WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **3126/19**
Applicant: **Michael Duck**
Respondent: **EB & DE Bunt Pty Ltd**
Date of Determination: **21 August 2019**
Citation: **[2019] NSWWCC 279**

The Commission determines:

1. There is an Award for the respondent with respect to the Applicant's claim for injury to the right and left wrists in the form of bilateral carpal tunnel syndrome.

2. There is an Award for the respondent with respect to the claim for proposed bilateral carpal tunnel release.

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

Gerard Egan
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 GERARD EGAN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Jackson

Ann Jackson
A/Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Michael Duck (the applicant) claims a finding or Order that proposed bilateral carpal tunnel surgery is reasonably necessary as a result of injuries sustained in "August 2017" when he fell during the course of his employment with EB & DE Bunt Pty Ltd (the respondent).

2. There is no dispute that the applicant suffered an injury on that day. However, the respondent says that such injury(ies) did not include the left or right wrists, or in the context of this dispute, the median nerve or carpal tunnels.

3. That is, while the surgery may be reasonably necessary, it is not "as a result of" the injury.

4. At teleconference on 24 July 2019, the applicant was represented by his solicitor Ms Alix Ryan, and the respondent by Ms Laura Risti. Upon direct questioning, Ms Ryan confirmed that the applicant relied upon direct frank injuries to both wrists, not a secondary condition for either limb. In this regard, the applicant says that the surgery is a direct result of the fall.

ISSUES FOR DETERMINATION

5. The issues to determine are:

    (a) Whether the Applicant suffered injury to the left or right wrist in the fall in August 2017.

    (b) I whether the proposed bilateral carpal tunnel surgery is reasonably necessary as a result of injuries sustained on the fall in "August 2017".

6. Because of the reliance only on frank injuries to both wrists, it will be necessary to deal with the left and right side separately.

PROCEDURE BEFORE THE COMMISSION

7. The parties attended arbitration in Coffs Harbour on 16 August 2019. 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.

8. Mr Hanrahan of counsel appeared for the applicant who was also present. Mr Combe appeared for the respondent.

EVIDENCE

Documentary evidence

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

    (a) Application to Resolve a Dispute (the Application) and attached documents;
    (b) Applications to a Admit Late Documents dated 7 July 2019 and 7 August 2019;
    (c) Reply; and
    (d) Application to a Admit Late Documents dated 9 August 2019.

10. Upon being made aware of the declared reliance upon a direct injury to the wrist, Mr Hanrahan, confirmed that the applicant proceeded only on that basis, not a secondary condition for either limb.

Oral evidence

11. Mr Hanrahan applied to lead oral evidence regarding the nature of the accident. Mr Combe did not object. Accordingly, there is oral evidence and the applicant was cross examined. The evidence was recorded.

FURTHER BACKGROUND AND THE EVIDENCE

Applicant's statement dated 11 June 2019

12. In a statement dated 11 June 2019, (almost two years post accident) the applicant describes the incident as follows:

> "Whilst shoving to push the ramp into the truck I lost my footing and fell forward directly onto my right elbow and hands. I recall that I had pain in the right elbow and was bleeding on my hands following the fall."

13. Regarding the aftermath, he says"

> "I initially thought I had only bruised my right elbow but it got worse and worse with time as I continued to try and work. Over the next few months my symptoms became worse and I then started to develop paraesthesia affecting both hands and more so the right. I worked up until about September 2017 until I was unable to continue due to my injuries. I have not returned to work since then".
>
> …
>
> "Not only did I sustain an injury to my right elbow as a result of the accident, I also sustained an injury to my left and right wrists. Initially my primary focus was on the injury to my right elbow because that was causing most of my symptoms. in particular, pain at the time."

14. He describes seeing a general practitioner at Palm Tree Medical Practice, Darrin Marshall, Orthopaedic Surgeon, and having Physiotherapy at Coffs Physio and Back Care.

