WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**4012/19**
Applicant:	**Steven Smith**
Respondent:	**Brambles Limited**
Date of Determination:	**2 December 2019**
Citation:	**[2019] NSWWCC 383**

The Commission determines:

1. I find that the proposed surgery recommended by Dr Donnellan on 14 January 2016, is reasonably necessary, as I am satisfied there is a causal connection between the injury to the left shoulder and the cervical spine

2. The respondent will pay the costs of and associated with the surgery recommended by Dr Donnellan on 14 January 2016.

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

John Wynyard
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 JOHN WYNYARD, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Steven Smith, the applicant, brings a claim for the cost of recommended surgery by Dr Donnellan for treatment to the cervical spine. A claim for weekly compensation was discontinued at the commencement of the hearing.

2. Mr Smith was injured on 26 May 2000, when he dislocated his right shoulder. He has received extensive treatment from a large number of medical practitioners since that time. The application pursuant to s 60(5) is for a C4/5 and C5/6 Anterior Cervical Discectomy and Fusion + post-operative rehabilitation as requested by Dr Donnellan.

3. Part 4 of the Application to Resolve a Dispute (the ARD) claimed injury to the left shoulder, cervical spine and thoracic spine, pleading in the alternative that Mr Smith suffered a consequential neck, upper back/thoracic spine injury materially contributed to by the poor outcomes in treatment to the left shoulder over the years, including a significant change in the applicant's posture and altered lifting mechanics as he sought to compensation for and alleviate pain in the left shoulder while performing work and domestic duties.

4. The first notice given by the insurer that disputed the claim for injury to the cervical spine (also, the lumbar spine), was a s 74 notice issued on 1 December 2016. Mr Smith sought a review on 9 July 2019[1], and the respondent issued a "s 78 notice" in response on 26 August 2019 (strictly speaking, it was a notice pursuant to s 287A). The ARD and Reply were duly lodged thereafter.

ISSUES FOR DETERMINATION

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

    (a) Did Mr Smith injure his cervical spine in the accident of 26 May 2000;

    (b) Did Mr Smith suffer a consequential condition in his neck as a result of the injury of 26 May 2000.

Matters previously notified as disputed

6. The s 78 notice raised defences only in relation to the claim for injury to the "lumbar and/or cervical spine". It did not raise the question of consequential condition for consideration and did not challenge the claim regarding the thoracic spine.

Matters not previously notified

7. However at Part 3 of the Reply the respondent renewed its denial on the basis of injury but added the claim for the thoracic spine to the denial. It also sought leave to raise the issue of notice with regard to the thoracic spine "as now claimed in the ARD".

8. Leave was granted pursuant to s 289A(4) for the respondent to rely on the matters raised in Part 3 and additionally to challenge the question of whether the injury to the cervical spine was a consequential condition.

[1] ARD 533

PROCEDURE BEFORE THE COMMISSION

9. This matter was heard over two hearing days, 18 September 2019 and 18 October 2019. On both occasion Mr Smith was represented by Mr Luke Morgan of counsel and the respondent by Mr David Saul of counsel. 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.

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 attached documents;

    (c) Application to Admit Late Documents (ALD) dated 3 October 2019.

Oral Evidence

11. No application was made in respect of oral evidence.

FINDINGS AND REASONS

Regulation 44

12. At the commencement of the proceedings Mr Morgan discontinued the claim for weekly compensation so that the outstanding issue relates to the claim for surgery to the cervical spine. In that regard a preliminary issue was raised as to the respective qualifications of Dr Anil Nair and Dr James Bodel as it was submitted by Mr Saul that the medical reports of both doctors infringed the provisions of regulation 44 of the *Workers Compensation Regulation 2016*. Dr Nair's letterhead did not reveal his qualifications and I made a direction that the applicant was to lodge and serve the qualifications relied upon during argument relating to Dr Nair. That material was supplied in the ALD dated 3 October 2019. It demonstrated that both Dr Nair and Dr Bodel were Orthopaedic Surgeons.

13. Regulation 44 provides:

> **"Restrictions on number of medical reports that can be admitted**
>
> **44 RESTRICTIONS ON NUMBER OF MEDICAL REPORTS THAT CAN BE ADMITTED**
>
> (1) In any proceedings on a claim or a work injury damages threshold dispute in relation to an injured worker, only one forensic medical report may be admitted on behalf of a party to proceedings.
>
> (2) A report referred to in subclause (1) must be from a specialist medical practitioner with qualifications relevant to the treatment of the injured worker's injury.

(3) Where the injury has involved treatment by more than one specialist medical practitioner, with different qualifications, then an additional forensic medical report may be admitted from a medical practitioner with qualifications in that specialty.

(4) In this clause--

"forensic medical report" , in relation to a claim or dispute--

(a) means a report from a specialist medical practitioner who has not treated the worker and that has been obtained for the purpose of proving or disproving an entitlement, or the extent of an entitlement, in respect of the claim or dispute, and

(b) includes a medical report provided by a specialist medical practitioner in respect of an examination of the injured worker pursuant to section 119 of the 1998 Act, and

(c) does not include a report from a specialist medical practitioner who has not treated the worker and that has been obtained for the purpose of proving or disproving an entitlement, or the extent of an entitlement, in respect of another claim or dispute."

14. The respondent retained Dr Bodel. His reports were dated:

- 14 August 2001 (x 2)
- 12 September 2002 (x2)
- 17 January 2003
- 4 December 2003
- 24 February 2004
- 30 April 2004
- 12 November 2009
- 24 May 2011
- 17 April 2015
- 25 October 2015

15. There was litigation between the parties in matter number 4645/02, 20097/2003 and 7905/2011.

16. During argument I was referred to an arbitral decision of *Karen McHugo v Coles Supermarkets Australia Pty Ltd*[2] in which, under similar circumstances, Arbitrator Burge found that regulation 44(4)(c) applied to deprive regulation 44 of any application.

17. Mr Morgan submitted that the subject dispute did not arise until 1 December 2016 by virtue of the issue of the s 74 notice of that date. None of Dr Bodel's reports post-dated this dispute, notwithstanding that he addressed the condition of the cervical spine in some of his earlier reports.

18. Mr Saul submitted that the content of Dr Bodel's reports, in as much as they discussed the condition of the cervical spine, must have been in response to a dispute about injury to the cervical spine.

19. On the morning of the second day, 18 October 2019 I found that, the provisions of regulation 44 did not apply. Whilst injury to the neck (and back) had earlier been pleaded generally, no specific claim had concerned injury to the neck, let alone surgery to the neck. Mr Smith lodged his Application for Determination in matter number 9645-2002. The "nature of the

[2] [2019] NSWWCC 98

injury" was described as "left shoulder blade, neck, surrounding area and back."[3] The "particulars of compensation claimed" however, sought lump sum compensation for the loss of efficient use of the left arm at or above the elbow, and for permanent impairment to the back.

20. The other documentation lodged by the applicant regarding the prior claims in this matter did not contain the pleadings, but I note that the Discontinuance in matter 20097 of 2003 related to lump sum claims for the left arm, back and neck as from 22 June 2004 "in view of forthcoming surgery."[4] What the respondent had put in dispute in that matter is not known.

21. In matter 7905-2011, the lump sum claim was limited to injury to the left arm at or above the elbow. It was the subject of a Medical Assessment Certificate dated 28 October 2011, and the consequent Certificate of Determination of 14 February 2012.[5]

22. Whilst the documentation regarding these earlier matters was incomplete, I infer from what was lodged that although the neck may have been mentioned as an ambit claim, it was not the subject of any specific application for compensation and was not disputed prior to 1 December 2016.

23. As the reports of Dr Bodel all pre-dated 1 December 2016, and were obtained for the purpose of proving or disproving an entitlement in respect of another claim and another dispute, the provisions of regulation 44(4)(c) apply, and those reports are accordingly admissible. I reject Mr Saul's argument that, because Dr Bodel discussed Mr Smith's neck condition, there must have been a dispute about it. Whilst his pleadings in prior disputes may have mentioned the neck, it does not follow that the respondent disputed the claim, simply because its medico-legal expert investigated the allegation. Moreover, the consideration of Mr Smith's neck condition was in relation to different claims. He has not previously sought a declaration pursuant to s 60(5) of the *Workers Compensation Act 1987* regarding the proposed cervical surgery.

The evidence

24. Mr Smith made statements on 4 October 2018 and 15 November 2018. On 4 October 2018[6], he said that his job was extremely physical in nature, requiring the use of his arms overhead, pulling, pushing and manipulating heavy weights and constantly looking after the crane loads.

