WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **5643/19**
Applicant: **Matthew Coleman**
Respondent: **Qantas Airways Limited**
Date of Determination: **30 January 2020**
Citation: **[2020] NSWWCC 27**

The Commission determines:

1. The applicant sustained an injury to his left ulnar nerve in the course of his employment with the respondent on 20 May 2016.

2. The applicant has required treatment for the injury to the left ulnar nerve, including a left cubital tunnel release and ulnar nerve transposition, which was performed on 10 March 2017.

The Commission orders:

3. This matter is remitted to the Registrar for referral to an Approved Medical Specialist as follows:

Date of injury:	20 May 2016
Body part:	Right upper extremity (shoulder, ulnar nerve); left upper extremity (ulnar nerve)
Method of Assessment:	Whole Person Impairment

4. The following documents are to be referred to the Approved Medical Specialist:

   (a) Application to Resolve a Dispute with attachments, and
   (b) Reply with attachments.

5. The respondent is to pay the applicant's reasonable medical expenses for treatment of the injury to the left ulnar nerve, subject to the provisions of section 59A of the *Workers Compensation Act 1987*.

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

John Isaksen
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 ISAKSEN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Matthew Coleman, claims that he sustained an injury to his right shoulder, right arm and left arm on 20 May 2016 whilst employed as a long haul flight attendant with the respondent, Qantas Airways Limited.

2. The applicant claims that he was retrieving his own wheelie bag from an overhead storage locker after the flight he was working on had reached Santiago and all the passengers disembarked. As he was doing this the bag slid out of the locker and the weight of the bag came onto his right arm, causing him to feel pain in his right shoulder and down the right arm, and also numbness and tingling in his left hand.

3. The respondent has accepted liability for injury to the right shoulder and right arm but denies that the applicant sustained any injury to the left arm.

4. The applicant has made a claim pursuant to section 66 of the *Workers Compensation Act 1987* (the 1987 Act) for 17% permanent impairment resulting from the injury sustained on 20 May 2016, which includes 10% whole person impairment for the injury the applicant claims to have sustained to the left arm.

5. The applicant concedes that without the assessment of permanent impairment for the injury to the left upper extremity he would not meet the threshold required for a lump sum payment for permanent impairment.

6. The applicant also seeks an order that the respondent meet the cost of his reasonable medical expenses for treatment of his left arm.

ISSUES FOR DETERMINATION

7. The parties agree that the following issue remains in dispute:

    (a) Whether the applicant sustained an injury to his left upper extremity in the course of his employment with the respondent on 20 May 2016 (section 4 of the 1987 Act)

PROCEDURE BEFORE THE COMMISSION

8. The parties attended a conference and hearing on 23 January 2020. 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.

9. Mr Luke Morgan appeared for the applicant, instructed by Mr Hyland. Mr Josh Beran appeared for the respondent.

10. The applicant discontinued a claim made in the Application to Resolve a Dispute (ARD) for an injury to the cervical spine.

11. Mr Morgan objected to the respondent relying upon two independent medical reports, namely Dr Harrington dated 9 March 2017 and Dr Powell dated 27 August 2019. I allowed both reports into evidence pursuant to Regulation 44 (4)(c) of the *Workers Compensation Regulation 2016* on the basis that the two reports were obtained for different claims. The report from Dr Harrington was in response to the claim for injury to the left upper extremity

made by the applicant, including the need for surgery, and also to provide an opinion on proposed surgery to the right shoulder. The report from Dr Powell was in response to the claim made pursuant to section 66 of the 1987 Act.

EVIDENCE

Documentary evidence

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

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

Oral evidence

13. There was no application to cross-examine the applicant or adduce oral evidence.

FINDINGS AND REASONS

The applicant's case

The applicant's evidence

14. The applicant has provided a statement dated 25 October 2019.

15. In that statement the applicant describes the incident on 20 May 2016 as follows:

> "Prior to suffering injury, I had operated on a 15 hour Qantas flight from Sydney to Santiago, Chile. The aircraft I worked on was a 747. On the flight I was rostered to work as a business class galley operator. By the end of the flight I was exhausted.
>
> At the conclusion of the flight, after passengers had disembarked, I went to retrieve my crew carry on wheelie bag from an overhead storage locker. The weight of the bag was approximately 15 kg.
>
> In sliding my bag out of the overhead locker, I used my dominant right-hand. As I slid my bag out of locker, it slipped on the edge of the locker and fell. The weight of the falling bag caught me by surprise.
>
> When the weight of the bag came onto my right hand/arm, I felt a 'popping' sensation in my right shoulder. I immediately suffered an 'electric shock 'type of pain in the base of my neck on the right side and in my right shoulder. This pain radiated down into my right elbow. I also suffered an uncomfortable numbness sensation in both of my hands and a tingling sensation in the tips of my right and left hand fingers."

