of injuries to her cervical spine, thoracic spine and left shoulder and consequential conditions in her right shoulder and scarring. Blue Haven concedes that Ms Miller suffered injury to her neck and left shoulder and that her scarring should be assessed. It concedes that the left shoulder injury involves a brachial plexus injury.

3. The issues to be determined in these proceedings are whether Ms Miller suffered an injury to her thoracic spine and a consequential condition in her right shoulder.

PROCEDURE BEFORE THE COMMISSION

4. The claim was listed for conciliation conference and arbitration hearing in Wollongong on 3 March 2020. Mr Boulton of counsel, instructed by Mr Wells, appeared for Ms Miller and Mr Combe of counsel appeared for Blue Haven.

5. 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.

6. Mr Boulton sought to argue that Ms Miller suffered a thoracic spine injury or, in the alternative, a consequential condition in her thoracic spine. When asked to specify whether an injury or consequential condition was relied on because the relevant tests are different, he informed me that it was a thoracic spine injury.

EVIDENCE

Documentary Evidence

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

    (a) Application to Resolve a Dispute and supporting documents (ARD);

    (b) Reply and supporting documents;

    (c) Ms Miller's Application to Admit Late Documents dated 11 February 2020, and

    (d) Further Application to Admit Late Documents dated 25 February 2020, omitting the attachments at page 6 and following.

8. There was no oral evidence.

9. Ms Miller said in her statement dated 9 December 2019 that while assembling her desk, the return fell awkwardly on her left shoulder and chest. She was most concerned about pain in her low back and foot but the pain in those areas subsided and her neck pain increased. She did not immediately seek medical treatment.

10. Ms Miller prepared a further statement dated 11 February 2020. She said that when the desk fell on her she had a whiplash injury to her neck and that she injured her upper back when she struck the floor. She said that on she attended Corrimal Physiotherapy on a few occasions and saw Tim Mann who is a friend of her ex-husband, Craig.

11. Ms Miller said:

> "In terms of the right arm and right shoulder I have gradually developed pain and restriction in what I do. I am right-handed and now rely almost totally on my right arm to carry out tasks, certainly any heavy tasks. Also if I use my right arm to any extent I develop discomfort in the right side of my neck and also I develop swelling on the left side in the region of my sternoclavicular joint and neck - brachia! plexus. In other words, because of the pain, swelling and problems that I have in the upper left side I am restricted in what I can do with my right arm and have to be careful with what I do with my right arm.
>
> I have experienced and continue to experience pain and discomfort in my upper back region (thoracic spine). I recall Professor Carmody suggesting that Botox should be injected to my trapezius region.
>
> I have been told I have thoracic outlet syndrome from a brachial plexus injury. Also, when I fell I fell heavily with a significant weight upon my chest and I struck my upper body/back on the floor with the weight of the desk upon me.
>
> In terms of my upper back I also note that I wore a sling on medical advice supporting my left arm for some 3 years. The sling was tied around my neck and it caused pain and discomfort in my neck and upper back."

12. There is considerable medical evidence in the file. Much of it can be summarised briefly because the issues I am required to determine are limited.

13. On 18 April 2016, she saw a physiotherapist then her general practitioner, Dr Rajapaska, who referred her for an MRI scan. Dr Rajapaska recorded that Ms Miller had left shoulder pain after lifting a desk at work. She noted paraesthesia in the "elbow/hand."

14. An MRI scan of Ms Miller's cervical spine on 22 April 2016 showed minor spondylosis with unco-vertebral spurring at C5/6 and C6/7.

15. On 26 April 2016, Ms Miller saw Mr Mann who prepared a note which commences "Hi Craig" saying that she had a "cervical-thoracic-clavicle rib problem." He set out his findings O/E, which I understand to refer to "on examination". After the symbol Rx, he set out five items including "Thoracic screw" and what may be T5 or Ts. After those five items he wrote "all this gave some ease." Ms Miller explained the provenance of the notes in an email attached to her second statement, saying that her ex-husband, Craig, is a physiotherapist.

16. He saw Ms Miller on two further occasions on 2 and 9 May. His notes for 2 May note what may be "ISc Sh p."

17. Dr Rajapaska referred Ms Miller to A/Prof John Ireland who reported on 17 May 2016. He obtained the history that Ms Miller had "hurt her left shoulder region and her back". He said that she had noticed pain around the left lateral neck though to her sternoclavicular joint. She had pain in the shoulder with radiation to the upper arm and some swelling and prominence of the sternoclavicular joint. A/Prof Ireland recommended an injection into the left bicipital groove and aspiration and injection of the left sternoclavicular joint.