15. He denies any previous injuries or symptoms in the affected areas of his elbows and wrists.

16. There is no written report of injury or claim in evidence.

Oral evidence

17. The applicant provided more particular evidence of the activity he was undertaking when he fell forward onto his upper limbs. In evidence In Chief he described picking up the 68kg ramp and placing one end on the end of the truck tray. He said he was holding either side of the ramp with both hands. As his feet slipped backwards, he fell forwards continuing to hold onto the ramp. He said both hands hit the ground and his right elbow in particular struck the gravel, resulting in a piece of gravel being lodged in the elbow joint. He confirmed that his right hand was bleeding, but also said both hands were injured.

18. The applicant was cross-examined about some details of the injury, in particular the fact that the description in his statement does not refer to such detail, even though it was prepared for these proceedings with the assistance of his Solicitor. (He initially claimed to have written the Statement himself but then clarified that it was "the initial statement" that he provided to his Solicitor.)

19. Similarly, Mr Combe put to the applicant that he had never described the injury in the terms he now presents to any of his doctors, pointing to the absence of such records in contemporaneous notes. The applicant said he told the doctors everything but does not know whether or why they did or did not record it.

Other statements (both dated 16 August 2019)

20. Mr Lincoln Bunt says the applicant told him of the fall on the afternoon of the incident. He slipped and hurt his elbow but did not specifically say if he fell on his elbow, hands or both. He only "commented he had hurt his elbow, not fallen on it". It happened on a site of a client, John O'Neill. Mr Bunt does not thereafter recall him favoring his elbow. He says:

> "At no point did he say he had hurt his hands, he did not show me any injury to his hands. I did not visually see any injury to his hands."

21. The applicant continued accepting allocated work over the next days without complaint about an injury, and over the following weeks he went about his own job as normal. Mr Bunt says there was no visual indication of an injury to his elbow or his hands.

22. Mr Bunt describes the applicant presenting to work one Monday morning late for the job he was supposed to be on that day. After questioning the applicant, Mr Bunt said:

> "He told me he had been using the Cherry picker on that Weekend to scrub mould off the walls of his house. I am also aware he was renovating his house during this time."

23. Ms Dawn Bunt is another owner of the respondent's business. She says she didn't know of the applicant's injury until she was handed a "normal" doctor's certificate about seven or eight weeks after the alleged injury. She says the applicant had never spoken to her about being in pain and had never requested any time off due to a work related incident.

24. Ms Bunt was also aware that during this time, both before and after the incident he had been working on renovating his own house. The applicant was put off work in January 2018 due to business downturn.

Palm Tree Medical Centre clinical notes

25. Notes dating back to 2011 are produced. These show infrequent attendances upon the general practice. The main general practitioner is Dr Ruthnam. All entries up until September 2017 are for unrelated conditions.

26. On 21 September 2017, Dr Ruthnam records "FELL AND INJURED RIGHT ELBOW 2 MTHS AGO".

27. On 3 October 2017:

> "Examination: NECK FROM SHOULDER FROM NO NEURODEFICIT
> RIGHT ELBOW- ROM GOOD BUT TENDER AND RESTRICTED.. ?
> MUSCULAR AVULSION. REFR INJECTION"

28. On 17 October 2017, the clinical note records that the injection helped improve the right elbow pain. On 23 October 2017, the right elbow was still sore, the applicant was referred to "Faye Wiffen" (a physiotherapist), and was put off work for three weeks

29. On 23 October 2017, Dr Ruthnam question whether or not radial nerve involvement existed, and loaded the Applicant had seen a chiropractor (no evidence from a chiropractor is before me). He was referred to Dr Darrin Marshall, orthopaedic surgeon. The note also records a reference to "PAIN Mx – Dr Jin or Dr Clarke". I interpret this note to be a consideration for pain management, however there are no notes all reports from either Dr Jin or Dr Clarke before me.

30. On 19 December 2017, Dr Ruthnam records that Dr Martin had arranged for a further injection into the right elbow on 12 December 2017 with the note "feeling better".

31. On 23 January 2018, a clinical note records "DOING WELL OVER XMAS-ARM FLARED UP WITH LAWN". The following entries do not throw any light on the principal issue, however in April 2018, the applicant is referred to Dr Shaun Clark, presumably the same practitioner referred to in the context of pain management I'm 23 October 2017.