16. The applicant states that he reported the incident to the operating Customer Service Manager (CSM) on board the aircraft and placed the CSM on notice that he was suffering from pain in his right shoulder and right elbow and numbness in each hand and tingling in the fingers of each hand.

17. There is in evidence a copy of an Incident Report form which states: "When Matthew retrieved his bag from overhead locker he felt a sharp pain in his right shoulder resulting in some numbness in the outside of his right hand." The form also states that the nature of the injury was a strain or sprain to the hand from "Lifting/Carrying".

18. The applicant states: “For reasons I am not aware of, on the Incident Report the CSM completed and submitted to Qantas, the CSM did not note that I was also suffering from left hand numbness and tingling in the tips of my left hand fingers.”

19. There is also a claim form in evidence, which was completed by the applicant on 29 May 2016, and which identifies the injury as: “numb right hand and sore right shoulder”. The description of the incident in the form reads: “I was getting my bag from overhead locker on plane and had sharp pain in shoulder and electric pain down to hand.”

20. The applicant also completed a form headed “Statement of Events” dated 30 May2016, wherein he answers to the question of the exact nature of the injury: “sharp pain in right shoulder, numb right hand”. The applicant also writes that after the incident he went to the hotel he was staying at in Santiago and iced his shoulder and hand four hours.

21. The applicant states that it was several days before he was able to return to Sydney as there was no reserve cabin crew in Santiago. After he returned to Sydney, the applicant consulted an old family doctor, Dr Hirschowitz, in Bondi. The applicant was referred for an MRI scan of the cervical spine and nerve conduction studies of both arms.

22. The applicant resides near Tuncurry/Forster and transferred his care to Dr Norus at the Pacific Palms Medical Centre, and later Dr Malferrari at the Forster Tuncurry Medical Centre. The applicant states that he did inform Dr Norus that he was suffering left hand numbness and tingling, in addition to symptoms in the right shoulder and right arm, but that Dr Norus advised him to prioritise treatment for his most significant issues, being treatment for his right shoulder and right elbow.

23. The applicant was referred by Dr Norus to a sports physician, Dr Best. Dr Best in turn referred treatment for the applicant’s right elbow to Dr Nicklin.

24. The applicant underwent surgery to his right elbow, performed by Dr Nicklin, on 15 September 2016. The respondent met the cost of that surgery.

25. The applicant states that shortly before Christmas 2016 he awoke to find his left hand had ‘clawed’ and it was very difficult to lift his hand. He states that he returned to see Dr Nicklin, who recommended surgery on the left elbow. The respondent would not meet the cost of that surgery, so the applicant underwent that surgery at the Sydney Eye Hospital on 10 March 2017.

26. The applicant also underwent surgery to his right shoulder on 5 April 2017. That surgery was performed by Dr Sher and the costs were met by the respondent.

27. The applicant states that he continues to suffer pain in his right shoulder and down to the right elbow, and also experiences numbness and tingling in the fingers of both hands.

The applicant’s medical evidence

28. There are clinical notes from Dr Hirschowitz in evidence. The first entry on 2 June 2016 reads, as best as I can discern: “W/C? Cervical spine inj - bilateral neural change in hand.” There is a Certificate of Capacity from Dr Hirschowitz dated 31 May 2016 which provides a diagnosis of injury as bilateral carpal tunnel and an injury to the right shoulder.

29. The applicant was referred by Dr Hirschowitz for nerve conduction studies. The subsequent report from Dr Simon, dated 6 June 2016, identifies bilateral carpal tunnel syndrome of moderate severity on the right and mild on the left, and bilateral moderate to severe ulnar neuropathy at the elbow, worse on the right.

30. Following those nerve conduction studies, Dr Hirschowitz issued a further Certificate of Capacity dated 7 June 2016 which stated the diagnosis of injury to be C6 nerve root injury and upper median and ulnar nerve injury.

31. A further Certificate of Capacity was issued by Dr Hirschowitz dated 21 June 2016 which changed the diagnosis of injury again, this time being impingement lesion of the right shoulder, this being after the applicant attended Dr Best on or about 14 June 2016.