25. On 26 May 2000, whilst assisting a colleague to move a 10-tonne counterweight which is lifted by mobile crane, he had been pulling on a rope to line the counterweight up on the trailer of a truck. He was pulling the rope with his left arm and using his whole body weight, when he felt his left shoulder pop out of its socket. When he let the weight go he said "I felt a strange sensation like the shoulder relocating into place". He said that he experienced the sharp and immediate pain in the left shoulder and a tearing type sensation around the whole of the shoulder area, including the upper back. He said "I also felt immediate pain and an unusual discomfort through my upper back, in particular around my left shoulder blade and also in the upper part of my back and lower part of my neck immediately adjacent to and above the shoulder blade."

26. Mr Smith saw the respondent's local medical officer, Dr Louse. Physiotherapy followed. Mr Smith said[7]:

[3] ARD 499
[4] ARD 506
[5] ARD from 509
[6] At p 536
[7] ARD page 537

> "I complained predominantly of pain to the left shoulder but also complained of pain in around my trapezius, neck and upper back. I could not locate the exact origin of the pain but the trauma was to the back of the shoulder and generally I believed my shoulder must be the main injury."

27. Mr Smith said he was off work for several weeks and then put on a graduated light duties programme that upgraded him to normal hours. He was unable to return to his normal pre-injury duties and he said he was still in pain and could not use his left arm overhead.

28. He continued to experience difficulties with his left shoulder. The pain persisted and it would "lock" occasionally.

29. Mr Smith said that he experienced increasing pain in his neck and upper back, as it would travel "between my left shoulder, neck and upper back".

30. Mr Smith said there would be muscle spasm in the left shoulder and his pain would travel to the neck and upper back area.

31. He remained under the care of his regular GP, Dr Kitto.

32. On 30 April 2003, Dr Peter Giblin, Orthopaedic Surgeon, was asked for his opinion by Mr Smith's then solicitors. Dr Giblin recorded that Mr Smith's complaint that he felt that symptoms radiated up towards his neck. In taking a history of the injury Dr Giblin recorded that Mr Smith felt his left shoulder pop out of its socket.

33. Dr Giblin in physical examination observed a full range of motion of the neck. His diagnosis however was that provisionally there was a soft tissue injury to the left shoulder with secondary soft tissue symptoms at the base of the neck substantially causally related to the subject injury.

34. In August 2003, he was referred to Dr Daniel Biggs, Orthopaedic Surgeon. Dr Biggs' report was dated 14 August 2003, in which he took a consistent history of the dislocation of the left shoulder. Dr Biggs noted that the shoulder had spontaneously relocated but he observed that Mr Smith "had problems with regards to lack of confidence and ongoing pain with the left shoulder since".

35. Dr Biggs noted pathology in the left scapular, which was "snapping" and a complaint of pain in the superomedial angle of the scapular and quite marked pain on anterior apprehension.

36. Dr Biggs' opinion was that Mr Smith might well have an underlying anterior labral tear and having secondary problems with regard to the periscapular and cervicothoracic pain.

37. An MRI was planned for the left shoulder.[8]

38. In his statement of 4 October 2018 at [22], Mr Smith said that when he met Dr Biggs in August 2003 Dr Biggs had told him that "he suspected that I had a labral tear and problems around my neck".

39. Mr Smith said that a stabilisation procedure was recommended when he returned to see Dr Biggs, but such a procedure could not be undertaken until his complaints of pain had been addressed. He was referred to a Musculoskeletal Physician, Dr Adler.

[8] ARD page 69

40. Mr Smith said that to the best of his recollection he returned to see Dr Biggs in "2009". He reported that Dr Biggs thought that all the pain that Mr Smith was experiencing was coming from his cervical and upper back area and accordingly did not want to proceed with the left shoulder stabilisation procedure.

41. In fact Mr Smith saw Dr Biggs again in 2008. Dr Biggs' report of 17 April 2008 confirmed that Mr Smith's main complaint on that day were of "left sided neck pain and spasm with radiation of pain to the medial border of the left scapular".
42. Dr Biggs remarked that Mr Smith had exquisite pain and spasm over the medial border over the left scapular as well as tightening of the left cervico-thoracic musculature:

> "I feel that Mr Smith's main problem now is with his periscapular pain and spasm".[9]

43. Dr Robert Adler, Specialist in Pain Management, wrote to Dr Biggs on 17 June 2008. The history Dr Adler took was:

> "Thank you for kindly referring Mr Smith, a 39 year old man who suffered a dislocation of left shoulder in 2000, and has since experienced ongoing problems with left sided neck pain, muscle spasming and left scapular pain."

44. Dr Adler reported that Mr Smith "has considerable difficulty using his left shoulder in any activities, this precipitating left cervical scapular muscle spasming that is painful and can last some hours. There is always pain in this region present to some degree. He largely favours his right arm particularly for any handling of objects".[10]

45. Dr Adler also noted that Mr Smith had been made redundant from the respondent in 2003, but had since continued working operating a small bobcat.

46. In August 2009, Mr Smith was referred to Dr Jonathan Herald, Orthopaedic Surgeon. In his first report of 5 August 2009 Dr Herald noted the longstanding history of problems with Mr Smith's left shoulder since the 2000 injury. He recorded a consistent history that Mr Smith continued to have shoulder problems. Dr Herald noted that Mr Smith had seen Dr Biggs in 2003 but when he returned in 2009 at that stage the predominant pain was mostly in the posterior periscapular region and cervical region, and not so much over the anterior shoulder region.

47. Dr Herald noted that Mr Smith continued to have two areas of pain, one in the posterior cervical region and the other anteriorly. Shoulder activity increased the pain and Dr Herald also noted the complaint of occasional clicking in the shoulder but no numbness, tingling or radiation down his arms"[11].

48. Dr Herald's initial diagnosis was impingement syndrome with partial thickness cuff tear. He thought that the posterior cervical region pain was secondary to that problem, although further treatment with a pain specialist might be necessary. Dr Herald recommended surgery.

49. An MRI scan on 25 November 2009 confirmed a labral tear with an associated para labral cyst. Dr Herald noted that after more than six years of conservative treatment, an arthroscopic rotator cuff surgical operation was the best treatment.[12]

50. On 14 December 2009, Mr Smith came to surgery with Dr Herald.[13] Mr Smith stayed under the care of Dr Herald who on 10 January 2010 recommended that Mr Smith have physiotherapy and hydrotherapy. Dr Herald said he would see Mr Smith again "as needed"[14].

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[9] ARD page 65
[10] ARD 66
[11] ARD page 85
[12] ARD page 88
[13] ARD 89

51. Mr Smith returned to see Dr Herald on 3 March 2010, at which time Dr Herald noted that Mr Smith was developing pins and needles down the left arm which Dr Herald though was "most likely part of his pain syndrome"[15].

52. Over the next six months or so, Dr Herald noticed a gradual improvement on the occasions that he saw Mr Smith. Dr Herald suggested that Mr Smith retrain for a new job as he would have a permanent impairment as a result of his shoulder injury[16].

53. On 25 March 2013, Dr Herald reported that Mr Smith was having some posterior shoulder pain and had been seeing Dr Manohar who Dr Herald reported, "had identified some disc problems in the neck which might be contributing to the pain".

54. Dr Herald examined some investigations and said that clinically it appeared Mr Smith's problems were mainly arising from the neck:[17]

> "He had a shoulder injury in 2000 and he may have had aggravation of arthritis as a result of nine years of overcompensation until he had his surgery in 2009".

55. Dr Herald noted that Mr Smith was then in the care of Dr Manohar.

56. In his statement, Mr Smith said that he felt increasing pain to his neck and upper back over the years. He said[18]:

> "28. I was also experiencing numbness and tingling in my left hand. The weakness in my left shoulder caused me to sit awkwardly and perform activities with awkward posture.
>
> I was putting a lot of strain on my neck and upper back because I felt I had to protect my left shoulder. When I would pick up items or perform duties at work, I put excessive body weight from my neck and upper back rather than my arm."

57. Mr Smith said that after the surgery with Dr Herald, he consulted Dr Ameer Ibrahim, Sports Physician.

58. On 20 July 2010, Dr Ibrahim began his letter to Mr Smith's GP, then Dr Khan, by saying[19]:

> "Many thanks for asking me to review Steven, a pleasant 40 year old gentleman who presents with a long history of left shoulder and neck issues.:

59. At that stage, Dr Ibrahim indicated that Mr Smith was having physiotherapy twice a week for 45 minutes at a time and doing hydrotherapy twice a week for an hour each time. Dr Ibrahim noted that Mr Smith was then running his own business with a "dingo digger". Pain was described by Mr Smith as being around the perispinal muscle and the trapezius area on the left side. No radiation down the arm was reported. Dr Ibrahim thought that the shoulder surgery with Dr Herald had been complicated by an adhesive capsulitis which was in the process of resolving. Dr Ibrahim said[20]:

> "However, continued movement of his shoulder and wasting of certain muscles has led to poor scapulohumeral control and it is this abnormal scapular movement that is causing his pain in the paracervical and trapezius area."

