WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**5847/20**
Applicant:	**Heather Johnson**
Respondent:	**Tysin Pty Ltd Brownsugar at Bayviews (In Liquidation)**
Date of Determination:	**7 January 2021**
Citation No:	**[2021] NSWWCC 6**

The Commission determines:

1. The applicant sustained a consequential neuropathic pain syndrome affecting her right upper extremity as a result of the injury on 23 June 2013.

The Commission orders:

1. The matter is remitted to the Registrar for referral to an Approved Medical Specialist for assessment as follows:

Date of injury:	23 June 2013
Body parts:	Right upper extremity
	Skin (scarring)
Method:	Whole Person Impairment

2. The materials to be included in the referral are to include the Application to Resolve a Dispute and all attachments, Reply and all attachments, the documents attached to the Application to Admit Late Documents filed by the applicant on 1 December 2020 and this Certificate of Determination and Statement of Reasons.

A 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.

L Golic

Lucy Golic
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Ms Heather Johnson (the applicant) was employed by Tysin Pty Ltd Brownsugar at Bayviews (In Liquidation) (the respondent) as a chef. On 23 June 2013, the applicant lacerated her thumb on a broken glass whilst at work. The applicant was treated at hospital and received sutures.

2. After returning to work, approximately one week later, the applicant felt something “give way” in her thumb and experienced a significant increase in pain. An ultrasound confirmed a rupture of the flexor pollicis longus (FPL) tendon. The applicant was referred to Dr Andrew J Myers who performed surgery.

3. The applicant made a claim for compensation and received weekly benefits and compensation under s 60 of the *Workers Compensation Act 1987* (the 1987 Act).

4. On 13 February 2020, the applicant made a claim for lump sum compensation pursuant to s 66 of the 1987 Act in reliance on an assessment of 16% whole person impairment (WPI) of the right upper extremity (shoulder, hand) and skin (scarring) by Dr W G D Patrick, dated 11 September 2019.

5. On 16 June 2020, the respondent’s insurer declined liability to pay lump sum compensation in a notice issued pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act).

6. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) lodged in the Commission on 8 October 2020. The applicant seeks lump sum compensation in accordance with the assessment of Dr Patrick.

PROCEDURE BEFORE THE COMMISSION

7. The parties appeared for conciliation conference and arbitration hearing on 8 December 2020. The applicant was represented by Mr Greg Schipp instructed by Ms Katherine Boshev. The respondent was represented by Mr Tony Baker, instructed by Ms Emily Angwin.

8. 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

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

   (a) whether the applicant sustained a consequential neuropathic pain syndrome or "shoulder/hand" syndrome as a result of the injury on 23 June 2013; and

   (b) the degree of permanent impairment resulting from the injury.

EVIDENCE

Documentary Evidence

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

    (a) ARD and attached documents;

    (b) Reply and all attachments; and

    (c) documents attached to an Application to Admit Late Documents filed by the applicant on 1 December 2020.

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

Applicant's evidence

12. The applicant's evidence is set out in statements made by her on 9 September 2020 and 26 November 2020

13. The applicant's first statement was brief and indicated only that during the course of her employment on 23 June 2013 she sustained injury to her right thumb/hand. Consequential events necessitated surgical intervention and led to the development of neuropathic pain syndrome.

14. In her supplementary statement, the applicant refuted the opinion formed by the insurer's doctor, Dr Bosanquet that the only ongoing work-related injury involved her right thumb. The applicant said she had been diagnosed with a pain syndrome affecting not only her thumb but also her hand, wrist, elbow and shoulder. The applicant described a range of restrictions resulting from the injury.

Initial notification of injury and claim forms

15. An initial notification of injury form dated 7 July 2013 described the applicant cutting her thumb when a glass broke whilst the applicant was washing dishes. Initially, doctors put in three stitches and said the applicant could return to work. The pain continued and a week later it was discovered that a tendon was cut which would require surgery and six weeks off work.

16. The injury was described in a consistent fashion in an employer injury claim report dated 8 July 2013.

Treating medical evidence

17. A discharge letter from John Hunter Hospital dated 7 July 2013 described a ruptured FPL tendon at the right thumb and stated:

    > "Patient who is a chef and right-handed partially lacerated her FPL tendon on 23/06/2013 at work and not picked up at Belmont, with full/complete rupture of the FPL tendon on the 06/07/13 when she lifted a tray of chicken…"

18. The applicant's treating surgeon, Dr Andrew J Myers prepared a report dated 9 July 2013. Dr Myers took a history of a deep laceration to the applicant's right thumb at work on 23 June 2013 when a glass she was holding shattered. The applicant had alteration in sensation and bled profusely. The applicant went to Belmont District Hospital where the wound was simply washed without formal inspection and sutured. The applicant returned to work and was still able to bend her thumb until 6 July 2013. The applicant was lifting large trays of chicken and felt a sudden snapping sensation in her thumb and "quite horrendous" pain.