32. The reporting letter from Dr Best dated 14 June 2016 states that the applicant was referred for "right shoulder and upper limb problems." Dr Best writes:

> "He suffered an acute injury on 20th May 2016. He was performing an overhead movement when he felt acute pain, this radiated into the upper arm and then to the hand. His symptoms have worsened and he is unable to lie on his left side, there is also bilateral tingling and numbness in both hands."

33. Dr Best also writes there were findings of bilateral carpal tunnel syndrome and right greater than left ulnar neuritis.

34. Dr Best provides a separate letter to the respondent on the same day. He writes that the diagnosis is right shoulder impingement related to calcific tendonitis, bilateral carpal tunnel syndrome and right ulnar neuritis. He also writes that the applicant was completely asymptomatic prior to the incident and that the overhead lifting incident would have triggered his shoulder problem.

35. The history recorded by Dr Nicklin in his first report dated 26 July 2016 is the applicant sustaining an injury to the right shoulder when lifting a 12-15kg bag out of an overhead locker. Dr Nicklin records the applicant having a tearing like pain in his right shoulder with pain going down the right arm. He writes that the applicant has attended upon him for problems with sensation and power in the right hand. He notes that the nerve conduction studies show median and ulnar neuropathy in both arms.

36. Dr Nicklin provides several further reports in regard to treatment of the right ulnar nerve and then provides a report dated 7 February 2017 which commences:

> "I reviewed Matthew today over 4 months following release and transposition of the right cubittal tunnel. He now presents with worsening of the left sided ulnar nerve signs. These were first documented in the nerve conduction studies undertaken on 6 June 2016, but his symptoms were more marked on the right side, so surgery was performed on that side. Matthew reports ongoing altered sensation in the ulnar nerve distribution and loss of power in the hand."

Dr Nicklin then recommends a left cubital tunnel release and transposition.

37. Dr Nicklin also provides a letter to the respondent on that same day wherein he writes that the applicant's left sided ulnar nerve pathology was documented in June 2016, which was prior to his first consultation with the applicant, and Dr Nicklin considers that pathology part of the applicant's initial presentation. He writes: "…symptoms in the left arm were noted at the same time as the right sided symptoms and came on after the initial injury at work."
Dr Nicklin concedes that the symptoms in the left arm may have occurred regardless of the work injury but that "the onset of symptoms around the time of the workplace injury suggests that this was the initiating cause and thus significant factor." Dr Nicklin also writes that there was no history of direct injury to the left arm.

38. Dr Sher, whom the applicant attended for a second opinion for treatment of his right shoulder, takes a history in his first report dated 2 February 2017 of the incident on 20 May 2016 as: “taking his bag out of an overhead locker when it slipped and pulled his arm downwards.”

39. The applicant attended Dr McGlynn, hand surgeon, at the request of his solicitors for an assessment of impairment from the ulnar nerve injuries and has provided a report dated 6 March 2019.

40. The history of the injury taken by Dr McGlynn is that the applicant had lifted a bag out of an overhead locker and it slipped and he took most of the weight with the right hand. Dr McGlynn records that the applicant felt a funny feeling in his right shoulder and electric shock shooting pains radiating from both the elbows to the hands, with the right arm being worse than the left.

41. On the question of the cause of the injury to the arms, Dr McGlynn writes:

> “The onset of neuropathic pain on the day of injury and subsequent identification of slowing of both ulnar nerves makes it more likely than not he sustained an injury to both ulnar nerves in the workplace incident. Initially the symptoms were worse on the right; however, both progressed rapidly with development of motor loss.”

42. Dr McGlynn identifies compression, traction and friction as being implicated in the cause of cubital tunnel syndrome and opines that traction is the most likely cause in this instance. He writes that the falling bag created a traction force of both upper limbs, the right worse than the left. This in turn caused acute inflammation of the nerve with swelling, which then caused further compression of the nerve in the cubital tunnel.

43. The applicant also attended Dr Bodel, orthopaedic surgeon, at the request of his solicitors for an assessment of impairment of the right shoulder injury and has provided a report dated 31 March 2019.

44. Dr Bodel takes a history of the applicant bringing down a wheelie bag weighing about 15 kilograms from an overhead locker with his right arm, the bag then slipping and, with his right hand still engaged in the handle of the bag, feeling a sudden popping sensation in the region of the right shoulder when the weight of the bag applied a traction force to the neck and right arm. Dr Bodel also records the applicant feeling an electric shock running down the right arm and numbness and tingling in the fingers of both hands.