32. The clinical notes contain references to occupational therapy, and the development of psychological issues.

Dr Darrin Marshall, treating orthopaedic surgeon

33. The applicant first saw Dr Marshall in November 2017. There are six reports from Dr Marshall in evidence. On 29 November 2017, Dr Marshall notes to clinical presence of epicondylitis symptom. he records the applicant is falling down, hitting his right elbow joint posterolaterally. Dr Marshall described the pain as initially "up the arm and then down towards the hand area", but said an injection into the right elbow helped a lot.

34. The applicant was then very tender over the right epicondyle and proximal extensor or muscle mass. Resisted finger and wrist extension was extremely uncomfortable over the right epicondyle. An ultrasound had shown some pathological features of epicondylitis. He suggested the condition could be self-limiting. And by 18 April 2018, was surprised because there was no improvement. On that examination, Dr Marshall records:

> "He has mentioned a little bit of numbness, possibly down in the hand area, but he is not very clear and specific where that is and how often."

35. Dr Marshall said:

> "I have discussed with Michael that in the first instance I think we should repeat the MRI scan of his elbow first and just see whether anything has changed from his previous one. We will then need to think about a nerve conduction test, as it is possible that he may have radial tunnel syndrome which could be causing some of this pain and hence why he hasn't had a good response to cortisone or other treatment modalities.
>
> I will see Michael back with those results and then will work out if he needs a scan of his neck done. However, just going based on the history he doesn't get significant pain and the pain doesn't seem to be running from the neck down to the hand, but we can certainty do that if required down the track."

36. Nerve conduction studies were performed by Dr Loiselle, neurologist, on 16 May 2018 and concluded that there was moderate median neuropathy, causing moderate bilateral carpal tunnel syndrome. This seems to be the first reference from any clinician of median nerve involvement. The distinction being that the radial nerve tunnel (as suspected by Dr Marshall and diagnosed by Mr Robinson) is obviously different to the median nerve tunnel (wrists).

37. On 5 June 2018, Dr Marshall requested approval to fund a bilateral carpal tunnel release.

38. On review by Dr Marshall on 4 September 2018, he noted that the insurer had not approved bilateral carpal tunnel release. Dr Marshall said:

> "I am quite surprised to see this because Michael certainly did mention his hand numbness he was getting at the very first presentation and I was alarmed enough to suspect carpal tunnel in which we ordered a carpal tunnel test.
>
> The majority of his symptoms and pain were certainly at the elbow region that the lateral epicondylitis is and hence I think everyone has been more focused on that but his mechanism of injury and his initial symptoms he has now told me he had from the very first day is certainly consistent with carpal tunnel syndrome. His nerve conduction supports that as well. He denies any symptoms prior to the injury and he denies symptoms in his left hand prior to the injury. One could assume that all the extra work and lifting he was doing with his left hand while his right elbow recovered could have exacerbated carpal tunnel features on the left side.
>
> I am disappointed for Michael that they have done that but he knows there is avenues (sic) that that decision can be appealed and for such a simple operation it can make a huge difference to Michael's symptoms and his ability to return to work."

39. Dr Marshall put the applicant on the public waiting list for the surgery.

40. On 6 February 2019, Dr Marshall prepared a medicolegal report to the applicant's solicitors. However, the report seems to answer questions posed to Dr Martin but the questions are not in evidence. Nevertheless, Dr Marshall's opinion, and the facts upon which he bases it, are tolerably clear:

> "The initial pain started at the elbow and spread down towards his hand area.
>
> Michael initially had all the classic clinical features of lateral epicondylitis of his right elbow. He was reviewed again on 18 April 2018 and on that occasion, he still had features of localised lateral epicondylitis, which did not have seemed to improve much from his initial examination. He was not complaining of any neck pain at the time. He had some features that could explained by radial tunnel syndrome, and hence a nerve conduction test was requested.
>
> I have not treated this patient for a condition in the same part of the body.
>
> I am not aware of any other previous injury to Michael's right elbow or hand. He did mention the injury to his shoulder.
>
> The current working diagnosis is one of right elbow lateral epicondylitis and bilateral carpal tunnel syndrome.