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[14] ARD page 92
[15] ARD page 95
[16] ARD page 101
[17] ARD page 102
[18] ARD page 338 [28]
[19] ARD 103
[20] ARD page 103

60. On examination, Dr Ibrahim said "there were no issues with his cervical spine and he had a full range of motion at this level"[21].

61. On 12 August 2010, Dr Ibrahim noted that Mr Smith had come in for the first of a series of injection around the trapezius, the levator scapulae and the left paraspinal muscles.[22] A further injection was given on 19 August 2010 in the scapular and paraspinal muscles.

62. On 28 September 2010, Dr Ibrahim was happy to report that the flexion internal rotation and external rotation had improved and a fourth injection was given around the left shoulder girdle region[23].

63. The course of injections continued until 1 March 2011 when he was given his final injection in the myofasdal trigger points of Mr Smith's left shoulder.

64. On 31 March 2011, Dr Peter Conrad reported to Mr Smith's solicitors.[24] Dr Conrad took a history of involvement only of the left shoulder in the subject injury. He noted that since leaving the respondent in 2002, Mr Smith had held four jobs - last working in November 2009 driving a "hook bin truck."

65. Under "present symptoms" Dr Conrad noted a complaint of pain radiating from the left shoulder to the left side of the neck, which was worsened by lifting anything heavy with his left arm, or lifting that arm above shoulder height.

66. Dr Conrad did not examine the neck on this occasion. His opinion was that Mr Smith had injured the glenoid labrum and rotator cuff in the left shoulder.

67. In a later report dated 21 June 2011, Dr Conrad was sent a DVD of surveillance operations in 2002 and 2009. He concurred with an earlier report of Dr James Bodel dated 12 November 2009, that nothing was shown or described that was inconsistent with Mr Smith's presentation on 31 March 2011 - or indeed to Dr Bodel.

68. In a statement, Mr Smith confirmed that history with Dr Ibrahim. He said he continued with home strengthening exercises, acupuncture and pain medication all of which only provided short term relief. He said:

> "I continued with my awkward posture from stiff muscles. I continued to put increasing pressure and weight on my neck and upper back when performing light duties at work and basic home duties such as cooking and basic cleaning."

69. As I have indicated above, earlier litigation ensued between the parties. An Application for Determination within the Compensation Court in matter 9645/2002 was issued on 3 October 2002. It sought a lump sum for loss of efficient use of the left arm at/above the elbow. A further matter of 20097-2003 was discontinued in June 2004 in respect of further claims (I assume) for lump sum compensation, the discontinuance being because of "forthcoming surgery."[25] A Medical Assessment Certificate was obtained in matter number 007905-2011 which assessed only the left arm at/above the elbow. The AMS was Dr Mohammed Assem who reported on 28 October 2011[26].

[21] ARD page 103
[22] ARD page 104
[23] ARD page 106
[24] ARD page 122
[25] ARD page 506
[26] ARD page 509

70. In taking a history of the injury the AMS said[27]:

> "He believes the left shoulder popped out and then spontaneously relocated. He experienced immediate left shoulder discomfort radiating to the left side of his neck and periscapular region."

71. The AMS referred to reports of medico-legal referees that we have not yet considered. They were reports of Dr Bodel dated 24 May 2011, and Dr Conrad, dated 31 March 2011. Neither specialist identified any pathology in the neck, and the AMS was asked to assess only the left shoulder.

72. On 14 August 2012, Mr Smith was seen by Dr John Ditton for the insurer. Dr Ditton said[28]:

> "Mr Smith complained of pain in the left side of his neck and over the posterior aspect of the left shoulder."

73. In taking a consistent history of the injury and subsequent developments, Dr Ditton took a history that between 2000 and 2009 Mr Smith continued to work using pain killers, heat packs and exercise to manage his pain.

74. Dr Ditton examined Mr Smith's neck in view of the complaints of pain over the lower cervical facets on the left. He found a full range of movement of the cervical spine with some local tenderness over the spinus process at C4. There was no muscle spasm or focal tenderness over the muscles of the neck or the shoulder. Dr Ditton diagnosed pain in the region of the left shoulder:[29]

> "At this time the distribution of the pain would suggest that the pain is partly arising from the injury to his shoulder capsule and partly from chronic tension in the muscles surrounding an abnormal joint."

75. He discounted any consideration of a chronic regional pain syndrome.

76. Mr Smith was then referred to Dr David Manohar, Occupational Pain Physician in early 2013.

77. Dr Manohar reported to Dr Khan on 11 February 2013. Dr Manohar noted an MRI scan of 1 February 2013 which showed pathology at C4/5, C5/6 and C6/7, including a right sided paracentral annular tear at C6/7. Dr Manohar proposed "diagnostic neural blockade" at those levels. The conclusions of the pathologist, Dr Kapoor were:[30]

> "1. Canal stenoses at C4/5 with disc osteophyte, and at C6/7 with right-paracentral disc protrusion.
> 2. No cord contact or oedematous changes.
> 3. I also do note the presence of a moderate central canal stenosis at T2/3 with focal disc protrusion, follow up dedicated imaging of the thoracic spine could be performed if deemed clinically indicated.
> 3. Mild to moderate bilateral foraminal stenosis, at the levels of C4/S and C5/6, more marked on the left."

78. An application was made apparently to the insurer which was declined, and Mr Smith said he paid for the procedure himself, although he did not relate what date that was.

79. Mr Smith said he was then referred to Dr Ron Muratore on 1 April 2014. Dr Muratore was an Injury Management Consultant to whom Mr Smith was referred by Dr Khan.

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[27] ARD page 510
[28] ARD page 142
[29] ARD page 145
[30] ARD page 15

80. On 1 April 2014, Dr Muratore took a consistent history, saying that when he continued on modified duties with the respondent, "[Mr Smith] had persistent pain and extreme muscle spasm in the left side of his neck, the left trapezius and the left arm"[31].

81. Dr Muratore took a history that between 2003 and 2009 Mr Smith was self-employed using a "Dingo Digger" until some time in 2009, he sought the advice of Dr Nath because of persistent pain, and obtained an MRI scan. Dr Muratore recorded the surgery undergone by Mr Smith with Dr Herald, reporting that post operatively Mr Smith's pain improved for a period of time, and he underwent another course of physiotherapy and hydrotherapy. Because he was not pain free he was then referred to Dr Ibrahim and the course of injections that I have just mentioned.

82. Under "Current Symptoms" Dr Muratore said:

> "He complaints of left-sided neck pain, which radiates down to the mid-thoracic spine into the left scapular and at times it is associated with paraesthesia in the left hand and left foot."

83. Dr Muratore diagnosed cervical spondylosis[32]. He noted the surgically repaired labral tear in respect of which Dr Muratore thought there had been a complication of persistent pain syndrome.

84. On 11 May 2015, Dr Muratore again reported to Dr Khan. He recorded a consistent history of the subluxation of the left shoulder on 26 May 2000 and said that as Mr Smith had ongoing symptoms, including pain radiating to the left side of his neck, Mr Smith went to see Dr Ibrahim, as has been seen, some six years later.

85. Dr Muratore noted that Mr Smith had retrained in 2012 completing a Certificate RV in Workplace Safety Management and Certificate RV in Workplace Training Assessment. He had obtained employment with Absolute Forklifts and worked there 12 months. He then found work with Simili Training in 2015, but left shortly before the appointment with Dr Muratore.

86. Dr Muratore gave a thorough examination and noted the investigations that had been taken at that stage. His diagnosis again was of cervical spondylosis with a Persistent Pain Syndrome.

87. In a third report of 15 June 2015, Dr Muratore reported to the insurer. When asked about his diagnosis, Dr Muratore said that the cervical spondylosis was constitutional. There may have been an aggravation at the time of the initial injury in May 2000 Dr Muratore said, however the work related aggravation had long since ceased. He thought there was no causal link between the cervical spondylosis and the left shoulder injury of 25 May 2000[33].

88. Mr Smith then said that he continued with basic treatment and regular GP attendances until in March 2015 he was referred to Dr Donnellan.

89. Dr Michael Donnellan, Neurosurgeon, reported to Mr Smith's then solicitors on 23 August 2017. Dr Donnellan took a history that he first saw Mr Smith on 4 March 2015 when he presented complaining of ongoing left sided neck pain and left scapular pain "since an accident at work on 26/05/2000". He said regarding the actual injury[34]:

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[31] ARD page 106
[32] Reply page 108
[33] ARD page 121
[34] ARD page 173

> "He said he felt as though his shoulder had dislocated and then relocated. He had ongoing shoulder pain in the front of his shoulder until Dr Herald did a procedure in 2009. From the time of that injury he also had pain going into the medial aspect of his scapular and also the back of his shoulder. There was pain going into the left hand side of his neck. He also complained of paraesthesia and discolouration of his left hand."