19. The applicant presented to hospital and was diagnosed with a ruptured FPL tendon, which was confirmed on ultrasound to have retracted 2 cm.

20. Dr Myers stated:

> "This is obviously predictable from her history that she has given. She almost certainly had an isolated digital nerve and digital artery injury due to the numbness and the pain that she was feeling, plus she had an incomplete FPL tendon laceration. This was not managed appropriately, and she has been moving her thumb to the stage where her tendon has snapped. This is obviously going to be difficult to manage."

21. Dr Myers said the condition required surgery to repair the nerve, artery and tendon, if possible. He continued:

> "This is a work related injury. There was no pre-disposing or underlying condition. I am convinced that this was the scenario all the time, and she has partially lacerated her tendon and she has now has two separate work-related injuries. The first one was where she cut the tendon partially, and the second was when the tendon has ruptured."

22. An operation record indicates that Dr Myers performed surgery on 10 July 2013. The FPL tendon was repaired and seem to be solid. The digital nerve was cleaned of scar tissue and cut back to healthy nerve. A primary repair was then performed and seen to be excellent. The artery was not suitable for repair as it had thrombosed.

23. In a report dated 22 August 2013, Dr Myers reported that the applicant's range of motion was starting to improve. The scar had improved but was still thick. The applicant's sensation was not returning as yet. The applicant was to continue with range of motion activities, tendon gliding exercises and splint weaning. The applicant was unable to return to normal duties.

24. Ongoing sensitivity over the scar was reported by Dr Myers on 3 October 2013 but said to be settling by 28 November 2013. On 19 December 2013, Dr Myers reported the applicant's pain had increased after an attempt to wean off Lyrica. Improvements were reported again in March 2014.

25. On 11 September 2014, Dr Myers reported that the applicant's pain specialists were recommending stellate ganglion blocks. Dr Myers stated,

> "Her thumb movement is good. She still has symptoms of complex regional pain syndrome and I would like to see how she continues to improve with the pain management."

26. On 6 November 2014, Dr Myers reported that the applicant had undergone two stellate blocks. Improvements in the applicant's pain levels were reported in November and December 2014 and March 2015.

27. Dr Myers reported on 21 July 2016 that the applicant had failed to attend appointments since March 2016 and her file was to be closed.

Dr Brett McClelland

28. Both the applicant and respondent have lodged a historical medicolegal report prepared for the insurer by hand surgeon, Dr Brett McClelland, dated 30 August 2016.

29. Dr McClelland took a history of injury that was consistent with the other evidence and stated:

> "Heather had extensive Hand Therapy following her procedure including splinting and exercise programmes. She reports a very problematic recovery in both the physical and psychological aspects. She had ongoing problems with weakness of the thumb, together with pain in the area. She does report issues with the level of support she received in her workplace. In January of 2014, Heather was diagnosed with secondary anxiety, depression and Post Traumatic Stress Disorder. She was sent to Ms Helen Kelson a psychologist for management. Heather reports no history of mental illness prior to her injury. She had some ongoing challenges working in environments with glasses, or dealing with any broken glass. Heather was also managed by Dr John Prickett and Dr Christie Mason from Newcastle Integrated Pain Management since October of 2014 with support in her pain control. She was trialled on Lyrica that was not well tolerated and she went on to have two stellate ganglion blocks. She does still report pain present on a daily basis."

30. At the time of Dr McClelland's report, the applicant had issues with cold intolerance and was taking Lyrica. The applicant continued to see Dr Mason for pain psychology.

31. Dr McClelland's examination noted a well-healed Brunner style scar, reduced sensitivity in the radial digital nerve distribution and mild tenderness along the path of the FPL tendon tracking into the distal forearm. There was some irritability along the scar with dysaesthesia and a positive Tinel's test over the radial digital nerve.

32. Dr McClelland gave the opinion:

> "She suffered from a laceration to her flexor pollicis longus tendon, as well as her radial neurovascular bundle. These were repaired surgically and Heather has had some ongoing post-surgical pain and stiffness, together with some significant psychological problems."

33. Dr McClelland assessed the applicant as having 2% WPI of the upper extremity.

Dr W G D Patrick

34. The applicant relies on medicolegal reports prepared by general and vascular surgeon, Dr WGD Patrick dated 11 September 2019 and 19 November 2020.

35. In his initial reports, Dr Patrick diagnosed a work-related injury to the applicant's right thumb and hand with consequential events proceeding to surgical intervention and development of neuropathic pain syndrome/CRPS 1.