18. The treatment was undertaken and A/Prof Ireland said it provided relief for a few days. On 14 June 2016, A/Prof Ireland recommended another cortisone injection and proposed excision of the sternoclavicular joint if the injection did not provide relief.

19. Prof R Lane saw Ms Miller on 8 August 2016. He diagnosed a local brachial plexus injury probably related to the dislocation of the posterior aspect of the sternoclavicular joint. He recommended the surgery proposed by A/Prof Ireland.

20. A/Prof Ireland undertook surgery on 12 August 2016 being excision of the medial end of the left clavicle. He noted that Ms Miller suffered chronic synovitis changes and a disrupted meniscus in the left sternoclavicular joint.

21. By November 2016 Ms Miller had experienced little improvement and he ordered an MRI scan. By mid-November A/Prof Ireland noted that her shoulder pain had settled.

22. On 9 December 2016, Dr Rajapaska completed a questionnaire for Blue Haven's insurer. She said that the current clinical diagnosis was:

> "(1) Disruption of left sternoclavicular joint with synovitis
> (2) Adjustment disorder (to injury)."

23. On 20 January 2017 A/Prof Ireland noted that Ms Miller continued to suffer swelling and discomfort in the neck and the left supraclavicular region. He thought that those symptoms were related to thoracic outlet syndrome and referred her to Prof Lane who recommended conservative treatment.

24. Dr Rajapaska referred Ms Miller to Dr G Bashford, a specialist in rehabilitation and pain medicine who reported on 14 June 2017. He noted that Ms Miller had "fairly widespread pain felt worst in and around the left shoulder and anterior chest wall involving much of the left (non-dominant) upper quadrant." Dr Bashford noted this was "regardless of underlying diagnosis of thoracic outlet syndrome in the sternoclavicular pathology."

25. Prof Lane saw Ms Miller again on 18 April 2018 with respect to a pulsate feeling in the left ear and associated tinnitus, which he said was well known to be associated with inflammatory processes in the root or side of the neck.

26. A/Prof J Carmody, neurologist, reported on 25 May 2018. He noted that Ms Miller had a chronic pain syndrome which affects her upper chest wall, left upper limb and left shoulder. He said:

> "We had a lengthy discussion about the pros and cons of Botox for relieving spasm. She identifies the left sternocleidomastoid and trapezius as the main culprits. I would be happy to provide a low does trial of Botox into the left trapezius +/- right trapezius (for symmetry)."

27. There are no other reports from A/Prof Carmody.

28. On 15 August 2018, Dr Rajapaska wrote to "ED" at Wollongong Hospital and said:

> "Thank you for seeing Ms Gai Miller who has come in with severe left sided pain in the neck, vertigo, severe tinnitus, and is unable to look after herself. As a result she now has weight loss.
>
> Ms Gai Miller, who sustained a disruption of the left sternoclavicular joint requiring surgical management, subsequent thoracic outlet syndrome and an adjustment disorder as a result. The injury occurred whilst at work, while lifting a desk, the desk fell onto the left upper body on the 6th April 2016. She initially had severe pain and swelling over the left upper chest wall & shoulder, left sided neck pain & burning including the ear, and tinnitus.
>
> She was initially managed conservatively with rest, analgesia and NSAID. She was reviewed by a physiotherapist who felt she may be having a thoracic outlet syndrome from the injury, subsequently advising techniques to avoid aggravating exercises and those she could perform."

29. On 31 August 2018, Ms Miller saw Dr B Cass, orthopaedic surgeon at A/Prof Ireland's request to consider if further surgery was required. He did not consider that further surgery would provide benefit. He noted that Ms Miller had problems with her sternoclavicular joint and ongoing pain and "bother" with the:

> "sternocleidomastoid muscle, with pec minor, with protraction of the scapula, with real pain radiating up to the ear, dizziness, occasional feelings of deafness and even vision change and severe dizziness on turning and moving the neck."