It is very clear that the injury that Mr Duck sustained whilst working for E&D Bunt is the sole contributor to his lateral epicondyfitis diagnosis. It would also be reasonable to conclude that his carpal tunnel syndrome was also directly related to his fall if all the details provided by Mr Duck about his injury and how he landed and the bleeding coming from his hands could certainly explain why carpal tunnel syndrome has developed (sic).

No operative treatment has been provided to Mr Duck at this point in but I have recommended that he initially start with a carpal tunnel release surgery to try and relieve the pressure off his median nerve. If this surgery is successful and it relieves him of his forearm pain Mr Duck may be able to return to some form of employment. It still does not answer the question if his elbow pain will be resolved and I do not expect the carpal tunnel surgery to make any difference at all to his lateral elbow pain, as this condition is not made worse or better by carpal tunnel surgery."

41. And further:

"On last review of Mr Duck on 12 February 2018 (sic – the above reports indicate further reviews after this date) his situation has not changed. He is still experiencing significant symptoms of both carpal tunnel syndrome and forearm pain and numbness. He is unable to do any heavy work as his symptoms exacerbate as soon as *he* attempts to do that.

The prognosis should be very good if the diagnosis of both carpal tunnel and lateral epicondylitis is correct.

Currently, Mr Duck potentially needs two surgeries. One is a carpal tunnel release and a lateral epicondyle release. The carpal tunnel surgery is being proposed to Mr Duck as the first treatment, as it is a more reliable procedure that could potentially relieve the majority of the pain in his arm and the tingling in his fingers, I would consider the treatment appropriate to relieve the pressure off his median nerve that has been a direct effect of the injury to his hand. The treatment is aimed to restore the patient is health to normal. The treatment is effective in promoting recovery. The treatment will prevent any further deterioration of the nerve compression and the treatment is very cost effective. There is no other form of treatment for carpal tunnel that I am aware of that has a better long term option than surgical decompression. The treatment of performing carpal tunnel release surgery on a patient who has carpal tunnel syndrome is the gold standard of care in Australia and I don't think any professional body would say otherwise. I have included a copy of the proposed surgical costs.

Please note that I do not have an anaesthetic estimate. This will be an additional cost.

It is not the scope of this treating report to get into an argument with what Dr Smith has said. Michael Duck in my opinion clearly has carpal tunnel syndrome. He has the classic clinical features of numbness and paraesthesia in his fingers that are particularly worse at night time. He has clear nerve conduction studies that not just say he has mild, but moderate carpal tunnel syndrome features. He has electrical activity on nerve testing that his nerve conduction velocities are slowing as they go through a compressed carpal tunnel. It is not my routine to obtain ultrasound scans on patients with carpal but it is diagnosed both clinically and with nerve conduction studies. I have performed over two and a half thousand of these procedures based on this diagnostic tool and find nerve conduction studies to be quite reliable in this situation.

It Is a very simple quick, effective procedure with a very quick recovery time frame with the potential to significantly reduce Mr Duck's symptoms. What I cannot answer though is whether his lateral epicondylitis features will be made better from this surgery."

Coffs Physiotherapy and Back Care

42. The applicant attendant physiotherapist, Tim Robinson from 27 November 2017 onwards. On the first examination Mr Robertson noted problem with pain around the elbow. He noted previous right shoulder problems sometime prior. He only considered involvement at the epicondyle, and perhaps spine or scapula involvement. He also noted resisted extension testing in the finger and wrist, and also noted possible radial nerve neuropathy. This feature was noted in several examinations over several months. Thereafter he concentrated on those symptoms only and did not make mention of any median, or carpal tunnel involvement.

43. However, on 4 December 2017, Mr Robinson prescribed a wrist brace, and this recommendation continued in notes thereafter.
44. On 22 January 2018, Mr Robinson noted a flare up of pain after the applicant mowed the lawn. On 4 April 2018, some right-sided neck pain (C5/6) was noted which Mr Robinson thought could "potentially be feeding into his radial tunnel/lateral epicondylagia".

Investigations

45. The only investigations are radiological scans of the right elbow and the nerve conduction studies referred to the above.