36. Dr Patrick took a history of the injury on 23 June 2013 that was consistent with the other evidence. The applicant was seen at the Emergency Department of Belmont Hospital:

> "She was complaining that the distal thumb was numb and that pain was severe. It was about a 3cm laceration at palmar aspect of base of thumb in the region of the MP crease. It was felt at the hospital that nerves and vessels were intact and sensation normal. X-ray was carried out - not showing any obvious foreign body. Somewhat unfortunately the laceration was sutured there, apparently without exploration, and she was sent for follow up by GP. There were just three sutures inserted."

37. Dr Patrick referred to the reports from Dr Myers and noted that the applicant was reviewed by a hand therapist at Dr Myers' rooms two weeks following the surgery. Dr Patrick noted that the applicant experienced difficulty both physically and psychologically following the injury and was treated by clinical psychologist/psychiatrist as well as a pain specialist, Dr John Prickett. The applicant had two stellate ganglion block injections which resulted in some improvement for a time but then faded. The applicant was seen by a clinical psychologist, Dr Christie Mason associated with Northern Integrated Pain Management. The applicant was unable to satisfactorily return to work and at various stages had been thought to be suffering from complex regional pain syndrome (CRPS1) affecting her right upper extremity.

38. Dr Patrick said the applicant had developed so-called "shoulder/hand" syndrome and stiffness of the right shoulder now.

39. The applicant reported symptoms of pins and needles into the right hand and particularly the thumb and region of the thenar eminence. The applicant had developed significant stiffness of the right shoulder and could not elevate her right arm fully.

40. The applicant was taking considerable medication including Lyrica for neuropathic pain and tramadol.

41. Dr Patrick's examination revealed:

> "Heather Johnson does appear to have some degree of shoulder/hand syndrome. There is full range of active motion in all directions at left shoulder, but at the right shoulder active flexion is now to no degrees and with active extension 40 degrees, abduction 120 degrees, adduction 30 degrees, external rotation 40 degrees and internal rotation 60 degrees, all consistent to repeated goniometer measurement.
> ..
> There is significant dysaesthesia/allodynia over volar and radial aspects of right thumb. There is some allodynia extending approximately over thenar musculature and distal radial right forearm. Grip strength right hand is clearly weaker, significantly less than half compared to the left. There appears to be a lack of sweating right hand compared to left but she does not satisfy criteria to be assessed as a CRPS1 and she is not a CRPS2. Nevertheless, there is a significant neuropathic pain syndrome here. Wrist movements are reasonably satisfactory. She cooperates fully."

42. In assessing the degree of permanent impairment, Dr Patrick stated:

> "After long consideration, I do believe that the only appropriate methodology here is to make use of the rarely utilised para 2.2 WCG4 p10 where it states in part 'there can be clinical conditions where evaluation of impairment may be difficult. Such conditions are evaluated by their effect on *function of the upper extremity*...'."

43. Dr Patrick assessed the applicant as having 15% WPI of the right upper extremity and 1% WPI for scarring.

44. In his supplementary report, Dr Patrick indicated that he had reviewed the medicolegal report prepared by the respondent's expert, Dr John Bosanquet dated 19 May 2020. Dr Patrick commented:

> "Dr Bosanquet seems focussed on the fact that because there was "no specific injury to these parts" being other parts of her right upper extremity and stating that there is no causal connection to the right thumb injury on 23 June 2013, - I believe he is ignoring the possibility of a neuropathic pain syndrome. My own view (Dr Patrick) at the time of my own examination of Heather Johnson in 2019 was that the diagnoses at that stage were of a significant neuropathic pain syndrome right upper extremity with some degree of shoulder/hand syndrome, but not satisfying the strict criteria to be assessed as CRPS1. Nevertheless, her neuropathic pain syndrome is significant, and she has very significant diminution in her capacity to use her right hand and arm compared to prior to 7 June 2013. She has limitation in range of active motion at right shoulder and also the thumb, and to some extent entire hand compared to the left now. She was right hand dominant.
> …
>
> The shoulder/hand neuropathic syndrome is a real and genuine entity. Heather Johnson, I believe, does have ongoing significant problems with this right hand and upper extremity. My view strongly is that Heather Johnson is suffering from a "shoulder/hand syndrome", a form of neuropathic pain syndrome post-injury. She quite simply cannot work as a chef now and this has been a great loss for her."

Dr John Bosanquet

45. The respondent relies on a medicolegal report prepared by orthopaedic surgeon, Dr John Bosanquet, dated 19 May 2020.

46. Dr Bosanquet's history of injury was consistent with the other evidence. Dr Bosanquet noted that following the incident on 23 June 2013, the applicant had paraesthesia in the thumb and altered sensation down the radial side.

