WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **1058/20**
Applicant: **Marcelo Cabezas**
Respondent: **Hyntor Pty Limited**
Date of Determination: **28 April 2020**
Citation: **[2020] NSWWCC 130**

The Commission directs:

1. Leave is granted to the applicant to amend the Application to Resolve a Dispute to delete the words “and deterioration” in the injury description.

2. Leave is granted to the respondent to admit into evidence the complete report of Dr Stephen Rimmer dated 25 February 2019 by way of an Application to Admit Late Documents dated 23 April 2020 on the basis that page 2 of the report was missing in the supporting documents attached to the Reply.

The Commission determines:

3. The applicant suffered a consequential injury to his right shoulder as a result of the accepted injuries to his cervical spine and left shoulder in the course of his employment with the respondent on 3 March 2015.

The Commission orders:

4. The matter is remitted to the Registrar for referral to an Approved Medical Specialist for assessment pursuant to the *Workplace Injury Management and Workers Compensation Act 1998* as follows:

Date of injury:	3 March 2015.
Body System:	The spine (cervical spine); the left upper extremity (left shoulder); and right upper extremity (right shoulder).
Method of Assessment:	Whole Person Impairment.

5. The following documents are to be provided to the Approved Medical Specialist:

    (a) Application to Resolve a Dispute dated 26 February 2020 and attached documents;

    (b) Reply dated 18 March 2020 and attached documents;

    (c) Respondent’s Application to Admit Late Documents dated 23 April 2020 and attached complete report by Dr Stephen Rimmer dated 25 February 2019;

    (d) This Certificate of Determination and Statement of Reasons.

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

Anthony Scarcella
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 ANTHONY SCARCELLA, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Mr Marcelo Cabezas, is a 48-year-old man who was employed by Hyntor Pty Limited (the respondent) as a bricklayer/labourer.

2. On 3 March 2015, in the course of his employment with the respondent at a construction site in Annandale, Mr Cabezas sustained injuries to his cervical spine and left shoulder, whilst attempting to lift a brick elevator/conveyer belt machine. He alleges that he subsequently developed symptoms in the right shoulder from overuse.

3. On 19 December 2018, Mr Cabezas claimed permanent impairment compensation under section 66 of the *Workers Compensation Act 1987* (the 1987 Act) in respect of the spine (cervical spine), left upper extremity (left shoulder) and right upper extremity (right shoulder).[1]

4. On 21 March 2019, the respondent issued a Dispute Notice pursuant to section 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) denying injury to the right shoulder within the meaning of sections 4 and 9A of the 1987 Act and denying any consequential injury to the right shoulder. The respondent also disputed that Mr Cabezas' level of permanent impairment exceeded the threshold imposed by section 66(1) of the 1987 Act.[2]

5. Mr Cabezas lodged an Application to Resolve a Dispute (ARD) dated 26 February 2020 in the Workers Compensation Commission (the Commission) claiming permanent impairment compensation under section 66 of the 1987 Act.

ISSUES FOR DETERMINATION

6. The parties agreed that the following issues remained for determination:

    (a) Did Mr Cabezas suffer a consequential injury to his right shoulder as a result of the accepted injuries to his cervical spine and left shoulder on 3 March 2015?

    (b) Is Mr Cabezas entitled to lump sum compensation within the meaning of section 66 of the 1987 Act?

Matters previously notified as disputed

7. The issues in dispute were notified in the Dispute Notice referred to above.

Matters not previously notified

8. No other issues were raised.

PROCEDURE BEFORE THE COMMISSION

9. The parties participated in a telephone conciliation conference/arbitration on 23 April 2020. Mr Luke Morgan of counsel appeared for Mr Cabezas and Mr Simon McMahon of counsel appeared for the respondent.

[1] Application to Resolve a Dispute at pages 259-260
[2] Application to Resolve a Dispute at pages 261-266

10. I am satisfied that the parties to the dispute understood the nature of the application and the legal implications of any assertion made in the information supplied. I 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.

EVIDENCE

Documentary Evidence

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

    (a) ARD dated 26 February 2020 and attached documents;

    (b) Reply dated 18 March 2020 and attached documents;

    (c) Respondent's Application to Admit Late Documents dated 23 April 2020 and attached complete report by Dr Stephen Rimmer dated 25 February 2019.

Oral Evidence

12. Neither party sought leave to adduce oral evidence from or to cross-examine any witness.

SUBMISSIONS

13. The parties made oral submissions at the arbitration hearing which were sound recorded. The sound recording is available to the parties. I will refer to the parties' submissions under each relevant issue for determination set out below.

FINDINGS AND REASONS

Did Mr Cabezas suffer a consequential injury to his right shoulder as a result of the accepted injuries to his cervical spine and left shoulder on 3 March 2015?

14. The onus of establishing injury falls on Mr Cabezas and the standard of proof is on the balance of probabilities, meaning that I must be satisfied to a degree of actual persuasion or affirmative satisfaction: *Department of Education and Training v Ireland*[3] (*Ireland*) and *Nguyen v Cosmopolitan Homes*[4] (*Nguyen*).

15. It is unnecessary for me to determine whether Mr Cabezas' right shoulder symptoms are in themselves 'injuries' pursuant to section 4 of the 1987 Act: *Moon v Conmah Pty Ltd* (*Moon*),[5] *Kumar v Royal Comfort Bedding Pty Ltd*[6] (*Kumar*) and *Bouchmouni v Bakos Matta t/as Western Red Services*[7].

16. Further, section 9A of the 1987 Act does not apply to a condition that has resulted from an injury: *Tiritabua v Bartter Enterprises Pty Ltd*[8].