90. He took a history that Mr Smith had been referred to a physiotherapist a Mr Stephen O'Connell, saying at that time as well as his shoulder pain, Mr Smith complained of neck pain. Dr Donnellan said:

> "He saw Dr Bodel on several occasions and he was also referred to Dr Adler in 2008 in terms of his ongoing neck pain."

91. Mr Smith said he returned to see Dr Donnellan in August 2015 who had by that time identified "a significant disc prolapse" Mr Smith underwent a course of injections which he found most beneficial, however the effects of the injections were not longstanding. In discussion with Dr Donnellan, Mr Smith was recommended the surgery that is the subject of this application.

92. Mr Smith stated that his condition had not improved at all, notwithstanding the various treatment options he has exercised.

93. Mr Smith also referred to his post injury employment. He in fact worked with his 'Dingo Digger' from 2003 to 2006. He said that during that time he felt a flare up in his symptoms, but without suffering an injury or any traumatic event.

94. In 2006, Mr Smith worked for Todium Freight Mine as a truck driver for 12 months and then worked for CLM Infrastructure driving a hooked in truck from 2006 to 2009. He confirmed that he obtained his training and assessing certificate, a first aid certificate and work health and safety certificate.

95. From 2013 to 2014, he worked as a forklift trainer which he said was not physical or strenuous.

96. He said that in 2015, he said he trained and assessed digging, rigging and crane operating, again duties that were not physical in nature, Mr Smith said.

97. He said that in 2016, he worked as a site foreman and first aid officer directing and instructing workers and sometimes demonstrating duties.

98. In 2017, he worked as a train onsite operator which involved checking oil, water, tyre in respect of lifting equipment and filling in the safety checklist.

99. He said that on 21 March 2018, his GP certified him as being totally unfit for work.

100. Mr Smith described his current somewhat distressing circumstances, stating that his relationship with his partner had broken down because of the effect of the injury on his personality. He said that he had been told by "all of his doctors" that the surgery is the only thing that would allow him to return to his pre-injury lifestyle.

Statement 15 November 2018

101. Mr Smith made a further statement when some surveillance material had been served upon him. He noted that the footage was taken on 24, 25, 26 and 27 October 2016 when he was employed by Devcon Partners Pty Ltd, which was a building and construction company. He said he was hired as construction site foreman and commenced there in early 2016. His employment was undertaken on the basis that the employer understood that Mr Smith had sustained a shoulder and neck injury in 2000 which was continuing "to cause me grief".

102. The employer agreed to limit Mr Smith's work so that he would not be required to do any hard physical manual labour intensive work. Mr Smith said that there were some rare occasions when he found himself on site when labourers had called in sick. He would then perform some of the more physically demanding tasks. What he was seen doing on 24 October on the video is one example of this. He said[35]:

> "10…. I feel as though my disabilities have been consistent since the accident in 2000 as well as the bad outcome of treatment to my shoulder over the years which altered my lifting mechanics and also contributed to the current condition of my neck."

103. Mr Smith conceded that the footage on 24 October showed him using a shovel and placing sand and gravel in a cement mixer. It also showed him picking up bags of cement to empty into the mixer and further showed him pushing the wheelbarrow full of cement where it was required onsite. Mr Smith said this is not a task that he would normally do. He could not recall doing such a task prior to that occasion.

104. He said that the footage on 25, 26 and 27 October did not show him undertaking any heavy manual labouring tasks. Mr Smith said that in any event, the footage on 24 October showed him working slowly and using small loads on his shovel with only small loads in the wheelbarrow. Mr Smith concluded by expressing his frustration at the misfortune that has overtaken him. He said that the video did not show the toll his injuries and disabilities have taken on his personal life with his family.

105. Mr Smith said that the video footage of the remaining three days showed him operating machinery including a digger and excavator. He said he would normally operate those machines when needed and that although they were not physically labour intensive jobs, by the end of the day he still suffered pain and discomfort.

106. A statement was lodged by Mr Kane Heckenberg, Director of Horizon Waterproofing dated 12 November 2018. Mr Heckenberg had known Mr Smith for many years and they became close friends. He said that he had offered Mr Smith some work but that Mr Smith had always declined because he knew he would not be able to complete the physical labouring tasks that were required for his business. Mr Heckenberg noted that Mr Smith's health has deteriorated and that it is clear to him that Mr Smith had lost a lot of weight and muscle.

107. A further reference dated 15 November 2018 was lodged by Lesley Sweeney, Director of Sweeney Advertising. Ms Sweeney said that she and her husband had known Mr Smith for many years and spoke of the effect the 2000 injury has had naming it as "his injury to his shoulder and neck". Ms Sweeney reflected on Mr Smith's state of health prior to the injury referring to his professionalism and his abilities within his chosen field. Since 2000 Ms Sweeney said that she and her husband had noticed Mr Smith's slow deterioration as the pain, limitations and financial struggles had taken their toll. Ms Sweeney noted that notwithstanding his adversity, Mr Smith had attempted to retain and create a career path that would accommodate his injuries.

[35] ARD page 545

108. A further testimonial dated 15 November 2018 was given by Mr Charlie Daher, the Office Manager of Devcon Partners.[36] Mr Daher confirmed the light duty nature of the work that Mr Smith was largely doing and conceded that on the rare occasion when a labourer did not show up for work, Mr Smith would step in himself. He was however told by his employers to only do that which he was physically able to do.

109. Ms Sweeney also made a statement dated 27 March 2019[37]. She referred to her earlier reference. She said that following the 2000 injury, it was clear that Mr Smith was experiencing significant pain to his left shoulder. She said that was Mr Smith's greatest concern, but occasionally he would mention pain and discomfort in his upper back and neck. He would point to the entire upper area and complain of pain and discomfort. She said that Mr Smith would on many occasions complain of shoulder, upper back and neck pain.

110. Ms Sweeney also said that over the years said noticed, the disabilities within the shoulder were changing his posture.

Medico-legal Opinion

Dr Bodel

111. However, Dr James Bodel. Orthopaedic Surgeon had been seeing Mr Smith over a period of years for the employer. He first saw Mr Smith on 14 August 2001 in relation to the subject injury of 26 May 2000. He took a consistent history of the dislocation, although he simply said that whilst lining up the counter weight "he pulled his left shoulder". He recorded that Mr Smith continued to have cramping and locking in the shoulder. Mr Smith began to develop a prominence of the scapular on the upper part of his back. He complained that his shoulder would often "spasm up[38]".

112. Dr Bodel's opinion on that occasion was that there had been an injury to the left shoulder and the "upper part of the back". He said that it was difficult to be certain as to the exact pathology but he suspected a nerve injury which appeared to be recovering. He thought that Mr Smith may have suffered rotator cuff pathology and he wanted to see an ultrasound.

113. Dr Bodel's next report was a year later on 12 September 2002[39]. He noted that a year had passed since his first assessment and noted that Mr Smith was then self-employed with his "Dingo Digger". Mr Smith complained of developing a prominence around the medial border of the scapular in the upper part of the back. On examination Dr Bodel said[40]:

> "Inspection of the head and neck area shows no deformity or wasting."

114. Dr Bodel thought that Mr Smith had "definite signs of probable pathology in the left shoulder" and recommended an MRI scan to confirm that. He also said[41]:

> "[Mr Smith] should also be encouraged to exercise to strengthen his neck and shoulder girdle region and this will enhance function over time".

115. In a short addendum report of the same dated 12 September 2002 in assessing impairment and loss as a result of the injury Dr Bodel said[42]:

> "The patient has no evidence clinically of any permanent impairment of function in the neck and no evidence clinically of any permanent impairment or function in the back".

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[36] ARD page 550
[37] ARD page 551
[38] ARD page 24
[39] ARD page 28
[40] ARD page 28
[41] ARD page 30
[42] ARD page 31

116. In his next report of 2 December 2003, a year later, Dr Bodel took a consistent history and noted the various work activities Mr Smith had undertaken. Under "Current Complaints" however Dr Bodel said[43]:

> "This gentleman continues to complain of pain on the left side of the neck, the top and front and back of the left shoulder as well as along the medial border of the scapula."

117. On examination, Dr Bodel said:

> "He is a well-muscled individual and he has a good range of neck flexion, extension and rotation without crepitus on the rotational movement or pain on resisted movement."