30. Dr Cass considered that further investigation of the thoracic outlet syndrome and first rib might be beneficial.

31. On 20 September 2018, Prof Lane examined Ms Miller again with respect to her unusual pain into the left supraclavicular fossa. He noted investigations had confirmed that she has thoracic outlet compression bilaterally at both the artery and vein. His investigations also showed that Ms Miller had a clot in her internal jugular vein for which she was treated.

32. Ms Miller underwent a bone scan and SPECT/CT on 24 October 2018. It showed:

> "SPECT/CT confirms mild degenerative changes in the cervical spine including facet joint arthropathy at C3-C4 bilaterally (mildly active bilaterally), and does not show increased uptake in the left sternoclavicular joint nor asymmetry of uptake between the sternoclavicular joints, and also shows no abnormality in the left first rib. There are discovertebral degenerative changes including minor osteophytes at multiple levels in the thoracic spine which are mostly only mildly active scintigraphically."

33. Following that scan, gallium was injected in preparation for a further scan to define or exclude infection of the left sternoclavicular joint.

34. The further scan was undertaken on 26 October 2018 and did not show active infection. The report said that "in the SPECT, low-dose CT exam minor irregular cervical and thoracic vertebral body uptake is noted."

35. Those investigations were carried out at the request of Dr A Stanton, vascular surgeon, whose reports appear in the Reply. He noted on 5 November 2018 that the scans were negative for infection and did not show evidence of superficial or deep vein thrombosis. On 16 November 2018, Dr Stanton noted that a CT scan of the brain and cervical vertebrae showed some C3/4 cervical disease bilaterally and he did not make any arrangements to see Ms Miller again.

36. On 9 September 2019, Dr Rajapaska wrote to an unnamed doctor, saying that she felt Ms Miller would be a candidate for cannabinoid oil. She described Ms Miller's symptoms:

> "She initially had severe pain and swelling over the left upper chest wall & shoulder, left sided neck pain & burning including the ear, vertigo, and tinnitus. She has now had reduced hearing in the left ear."

Medico-legal and related reports

37. Blue Haven's insurer referred Ms Miller to Dr T Rebbeck for a specialist physiotherapy assessment described in her report dated 7 June 2018. Dr Rebbeck recorded that Ms Miller's persistent symptoms included "constant burning and sharp pains in the region of her chest, posting thoracic region neck and arm." Dr Rebbeck attached a pain diagram showing pain over the whole of her left arm and shoulder, her neck up to her left ear, the right side of her neck and the area toward her right shoulder."

38. Dr Rebbeck's opinion was that:

> "widespread non-dermatomal pain such as this could not come from one single nociceptive source or one single structure. Rather this presentation represents more what is seen in central sensitisation. Supporting the presence of central sensitisation or abnormal sensory processing are several features including the allodynia, the pressure hyperalgesia, and the lack of response to management of proposed specific pathologies."

39. She recommended pain management, specialist physiotherapy including pain education and graded activity under the principles of cognitive behavioural therapy, and ongoing psychology.

40. Ms Miller's solicitors qualified Dr WGD Patrick who reported on 28 August 2019. He said that the nature of the injury was:

> "Work-related injuries predominantly to cervical spine, upper back, left shoulder, right shoulder, and with also likely injury to left sterno-clavicular joint region (and second costal cartilage below) - proceeding to surgery, and likely thoracic outlet syndrome. (TOS), predominantly left sided, and intercurrent internal jugular vein thrombosis (with the thrombosis largely resolving to appropriate therapy), and probably also some consequential still not clearly diagnosed disorders of balance, and tinnitus."

41. Dr Patrick summarised Ms Miller's treatment. When setting out her symptoms he recorded stiffness in the cervical and thoracic spinal regions. When recording his examination findings, he noted muscle guarding and restriction of movement in the cervical spine but did not record any findings for the thoracic spine. He noted that the range of movement of the right shoulder was slightly restricted but the left was markedly restricted.

42. Dr Patrick said that Ms Miller suffered a significant injury to her sternoclavicular joint region on the left, consequential thoracic outlet syndrome, aggravation of the left shoulder, cervical spinal injury. He noted that she suffered problems with balance, tinnitus and loss of hearing and that her condition was complicated by internal jugular vein thrombosis.

43. In a separate report, Dr Patrick considered that Ms Miller's cervical spine, thoracic spine, right and left upper extremities (shoulders) and brachial plexus (lower trunk C8-T1) were rateable for assessment. He said that there was "significant demonstrable muscle guarding at both cervical and thoracic paravertebral levels." Dr Patrick assessed the injury to the lower truck of the brachial plexus with the injury to her left shoulder.