17. The respondent did not dispute that Mr Cabezas sustained injuries to his cervical spine and left shoulder in the course of his employment with the respondent on 3 March 2015. I am required to conduct a common sense evaluation of the causal chain to determine whether

[3] *Department of Education and Training v Ireland* [2008] NSWWCCPD 134
[4] *Nguyen v Cosmopolitan Homes* [2008] NSWCA 246
[5] *Moon v Conmah Pty Ltd* [2009] NSWWCCPD 134 at [43], [45] and [50]
[6] *Kumar v Royal Comfort Bedding Pty Ltd* [2012] NSWWCCPD 8 at [35]–[49] and [61])
[7] *Bouchmouni v Bakos Matta t/as Western Red Services* [2013] NSWWCCPD 4
[8] *Tiritabua v Bartter Enterprises Pty Ltd* [2008] NSWWCCPD 145 at [47]

the right shoulder symptoms complained of by Mr Cabezas have resulted from the accepted injuries to his cervical spine and left shoulder on 3 March 2015: *Kooragang Cement Pty Ltd v Bates*[9] (*Kooragang*), through a careful analysis of the evidence and a careful analysis of the expert evidence: *Kirunda v State of New South Wales (No 4)*[10] (*Kirunda*).

18. I now turn to the application of the relevant legislation and the legal principles referred to above to the available evidence in this matter.

19. At the outset, I note that the date of Mr Cabezas' subject injury has variously been referred to in the evidence as 2 March 2015 and 3 March 2015. The ARD referred to the date of injury as being 3 March 2015, as did Mr Cabezas' evidentiary statement. The Dispute Notice dated 21 March 2019 referred to the date of injury as being 2 March 2015, as did the Employer Injury Claim Form dated 21 March 2015. As the ARD pleaded 3 March 2015 as the date of injury and the respondent did not raise an objection in this regard, and for the sake of consistency, I will refer the date of injury as 3 March 2015.

20. Mr Cabezas' principal submissions may be summarised as follows:

    (a) Mr Cabezas must establish on the balance of probabilities that the consequential injury to his right shoulder is as a result of the accepted injuries to his cervical spine and left shoulder on 3 March 2015. On the evidence contained in the ARD, one would be more than comfortably satisfied that the requisite causal connection has been established.

    (b) The respondent relied on the opinion of Dr Stephen Rimmer, Orthopaedic Surgeon to deny liability in relation to Mr Cabezas' right shoulder. The opinion was based on an incomplete history taken by Dr Rimmer. The history taken by Dr Rimmer failed to record the onset of symptomatology in the right shoulder. However, he then went on to dismiss, without explanation, any suggestion that there was a relationship between the right shoulder symptomatology and the accepted left shoulder and neck conditions. Dr Rimmer did not have a fair climate available to him in which to express an opinion and his opinion suffered as a consequence.

    (c) In relation to the onset of his right shoulder symptoms, Mr Cabezas' evidentiary statements were consistent with the evidence of Dr Vipin Goyal, General Practitioner, who, in his response to the insurer's questionnaire dated 26 August 2017, reported that Mr Cabezas was suffering from right shoulder pain from chronic overuse, in addition to the problems in his neck and left shoulder.

    (d) In a referral letter from Dr Goyal to Dr Hugh Jones, Orthopaedic Surgeon dated 9 September 2017, Dr Goyal referred to Mr Cabezas having sustained a left shoulder injury at work. Since then, he had been favouring his right shoulder. His pain from overuse of the right shoulder was getting worse. He had a weak left shoulder. Dr Goyal requested Dr Jones to assess Mr Cabezas. So, some six months prior to providing his evidentiary statement dated 13 February 2018, Mr Cabezas' treating medical practitioners were turning their minds to the consequences of the left shoulder condition and its impact on the right shoulder.

[9] *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796
[10] *Kirunda v State of New South Wales (No 4)* [2018] NSWWCCPD 45 at [136]

(e) In his reports dated 12 February 2020 and 21 February 2020, Dr Goyal made his reasons for treating Mr Cabezas' right shoulder in 2017 very clear, in the light of the complaints that were being made.

(f) In contrast to the opinion expressed by Dr Rimmer, there is the detailed and reasoned opinion of Dr Sheikh Habib, Orthopaedic and Trauma Consultant. Dr Habib provided a detailed analysis of how and why the injury occurred and the consequences of the over reliance on the right upper extremity. Dr Habib explained the reasoning process behind coming to the conclusion that Mr Cabezas had developed a consequential condition in his right shoulder.

(g) On the evidence, one would be more than comfortably satisfied that the requisite common sense chain of causation has been established with respect to the pathology that has now been identified in the right shoulder. There is no doubt that Mr Cabezas had problems in his right shoulder before 3 March 2015 and that he made an excellent and full recovery returning to manual employment as a bricklayer. The fact that there was previous pathology in the right shoulder is irrelevant. The question as to whether there is to be any section 323 deduction under the 1998 Act is a matter for an Approved Medical Specialist (AMS). The cervical spine and both shoulders should be referred to an AMS for an assessment of whole person impairment as a result of injury on 3 March 2015.

21. The respondent's principal submissions may be summarised as follows:

(a) It is unclear what Mr Cabezas meant when he referred to "overuse". Everyone seems to have adopted that terminology. There was very little evidence to assist in determining what the overuse was.