Forensic report

46. The respondent had the applicant examined by Dr Ian Smith, orthopaedic surgeon on 20 July 2018. Dr Smith described in the accident as landing on his right elbow. He noted the injections into the right elbow with limited benefit. You described the applicants presenting symptoms as including weakness of grip and "some pain in the volar wrist. He has pins and needles in whole hand also", as well as continuing right elbow pain.

47. Dr Smith noted the reports of Dr Marshall, but did not record Dr Marshall's initial observation of pain in the right elbow spreading down into the hand. He recorded tenderness about both lateral epicondyles and the left medial epicondyle. He said there were no sensory losses in the upper limbs, but the applicant complained of numbness in his right hand. He noted loss of power in all movements of the light upper limb, from the small muscles of the hand to the right shoulder. Both ulnar nerves were said to be clinically normal at the elbow. The MRI and ultrasounds of the right elbow were notes, as was the electrical studies identifying carpal tunnel syndrome by Dr Loiselle.

SUBMISSIONS

48. Both Counsel made lengthy and helpful submissions which were recorded. I do not propose to detail them in full.

Applicant's submissions

49. Mr Hanrahan's submissions included:

    (a) I would accept the mechanism of injury as the applicant now describes resulting in significant force on the hands and elbows. The fall was said to have been witnessed by the applicant's "boss", who undoubtedly was Mr O'Neill, the Site Owner. The absence of any evidence from Mr O'Neill to contradict the applicant's version of events should be taken into account to the affect that it would not assist the respondent.

(b) I would accept the applicant is a stoic person given the relatively few attendances on his General Practitioner.

(c) The clinical notes of all doctors are, “riddled with errors” and I would treat them with significant caution.

(d) I would accept that the paraesthesia in the applicant’s hands developed some months after the injury as proposed by him in his statement.

(e) It was obvious that the right elbow is the primary source of treating practitioner’s attention and it is relatively clear that any symptoms or conditions in his wrists and arms were overlooked for some considerable months until nerve conduction studies were conducted on 16 May 2018.

(f) Despite the faults of the clinical notes, it is clear the applicant complained of symptoms radiating down to his hand on first examination by Dr Marshall in November 2017.

(g) Dr Marshall’s focus was clearly on the right elbow and the difficulty it presented. He was surprised in April 2018 that it had not resolved but his attention remained very specifically on the elbow, although he mentioned on 18 April 2018 that there was some numbness in the hand area.

(h) The applicant is obviously not a clear historian as Dr Marshall says so in April 2018 when he attempted to describe the hand symptoms.

(i) Dr Marshall therefore continued to focus on the right lateral elbow and the radial nerve, sufficient to lead him to refer the applicant for nerve conduction studies regarding the radial nerve, leading to the discovery of bilateral carpal tunnel syndrome. After this he declared that the studies “would certainly explain a lot”, particularly the applicant’s night time symptoms (although he is not clear on when those symptoms first set in).

(j) Dr Marshall explains why there was a delay in identifying Carpal Tunnel Syndrome as opposed to the other suspected pathology of Radial Tunnel Syndrome.

(k) Even if the Carpal Tunnel Syndrome is not the direct result of the fall onto both hands and wrists, the need for the treatment still “results from” that injury and if it be necessary, the employment fall is still a substantial contributing factor to the Carpal Tunnel Syndrome.

(l) I would not accept Dr Smith’s opinion that the Carpal Tunnel is not involved simply on the assertion that the electrical test may produce false positives. He does not explain why it is wrong in this case.

(m) Finally, there is a temporal connection between the symptoms onset; there is an explanation of the systems and diagnosis by Dr Marshall; the clinical expertise of the General Practitioner and treating Orthopedic Surgeon is the most reliable historical material and I would find that the applicant suffered the injury and the proposed treatment is reasonably necessary as a result of the injury (in both hands).

(n) I would not accept criticism of the applicant for not talking about his Carpal Tunnel Syndrome. He is not the expert and it was the experts to elicit the relevant symptoms and make diagnosis.