47. Dr Bosanquet took a history of the referral to Dr Myers and subsequent surgery. The applicant was in a splint post operatively and had physiotherapy twice a week. The applicant had ongoing pain and restricted movement:

> "Due to her pain she was referred to a pain specialist Dr John Prickett and also a psychologist Kristy Mason. The Lyrica did give side effects. When she attempted to come off the Lyrica she had increasing pain. She developed some symptoms suggestive of Complex Regional Pain Syndrome with pain radiating to her elbow, shoulder and neck. She eventually had two stellate ganglion blocks, the first in 2014. These worked well and she was able to reduce her Lyrica dose. However, the pain gradually crept back. She did attempt to go back to work but only lasted for a month. She has thought of another career doing a Certificate III at TAFE in business administration. She has applied for work through multiple agencies but so far has not found employment."

48. Dr Bosanquet recorded an examination as follows:

> "There was some pain in her right shoulder with terminal abduction. In her right forearm there was no swelling and it was of normal colour and temperature. In her right wrist she had full flexion/extension, pronation and supination, abduction and adduction. In her right thumb there was a 4cm jagged scar across the volar aspect extending from the radial side of the PIP to the 1st web space. There was altered sensation with loss of sensation adjacent to the scar and altered sensation further."

49. Dr Bosanquet gave an opinion as follows:

> "This 26-year-old woman, who has worked as a chef, has sustained an injury to her right dominant thumb during the course of her work on 23/06/2013. She has divided the radial digital nerve and partially severed the flexor pollicis longus. With a further injury two weeks later she has completely ruptured the flexor pollicis longus requiring surgery, both to repair that tendon and repair the digital nerve. In recovery, she has had some issues with pain but has regained a good range of movement. She has not yet returned to work."

50. Taking into account the loss of movement in the applicant's right thumb and loss of sensation in the thumb, Dr Bosanquet assessed the applicant as having 3% WPI. Asked to consider whether there was any causal connection between the original injury on 23 June 2013 and other parts of the right hand and shoulder as assessed by Dr Patrick, Dr Bosanquet stated:

> "It is my opinion that there is no other causal connection to the other parts of the right upper extremity i.e. right shoulder, as assessed by Dr Patrick. There was no specific injury to these parts. As a note, Dr Patrick has invoked Paragraph 2.2 Workers Compensation Guidelines, page 10, to find a whole person impairment of 25%. It is my opinion that there is no need to invoke Paragraph 2.2 on page 10 as her impairment is quite readily measurable."

51. Dr Bosanquet made no assessment of WPI for scarring.

Applicant's submissions

52. Mr Schipp set out the history of injury on 23 June 2013 and subsequent events including the later discovery that the tendon at the applicant's right thumb had ruptured and the necessity for surgery. Mr Schipp noted that the applicant was in receipt of workers compensation payments for five years.

53. Mr Schipp described the issue in dispute as whether there was a consequential condition affecting the applicant's shoulder. Mr Schipp referred to the applicant's statements and noted that symptoms in the applicant's upper extremity were described.

54. Mr Schipp noted that the applicant had not relied on two separate injuries and there was no notified dispute from the insurer that there were two separate injuries. Mr Schipp submitted that there was no suggestion from any doctor that the full rupture of the FPL tendon would have occurred without the partial rupture on 23 June 2013. There was no medical evidence including from Dr Bosanquet to indicate that the applicant's condition was caused by anything other than the incident on 23 June 2013.

55. Mr Schipp referred me to the treating medical evidence including the hospital discharge summary and the reports of Dr Myers, including his opinion that there was no predisposing condition. Dr Myers' reports confirmed the presence of a nerve injury thus increasing the likelihood of neuropathic pain.

56. Mr Schipp submitted that the report of Dr McClelland three years after the injury revealed a problematic recovery. The applicant had been referred for pain management and prescribed Lyrica for neuropathic pain. Mr Schipp noted that that treatment had been paid for by the insurer. Tenderness at the applicant's distal forearm was noted in Dr McClelland's examination.

57. Mr Schipp referred me to the first report of Dr Patrick. Dr Patrick found a consequential neuropathic pain syndrome and noted that the applicant had been seen by pain specialists. Mr Schipp noted that stellate ganglion blocks had been performed. The applicant had symptoms of CRPS1 and reduced range of movement in the right shoulder. Dr Patrick also noted dysaesthesia and allodynia at the right distal forearm.

58. Mr Schipp referred to the respondent's medical evidence and noted that Dr Bosanquet took a history of the applicant experiencing increasing pain when coming off Lyrica. Dr Bosanquet also noted the applicant had a history of CRPS symptoms, consistently with the opinion of Dr Patrick. Dr Bosanquet also noted pain in the mid forearm into the elbow as well as the right shoulder. When asked to give his opinion on whether there was any causal connection between those symptoms and the thumb injury, Dr Bosanquet simply referred to there being no injury to those body parts. Mr Schipp submitted that in giving this opinion Dr Bosanquet had asked himself the wrong question.