44. When setting out his assessment in respect of each of Ms Miller's shoulders, Dr Patrick said:

> "The numbers within the parentheses in respect of both right and left shoulders, are the percent upper extremity impairments relating to goniometer-measured ranges of active motion in flexion, extension, abduction, adduction, external and internal rotation respectively, totalling 8% uei for right shoulder and 16% uei for left shoulder, which equate to 5% WPI and l 0% Whole Person Impairment respectively.
> The deductible proportion all injured regions is appropriately one tenth of the assessed impairment in respect of any pre-existing constitutional, developmental or degenerative condition which might be contributing to her impairment assessments now."

45. Blue Haven's solicitors qualified Dr J Powell, orthopaedic surgeon, who saw Ms Miller on 19 November 2019. He obtained the following history:

> "She tried to improve access to her work area by moving the desk returns which were stacked on their ends as they did not have four feet. She was moving one of these when it overbalanced and fell towards her, striking her on the anterior aspect of the left upper chest region in the area of the left clavicle. She was knocked over by the weight of the desk. While it had landed on top of her and she was protected from the full force of impact on the floor by the leg arrangement. She indicated that her head and neck were turned to the right. She was able to get out herself from under the return.
>
> She had pain about the left side of the neck down to the base of neck, supraclavicular fossa region, along the clavicle particularly at the medial end, upper anterior chest and extending out to the shoulder region with radiation to the posterior upper scapular area."

46. After setting out the history of treatment, Dr Powell recorded Ms Miller's current symptoms;

> "Ms Miller has constant pain at the root of neck, supraclavicular region, upper anterior chest extending to the superior scapular region and laterally to the anterior shoulder and lateral deltoid area, sometimes radiating further down into the arm.
> …
> She continues to suffer tinnitus and the deafness has increased.
>
> Since the development of symptoms in the left ear, she has also experienced difficulty with balance and walking.
> Sensory symptoms radiating to the upper limb and down to hand at times fluctuate in intensity.
>
> She has difficulty moving her left upper limb at the shoulder as this increases pain."

47. Dr Powell set out his findings on examination. He noted that her neck movements were reduced in all directions. In respect of her upper limbs he recorded:

> "In the right upper limb, she demonstrated a full range of movement at the shoulder, elbow, forearm, wrist and fingers with normal grip strength, intact intrinsic function and normal sensation.
>
> At the left shoulder, flexion was to 90° with extension of 20°, abduction to 80° with adduction of 20°, external rotation to 20° and internal rotation to 50°, with general discomfort on movement although muscular control appeared satisfactory. Power was difficult to test given the irritability about the shoulder girdle region.
>
> Movements at the right shoulder showed flexion to 170° with extension of 50°, abduction was to 170° with adduction of 40°, external rotation was to 70° and internal rotation to 80°."

48. Dr Powell noted that he had not been asked any specific questions. He said that there was no primary injury to Ms Miller's neck and no assessable impairment of the left shoulder. He considered that she suffered a "vascular type thoracic outlet syndrome" and that providing a rational explanation for the condition and distribution of symptoms into her limbs was beyond his area of expertise.

49. Dr Powell was asked to review a series of medical reports and to provide his opinion on a number of questions. He said that it was difficult to provide an orthopaedic diagnosis to explain Ms Miller's symptoms and considered they were "largely of some form of pain related disorder." He said that there was no right shoulder injury nor pathology and no indication that Ms Miller suffered any primary or secondary injury to the thoracic spine. He confirmed his opinion that there was no primary injury to Ms Miller's left shoulder. He considered that the only orthopaedic component of her injury and management was the results of the "excision of the sternoclavicular joint."

SUBMISSIONS

50. Counsel's submissions were recorded.

51. Mr Boulton said that there was evidence that Ms Miller had suffered an injury to her thoracic spine, including in her statement dated 11 February 2020 in which she said that she struck her upper back on the floor at the time of the injury.