118. Under Investigations Dr Bodel noted that there had been no CT or MRI scan of the cervical spine.

119. In giving his opinion Dr Bodel spoke of persisting symptoms in the left shoulder. He recommended surgery as the best way to treat his subluxation problem.

120. On 24 February 2004, Dr Bodel clarified that Mr Smith had genuine pathology in the left shoulder. If Mr Smith's symptoms became significant, will then surgical stabilisation was warranted, Dr Bodel said.

121. On 30 April 2004, Dr Bodel viewed the video surveillance footage which has already been mentioned in these reasons. This related to video however taken in 2003 which showed Mr Smith on his mini digger. Dr Bodel did not find any inconsistencies in the footage with his earlier findings.

122. Dr Bodel did not report again until 12 November 2009, when he noted that he had seen Mr Smith on 2 August 2009, 5 September 2002, 24 June 2003 and 4 December 2003.

123. In his summary of injuries on this occasion, Dr Bodel described:

> "Injury to the neck and injury to the left shoulder"[44].

124. He took a history that in fact the left shoulder had "dropped out and popped back in again" in relation to the subject injury.

125. In his report of 24 May 2011 Dr Bodel took a consistent history of the work injury of 26 May 2000, and Mr Smith's subsequent treatment to that point. Dr Bodel noted in the history that the "shoulder" and the "neck" have steadily deteriorated over time without additional accident or injury.

126. Dr Bodel gave no diagnosis relating to the cervical condition.

127. On 17 April 2015 Dr Bodel again reported to the insurer[45]. Dr Bodel recorded that Mr Smith felt pain in the neck, the left shoulder and the arm at the time he sustained a "sudden traction injury" to the left shoulder. He noted that an MRI scan of the cervical spine showed some disc pathology to the upper cervical region. He did not identify the date of that scan. He related how Dr Donnellan saw Mr Smith on 11 March 2015 and noted a "slightly altered sensation in the left C6 dermatome and more dense sensory loss in the left C7 dermatome" on examination, as a result of which an MRI scan was carried out showing significant disc pathology at C4/5, C5/6 and C6/7. Again no dates were given by Dr Bodel for that imaging.

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[43] ARD page 35
[44] ARD page 41
[45] ARD page 50

128. On this occasion when Dr Bodel examined Mr Smith, he found that Mr Smith[46]:

> "…has tenderness in the trapezius muscles at the base of the neck on the left hand side with some guarding in the region. He has a reduced range of neck flexion, extension and rotation in all directions and is most restricted on extension and rotation to the right."

129. Dr Bodel was not aware of the surgery proposed but did acknowledge that there was significant disc pathology at the cervical spine. He said:[47]

> "It is appropriate for [Mr Smith] to have been referred to Dr Donnellan for an opinion as the injury was always an injury involving the neck and the whole of the left arm and not just the left shoulder"

130. On the same page Dr Bodel said:

> "Based on the history over the many years that I have seen him there does appear to be a causal link between the nature of his original injury and the ongoing pathology which is now largely in the neck."

131. When asked whether any of the current impairment of the neck (relevantly) was a separate condition which has arisen after and separately from the injury on 26 May 2000, Dr Bodel said:

> "I note 13 years ago I assessed that there was no clinical evidence of permanent impairment of function of the back or neck at that time but he did have symptoms of radiculopathy in the left upper limb.
>
> He now has signs suggesting nerve root tension and there ls a causal link back to the original injury as there is no history of any other accident or injury."

132. Dr Bodel's last report was dated 25 October 2015[48]. Dr Bodel was by then made aware of the proposed surgery. He was then asked as to whether Mr Smith did in fact injure his neck (cervical spine) in the subject injury. Dr Bodel said that he had "carefully" reviewed the documentation including the reports that he had prepared in relation to this matter. He said[49]:

> "The initial prime concern for this gentleman at the time of his injury was the unstable left shoulder joint which was caused by the "pulling" event that occurred whilst this large counterweight was being loaded onto the back of a truck. This type of event could cause a subluxation of the shoulder which appears to have been the case and also a traction injury on the cervical spine causing disc pathology in the cervical region.
>
> His initial complaints were primarily in relation to the shoulder but within a fairly brief period of time in the overall sequence of events, the neck became a significant complaint with basal neck pain and periscapular pain over the upper part of the back as well as the shoulder pain."

[46] ARD page 53
[47] ARD page 55
[48] ARD page 56
[49] ARD page 57

133. The respondent's solicitors asked Dr Bodel to explain the following[50]:

> "You initially only diagnosed injury to the left shoulder in 2002, however, by 2009 you additionally diagnosed injury to the neck - but did not provide any reasoning for this subsequent diagnosis. Given your original opinion expressed in 2002 that only a left shoulder had been injured and given the complicated history in this matter, please confirm whether your diagnosis of a neck injury was by mistake."

134. Dr Bodel responded:

> "Quite correctly, I did identify initially that the pathology was primarily in the region of the left shoulder.
>
> When reviewed in 2009 he was complaining of neck pain and often the two co-exist.
>
> I am satisfied that the two are causally linked and that the injury to the neck for which treatment has now been recommended is causally linked to the original injury."

135. Dr Bodel then referred to the mechanism of injury that he said "could have caused" pathology in the left shoulder and the neck.

136. Dr Bodel also said[51]:

> "I am satisfied that there may have been some minor pre-existing degenerative change in the neck but that the main cause for his need for surgery has arisen as a consequence either directly or as a consequential injury to the neck arising from the original work injury on 26 May 2000."

137. Dr Bodel conceded that it was possible that the neck complaints had occurred at some later stage after Mr Smith had ceased work with the respondent, but he said that he had not seen any medical evidence which would confirm that to be the case. Dr Bodel noted the surveillance evidence, and said:

> "He clearly was coping with it at that time from a functional point of view."

138. He then said:

> "As I have indicated however, historically he indicated to me that the pain occurred as a consequence of the original injury on 26 May 2000 and I have not seen any medical evidence to the contrary".

Dr Anil Nair

139. On 23 May 2018 Dr Anil Nair, Orthopaedic Surgeon, provided a report to Mr Smith's solicitors as his medico-legal referee. He took a history of the subject injury in short form. he said:[52]

> "At around 2003, he first complained about symptoms in his cervical spine….."

[50] ARD page 57
[51] ARD page 58
[52] ARD page 3

140. Dr Nair noted that Mr Smith had been seen by Dr Bodel and Dr Giblin. Dr Nair observed the applicant in what he called "objective testing."[53] He saw no impediment in Mr Smith's gait. He noted that Mr Smith arose from the chair without apparent difficulty and that he had wasting in the left pectoral girdle musculature. He saw an MRI scan of the cervical spine dated 27 March 2015 together with a bone scan and SPECT CT Scan of 30 march 2015 together with flexion-tension MRI cervical scan dated 1 February 2013 and 2 March 2013

141. Dr Nair noted that Mr Smith had clinical and radiological features of cervical radiculopathy. He said[54]:

> "Based on the evidence at hand, I conclude that he sustained an injury to his cervical spine during the incident on 26 May 2000."

142. When asked whether there was an acceptable explanation for the delay between the complaints about the shoulder and those of the neck, Dr Nair thought the delay was acceptable as the regions are "anatomically contiguous. There is often a masking effect evident between cervical and shoulder affixations".

143. When asked whether the injury to the cervical spine had been suffered as a result of the frank incident on 26 May 2000 Dr Nair concluded that the cervical spine injury was due to the subject accident. He said that Mr Smith[55]:

> "manifests no tendency towards the development of degenerative changes in the cervical spine. He manifests no systemic tendency toward the development of degenerative arthritis as evidenced by a lack of involvement by the small joints of his hand as well as the hips and knee joints".

144. Dr Nair thought that the cervical spine injury was not recognised at the time due to the dislocating and "redislocating" of the left shoulder. Dr Nair thought that the proposed C4/5 and C5/6 cervical discectomy and fusion were "reasonable and necessary".

145. Dr Nair supplied a further report on 18 October 2018 when he was asked to answer a number of questions from Mr Smith's solicitors regarding the surveillance carried out on Mr Smith in 2002, 2003 2006, 2010 and 2016. Dr Nair conceded that the surveillance showed Mr Smith performing activities demonstrating function, but said such activities were not mutually exclusive with the cervical canal stenosis at the C4/5 and the foraminal stenosis at C4/5 and C5/6.

146. Dr Nair disagreed with the opinion of the respondent's specialist, Dr Michael Davies as to causation, again repeating that Mr Smith did not have osteoarthritis in the more commonly affected joints of the body. Dr Nair said:

> "To assume that the C4/5 and C5/6 degeneration is a de novo process, is in my opinion not empirical."