(o) Dr Marshall clearly hopes the proposed carpal tunnel releases will impact the overall symptoms in the elbow. As such, it could also be held that the treatment is reasonably necessary as a result of the elbow injury (but this would only apply on the right). This would be so, even if the Carpal Tunnel Syndromes were totally unrelated to the accident itself.

Respondent's submissions

50. Mr Combe for the Respondent submitted:

(a) The applicant has never pleaded that the treatment was a result of the elbow injury and that argument should not be entertained.

(b) The applicant carries the onus and the way the case is presented, I would need to find that the Bilateral Carpal Tunnel is a direct result of the fall in August 2013 and not a secondary consequence thereof.

(c) There is significant inconsistencies with the applicant's oral evidence presented today in his statement, more by omission.

(d) I do not accept the statement or the oral evidence because there is no contemporaneous record from any of the treating Practitioners as any involvement of the hands until a significant time after the actual injury. It is not an oversight by one or two doctors, all doctors are consistent in that approach. The history provided by the applicant to Dr Smith only involved landing on the right elbow as well.

(e) Accordingly, I should not accept the applicant's mechanism of injury and that undermines all opinions provided in the matter.

(f) The only relevant reference to any pathology is to the lateral epicondyle and possible radial tunnel involvement.

(g) The only reference to hand involvement at any early stage was by Dr Marshall who still only implicated the right hand as having pain radiating down to it, no numbness recorded.

(h) There is no reference to any symptoms in the left hand at all in the materials.

(i) The only time Carpal Tunnel Syndrome became an issue is after the nerve conduction study when the diagnosis shifts from the radial tunnel to the carpal tunnel without explanation as to differing symptoms or diagnostic signs clinically.

(j) Dr Marshall's opinion on the cause of the bilateral carpal tunnel syndrome relies upon an acceptance of the applicant's evidence (he specifically says so) and I would not be satisfied of that mechanism of injury for the above reasons.

(k) No doctor has presented a scientific basis for the cause.

(l) Dr Marshall's opinion linking the left hand to the injury itself is that it is a secondary condition as a result of overuse of the left hand due to the right-sided injury, but that is not claimed.

(m) I would accept the evidence of the lay witnesses, Dawn and Lincoln Bunt to the affect that the applicant only ever complained about his elbow and not his hands.

FINDINGS AND REASONS

51. Although Dr Smith doubts the diagnosis, I am comfortably satisfied that the diagnosis is sound, at least for the right hand. I note in combination with right hand numbness (noting that there is no mention of left hand symptoms at all, despite the positive electrical tests), there are obviously positive nerve conduction studies.

52. Causation regarding the bilateral carpal tunnel syndrome is a question of fact: *March v E & MH Stramare Pty Ltd* [1991] HCA 12; 171 CLR 506 per Mason CJ at [16]. It falls to be determined on a simple common sense test in accordance with *Kooragang Cement Pty Limited v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796 (*Kooragang*). I must feel actual persuasion of the occurrence or existence of the fact in issue before it can be found: *NOM v* DPP [2012] VSCA 198 at [124]. See also Dixon J in *Briginshaw v Briginshaw* [1938] HCA 34; 60 CLR 336.

53. The Court of Appeal in *Nguyen v Cosmopolitan Homes* [2008] NSWCA 246 (*Nguyen*) summarised the approach as follows:

> "(1) A finding that a fact exists (or existed) requires that the evidence induce, in the mind of the fact-finder, an actual persuasion that the fact does (or at the relevant time did) exist;
>
> (2) Where on the whole of the evidence such a feeling of actual persuasion is induced, so that the fact-finder finds that the probabilities of the fact's existence are greater than the possibilities of its non-existence, the burden of proof on the balance of probabilities may be satisfied;
>
> (3) Where circumstantial evidence is relied upon, it is not in general necessary that all reasonable hypotheses consistent with the non- existence of a fact, or inconsistent with its existence, be excluded before the fact can be found; and
>
> (4) A rational choice between competing hypotheses, informed by a sense of actual persuasion in favour of the choice made, will support a finding, on the balance of probabilities, as to the existence of the fact in issue." (at [55])

54. In *Kumar v Royal Comfort Bedding Pty Ltd* [2012] NSWWCCPD 8 (*Kumar*), Mr Kumar's employer submitted that a finding of a consequential back condition by the Arbitrator was "not supported by reasoned opinion or change in pathology". Roche DP (at [55]) held that it was not necessary to establish that there was "significant pathology" in his shoulder, only that the proposed surgery was reasonably necessary as a result of the back injury on 19 March 2009. However, in *Kumar*, there was a relevant injury.