(b) Mr Cabezas attended the Liverpool Hospital Emergency Department as a result of a motor vehicle accident in December 2015. The emergency discharge summary referred to Mr Cabezas having been involved in a motor vehicle accident and complaining of immediate slight neck pain which increased in severity, slight pain to both shoulders, the left knee and lower back. Dr Habib took no notice of that particular event. Dr Habib took a history from Mr Cabezas that there were no fresh or aggravation injuries sustained in the motor vehicle accident. This history was inconsistent with the discharge summary. Dr Habib did not provide any reasoning as to why he ignored the description of symptoms in the discharge summary. Dr Habib provided his opinion on the basis of an unconsidered history.

(c) Mr Cabezas' evidence was that following the left shoulder arthroscopy by Dr Jones on 31 August 2016, he was experiencing symptoms and pain in his right shoulder.

(d) On 16 February 2017, Dr Jones reported that Mr Cabezas was progressing well following revision arthroscopic subacromial decompression of his left shoulder; he had a much improved range of motion and pain; and he was happy with his progress. There was no mention of any right shoulder symptomatology to Dr Jones and this was inconsistent with Mr Cabezas' evidence that he experienced symptoms and pain in his right shoulder after the left shoulder arthroscopy.

(e) On 27 May 2017, Mr Cabezas underwent a right shoulder ultrasound and x-ray. Significant weight should be given to the clinical notes in the ultrasound and x-ray report, which refer to "chronic shoulder pain". The inference being that it relates to his right shoulder symptoms going back quite some time. This was inconsistent what Dr Jones reported on 16 February 2017.

(f) On 19 September 2017, Dr Jones reported around four months of gradual onset of antero-lateral right shoulder pain on the background of prior right shoulder rotator cuff repair performed in 2012. Dr Jones seemed to link the problem back to the rotator cuff repair performed in 2012. Dr Jones did not provide an opinion that linked the right shoulder symptoms as being consequential to the left shoulder and neck injury. Dr Goyal, a general practitioner, did draw the link but it is questionable as to whether he holds the necessary qualifications to do so.

(g) Mr Cabezas' supplementary statement was dated some 2.5 years after the alleged onset of right shoulder symptoms. The supplementary statement ought to be treated with caution.

(h) On 25 February 2019, Dr Rimmer reported, after having considered the information provided to him, that in relation to the right upper extremity, he could not see any relationship with employment on 2 March 2015. On the evidence, Dr Rimmer's opinion ought to be preferred.

(i) When one considers the clinical picture, including the motor vehicle accident in December 2015, there is no causative link as to the overuse and the right shoulder condition. There should be an award for the respondent in relation to the alleged consequential condition to the right shoulder. The left shoulder and cervical spine should be remitted to the Registrar for referral to an AMS to assess whole person impairment.

22. Mr Cabeza's submissions in reply may be summarised as follows:

(a) In relation to the motor vehicle accident on 16 December 2015 and the hospital discharge summary, if the respondent intends to present a different argument on causation related to the motor vehicle accident, then it bears the onus of bringing the evidence to prove that argument: *Watts v Rake*[11] (*Watts*) and *Purkess v Crittenden*[12] (*Purkess*).

(b) On 9 December 2015, Dr David Manohar, Consultant Physician Musculoskeletal, Spine and Interventional Pain Medicine reported that he had performed diagnostic neural blockade to the left C4/C5 nerve roots and that he intended to proceed with right-sided blocks. Dr Manohar was treating both sides of Mr Cabezas' neck with pain going into both shoulders. That fact torpedoes the respondent's submission that there was some intervening event, such as the motor vehicle accident.

(c) The reference to "chronic pain" in the right shoulder ultrasound and x-ray report and that which was contained in Dr Jones' report is consistent with Mr Cabezas' evidence and Dr Goyal's reports.

[11] *Watts v Rake* [1960] HCA 58; 108 CLR 158; [1961] ALR 333
[12] *Purkess v Crittenden* [1965] HCA 34; 114 CLR 164; 39 ALJR 123; [1966] ALR 98

23. In evidence there are statements by Mr Cabezas dated 13 February 2018[13] and 27 September 2019.[14] Mr Cabezas stated that between 2004 and the commencement of his employment with the respondent in 2014, he was a self-employed bricklayer/labourer. The Employer Injury Claim Form dated 21 March 2015[15] recorded that Mr Cabezas commenced employment with the respondent on 21 May 2014.

24. Mr Cabezas stated that he sustained a right rotator cuff injury in about 2011/2012.

25. On 19 August 2011, Mr Cabezas underwent a right shoulder ultrasound by Dr Mark Waterland, Radiologist, who reported a moderate full-thickness partial tear at the insertion of the supraspinatus tendon extending up to the biceps tendon insertion. He observed that the tear had an average precision measurement of 10 mm and that there was 12 mm of retraction of the tendon. There was tendinosis in the more posterior supraspinatus tendon. He also noted that the tear was slightly larger than on the previous study of 6 March 2009 and now extended up to the biceps tendon. The other rotator cuff tendons and the biceps tendon defined normally. There was a minimal joint effusion and thickening of the subacromial bursa.[16]

26. Mr Cabezas stated that he came under the care of Dr Jones. In about September 2012, Mr Cabezas underwent surgery to repair his right rotator cuff by Dr Jones. Following surgery, Mr Cabezas underwent rehabilitation and made a complete recovery. He was symptom free and returned to full-time work as a bricklayer after 12 weeks. Mr Cabezas' evidence in this regard was unchallenged.

27. Mr Cabezas stated that on 3 March 2015, whilst attempting to lift a brick elevator/conveyer belt machine, he injured his left shoulder and left arm. He consulted his then general practitioner, Dr Gordon Harris, who referred him for an ultrasound. Mr Cabezas was also referred to Dr Manohar, Dr Greggory Burrow, Orthopaedic Surgeon and Dr Jones. Mr Cabezas' left shoulder and neck became very painful and the treatment he received failed to reduce his pain.