147. When asked about Dr Bodel's conclusions in his report of 17 April 2015 Dr Nair said:[56]

> "Scrutiny of the medical records do suggest pain in the subaxial cervical spine originating back to the original injury of 26 May 2000."

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[53] ARD page 4
[54] ARD page 5
[55] ARD page 6
[56] ARD page 3

148. Dr Nair also agreed with Dr Bodel that the original injury was, on the balance of probability:

> "…the catalyst behind the development of C4/5 and C5/6 disc injuries that have been the source of clinical symptoms of these times".

149. Dr Nair reported again on 27 March 2019, and his report again took the form of answering questions from Mr Smith's solicitors. Dr Nair confirmed his opinion that the subject injury was the cause of the neck problems. He said: [57]

> "There is no substantial evidence to support the hypothesis of altered gait or posture causing injury to the disc. Using A Priori deductions, it is more than likely that the injury sustained on 26 May 2000 is the catalyst for the current symptoms."

150. When being asked whether the mechanism of the frank injury was consistent with the injury to C4/5 and C5/6 and also whether such injury was consistent with "our client's altered mechanics due to his left shoulder injury", Dr Nair said:

> "It is challenging to hypothesise and indeed, the following answer is based on the balance of probabilities. It is certainly possible that the injury initiated the degenerative cascade heralded by the mild and non-intrusive subaxial cervical and trapezial pain and ultimately progressing into a true radicular component. …
> Mr Smith demonstrates no frank and intrinsic tendency towards the development of degenerative arthritides."

Dr Michael Davies

151. The employer relied upon reports from Dr Michael Davies, Neurosurgeon. His first report was dated 2 November 2016. Dr Davies took a consistent history of Mr Smith experiencing his shoulder pop out and then pop back in again. He took a history that there was immediate pain in the left shoulder "which he said radiated up into the left side of his neck"[58].

152. Dr Davies was told by Mr Smith that the shoulder pain suddenly deteriorated in September 2009 when he was referred to Dr Herald. Dr Davies noted the history of the injections performed by Dr Ibrahim and the complication of adhesive capsulitis following surgery in December 2009.

153. Dr Davies noted that Mr Smith had post-operative hydrotherapy, physiotherapy and a gym program. Dr Davies took a consistent history of the technical courses Mr Smith completed and, in general terms, his subsequent employment.

154. Dr Davies recorded that Mr Smith's duties were mainly of a light nature, but occasionally he had to work with the excavator or bobcat. Mr Smith complained to Dr Davies on this occasion of pain around the left shoulder going into the left side of the neck, which fluctuated in intensity. He said that he had limited ability to elevate the left upper limb because of the pain around the left shoulder girdle and a limitation of neck rotation to the left side as it caused increased pain in the neck and left scapular region. Mr Smith said that he did not like the medications he had tried, and in 2016 when he saw Dr Davies for the first time, he was using hot and cold packs and stretching to treat his symptoms.

[57] ARD page 8g
[58] Reply page 53

155. Dr Davies noted that Dr Donnellan had recommended anterior cervical discectomy and fusion at C4/5 and C5/6. Dr Davies had available the investigations that had been taken up to that point. He said that the multi-positional MRI of the cervical spine on 1 February 2013 showed a disc osteophyte complex at C4/5 causing mild canal stenosis and a moderate degree of foraminal stenosis particularly on the left side. There was a right paracentral disc protrusion at C6/7 reported and foraminal stenosis at C5/6 more likely on the left side.

156. The plain x-rays of 12 November 2014 were not available, but Mr Smith showed Dr Davies a copy of the report which showed significant degenerative changes at C5/6, some disc space narrowing, slight retrolisthesis and moderate narrowing of the exit foramina bilaterally. Subsequent imaging dated 27 March 2015, involving both CT and an MRI scans of the spine, was considered by Dr Davies.

157. Dr Davies acknowledged that he had been told by Mr Smith of pain radiating down the left side of the neck ever since the injury. Dr Davies said[59]:

> "However, I note number of independent medical examinations record a normal range of neck movements and no pain with neck movements."

158. Dr Davies noted that there appeared to have been a fracture of the left distal radius which was repaired on 10 December 2013. Dr Davies was told that the fall was unrelated to work and that Mr Smith did not suffer any further injuries in relation to that incident. He particularly denied that there had been any effect on his longstanding left shoulder problem. Dr Davies said:

> "I found the mechanism of injury he described somewhat unusual but he insisted that his arm and hand were not outstretched at the time of the impact on the ground."

159. Dr Davies' diagnosis on this occasion was of cervical spondylosis. He said:

> "I do not believe his neck condition relates to the injury that occurred in May 2000. I note he had a number of independent medical assessments over the years. The first one to record any neck problems is the report of Dr Bodel in November 2009, more than nine years after the injury. One of his treating specialists records no cervical spine problems in July 2010. There is no mention of any cervical spine problems and no cervical spine examination findings recorded in Dr Conrad's report of 31 March 2011.I note a report from Dr Perla in September 2012, which records a full normal active range of movement in the cervical spine and there is no mention of any neck pain at that time."

160. Dr Davies was then asked whether the left shoulder injury caused any secondary injury to the cervical spine.

161. Dr Davies referred to reports of Dr Ibrahim who recorded no issues with the cervical spine. Dr Davies also referred to the report of Dr Herald of 5 March 2013 in which he thought that Mr Smith's may have aggravated cervical arthritis as a result of nine years of over compensation when he had the shoulder surgery in 2009. Dr Davies said:[60]

> "Given the multilevel nature of his cervical spondylosis and the mechanism of injury, I do not believe he suffered either a primary or a secondary injury to the cervical spine."

[59] Reply page 57
[60] Reply page 59

162. Dr Davies found that the work injury was not the main contributing factor to the cervical spine complaints. He said that the main contributing factor related to the underlying cervical spondylosis.

163. He noted that there was no record of any neck problems or abnormal examination findings in the cervical spine for many years after the injury, and indeed no investigations of the cervical spine until nearly 13 years later.

164. Dr Davies was asked to consider whether the cervical spine complaints would have become evident around the same time in his life in any event, even had he not had the accident in May 2000. Dr Davies said:

> "He has multilevel cervical spondylosis, which suggests an underlying genetic cause. It is possible that some of his work activities since the subject injury have contributed to it."

165. Dr Davies was asked about Mr Smith's current capacity for work. Dr Davies recommended that he avoid overhead activities with his left upper limb and to avoid heavy lifting and carrying activities with the left upper limb. He said:

> "However, based on other information available to me, he is clearly able to elevate his left arm through a greater range than was demonstrated during the consultation and is clearly able to lift at least moderately heavy weights. He certainly appears to be able to undertake duties on a building site, including lifting bags of cement, lifting and pushing wheelbarrows and lifting a cement mixer onto a truck. I also note the report from Dr Bodel in January 2003 relating to surveillance material that indicates Mr Smith was capable of undertaking 'quite vigorous activities including lifting the heavy augur onto his shoulder'."

166. He thought that the proposed surgery was not reasonably necessary as a result of the subject injury.

167. In a separate report of the same date, Dr Davies considered a surveillance report which had been prepared by Procare between 24 and 27 October 2016. Dr Davies noted that he was relying on pictures and the description in the report. He said he would need to see the full surveillance to be sure, but it appeared that Mr Smith had been able to move his neck quite well in all directions and to be able to lift quite heavy weights. He noted that most of the picture did not show Mr Smith elevating his left arm beyond about 90º but that, whilst helping to lift a cement mixer on the back of a truck on one occasion, he was seen with his arm significantly elevated above his head.

168. Dr Davies reported again to the respondent on 28 October 2018, after a further consultation with Mr Smith on that date. Dr Davies ascertained that Mr Smith had continued working. He worked as site foreman with Devcon partners, leaving that employment to do assessing and training work with Glenmore Civil. He worked a few more days with Devcon and was asked to return to work for them but he was unwilling to do so. He had stopped work in March 2017.

169. There had been no new investigations since Dr Davies had seen Mr Smith in 2016.

170. Dr Davies said with regard to history that Mr Smith reported pain in the left side of his neck ever since the injury in May 2000, which report was at odds with a number of other contemporaneous and other medical reports which he had discussed in his 2016 report.

Dr Davies repeated that the diagnosis was cervical spondylosis. He noted the investigations showed multilevel spondylitic changes in the cervical spine and that he did not believe that all of those changes could be attributed to the subject injury either by way of cause or aggravation. He said[61]:

> "I remain of the opinion that there is no direct link between his neck condition and the alleged injury. There are multiple medical reports that either record no neck symptoms or specifically indicate no neck pain and normal neck movements. I note that reports from Dr Bodel in August 2001 and September 2002 record normal neurological examination in the upper limbs. His report of December 2003 notes some difficulty eliciting the left biceps reflex but no other findings suggestive of radiculopathy. His report of November 2009 notes a diminished left biceps reflex and sensory impairment in the left C6 dermatome.
>
> I do not believe the onset of some neurological findings in the left upper limb more than three years after the injury, together with a number of medical reports recording no neck problem and normal neck movements over many years up to late 2012, is consistent with a work incident having caused a neck injury, either by way of causation or aggravation."