45. Dr Bodel opines that the applicant suffered a traction injury to the right upper limb with some involvement of the left arm, although the main force was applied to the right arm. He opines that the applicant suffered a traction injury to the right shoulder and that the applicant’s bilateral neuritis is a consequence of the same traction injury.

The respondent’s case

46. Dr Harrington, orthopaedic surgeon, has provided a report at the request of the respondent dated 9 March 2017. The history of the injury taken by Dr Harrington is that the applicant was retrieving his bag from an overhead compartment when it dropped suddenly and he wrenched his right shoulder and developed pins and needles in his right hand.

47. Dr Harrington writes that the nerve conduction studies show conductivity on the left as well as the right, but the applicant was not symptomatic in the left arm at the time of the studies. He writes that it was only around Christmas 2016 that the applicant had sudden ulnar nerve symptoms in his left arm, which resulted in clawing of his fingers and permanent numbness in those ulnar supplied fingers.

48. Dr Harrington diagnoses the applicant as having left ulnar neuritis but does not believe that it is related to the incident in May 2016. He opines that it is uncommon to develop clawing almost overnight.

49. Dr Powell, orthopaedic surgeon, has provided a report at the request of the respondent dated 27 August 2019. Dr Powell takes a history of the applicant sustaining a traction injury to the right upper limb when his bag fell from an overhead locker and he attempted to regain control of the bag. He records that the applicant had the immediate onset of pain in the right shoulder with radiation down the right arm with pins and needles involving the ulnar digits of the right hand.

50. Dr Powell writes that it would appear that the applicant's left elbow symptoms developed approximately six months after the workplace incident.

51. Dr Powell opines:

> "The available evidence indicates that the left elbow symptoms developed some time after the workplace incident involving the right upper limb. Noting the mechanism of injury and contemporaneous evidence I do not believe that the injury to the left upper extremity is a result of his employment and the workplace incident on 20/5/16."

Submissions by the parties to the dispute

52. Mr Beran for the respondent submits although there is some record of symptoms in the left hand soon after the incident on 20 May 2016, a review of all the evidence does not support a finding that the applicant sustained an injury to the left arm in that incident. Mr Beran submits that the existence of some symptoms does not prove an injury was sustained.

53. Mr Beran refers to there being no reference to the left hand or arm in any of the contemporaneous reports of injury. The Incident Report refers to the applicant having a sharp pain in the right shoulder and numbness on the outside of the right hand; the claim form completed by the applicant refers to a numb right hand and sore right shoulder; the "Statement of Events" completed by the applicant refers to sharp pain in the right shoulder and a numb right hand. Mr Beran points out that even the applicant's description of the incident which is set out in paragraph 15 above does not include any involvement of the left arm when trying to deal with the bag that began to fall from the overhead locker.

54. Mr Beran points out that none of the treating specialists when they initially see the applicant take a history of any direct injury to the left arm, and nor do any of the independent medical experts qualified by either party.

55. Mr Beran also refers to a report from Janet Robertson, physiotherapist, dated 11 July 2016 which states that the applicant presented on 30 June 2016 (some six weeks after the incident) with right shoulder arm pain, forearm and hand paraesthesia and weakness but no mention of left arm symptoms.

56. Mr Beran also refers to an entry in the clinical notes from Forster Tuncurry Medical Centre which does not bear a date but refers to the onset of symptoms in the left upper limb and includes: "Presents today with left ulnar nerve distribution numbness" and "denies trauma this time."

57. Mr Morgan submits that it defies belief that the applicant would not have also used his left arm when the bag began to fall from the overhead locker, even though most of the weight was being taken by the right arm, and that the left arm would have been injured in addition to the right shoulder and arm.

58. Mr Morgan submits that the applicant has been forthright and honest with the various doctors he has attended, there is no suggestion of him having any prior problems with his left arm, and his evidence of sustaining an injury to the left arm in the incident on 20 May 2016 should be accepted.

59. Mr Morgan submits that it is not unusual for an injured person to concentrate initial treatment on those injured parts of the body that are the most serious. The applicant sought treatment for his left arm after the more pressing problems with his right arm had been attended to.

Determination

60. In *Field v Department of Education and Communities* [2014] NSWWCCPD 16 (*Field*) DP Snell said at [38]:

> "It is for the tribunal of fact to assess the reliability of the evidence against the 'contemporary materials, objectively established facts and the apparent logic of events' (*Fox v Percy* [2003] HCA 22; 214 CLR 118 at [31])."