28. Mr Cabezas stated that he attempted to return to work with the respondent after 3 March 2015. He worked using only his right hand. He was unable to perform bricklaying work with one arm. The respondent could not continue to provide him with light duty work within his restrictions. Mr Cabezas' evidence in this regard was unchallenged.

29. Mr Cabezas had obtained casual employment as a night shift parcel sorter with Australia Post. It is not clear when he commenced such employment, but his evidence was that following the injury on 3 March 2015, he worked at Australia Post using only one arm and ceased his employment with Australia Post on 13 March 2015. Mr Cabezas' evidence in this regard was unchallenged.

30. Mr Cabezas stated that he had not returned to construction or labouring work after 3 March 2015 and could not even return to his casual work with Australia Post because of his injuries.

31. Mr Cabezas stated that on 30 April 2015, he underwent left shoulder surgery by Dr Burrow. He was certified unfit for work until November 2015. The medical evidence disclosed that Dr Burrow performed a left shoulder arthroscopic cuff repair – double row compression and a biceps tenodesis. The post-operative findings included a supraspinatus 2 cm full-thickness tear and a 50% tear of the long head of the biceps.[17] Mr Cabezas described the surgery as having failed because he remained in quite considerable pain and with limitations in his left shoulder. The medical evidence disclosed that about two weeks following the surgery

[13] ARD at pages 248-250
[14] ARD at pages 274-276
[15] ARD at pages 255-258
[16] ARD at page 129
[17] ARD at page 20

performed by Dr Burrow, Mr Cabezas' left biceps tenodesis ruptured.[18] On 23 June 2015, Dr Burrow referred to a left shoulder MRI scan reporting a partial tear of the rotator cuff. However, he believed that the tear was post-surgical.[19]

32. In November 2015, Mr Cabezas obtained employment as a security guard with MSS Security. Between 3 March 2015 and when he commenced his employment with MSS Security, Mr Cabezas did not use his left arm. Whilst he did attempt to perform activities at home, he did so by using his right arm and shoulder. At the time he commenced his employment with MSS Security, his left arm was still impaired. Whilst there was no extensive physical work involved in his duties as a security guard, any activities he needed to perform were always carried out using his right arm. When driving, he used his right arm on the steering wheel. In April 2016, Mr Cabezas was promoted to a full-time position with MMS Security. Mr Cabezas' evidence in this regard was unchallenged.

33. Mr Cabezas stated that Dr Manohar performed a nerve blockade to his neck in an attempt to relieve his pain. The procedure assisted for a short time, but symptoms returned. The medical evidence disclosed that, on 9 December 2015, Dr Manohar performed a diagnostic neural blockade to the left C4/C5 nerve roots and that he intended to proceed with right-sided blocks.[20]

34. Dr Harris retired. Mr Cabezas came under the care of Dr Goyal on 30 November 2015.[21] On 9 December 2015, Dr Goyal referred Mr Cabezas back to Dr Jones for his opinion and further advice because Mr Cabezas was not happy with the outcome of Dr Burrow's left rotator cuff repair and biceps tenodesis.[22]

35. On 16 December 2015, Mr Cabezas attended the Liverpool Hospital Emergency Department following a motor vehicle accident. The Liverpool Hospital Emergency Department Discharge Summary recorded Mr Cabezas' complaints as immediate slight neck pain which then increased in severity; slight pain to both shoulders; left knee pain; and low back pain.[23]

36. Mr Cabezas stated that he again came under the care of Dr Jones, who performed a left shoulder arthroscopy on 31 August 2016. On 8 September 2016, Dr Jones reported that Mr Cabezas underwent an arthroscopic evaluation of his left shoulder and a subacromial decompression on 31 August 2016.[24] Following the arthroscopy, Mr Cabezas noticed some improvement in his left shoulder but found that it was still impaired. Mr Cabezas' left arm was in a sling for some time following the arthroscopy. He experienced some improvement with physiotherapy but was still very conscious of "looking after"[25] his left arm as the pain was still present. He continued to use his right arm and shoulder for any physical work undertaken. He did not attempt to work with both arms. On 13 October 2016, Dr Jones reported that Mr Cabezas had been making slow progress following the revision arthroscopic and subacromial decompression of the left shoulder.[26] On 16 February 2017, Dr Jones reported that Mr Cabezas was progressing well following the revision arthroscopic subacromial decompression of his left shoulder, with a much improved range of motion and pain. Both he and Mr Cabezas were happy with his progress.[27]

[18] ARD at pages 22-26
[19] ARD at page 26
[20] ARD at page 37
[21] ARD at pages 33, 36 and 279
[22] ARD at page 35
[23] ARD at page 38
[24] ARD at page 112
[25] ARD at page 275 at [17]
[26] ARD at page 113
[27] ARD at page 114

37. In April or May 2017, Mr Cabezas stated that he noticed pain in his right shoulder for the first time since recovering from his 2012 rotator cuff surgery. He observed the pain to be in the top of his right shoulder in particular and that, from time to time, there would also be a stabbing pain at the rear of his right shoulder. The pain in his right shoulder worsened and he reported it to his general practitioner, Dr Goyal. He explained to Dr Goyal that he had been "using my right arm because of the pain and weakness in my left shoulder".[28] Mr Cabezas recalled Dr Goyal expressing a concern that he may develop symptoms in his right shoulder and right arm due to overcompensation.

38. On 26 May 2017, Mr Cabezas underwent a right shoulder ultrasound and x-ray by Dr Sonia Kariappa, Radiologist, on the referral of Dr Goyal. The ultrasound report disclosed heterogeneous supraspinatus and bursitis. The x-ray report disclosed features consistent with rotator cuff repair; mild narrowing of the subacromial space; and no soft tissue calcification. The clinical notes referred to chronic shoulder pain.