171. In his final report of 15 August 2019, Dr Davies confirmed his earlier opinions and stated that neither the neck condition nor an alleged low back condition were related to the claimed work injury.

Surveillance

172. Although many periods of surveillance were discussed in the medical reports to which I have referred, the respondent lodged only the latest report dated 28 October 2016[62]. Surveillance was conducted on 24, 25, 26 and 27 October 2016 with 31 hours of surveillance resulting in 137 minutes of footage. The authors of the report located Mr Smith's ABN and confirmed that he had been working for himself under the trading name of 'Minchinbury Dingo Services' from 2 October 2011. The ABN was active from 1 August 2001 to 23 August 2013. He became active again on 1 July 2014.

173. On 24 October 2016, Mr Smith was observed to leave his home at 6:21am from whence he went after a short stop at a 7-11 service station, to a location where there was a lot of construction in the area. At 7:30am Mr Smith was observed mixing sand into a concrete mixer. He was seen to pull the handle on the concrete mixer, to use a hose to add water and to lift and push a wheelbarrow full of concrete. He was observed to lift a 20kg bag of cement above shoulder height on numerous occasions into the concrete mixer. He was wearing a shirt with a company name of "Devcon". At 12:24pm he assisted another person to lift the concrete mixer into the back of a trailer and to secure it in that position. At 12:21pm Mr Smith was briefly seen at the worksite but by 1:04pm his vehicle had moved from the area and surveillance ceased at 3pm.

174. On 25 October 2016, Mr Smith was seen to depart at 6:55am and drove to the worksite he was seen at the day before after first picking up some supplies. At 8:34am Mr Smith was seen operating a mini excavator, firstly on the ground level of the building and then inside the rear of the building. He was observed to retrieve metal reinforcing rods from the tray of a Toyota Hilux that arrived at 10:25am. He was also seen to operate his excavator spreading dirt that was dumped from a truck at about 4:45pm. At 12:33pm the claimant was said to be out of sight at the rear of the building with the supervisor.

[61] Reply page 10
[62] Reply page 62

175. On 26 October 2016, Mr Smith was not seen although the operative saw Mr Smith's excavator being loaded on a truck which was followed to the Silverwater Depot of AllCott Hire.

176. On 27 October 2016, Mr Smith was seen to depart at 5:46 and again attended the 7-11 service station. Contact was lost but when the operative checked the Lidcombe construction site, Mr Smith's vehicle was parked there at 7:53am. Mr Smith was seen to converse with other people at the site and to drive a bobcat front loader and park it outside the site. He was observed in the morning carrying out what appeared to be a supervisor's role. He gave instructions to another male, he made phone calls. At 10:46am he drove the bobcat into the basement in order, the operative thought, to build a dirt ramp. He was seen to use he bobcat on a further occasion at 10:45am and surveillance ceased at 11:30am.

SUBMISSIONS

Mr Saul

177. Mr Saul relied upon the reports of Dr Davies, particularly his compendious report of 2 November 2016 to which he adhered in his later reports. Mr Saul submitted that the summary by Dr Davies of the history was correct. The main complaint was the left shoulder in 2000 and there was no substantive complaint about the cervical spine until 2009. Dr Davies had also considered the surveillance material in 2001, which showed Mr Smith engage in heavy work lifting heavy objects. I would, Mr Saul submitted, find that Mr Smith's neck symptoms have been caused by the cervical spondylosis to which the injury on 26 May 2000 made no contribution. He took me to the reports of Dr Davies and submitted that I would accept that there is no causal link to the subject injury.

178. If I was urged to find a consequential condition, Mr Saul submitted that applying the common sense test in *Kooragang Cement Pty Ltd v Bates*[63] and *Arquero v Shannons Anti Corrosion Engineers Pty Ltd,*[64] that I would not be able to be satisfied that any consequential condition had arisen.

179. Mr Saul relied on the surveillance which showed in 2016 Mr Smith with his arm in an elevated position when he was lifting his cement mixer. Mr Saul submitted that the question of whether the surgery was reasonably necessary was not an issue in this case, and that it was concerned with causation and Mr Smith's failure to satisfy onus in that regard.

180. Mr Saul observed that although Mr Smith referred to neck pain from time to time, it was not regarded as being sufficiently serious to be investigated. He submitted that there was no imaging of the cervical spine until 12 November 2014.

181. Mr Saul submitted that I would not accept Dr Bodel's history, as Dr Bodel could give no convincing reason as to why he supported a connection between Mr Smith's neck symptoms and the injury of 26 May 2000. He submitted that such justification as Dr Bodel attempted to make was infected by it being given ex post facto.

182. He submitted that when Dr Bodel described the injury in 2009 as being "injury to the neck", it came "out of the blue" and without explanation as to how the injury had occurred. Mr Saul submitted that the suggestion that the injury might be consequential, which was not made until 25 October 2015 was an ipse dixit. The radiology, Mr Saul said, showed multilevel disc pathology. How that could have occurred as a result of the shoulder injury was unexplained as was the fact that there was no symptomology complained of at the time, or any suggestion that the neck had suffered a trauma in the incident.

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[63] (1994) 5 NSWLR 452 (*Kooragang*)

[64] [2019] NSWWCCPD 3

183. In discussing Dr Herald's reports, Mr Saul submitted that it was clear by 2010 – 2011 Mr Smith was having neck issues. However, neither Dr Biggs, Dr Ibrahim nor Dr Potter in the years prior to 2010 found any neck pathology at all. Indeed Mr Saul submitted some of them examined the neck and found no difficulty.

Mr Morgan

184. Mr Morgan addressed on the second day, 18 October 2019. Mr Morgan conceded that Dr Bodel made no mention in 2001 of any neck difficulty. Mr Morgan rejected Mr Saul's submission that Dr Bodel's explanation was an ipse dixit. He said that[65] Dr Bodel explained clearly the mechanism involved, which was principally that the seriousness of the shoulder condition had masked the neck condition.

185. Mr Morgan submitted that the suggestion that the neck injury occurred whilst Mr Smith was engaged in other employment since the year 2000 was unsupported by any medical opinion, and that indeed Mr Smith's statement is "clear on the sequence of events". Mr Morgan submitted that I would accept Dr Donnellan's opinions, and submitted that the contemporaneous complaints of injury in 2000 were not confined to the shoulder itself, but also to its surrounding structures. Mr Morgan submitted that Dr Donnellan was correct when he said that the injury was complex.

186. Mr Morgan submitted that if I was not satisfied that the neck injury was caused at the same time as the shoulder injury, then I would accept Dr Donnellan's opinion that because of Mr Smith's posture as a result of the subject injury, it had caused a consequential condition.

187. Mr Morgan submitted that I would find that Mr Smith was a well-motivated individual, whose stoicism had prevented the doctors picking up the injury to the neck, as it had been masked by the shoulder injury.

188. Mr Morgan relied on a mention made by Dr Bodel in his report of 4 December 2003 in which he recorded a claim that Mr Smith had pain in the left side of his neck. Mr Morgan then took me through the various references in different reports to areas of the body that were adjacent to but separate from the neck. Dr Biggs referred to "cervico-thoracic pain". The clinical notes mention "rhomboids" and the "scapular", the upper part of the back was mentioned by Dr Bodel. The "left upper quadrant" was mentioned by Dr Potter. A complaint of pins and needles in the arm at ARD 95 was mentioned when Mr Morgan went through the clinical notes. References were made to "paraspinal", "trapezius" and the "posterior cervical region". Mr Morgan gave a thorough and painstaking survey of the evidence, referring to every reference to areas around the neck and the shoulder.

189. Mr Morgan submitted in the alternative that both Dr Donnellan and Dr Nair found that the degenerative condition was consequential and that the injury had made a material contribution.

Discussion

190. "The neck" as it was described in the Table of Disabilities, is now described in the guidelines as the "cervical spine." Anatomically speaking, its apex is C1, and it meets the thoracic spine at C7/T1. That junction is part of what Dr Nair described as "the subaxial cervical spine." The pathology confirmed on the first MRI taken of the cervical spine on 1 February 2013 was of canal stenoses at C4/5 and C6/7, and bilateral foraminal stenoses at C5/6 and C6/7. (Of interest too was the finding of the Radiologist Dr Kapoor, that there was a mild to moderate

[65] ARD page 57

foraminal stenoses at T2/3). These vertebrae are situated in the subaxial part of the cervical spine, that is to say, beneath the vertebrae that allow the head to be turned, extended and flexed.[66]

191. The respondent has submitted with some force that the complaints recorded by the various health professionals over the years since 25 May 2000 did not refer to the neck. The exception was said to be the mention by Dr Bodel on 2 December 2003 of a complaint of pain in the left side of the neck. However, that could be discounted, it was argued, as no mention of the neck was made again until Dr Bodel's later report of 12 November 2009.