61. The contemporary materials in this dispute include a claim form and "Statement of Events" form, both completed by the applicant some 10 days after the incident, which declare injury to the right upper limb but no mention of the left upper limb. The applicant states that he did inform the CSM that he had suffered numbness and tingling in the left hand and does not know why that was not included in the Incident Report form. However, the applicant provides no explanation as to why he did not refer to the left hand in the claim form and "Statement of Events" form, both of which were completed by himself.

62. Yet the applicant presented with symptoms in his left hand when he first attended a doctor for treatment. The handwritten notes from Dr Hirschowitz for the applicant's attendance on 2 June 2016 are brief and are in the doctor's own shorthand but I consider it reasonable to conclude that Dr Hirschowitz was recording the applicant as having symptoms in both hands. That is confirmed by the Certificate of Capacity issued by Dr Hirschowitz, although dated the day before on 31 May 2016, which includes bilateral carpal tunnel syndrome in the diagnosis of injury, being an injury that involves symptoms in both hands.

63. The referral by Dr Hirschowitz for nerve conduction studies is not in evidence, and the subsequent report from Dr Simon dated 6 June 2016 does not include a summary of the reasons for referral, but I consider it reasonable to infer from the evidence that the request for bilateral nerve conduction studies was due to the applicant presenting with symptoms in both hands.

64. Although Dr Hirschowitz changes the diagnosis of injury in the next Certificate of Capacity that he issues on 7 June 2016, and which is after the applicant undergoes the nerve conduction studies, to upper limb median and ulnar nerve injury, that is a diagnosis which is still consistent with the applicant presenting with symptoms in his hands.

65. There were conflicting views expressed by counsel for each party on the interpretation to be given to the two reports of Dr Best dated 14 June 2016. The report to Dr Hirschowitz included a recording of bilateral tingling and numbness in both hands, whereas the report to the respondent provided a diagnosis of bilateral carpal tunnel syndrome but only right ulnar neuritis. In my view, the recording of symptoms in the left hand in the report back to Dr Hirschowitz was consistent with what had already been recorded by that general practitioner. There had therefore been a consistent record of symptoms in the applicant's left hand for almost a month following the incident on 20 May 2016.

66. As regards the apparent logic of events, I consider it reasonable and understandable that although the applicant was pulling his bag out from the overhead locker, once it began to fall he also used his left arm to try and stop the bag from continuing to fall. Although the applicant's right arm took most of the weight because that was the arm that he was using to pull the bag from the locker, there would have been at least some strain upon his left arm. That is consistent with the subsequent findings of the nerve conduction studies and the applicant's presentation to doctors for treatment, where the main damage was identified and complained of in the right arm and hand but there were also some symptoms in the left hand.

67. The applicant's case does not need to be perfect, but it must be sufficient for a tribunal of fact to be satisfied on the balance of probabilities of the existence of a fact, that it must feel an actual persuasion of the existence of that fact (*Nguyen v Cosmopolitan Homes (NSW) Pty Ltd* [2008] NSWCA 246 (*Nguyen*)). McDougall J in *Nguyen* at [55] said: "A rational choice between competing hypotheses, informed by a sense of actual persuasion in favour of the choice made, will provide a finding, on the balance of probabilities, as to the existence of a fact in issue."

68. It is not necessary for the applicant to provide a word-perfect description of how he recalled the incident on 20 May 2016, or how that has been recorded by doctors he has seen, in order for the applicant to succeed. The applicant had no prior symptoms in his left hand or arm prior to this incident. He states that the weight of the falling bag took him surprise. I accept that the applicant has done his best to recount the incident which occurred quite suddenly and caused him immediate symptoms in both upper limbs. I accept from the details the applicant included in his claim form and "Statement of Events" form and his subsequent course of treatment that his main concern was the condition of his right arm, which involved both the shoulder and problems with sensation and power in the right hand. Consequently, I have an actual sense of persuasion from the applicant's description of what occurred at the time of the incident on 20 May 2016 and the recording of his complaints to doctors soon thereafter that the applicant did sustain an injury to his left upper limb on 20 May 2016.

69. That finding is supported by Dr Nicklin, the specialist who specifically treated the applicant for the injury to his ulnar nerves. In my view, Dr Nicklin is in the best position to provide an opinion on causation given his role in diagnosing the applicant's condition and charting a course of appropriate treatment.