39. On 7 August 2017, Mr Cabezas underwent a right shoulder MRI scan by Dr Matthew Lee, Radiologist, on the referral of Dr Goyal. The MRI scan report referred to bursitis and ongoing pain in its clinical notes. Dr Lee concluded that the scan demonstrated a high grade partial thickness tear of the supraspinatus tendon in the anterior mid part, with further tearing posteriorly; tiny partial thickness tears in the subscapularis; subacromial bursitis; and fluid/bicipital change in the inferior recess of gleno-humeral joint associated with adhesive capsulitis.[29]

40. On 26 August 2017, in response to a questionnaire submitted by the respondent's insurer, Dr Goyal reported that Mr Cabezas was suffering from right shoulder pain from chronic overuse.[30] On 9 September 2017, Dr Goyal referred Mr Cabezas back to Dr Jones. Dr Goyal's referral letter to Dr Jones referred to pertinent points in the history as being an injury to the left shoulder at work and thereafter, the favouring of the right shoulder. Dr Goyal opined that the pain from overuse of the right shoulder was getting worse and that Mr Cabezas had a weak left shoulder.[31]

41. On 19 September 2017, Dr Jones reported that Mr Cabezas presented with around four months of gradual onset of antero-lateral right shoulder pain on the background of prior right shoulder rotator cuff repair performed in 2012. He opined that Mr Cabezas had impingement type symptoms and signs clinically, with reasonable rotator cuff power. He referred to the MRI arthrogram which was difficult to interpret due to the prior right rotator cuff surgery. Dr Jones opined that Mr Cabezas did not have any major supraspinatus tear but, given his symptoms, he suggested a repeat investigation with arthrography.[32] There is no right shoulder MRI arthrogram in evidence.

42. Mr Cabezas stated that he underwent cortisone injections in his right shoulder, which provided some benefit for a short period of time. His right shoulder pain increased in severity and has been constant. He has persisted with hydrotherapy. Dr Goyal has prescribed Melatonin in relation to his sleep disturbance and Tramadol for pain relief. Mr Cabezas stated that he has attempted to minimise his intake of medication because of their side-effects. However, he is unable to manage the pain without medication.

[28] ARD at page 275 at [19]
[29] ARD at pages 61-62
[30] ARD at page 63
[31] ARD at page 56
[32] ARD at page 65

43. In evidence, there is a report by Dr Goyal dated 12 February 2020 addressed to Mr Cabezas' lawyers.[33] Dr Goyal confirmed that Mr Cabezas first consulted him on 30 November 2015 in relation to the injuries he sustained at work on 3 March 2015. The history he obtained was consistent with Mr Cabezas' evidence and the medical evidence. Dr Goyal reported that, in spite of ongoing pain, Mr Cabezas had worked full-time in the security industry without taking much time off. He opined that Mr Cabezas developed signs and symptoms of right shoulder pain and rotator cuff tendinitis due to overuse and overcompensation on the right side following left shoulder surgery and residual symptoms and pain in his left shoulder. Dr Goyal noted that Mr Cabezas was managing with analgesic medication and doing his best to keep his job. In a further report to Mr Cabezas' lawyers dated 21 February 2020, Dr Goyal clarified the response in his earlier report relating to the overuse of the right shoulder. Dr Goyal opined that Mr Cabezas' right shoulder condition was related to his initial injury in March 2015 and explained that the injury to his left shoulder, followed by two surgical procedures to it, caused a great deal of overuse and overcompensation in the right shoulder. He noted that during this time, Mr Cabezas continued working full-time in the security industry.

44. On 15 November 2018, Mr Cabezas consulted Dr Habib at the request of his lawyers. In evidence, there is a report by Dr Habib dated 15 November 2018.[34] Dr Habib listed the documents and imaging reports made available to him for the preparation of his report. He took a detailed work history, medical history, a history of the injury and post-injury work history which was consistent with the evidence. Dr Habib also took a history of Mr Cabezas' attendance at Liverpool Hospital on 16 December 2015 following a motor vehicle accident at low speed. He reported that Mr Cabezas denied any fresh injuries or aggravation injuries. The respondent submitted that this history was inconsistent with the complaints recorded in the Liverpool Hospital Emergency Department Discharge Summary. I will deal with that submission later.

45. On examination of Mr Cabezas' right shoulder, Dr Habib observed no deformity or swelling; tenderness anteriorly under the acromion and laterally; and tenderness at the mid trapezius area. He also recorded the active range of motion of the right shoulder and concluded that there was mildly positive impingement.

46. Dr Habib reviewed all the diagnostic imaging made available to him, listed them and summarised their findings and conclusions. Included in the diagnostic imaging he reviewed, were the right shoulder ultrasound and x-ray dated 26 May 2017 and the right shoulder MRI scan dated 7 August 2017. Dr Habib opined as follows:

> "Mr Cabezas was injured during the course of his employment on 03/03/15 while lifting a heavy brick conveyor belt machine. He also severely strained the neck. The imagery and clinical findings of rotator cuff tear required surgical repair. Unfortunately, the repair failed. Because of the persisting pain and movements restriction, Mr Cabezas was forced to use the right arm/shoulder while protecting the injured left shoulder resulting in an injury of the right shoulder.
>
> He also continued to experience considerable pain and stiffness of the neck. He required further surgery for the left shoulder to improve the symptoms of pain and stiffness. This had only partial success in improving the mobility."[35]

[33] ARD at pages 279-280
[34] ARD at pages 1-11
[35] ARD at page 6

47. Dr Habib diagnosed Mr Cabezas as having suffered a rotator cuff tear of the left shoulder with residual stiffness and a ruptured long head of the biceps tendon; cervical discopathy with referred non-verifiable radiculopathy; consequential rotator cuff tear with subacromial impingement and secondary adhesive capsulitis of the right shoulder.