192. Dr Bodel's opinion as to injury to the neck was accordingly clouded by the fact that it was given ex post facto, some six years after his first mention, and that it lacked contemporaneous support. I could therefore dismiss Dr Bodel's later careful explanation as to causation for that reason. The same reasoning applied to the opinion of Dr Nair, who was not retained until May 2018. The more acceptable reasoning was that of Dr Davies, who disbelieved Mr Smith's assertion of left sided pain in the neck since the injury as there was no record of neck problems or abnormal examination findings for many years after the injury.

193. Those submissions must be rejected. I have set out in some detail the complaints related to the various medical practitioners throughout the first eight years following the subject injury to the shoulder, as their reports tend to confirm Mr Smith's statement. After 2008 the evidence shows that Mr Smith had a problem in his neck, and it was common ground that he then had cervical spondylosis. The issue is whether that condition had been either caused or aggravated by the 2000 injury.

194. In his statement, Mr Smith was in no doubt that he experienced symptoms in his "upper back" at the time he dislocated his shoulder, and that they continued to bother him throughout the ensuing years. However, Mr Smith gave his version of events with the benefit of hindsight, some 18 years after the event. The danger that he might have inadvertently reconstructed events is ever present and caution must be applied to such assertions, especially as Mr Smith has an interest in the success of his case, which will enable him to undergo the surgery recommended.

Chronological complaints

195. In his first statement, Mr Smith said that he felt unusual discomfort through his upper back and the lower part of his neck "immediately adjacent to and above the shoulder blade." He said he complained to Dr Louse, the respondent's medical officer, but nothing was lodged from that practice.

196. The earliest report about the accident came from Dr Bodel on 14 August 2001. Dr Bodel's opinion was not limited to the shoulder, but to injury to the left shoulder and "the upper part of his back". Dr Bodel was uncertain of the pathology at that time, and suspected a nerve injury.

197. Dr Bodel's second report of 12 September 2002 was also the next in time chronologically. As indicated, on that occasion Dr Bodel examined Mr Smith and found no sign of impairment in the neck or back. No complaint was recorded then of neck pain, although Dr Bodel noted a prominence around the medial border of the scapula in the "upper part of his back."

198. On 30 April 2003, Dr Giblin recorded complaints of symptoms radiating up to the neck. Dr Giblin thought there was a secondary injury to the base of the neck substantially causally related to the subject injury.

[66] Mosby's Medical Nursing & Allied Health Dictionary, 5th edition, 158.

199. On 14 August 2003, Dr Biggs noted complaints of pain on examination over the superomedial angle of the scapular. He thought there might be an underlying anterior labral tear and secondary problems with regard to periscapular and cervicothoracic pain. Dr Biggs's clinical assessment of cervicothoracic symptomatology was later supported when MRI imaging was eventually carried out in January 2013.

200. On 17 April 2008, Dr Biggs recorded that Mr Smith was then complaining of left-sided neck pain and spasm pain radiating to the medial border of the left scapula. He noted tightening of the left cervico-thoracic musculature.

201. On 13 June 2008, Dr Adler recorded complaints of left-sided neck pain since the subject injury.

202. The respondent quite reasonably submitted that the pathology seen in 2013 might well have been caused by the nature of the work Mr Smith continued to do and the various other jobs he held subsequent to 25 May 2000. The arduous nature, which is apparent on the various surveillance reports which have been the subject of comment by various medical practitioners, demonstrated that from time to time Mr Smith was doing such work as concreting and mixing cement. It was submitted that I would be suspicious of Mr Smith's credit because he did not mention the work he was doing for Devcon until he had been served with a surveillance material showing that concreting work.

203. Whilst the point is well made, on consideration I reject it, as the evidence to which I have just referred demonstrates a continuous series of complaints that have been sustained in one form or other since the earliest report of Dr Bodel. The evidence has also shown that Mr Smith is well motivated to engage in employment. I accept the evidence of his witnesses that there had been a decline in his fitness over the years, and that he was not required to do heavy work at all times. I also accept that Dr Bodel saw the surveillance material prior to 2016 and did not find the activities being performed by Mr Smith to be inconsistent with his presentation.

204. I regard the above reports as confirmatory of a continuing complaint by Mr Smith of symptomatology that extended beyond the left shoulder alone. It is significant that Dr Biggs as long ago as 2003 suspected that cervical or thoracic pathology might be involved.

205. Dr Biggs's comment was referred to in Mr Smith's statement, that Dr Biggs thought Mr Smith might have "problems around his neck," and is further confirmation that Mr Smith's statement may be relied upon.

206. Thus Dr Bodel's summary of injuries on 12 November 2009 that included "injury to the neck" can be seen to have some historic support. I reject Mr Saul's submission that the reference to the neck "came out of the blue." The more contemporaneous evidence supports complaints by Mr Smith of symptoms beyond the shoulder itself.

Terminology

207. The terminology for the symptoms was varied. "The upper back" was referred to often by Mr Smith. I accept his statement that he could not locate the exact origin of his pain. "Base of the neck" was used by Dr Giblin; "periscapular and cervico-thoracic pain" was the description by Dr Biggs; "left-sided neck pain" was used by Dr Adler; Dr Herald referred to "cervical region" pain and "disc problem in the neck;" Dr Ibrahim described "pain in the paracervical and trapezius area;" Dr Conrad noted "pain radiating to the left side of the neck;" Dr Assem, the AMS, described "immediate left shoulder pain discomfort radiating to the left side of his neck and periscapular region."

208. For the respondent, Dr Ditton noted “pain in the left side of his neck and over the posterior aspect of the left shoulder.” Dr Davies recorded that Mr Smith felt immediate pain radiating up into the left side of the neck when the accident occurred, and that it had continued since.

Dr Davies and Dr Nair

209. Dr Davies based his rejection of Mr Smith’s allegations on the fact that no neck problems had been reported until 2009. This was incorrect, and his opinion is accordingly fatally compromised. The above references establish that there were many complaints recorded of neck or upper back pain between 2000 and 2009. The constant theme of the complaints were that they were in the upper back, or base of the neck.

210. Dr Davies also noted the investigations of 2014 and further imaging taken on 27 March 2015. He found that the imaging showed “multilevel” cervical spondylosis, and that suggested an underlying genetic cause. Dr Davies conceded that some of Mr Smith’s work activities since the subject injury might have contributed to it.

211. Dr Nair disagreed with the proposition that the degenerative condition of C4/5 and C5/6 was a “de novo process”, by which I take it Dr Nair meant a genetic condition. He said the catalyst for the development of the disc injuries was the injury of 25 May 2000. He opined it was possible that the “degenerative cascade” heralded by the mild and non-intrusive subaxial cervical and trapezial pain ultimately progressed to a true radicular component.

212. Dr Nair thought that Mr Smith did not otherwise manifest any systemic tendency to the development of degenerative changes in the cervical spine. There was no involvement of degenerative arthritis in the small joints of the hand, nor in the hips and knees.

213. For the reasons given above, I agree that a scrutiny of the medical records does suggest pain in the subaxial cervical spine originating back to the original injury, as found by Dr Nair. I accept that the injury to the left shoulder on 25 May 2000 also involved the subaxial cervical spine.

214. It follows that I also accept the opinion of Dr Bodel, who was, it must be remembered, retained by the respondent. He thought that the subluxation of the left shoulder in dealing with the counterweight also caused a traction injury to the cervical spine. He found a causal connection, as he had seen Mr Smith over many years, and maintained that view against a number of leading questions put to him by the respondent in correspondence. I am not totally convinced by his reasoning, which was somewhat circumlocutory, but taken against the backdrop of the actual complaints recorded by Mr Smith, and the history given in Mr Smith’s statement of 4 October 2018 (which I accept, for the above reasons), his opinion is within a fair climate.

215. I do not accept that Mr Smith’s cervical condition is consequential. There was no evidence that his posture was affected by his left shoulder injury to the extent that it involved his cervical spine.

SUMMARY

216. Accordingly, I find that the proposed surgery recommended by Dr Donnellan on 14 January 2016, is reasonably necessary, as I am satisfied there is a causal connection between the injury to the left shoulder and the cervical spine

217. The respondent will pay the costs of and associated with the surgery recommended by Dr Donnellan on 14 January 2016.