70. In his first report dated 26 July 2016, Dr Nicklin does not record the applicant sustaining an injury to his left arm or the left arm being involved in the incident which caused symptoms in the right shoulder and right hand. He does note bilateral median and ulnar neuropathy in both limbs from the nerve conduction studies. In his report dated 7 February 2019 to the respondent, Dr Nicklin considers the left ulnar nerve pathology was part of the applicant's initial presentation, that the symptoms may have occurred regardless of the injury, but that the onset of symptoms around the time of the work place injury suggests that this was the initiating cause and thus significant factor.

71. In my view, Dr Nicklin has given proper consideration to the likely cause of the injury that the applicant has sustained to his left ulnar nerve, has considered alternative explanations for the cause of the applicant's symptoms, and has come to the conclusion that the likely cause of the injury to the left ulnar nerve was the incident on 20 May 2016. While Dr Nicklin uses the word "suggests" rather than words such as likely or probable, I consider that when this report to the respondent is read in its entirety that Dr Nicklin is identifying the incident on 20 May 2016 as being the most likely cause of the injury to the applicant's left ulnar nerve.

72. It is noted that Dr Nicklin also writes of the applicant having no history of direct injury to the left arm but Dr Nicklin still opines that what has been described to him by the applicant suggests the incident on 20 May 2016 was the initiating cause of the injury.

73. Dr Nicklin records the worsening of left sided ulnar nerve signs some nine months after he initially saw the applicant and the ring and little fingers being "clawed" but that does not alter his opinion that the initiating cause and significant factor for the injury was the incident on 20 May 2016.
74. I prefer the opinion of the treating specialist to the opinions of the doctors relied upon by the respondent. I consider the opinion of Dr Harrington is compromised and cannot be relied upon because that opinion is based upon his understanding that the applicant did not have any symptoms in the left arm when he underwent the nerve conduction studies on 6 June 2016, whereas there is evidence from the records of both Dr Hirschowitz and Dr Best that the applicant was experiencing such symptoms around that time.

75. The opinion of Dr Powell is also compromised as that opinion is based on Dr Powell's understanding that the applicant's left elbow symptoms developed approximately six months after the workplace incident.

76. I agree with a submission made by Mr Morgan that the applicant initially concentrated on those injured parts of his body that caused him the most concern and this is a reason why there is less reference to the left arm in the first few months following the injury. The applicant needed prompt treatment to two separate injured parts of his body immediately following the incident. There was the injury to the right ulnar nerve, which led to surgery just two months after the incident, and the injury to the right shoulder, which was initially treated with physiotherapy and injections but ultimately involved an arthroscopy on 5 April 2017.

77. I consider that the serious injuries that the applicant had sustained to the right ulnar nerve and right shoulder, and the treatment required to those parts of his body, goes some way to explain there being little or no reference to the left arm in the initial reports of Dr Best, Dr Nicklin and the applicant's physiotherapist, Ms Robertson.

78. In *Trustees of the Society of St Vincent de Paul (NSW) v Maxwell James Kear as administrator of the estate of Anthony John Kear* [2014] NSWWCCPD 47 (*Kear*), DP Roche said at [38]:

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

79. Mr Beran argues that although the applicant may have reported some symptoms in the left hand soon after the incident on 20 May 2016, there was no sudden identifiable pathological change to the applicant's left ulnar nerve caused by that incident. However, I am satisfied from my review of the evidence and the apparent logic of the events which pertains to the incident, that the applicant did sustain sudden pathological change to his left ulnar nerve, even though the applicant's symptoms were not initially as severe in the left arm compared to his right arm.

80. The applicant had no prior symptoms in the left upper extremity prior to the incident; he describes an incident that was certainly capable of causing injury to the left arm; and he reported symptoms in his left hand to his general practitioner and first treating specialist on his initial consultation with each doctor. The applicant's claim of injury to the left upper extremity is supported by his treating specialist for that condition, Dr Nicklin, after that doctor gives due consideration to the history of the applicant's complaints and to the causes of symptoms complained of by the applicant.

81. There will therefore be a finding that the applicant sustained an injury to his left ulnar nerve in the course of his employment with the respondent on 20 May 2016. The matter will be remitted to the Registrar for referral to an Approved Medical Specialist for assessment of whole person impairment of the right upper extremity (shoulder and ulnar nerve) and left upper extremity (ulnar nerve).

82. Given the finding of injury to the left ulnar nerve, it is also appropriate that there be an order that the respondent pay the applicant's reasonable medical expenses for treatment of the left ulnar nerve. That should include the cost of surgery to the left ulnar nerve which the applicant underwent on 10 March 2017.