59. Mr Schipp noted that a supplementary report had been obtained from Dr Patrick which considered the opinion given by Dr Bosanquet. Dr Patrick noted that Dr Bosanquet referred to no neurology at all in performing his examination. Dr Bosanquet had not considered the possibility of a neuropathic pain syndrome. In that regard, Mr Schipp submitted that Dr Bosanquet's report was incomplete.

60. Referring to the relevant legal principles Mr Schipp submitted that there was a causal connection between the neuropathic symptoms and the injury. Dr Patrick had an appropriate factual background on which to base his opinions, was suitably qualified and had a full and correct history before him. There were consistent reports of neuropathic pain related to the thumb. Only Dr Patrick had considered the correct question. It was not relevant to ask whether there was an injury to the shoulder or the remainder of the upper extremity. Dr Bosanquet had failed to address the cause of the symptoms at the applicant's shoulder or consider whether there was a consequential condition.

Respondent's submissions

61. Mr Baker submitted that the applicant had brought a claim asserting that the injury on 23 June 2013 had resulted in permanent impairment. The respondent had disputed that there was a consequential condition as a result of the injury on 23 June 2013.

62. The applicant's statements referred to an injury on 23 June 2013 and described "consequential events necessitating surgery". Mr Baker said this identified a second event leading to the need for surgery. The applicant returned to work and was lifting a large tray of chicken when there was a significant change in the applicant's condition. Mr Baker suggested that the applicant would not have been lifting heavy trays of chicken if the applicant already had a significant injury to her hand. The applicant had been able to bend her thumb until the second event. In the second event, the applicant felt a sudden snapping sensation and was subsequently diagnosed with the ruptured FPL injury.

63. Mr Baker submitted that it was clear that Dr Myers considered that there were two separate work-related injuries. It was the second injury that required the surgery. Mr Baker submitted that it was disingenuous to treat the second event as a consequential event. The significant changes occurred in the second episode.

64. Mr Baker noted that there was no evidence from the applicant's general practitioner or pain specialists to assist the Commission. Dr Patrick had not satisfactorily explained how a nerve injury at the base of the thumb had travelled to the applicant's shoulder. Dr Myers' treating reports indicated improvements in the applicant's condition and a return to work, as well as attempts to wean the applicant off Lyrica. Psychological symptoms had come up but from Dr Myers' perspective there were no major changes to the applicant's pain profile and he expected to see the applicant back to full-time employment. At all material times, the repair appeared to be successful.

65. Mr Baker noted that the applicant had been seen by hand specialist, Dr McClelland in 2016. Three years after the event, Dr McClelland's examination contained no reference to symptoms in the applicant's wrist, elbow or shoulder nor was there any reference in the examination to any symptoms consistent with a neuropathic pain syndrome. Mr Baker submitted that it was significant that there were no relevant complaints of a consequential neuropathic pain syndrome made to Dr McClelland in 2016.

66. Referring to Dr Patrick's first report, Mr Baker noted that the applicant had been diagnosed with a post-traumatic stress disorder and came under the care of a clinical psychologist. Mr Baker noted that there was no evidence of care from a hand specialist or neurologist after 2016. Mr Baker submitted that there was no evidence from any treating doctors relevant to the consequential condition on which the applicant sought to rely. The applicant relied on an *ex post facto* history recorded by Dr Patrick. At the time of Dr McClelland's report in 2016, the symptoms subsequently complained of appeared to be completely quiescent. After that time, there was an absence of contemporaneous medical evidence other than a WorkCover certificate from 2018 indicating a downturn in capacity due to a recent psychological setback.

67. Mr Baker submitted that Dr Patrick had not identified when the applicant developed symptoms in the shoulder or whether she had any treatment. There was a "gaping hole" in the evidence. There was no x-ray or other imaging available for perusal. It was not apparent whether any doctor had ever investigated a local cause for the applicant's shoulder symptoms. Dr Patrick had not explained how, based on his examination which appeared to be relatively normal, he had reached the conclusion that there was a consequential neuropathic pain syndrome.

68. Mr Baker observed that Dr Bosanquet did look for neuropathic signs in his examination and took an accurate record of the applicant's history. Like Dr Patrick's examination, Dr Bosanquet's examination of the arm apart from the shoulder and thumb was essentially normal. Mr Baker submitted that Dr Myers, Dr McClelland and Dr Bosanquet's reports were consistent. Dr Patrick was the "odd man out" in attempting to determine a causal connection between the shoulder and the thumb injury.

69. Mr Baker submitted that there was a lack of evidence to demonstrate an unbroken causal chain between the event on 23 June 2013 and the shoulder symptoms consistently with *Kooragang Cement Pty Ltd v Bates*[1]. There was no evidence as to when the symptoms started or what investigations had been performed. The only regular treatment appeared to be regular psychological reviews. It was within the applicant's power to provide relevant evidence to lay the groundwork for an unbroken chain of causation. No such evidence had been provided. In all the circumstances, Mr Baker submitted that the Commission would prefer the opinion of Dr Bosanquet. The Commission would not be satisfied on the balance of probabilities that the applicant had a condition described by Dr Patrick as a "shoulder hand syndrome" as a result of the 2013 injury.