52. Mr Boulton noted that Tim Mann's notes referred to a cervical-thoracic-clavicle rib problem and that there was a reference to "Thoracic screw T5" or "Ts" and that the pain diagram in his notes showed that the intrascapular area was shaded. Mr Boulton also noted what may be a reference to scapula in Dr Rajapaska's notes for a date which appears to be 13 or 18 January 2017. He noted that the Gallium scan and Spect/CT report dated 26 October 2018 showed "minor irregular cervical and thoracic vertebral body uptake. He said that Dr Reddick's report referred to "posting thoracic region" and that the pain diagram in her report showed pain over the thoracic spine. He referred me to Dr Patrick's opinion that the thoracic spine was rateable for assessment.

53. Mr Boulton submitted that these references were enough to conclude that Ms Miller had suffered an injury to her thoracic spine, which had not been the subject of the initial focus of her treatment.

54. With respect to Ms Miller's right shoulder, Mr Boulton again took me to her statement and Dr Patrick's report.

55. Mr Coombe said that Ms Miller had not discharged her onus to prove that she had suffered an injury to her thoracic spine and that there was no contemporaneous evidence that she had done so. He said that I would not accept the references in Ms Miller's statement prepared in February 2020 as proof that she had suffered that injury. Ms Miller's recollection of Prof Carmody's suggestion with respect to Botox was not supported by his report. He said that the physiotherapy notes were not evidence of a diagnosis of thoracic spine injury.

56. Mr Coombe took me to Dr Rajapaska's notes in detail to argue that there was no contemporaneous reference to an injury to the thoracic spine and no evidence of complaint in respect of her right shoulder. He said that the brief references to which Mr Boulton had taken me were out of context and speculative.

57. With respect to Dr Patrick's report, Mr Coombe said that Dr Patrick had not said Ms Miller had suffered an injury to her thoracic spine or a consequential condition in her right shoulder and that there was no forensic basis for his opinion that the conditions were rateable.

FINDINGS AND REASONS

58. Ms Miller suffered a serious injury to her left shoulder and an injury to her neck. The left shoulder injury has resulted significant investigation and treatment. Blue Haven concedes that the left shoulder injury includes an injury to the brachial plexus.

Thoracic Spine

59. Ms Miller's case is that she suffered an injury to her thoracic spine on 6 April 2016 as defined in s 4(a) of the *Workers Compensation Act 1987* (the 1987 Act). Roche DP considered the meaning of injury in *Trustees of the Society of St Vincent de Paul (NSW) v Kear*[1]:

> "The authorities establish that a 'personal injury' is 'a sudden and ascertainable or dramatic physiological change or disturbance of the normal physiological state' (Gleeson CJ and Kirby J in [*Petkoska Kennedy Cleaning Services Pty Ltd v Petkoska* [2000] HCA 45; 200 CLR 286] at [39]). In other words, as stated at [81] in [North Coast *Area Health Service v Felstead* [2011] NSWWCCPD 51 (*Felstead*)] it is "a sudden identifiable pathological change."

60. There is no evidence that Ms Miller suffered an injury to her thoracic spine in the form of a sudden identifiable pathological change. The evidence to which I was taken to support the contention that she did suffer an injury to her thoracic spine is a series of references taken out of context with respect to complaints of pain.

61. There is no contemporaneous report of pain in the thoracic spine in Dr Rajapaska's notes.

62. The notes of Mr Mann do not provide a basis to determine that there was an injury to Ms Miller's thoracic spine. Ms Miller saw Mr Mann for physiotherapy treatment. His initial note was addressed to her ex-husband, who is also a physiotherapist, and the note contains a series of abbreviations which a physiotherapist would understand. The reference to thoracic screw is in the section after the abbreviation R, meaning treatment. Mr Mann noted that all of the components following the symbol gave some ease. I draw the conclusion that thoracic screw was part of the treatment administered but, without further evidence, am unable to determine what it was or why it was done.

63. Similarly Dr Rebbick's reference to "posting thoracic region" in a list of symptoms does not provide a basis to determine that Ms Miller suffered an injury to her thoracic spine, nor does a pain diagram which shows pain over her upper back.

64. In the absence of further explanation, I cannot conclude that references to interscapular pain were describing an injury to Ms Miller's thoracic spine. Ms Miller said in her second statement that she recalled that A/Prof Carmody suggested that Botox should be injected into her trapezius region. His report dated 25 May 2018 did propose a low dose trial of Botox for relief of spasm, identifying the sternocleidomastoid and trapezius, both of which are muscles. A/Prof Carmody did not propose treatment to Ms Miller's thoracic spine.