48. In evidence, there is a further report by Dr Habib dated 28 January 2020.[36] The further report was produced in response to a request by Mr Cabezas' lawyers posing certain questions and did not involve a re-examination of Mr Cabezas. Dr Habib sought to clarify his previously expressed opinion and explained that, following the injuries to his left shoulder and neck, Mr Cabezas relied heavily on the use of his right arm and right shoulder, whilst protecting the injured, painful and stiff left shoulder. This resulted in a consequential injury to the right shoulder, which had been asymptomatic, despite the surgery on it in 2012. Dr Habib further opined that Mr Cabezas' left shoulder injury, the subsequent surgeries on it and his reliance on the right arm made a material contribution to the condition of his right arm. As for the delay in the onset of right shoulder symptoms (early 2017), Dr Habib explained that, Mr Cabezas being right hand dominant, meant that he would be able to bear higher stresses than in his non-dominant arm. Therefore, the time lag in the onset of symptoms was not uncommon. Further, Mr Cabezas had taken considerable time off work following the injury to the left shoulder and also following the two surgical procedures to his left shoulder. During these periods, he did not have to use his arms in heavy physically demanding tasks and that would explain the seemingly delayed onset of right shoulder symptoms.

49. On 15 February 2019, Mr Cabezas consulted Dr Rimmer at the request of the respondent's lawyers. In evidence, there is a report by Dr Rimmer dated 25 February 2019.[37] Dr Rimmer listed the documentation reviewed by him in the preparation of his report. He noted that the only investigation brought to the consultation by Mr Cabezas was a right shoulder ultrasound dated 11 February 2019, which concluded that there was subacromial bursitis with a partial-thickness degenerative tear of the supraspinatus tendon. There is no right shoulder ultrasound report dated 11 February 2019 in evidence.

50. Dr Rimmer took a short history of injury. However, it included no history in relation to the onset of right shoulder symptoms. Dr Rimmer recorded Mr Cabezas' complaint that his right shoulder was a mess; and that he had pain to the anterolateral aspect, radiating to the right side of the neck. On examination of the right shoulder, Dr Rimmer observed that it was in symmetrical position; and no evidence of periscapular muscle wasting; and an intact right upper limb neurovascular system. He also recorded the active range of motion of the right shoulder and concluded that there was no impingement and that supraspinatus power was 5/5 and pain free.

51. Dr Rimmer diagnosed Mr Cabezas as being four years post left rotator cuff repair and eight years post right rotator cuff repair. He opined that Mr Cabezas' prognosis was guarded based on the history obtained and his examination. Dr Rimmer opined that, in relation to the right shoulder, he could see no relationship with employment as a frank injury, disease condition or consequential injury.

52. I accept Mr Cabezas as a witness of truth, who did his best to provide a history of his injuries, his treatment and his complaints to his various treating doctors and the forensic medical specialists. The histories he provided of injury, treatment and complaints of symptoms were, in the main, consistent. The evidence demonstrated him to be a hard worker. During a period prior to the subject injury and until 13 March 2015, he was working two jobs. On 30 April 2015, he underwent a surgical procedure to his left shoulder and, despite not making a full recovery, found himself suitable work as a security guard in November 2015 and continued to carry out such work. On 31 August 2016, he underwent a further surgical procedure to his left shoulder and again, despite not making a full recovery, he returned to work as a security guard.

[36] ARD at pages 277-278
[37] Respondent's Application to Admit Late Documents dated 23 April 2020 at pages 1-8

53. The respondent called into question Dr Habib's opinion on the basis that he failed to take any notice of the motor vehicle accident on 16 December 2015 and the contents of the Liverpool Hospital Emergency Department Discharge Summary; took an inconsistent history from Mr Cabezas that there were no fresh or aggravated injuries caused by the motor vehicle accident; and failed to provide any reasoning as to why he ignored the description of symptoms in the discharge summary. The respondent submitted that Dr Habib provided his opinion on the basis of an unconsidered history (the motor vehicle accident). I am unpersuaded by this submission. It is clear that Dr Habib reviewed the Liverpool Hospital Emergency Department Discharge Summary. It is also clear that he asked Mr Cabezas about it and received a response. The fact that slight neck pain, later increasing and slight shoulder pain were recorded in the discharge summary does not make Mr Cabezas' statement to Dr Habib on 15 November 2018 inconsistent. Dr Habib did not place any importance on the complaints recorded in the discharge summary based on the history provided to him that there were no fresh or aggravated injuries caused by the motor vehicle accident. Further, whilst the submission is not entirely clear to me, if the respondent intended to submit that the motor vehicle accident was a novus actus interveniens (an intervening act) that cut the chain of causation, then it bears the onus of bringing the evidence in support of that submission: *Watts* and *Purkess*. It did not do so.