[1] (1994) 10 NSWCCR 796 at [810].

Applicant's submissions in reply

70. Mr Schipp said the applicant's case was always put on the basis that there was an initiating event on 23 June 2013 and consequential events. The initial event involved the division of the nerve and tendon.

71. Mr Schipp submitted that the respondent's submissions were an attempt to "muddy the waters" by suggesting there might be other causes of the applicant's symptoms including by reference to the applicant's psychological condition. Mr Schipp submitted there was no medical evidence whatsoever to indicate an alternative cause for the applicant's symptoms. The insurer had accepted that the applicant suffered a nerve injury in the initiating injury. In the absence of medical evidence it must be accepted that there was a relationship between the injury and the symptoms in the applicant's shoulder. The suggestion that the applicant's psychological symptoms had any relationship to the shoulder symptoms was not supported by any medical evidence.

72. Whilst the applicant's condition did not satisfy the criteria for CRPS1 at the time of Dr Patrick's examination, that examination was consistent with that performed by Dr Bosanquet. Dr Bosanquet also took a history of the applicant's pain gradually creeping back following the stellate ganglion blocks. Mr Schipp submitted that it was not necessary for the applicant to provide a continuing record of medical treatment in order to establish the relevant causal chain. In any event, Dr Bosanquet's own history reflected a continuation of pain and treatment with Lyrica.

73. Mr Schipp submitted that there was nothing in the respondent's evidence to suggest an alternative cause for the applicant's symptoms. Dr Patrick provided a well-reasoned diagnosis. Dr Bosanquet had not suggested an alternative diagnosis or provided any reasoning to support his opinion other than that there was no specific injury to the relevant body parts. Mr Schipp submitted that that was the wrong question to ask.

FINDINGS AND REASONS

74. 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."

75. It has been accepted by the respondent that the applicant sustained an "injury" pursuant to s 4(a) of the 1987 Act to her right thumb and hand on 23 June 2013. Consequential scarring resulting from the injury is also not disputed. There is, however, a dispute as to whether other symptoms in the applicant's right upper extremity are consequential to the injury on 23 June 2013.

76. It is not necessary for the applicant to establish an 'injury' pursuant to s 4 of the 1987 Act to the remainder of the upper extremity. Deputy President Roche in *Moon v Conmah*[2] observed at [45]-[46]:

> "It is therefore not necessary for Mr Moon to establish that he suffered an 'injury' to his left shoulder within the meaning of that term in section 4 of the 1987 Act. All he has to establish is that the symptoms and restrictions in his left shoulder have resulted from his right shoulder injury. Therefore, to the extent that the Arbitrator and Dr Huntsdale approached the matter on the basis that Mr Moon had to establish that he sustained an 'injury' to his left shoulder in the course of his employment with *Conmah* they asked the wrong question."

77. A commonsense evaluation of the causal chain is required. The legal test of causation is that discussed by the Court of Appeal in *Kooragang Cement Pty Ltd v Bates*[3], where Kirby P said (at 461) (Sheller and Powell JJA agreeing):

> "From the earliest days of compensation legislation, it has been recognised that causation is not always direct and immediate…
>
> Since that time, it has been well recognised in this jurisdiction that an injury can set in train a series of events. If the chain is unbroken and provides the relevant causative explanation of the incapacity or death from which the claim comes, it will be open to the Compensation Court to award compensation under the Act."

78. His Honour said at 463–464:

> "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 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 commonsense 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. In each case, the question whether the incapacity or death 'results from' the impugned work injury (or in the event of a disease, the relevant aggravation of the disease), is a question of fact to be determined on the basis of the evidence, including, where applicable, expert opinions. Applying the second principle which Hart and Honoré identify, a point will sometimes be reached where the link in the chain of causation becomes so attenuated that, for legal purposes, it will be held that the causative connection has been snapped. This may be explained in terms of the happening of a novus actus. Or it may be explained in terms of want of sufficient connection. But in each case, the judge deciding the matter, will do well to return, as McHugh JA advised, to the statutory formula and to ask the question whether the disputed incapacity or death 'resulted from' the work injury which is impugned."

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[2] [2009] NSWWCCPD 134.

[3] (1994) 10 NSWCCR 796 at [810].

79. As has been pointed out by the respondent's submissions, there is very little treating medical evidence relevant to the disputed consequential condition before the Commission. There are in this case no records from the applicant's general practitioners or the pain specialists the applicant has consulted. There is no evidence of treatment by a hand specialist, neurologist or other relevant specialist since Dr Myers' file was closed in 2016 other than what is contained in a single WorkCover certificate dated 30 May 2018. In that document it was recorded that the applicant was seeing a hand therapist at Hunter Hand and Upper Limb Therapy at Broadmeadow. It is not identified what the nature, duration or frequency of that treatment was and there is no evidence from that practice.