65. Dr Patrick set out the history he obtained from Ms Miller and his reading of the medical reports in his longer report dated 28 August 2019. There is no reference to any injury to her thoracic spine in that history nor in the list of present symptoms, his findings on examination or his opinion. In his second report he considered that her thoracic spine was rateable for assessment. The thoracic spine is distinguished from the "brachial plexus (lower trunk (C8-T1) – TOS)" which is how thoracic outlet syndrome will be assessed. Dr Patrick explained his rating for the thoracic spine by saying that he observed significant demonstrable muscle guarding in the thoracic paravertebral region.

[1] [2014] NSWWCCPD 47.

66. Dr Patrick's observation of muscle guarding is not, by itself, a sufficient basis to find that Ms Miller suffered an injury to her thoracic spine.

Right shoulder

67. The only evidence with respect to the onset of any condition in Ms Miller's right shoulder is in her statement dated 11 February 2020, in which she said that she relies on her dominant right arm to perform all tasks. She said that if she uses her right arm she develops discomfort in the right side of her neck and swelling on the left in the region of her sternoclavicular joint and neck.

68. The only medical evidence with respect to her right shoulder that Mr Boulton was able to take me to was the report of Dr Patrick. Ms Miller's statement post-dates that report. There is no reference to Ms Miller's right shoulder in his list of present symptoms. In his examination findings, Dr Patrick noted that the range of active motion at the right shoulder is slightly restricted. Dr Patrick did not list Ms Miller's right shoulder when setting out his Opinion.

69. In his second report, Dr Patrick said that he considered that Ms Miller's right shoulder was rateable but did not say why. He made a deduction under s 323 of the *Workplace Injury Management and Workers Compensation Act 1998* with a generalised explanation only.

70. Dr Powell examined Ms Miller without a letter of instructions. He did not record any complaint with respect to her right shoulder. In order to assess the range of movement of her left shoulder, he recorded the range of movement in the right. When asked to assess her right shoulder, he found no impairment.

71. If I am to find that Ms Miller suffered a consequential condition in her right shoulder, I am required to undertake a commonsense evaluation of the chain of causation[2]. Roche DP described the nature of the task to be undertaken in *Kumar v Royal Comfort Bedding Pty Ltd*[3]:

> "It was not necessary to determine if Mr Kumar suffered an injury to his right shoulder under s 4 of the 1987 Act. Nor was it necessary to determine if Mr Kumar had suffered "significant right shoulder pathology", as Dr Wallace suggested. It was only necessary to determine if the right shoulder condition resulted from the accepted back injury. That question was a straightforward causation issue. On an objective view of the whole of the evidence, the compelling conclusion is that Mr Kumar's right shoulder condition resulted from stress placed on it due to mobilising and transferring during his recuperative period following his back surgery. It follows that the right shoulder condition has resulted from the back injury on 19 March 2009."

72. There is insufficient evidence in this case to conclude that Ms Miller does have a right shoulder condition. Her own evidence is limited and does not describe the tasks which are said to have caused the condition. There is no evidence in respect of it from her treating doctors nor any explanation in Dr Patrick's report as to how any condition in her right shoulder arose. Dr Patrick's report does not provide a satisfactory basis on which to make findings. In *Hancock v East Coast Timber Products Pty Limited*[4] Beazely JA said with respect to expert opinion:

> "what was required for satisfactory compliance with the principles governing expert evidence was for his reports to set out the facts observed, the assumed facts including those garnered from other sources such as the history provided by the appellant, and information from x-rays and other tests."

---

[2] *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452.
[3] [2012] NSWWCCPD 8.
[4] [2011] NSWCA 11.

73. Dr Patrick's report does not fulfil that requirement.

74. For those reasons, I am not satisfied that Ms Miller suffered an injury to her thoracic spine or that she suffers a consequential condition in her right shoulder.

75. I make the following orders:

    1. I remit the matter to the Registrar for referral to an Approved Medical Specialist (AMS) to assess the applicant's permanent impairment as a result of injury on 6 April 2016 to her:

        (a) Cervical spine;
        (b) Left upper extremity (shoulder and brachial plexus), and
        (c) TEMSKI.

    2. The following material is to be sent to the AMS:

        (a) Application to Resolve a Dispute;
        (b) Reply;
        (c) Application to Admit Late Documents dated 11 February 2020;
        (d) Application to Admit Late Documents dated 25 February 2020, and
        (e) A copy of this Certificate of Determination and reasons.