54. I do not accept the respondent's submission that Mr Cabezas' evidence was that following the left shoulder arthroscopy by Dr Jones on 31 August 2016, he was experiencing symptoms and pain in his right shoulder. Mr Cabezas' evidence was that, in April or May 2017, he noticed pain in his right shoulder for the first time since recovering from his 2012 rotator cuff surgery. The pain in his right shoulder worsened and he reported it to Dr Goyal. Mr Cabezas' evidence was supported by Dr Goyal's referral for the right shoulder ultrasound and x-ray by Dr Kariappa on 27 May 2017; Dr Goyal's referral for the right shoulder MRI scan by Dr Lee on 7 August 2017; Dr Goyal's response to a questionnaire submitted by the respondent's insurer dated 26 August 2017; Dr Goyal's referral letter to Dr Jones dated 9 September 2017; and Dr Jones' report dated 19 September 2017 referring to presentation with around four months of gradual onset of antero-lateral right shoulder pain. All the supporting evidence referred to above came about prior to Mr Cabezas' first evidentiary statement dated 13 February 2018. I accept Mr Cabezas' evidence that he first noticed the onset of right shoulder symptomology in April or May 2017, and I find accordingly.

55. The above finding results in the respondent's submission relating to Mr Cabezas' failure to refer to right shoulder symptoms to Dr Jones on 16 February 2017 as having no merit. Similarly, the respondent's submission that Mr Cabezas' supplementary statement was dated some 2.5 years after the alleged onset of right shoulder symptoms and ought to be treated with caution, also has no merit.

56. I reject the respondent's submission that the use of the words "chronic shoulder pain" in the clinical notes of the right shoulder ultrasound and x-ray dated 27 May 2017 led to an inference that it related to Mr Cabezas' right shoulder symptoms "going back quite some time". There was no basis to draw such an inference. The unchallenged evidence was that following Mr Cabezas' right rotator cuff repair in about September 2012, he underwent rehabilitation and made a complete recovery. He was symptom-free and returned to full-time work as a bricklayer after 12 weeks. I accept Mr Cabezas' unchallenged evidence in this regard and find accordingly.

57. I am unpersuaded by the respondent's submission that Dr Jones seemed to link Mr Cabezas' right shoulder symptoms back to the right rotator cuff repair performed in 2012. The basis of this submission seems to be the fact that Dr Jones referred to a background of prior right shoulder rotator cuff repair performed in 2012. On presentation, Dr Jones opined that Mr Cabezas demonstrated impingement type symptoms. I do not accept that Dr Jones was linking the impingement type symptoms on presentation with the right shoulder rotator cuff repair in 2012. I accept the respondent's submission that Dr Jones did not opine that the right shoulder symptoms were consequential to the left shoulder and neck injury. However,

Dr Jones was aware from Dr Goyal's referral letter dated 9 September 2017 of the latter's opinion that the injury to the left shoulder at work caused Mr Cabezas to favour the right shoulder and that the worsening right shoulder pain came from overuse. In such circumstances, it is not unusual for a treating specialist not to refer to the issue of causation.

58. The respondent submitted that it was unclear what Mr Cabezas meant when he referred to "overuse" and that this terminology was adopted by others, when there was little evidence to assist in determining what the overuse was. I reject the submission. The issue is not one of terminology but one of evidence. Mr Cabezas' unchallenged evidence is that he was conscious of looking after his left arm because of the pain and weakness in his left shoulder and continued to use his right arm and shoulder for any physical work undertaken. He did not attempt to work with both arms. He underwent the failed left shoulder procedure on 30 April 2015 and, despite not making a full recovery, found himself suitable work as a security guard in November 2015 and continued to carry out such work. On 31 August 2016, he underwent a further surgical procedure to his left shoulder and again, despite not making a full recovery, he returned to work as a security guard. I accept Mr Cabezas' unchallenged evidence that he favoured his left shoulder by making more use of his right upper extremity in carrying out physical tasks. He first noticed the onset of right shoulder symptomology in April or May 2017 and the timing in this regard is consistent with the evidence.

59. The respondent conceded that, taken in isolation, Dr Rimmer's opinion that he could see no relationship with employment in relation to Mr Cabezas' right shoulder symptoms, could be seen as an assertion without proof. The respondent submitted, however, that when Dr Rimmer's report is considered as a whole, it is clear that he formed the view that Mr Cabezas' right shoulder symptoms related to his 2012 right rotator cuff repair, supported by his diagnosis of "eight years post right rotator cuff repair".[38]

60. I found Dr Rimmer's evidence unpersuasive. Dr Rimmer did not fully engage with the issue of whether or not Mr Cabezas had sustained a consequential injury to his right shoulder as a result of the accepted injuries to his cervical spine and left shoulder on 3 March 2015. He failed to expose the reasoning process behind his opinion that Mr Cabezas' right shoulder symptoms had no relationship to employment. He simply provided a diagnosis that, arguably, related such symptomatology back to the 2012 rotator cuff repair. Whilst Dr Rimmer referred to Dr Habib's report dated 15 November 2018 in passing, he did not engage with the issue of consequential injury that was clearly raised by Dr Habib. Despite having Dr Habib's report available to him, he failed to record any history from Mr Cabezas in relation to the onset of right shoulder symptoms in April/May 2017. In circumstances where Dr Rimmer was on notice of the issue in dispute, such an omission is puzzling. Further, whilst Dr Rimmer had other diagnostic imaging reports relating to Mr Cabezas' right shoulder available to him, he only made short reference to the right shoulder ultrasound images provided to him at the time of consultation. He made no reference to the more sophisticated diagnostic imaging of the right shoulder, being the MRI scan report by Dr Lee dated 7 August 2017, that demonstrated a high grade partial thickness tear of the supraspinatus tendon in the anterior mid part, with further tearing posteriorly; tiny partial thickness tears in the subscapularis; subacromial bursitis; and fluid/bicipital change in the inferior recess of gleno-humeral joint associated with adhesive capsulitis. The MRI scan report dated 7 August 2017 was provided to Dr Rimmer and was referred to as one of the documents he reviewed for his consultation with Mr Cabezas.