80. The applicant's own evidence is extremely sparse. The applicant describes ongoing pain and restrictions affecting her thumb, hand, wrist, elbow and shoulder which she relates to the initial injury. The applicant's evidence does not, however, explain the timing of the onset of symptoms outside the thumb and hand, the treatment received for those symptoms or identify which, if any, treating doctors have diagnosed her with a neuropathic pain syndrome affecting those body parts.

81. It is the applicant who bears the onus of establishing on the balance of probabilities that there is a relevant consequential condition. The sparsity of the evidence presents a significant challenge for the applicant in discharging that onus.

82. It is necessary, however, to consider all of the evidence that has been placed before the Commission. The applicant and the respondent have put before the Commission contemporaneous evidence of the injury occurring on 23 June 2013.

83. I am satisfied on the basis of Dr Myers' report of 9 July 2013 and the hospital discharge letter dated 7 July 2013 that the incident on 23 June 2013 caused an incomplete FPL tendon laceration, which was not appropriately managed. There is evidence that the applicant also experienced an immediate alteration in sensation which led Dr Myers to form the opinion that there was injury to the digital nerve and digital artery in the initial event. The extent of the injury was not initially discovered and the applicant continued to move her thumb leading to a full rupture of the tendon approximately one week later whilst at work.

84. The respondent's submissions at arbitration hearing raised a question as to whether there was a second injury when the applicant's thumb gave way lifting a tray of chicken and the FPL tendon completely ruptured. This was not a dispute raised in any notice given to the applicant in writing prior to the commencement of the present proceedings. Nor was there a formal application under s 289A(4) of the 1998 Act. The history of the matter is that the insurer has paid compensation for treatment and incapacity resulting from both events. There is no suggestion that the second event, if it constituted a separate injury for s 4 of the 1987 Act, would be non-compensable, or that it involved a different body part or "injury" to that involved in the first event for the purposes of s 322 of the 1998 Act. Ultimately this is not a matter that is necessary for me to determine.

85. The applicant relies on a single injury on 23 June 2013. The relevant question is whether there is a neuropathic pain syndrome involving the applicant's right upper extremity which has arisen as a result of that injury.

86. As indicated above, the evidence is consistent with the applicant sustaining an injury to the digital nerve in the event on 23 June 2013, although it was not discovered until later. The surgery performed by Dr Myers on 10 July 2013 involved removal of scar tissue at the digital nerve, cutting back to a healthy nerve and repair, which Dr Myers described at the time as excellent.

87. At subsequent reviews with Dr Myers it was reported that the applicant continued to have difficulties with pain and sensation. On 22 August 2013, Dr Myers reported that sensation had not returned as yet. On 19 December 2013, Dr Myers reported that the applicant had experienced an increase in pain after an attempt to wean off Lyrica. Although Dr Myers' report in March 2014 suggested improvements had been gained, it is clear from the report of 11 September 2014 that the applicant had been referred to a pain specialist and had been advised to undergo stellate ganglion blocks. Dr Myers reported on that occasion that the applicant had symptoms of CRPS. At the time of the report dated 6 November 2014, two stellate ganglion blocks had been performed.

88. Although there is no evidence from the pain specialists who treated the applicant, I accept on the evidence from Dr Myers that pain specialists were involved in the applicant's treatment, that the applicant had symptoms of CRPS and that stellate ganglion blocks were performed, which is consistent with an attempt to improve pain and other symptoms in the right upper extremity.

89. This is consistent with the history recorded by Dr McClelland in 2016. Dr McClelland reported that the applicant had been managed by Dr John Prickett and Dr Christy Mason from Newcastle Integrated Pain Management since October 2014 to support her pain control. The applicant had been trialled on Lyrica and went on to have the two stellate ganglion blocks. The applicant reported pain present on a daily basis as well as issues with cold intolerance to Dr McClelland. Dr McClelland's examination revealed reduced sensitivity in the radial digital nerve distribution, dysaesthesia and tenderness into the forearm. Dr McClelland gave the opinion that there was injury to the radial neurovascular bundle which had been repaired surgically.

90. I accept the respondent's submission that Dr McClelland did not give an opinion that there was a neuropathic pain syndrome involving the right upper extremity, nor was there specific mention of symptoms involving the wrist, elbow or shoulder. It is significant, however, that the history recorded and the examination performed by Dr McClelland was otherwise consistent with that of the applicant's medicolegal expert, Dr Patrick.

91. Dr Patrick took a history of the applicant's pain improving for a time following the stellate ganglion blocks but then fading. Dr Patrick reported that at various stages the applicant had been thought to be suffering from CRPS affecting the right upper extremity. The applicant's treatment had included and continued to include Lyrica for neuropathic pain.