61. Rule 15.2(3) of the Workers Compensation Commission Rules 2011 provides that "evidence based on speculation or unsubstantiated assumptions is unacceptable."

[38] Respondent's Application to Admit Late Documents dated 23 April 2020 at page 5 at [3]

62. Further, it is well established in the authorities such as *Paric v John Holland (Constructions) Pty Ltd*[39] (*Paric*); *Makita (Australia) Pty Ltd v Sprowles*[40] (*Makita*); *South Western Sydney Area Health Service v Edmonds*[41] (*Edmonds*); and *Hancock v East Coast Timbers Products Pty Ltd*[42] (*Hancock*); that there must be a "fair climate" upon which a doctor can base an opinion. Whilst it is accepted that a doctor does not need to provide elaborate or detailed explanations for his conclusion, more than a mere "ipse dixit" (an assertion without proof) is required and the latter seems to be precisely what Dr Rimmer has done in this matter.

63. Mr Cabezas first came under the care of Dr Goyal on 30 November 2015, well before the onset of right shoulder symptoms in April/May 2017. The respondent submitted that it was questionable as to whether Dr Goyal held the necessary qualifications to provide an opinion in relation to the causal link between the right shoulder symptoms and the injuries to the left shoulder and cervical spine. In my view, Dr Goyal as Mr Cabezas' general practitioner, was in a good position to provide an opinion in relation to the causal link between the right shoulder symptoms and the injuries sustained by Mr Cabezas to his left shoulder and cervical spine in the course of his employment with the respondent on 3 March 2015. Dr Goyal clearly exposed his reasoning process in coming to his conclusion. He engaged with the issue at hand. He expressed his opinion as early as 26 August 2017 in response to a questionnaire submitted by the respondent's insurer and again expressed his opinion to Dr Jones in his referral letter on 9 September 2017. I found the opinions expressed by Dr Goyal persuasive.

64. I prefer the evidence of Dr Habib over that of Dr Rimmer. Dr Habib took a detailed history from Mr Cabezas and thoroughly examined the medical evidence made available to him. He reviewed all the diagnostic imaging reports, listed them and summarised their findings and conclusions. Dr Habib diagnosed a consequential right rotator cuff tear with subacromial impingement and secondary adhesive capsulitis of the right shoulder. He fully engaged with the issue of whether there was a consequential injury to the right shoulder. Between his two reports in evidence, he exposed the reasoning behind his opinion. Dr Habib explained that, following the injuries to his left shoulder and neck, Mr Cabezas relied heavily on the use of his right arm and right shoulder, whilst protecting the injured, painful and stiff left shoulder, resulting in a consequential injury to the right shoulder, which had been asymptomatic, despite the surgery in 2012. Dr Habib further opined that Mr Cabezas' left shoulder injury, the subsequent surgeries on it and his reliance on the right arm made a material contribution to the condition of his right shoulder. He also provided the reasoning behind the delay in the onset of right shoulder symptoms.

65. Having regard to the whole of the evidence, applying a common sense test and for the reasons referred to above, I am comfortably satisfied that Mr Cabezas has discharged the onus of proving on the balance of probabilities that there is a sufficient causal chain connecting the condition of his right shoulder symptoms to the accepted injuries to the cervical spine and left shoulder in the course of his employment with the respondent on 3 March 2015 and I find accordingly.

Is Mr Cabezas entitled to lump sum compensation within the meaning of section 66 of the 1987 Act?

66. Section 65(3) of the 1987 Act formerly provided that:

> "If there is a dispute about the degree of permanent impairment of an injured worker, the Commission may not award permanent impairment compensation unless the degree of permanent impairment has been assessed by an approved medical specialist".

[39] *Paric v John Holland (Constructions) Pty Ltd* [1985] HCA
[40] *Makita (Australia) Pty Ltd v Sprowles* [2001] NSWCA 305; 52 NSWLR 705
[41] *South Western Sydney Area Health Service v Edmonds* [2007] NSWCA 16; 4 DDCR 421
[42] *Hancock v East Coast Timbers Products Pty Ltd* [2011] NSWCA 11; 80 NSWLR 43

67. Section 65(3) of the 1987 Act was repealed by the *Workers Compensation Legislation Amendment Act 2018* (the 2018 amending Act) in schedule 2, clause 2. This schedule commenced on the date of proclamation which was 1 January 2019. Savings and transitional provisions were added by the 2018 amending act and appear in the 1987 Act in Schedule 6, Part 19L and clause 2 provides that an amendment made by the 2018 amending Act extends to an injury received before the commencement of the amendment, and a claim for compensation made before the commencement of the amendment. The repeal of s 65(3) applies to the present case.

68. The repeal of section 65(3) of the 1987 Act, allows arbitrators to make determinations of permanent impairment. Neither party submitted that this was an appropriate case for me to determine Mr Cabezas' entitlement to lump sum compensation without referral to an AMS. The difference in the assessments between Dr Habib and Dr Rimmer is sufficient for me to consider a referral to an AMS appropriate. As a result, I will remit the matter to the Registrar for referral to an AMS to assess the degree of permanent impairment of Mr Cabezas' spine (cervical spine) and left upper extremity (left shoulder) and right upper extremity (right shoulder) as a result of injury on 3 March 2015.

CONCLUSION

69. Mr Cabezas suffered a consequential injury to his right shoulder as a result of the accepted injuries to his cervical spine and left shoulder in the course of his employment with the respondent on 3 March 2015.

70. The matter is remitted to the Registrar for referral to an AMS for assessment under the 1998 Act in accordance with orders 4 and 5 in the Certificate of Determination attached to this Statement of Reasons.