92. The applicant described symptoms of pins and needles into the right hand and Dr Patrick's examination revealed significant dysaesthesia and allodynia over the right thumb and some allodynia into the right forearm. Dr Patrick also noted a lack of sweating on the right hand compared to the left. Although Dr Patrick found the applicant did not satisfy the criteria for CRPS1 he did find a significant neuropathic pain syndrome.

93. Dr Bosanquet also took a consistent history of ongoing pain leading to a referral to a pain specialist. The applicant's attempts to come off Lyrica caused increasing pain. Dr Bosanquet took a history of the applicant developing symptoms of CRPS with pain radiating into the elbow, shoulder and neck. The applicant's pain reduced with the two stellate ganglion blocks but gradually crept back.

94. Dr Bosanquet's examination also revealed loss of sensation adjacent to the scar and altered sensation further away. It appears that Dr Bosanquet did look for symptoms of CRPS but did not find any in his examination in that he noted no swelling and normal colour and temperature.

95. This review of the evidence reveals a consistent history being provided by the applicant of ongoing pain and altered sensation from the time of the injury on 23 June 2013. There is uncontradicted evidence of injury to the digital nerve in the injury on 23 June 2013. Whilst the applicant's pain appears to have improved periodically with treatment, sufficiently to allow a return to work at times, I accept that the applicant's pain has remained ongoing. Together with the evidence of continuing treatment with Lyrica, increased symptoms when attempting to reduce the Lyrica dosage, the involvement of pain specialists and the use of stellate ganglion blocks, I accept the evidence before the Commission is consistent with a neuropathic pain syndrome resulting from the injury on 23 June 2013.

96. I have considered the significant limitations in range of motion at the applicant's right shoulder which were noted on examination by Dr Patrick. Such restrictions are not recorded in any other evidence and it remains unclear when those symptoms came on. This is not disclosed in the histories nor is it addressed specifically in the applicant's evidence. Dr Patrick has, however, formed and maintained the opinion that those restrictions were associated with the significant neuropathic pain syndrome found by him and described as involving "some degree of shoulder hand syndrome".

97. It is unfortunate that there is no evidence to identify how or if shoulder restrictions have been reported, investigated or managed by the applicant's treating practitioners. It is also significant that, although Dr Bosanquet's examination of the right shoulder revealed pain on terminal abduction, he recorded elsewhere that the applicant had good movement at the shoulder as well as the wrist and elbow. Dr Patrick's finding of limitations in range of motion at the shoulder thus appears to stand alone.

98. Dr Bosanquet did, however, find some pain at the shoulder and took a history of pain radiating to the elbow, shoulder and neck. At the time of his examination, the applicant described pain radiating to the forearm and sometimes to the elbow. Dr Bosanquet has not dealt with these symptoms other than to say that there was no specific injury to the other parts of the right upper extremity. As indicated above, it is not necessary in the circumstances of this case for the applicant to establish "injury" to the remainder of the upper extremity. Dr Bosanquet does not specifically address whether there is a neuropathic pain syndrome that has resulted from the injury or address the reported symptoms in his assessment of permanent impairment.

99. After careful consideration of the evidence as a whole, I am satisfied on the balance of probabilities, notwithstanding the lack of recent treating medical evidence, and the evidence of concurrent psychological conditions, that there is a proper factual foundation for the acceptance of Dr Patrick's opinion that the applicant had a neuropathic pain syndrome affecting her right upper extremity which resulted from the injury to the applicant's thumb and hand on 23 June 2013. I am satisfied that the applicant's experience of neuropathic pain has changed from time to time but has involved her hand, wrist, forearm, elbow and shoulder.

100. I am satisfied that it is appropriate to remit the matter to the Registrar to be referred to an Approved Medical Specialist for assessment of the degree of permanent impairment to the applicant's right upper extremity and skin resulting from the injury on 23 June 2013.

101. The Approved Medical Specialist will be required to make an assessment of the degree of permanent impairment resulting from the injury based on the applicant's presentation at the time of examination. It will also be a matter for an Approved Medical Specialist to determine how permanent impairment is to be evaluated in accordance with the Guidelines.

SUMMARY

102. The applicant sustained a consequential neuropathic pain syndrome affecting her right upper extremity as a result of the injury to her right thumb and hand on 23 June 2013.

103. The matter is remitted to the Registrar for referral to an Approved Medical Specialist for assessment as follows:

Date of injury:	23 June 2013
Body parts:	Right upper extremity
	Skin (scarring)
Method:	Whole Person Impairment

104. The materials to be included in the referral are to include the ARD and all attachments, Reply and all attachments, the documents attached to the Application to Admit Late Documents filed by the applicant on 1 December 2020 and this Certificate of Determination and Statement of Reasons.