55. While I accept that in certain cases a fact finder may find a causal connection in the absence of medical evidence (*Fernandez v Tubemakers of Australia* (1975) 2 NSWLR 190, Glass JA, at 197; *MMI Workers Compensation (NSW) v Kennedy* (1993) 9 NSWCCR 482 (*Kennedy*)), and that the Commission has 'expert' status in certain areas, that proposition has its limits.

56. I also acknowledge the passage by Spigelman CJ (Giles and Ipp JJA agreeing) in *Australian Security and Investments Commission v Rich* [2005] NSWCA 152 at [170], where he said: "[a]n expert frequently draws on an entire body of experience which is not articulated and, is indeed so fundamental to his or her professionalism, that it is not able to be articulated".

57. However, expertise can only be used to interpret and draw inferences from acceptable evidence. It cannot be used to create evidence: H*evi Lift (PNG) Ltd v Etherington* [2005] NSWCA 42; *Conargo Shire Council v Quor* [2007] NSWWCCPD 245; *Rodger W Harrison and Peter L Siepen t/as Harrison and Siepen v Craig* [2014] NSWWCCPD 48. Findings must be based on the evidence, or reasonable inferences open to be drawn from the evidence, not on the judge's knowledge (*Strinic v Singh* [2009] NSWCA 15 at [60]).

58. In *Luxton v Vines* [1952] HCA 19; (1952) 85 CLR 352 (*Luxton*), at 359, it was held in that:

> "[The element of causation would not be established] where it is 'quite impossible to reconstruct from any materials' the manner in which the accident occurred and where that 'can be done only by conjecture' but where 'a number of conjectures is open, equally plausible'".

59. In *Flounders v Millar* [2007] NSWCA 238 (*Flounders*), Ipp JA said at [35]:

> "…it remains for the plaintiff, relying on circumstantial evidence, to prove that the circumstances raise the more probable inference in favour of what is alleged. The circumstances must do more than give rise to conflicting inferences of the equal degree of probability for plausibility. The choice between conflicting inferences must be more than a matter of conjecture. If the court is left to speculate about possibilities as to the cause of the injury, the plaintiff must fail".

Discussion, findings and reasons

60. I am not satisfied that the applicant has discharged his onus to establish a personal injury for the purpose of section 4(a) of the *Workers Compensation Act 1987* (the 1987 Act) for the following reasons.

61. I proceed on the acceptance of the applicant's version presented orally, that is that he fell downwards and landed on both his hands and his right elbow. However, regardless of the mechanism of injury, the medical evidence does not support the causal connection between the fall and the diagnosis of bilateral carpal tunnel syndrome with sufficient clarity to discharge the applicant's onus.

62. Whilst I acknowledge the caution required when dealing with busy practitioner's clinical notes, in cases where there is genuine dispute about the recollection of the applicant as to the onset of his symptoms and the link of any such symptoms to the accident itself, contemporaneous evidence may become important: *Department of Education & Training v Ireland* [2008] NSWWCCPD 134. That is not to say that corroboration is necessary for the applicant to succeed: *Chanaa v Zarour* [2011] NSWCA 199 at [86].

63. Whether or not the applicant had blood on his hands following the fall, it is clear that he did not present for any medical treatment for a considerable time after the injury, said to have occurred in August 2017. The first such attendance was upon Dr Ruthnam on 21 September 2017. On that occasion and all occasions for many months thereafter Dr Ruthnam only referred to the lateral epicondyle without any mention of symptoms of numbness, pain or anything else involving the hands and wrists.

64. The same can be said for Mr Robinson, the Physiotherapist who the applicant first saw on 27 November 2017. Mr Robinson, however, added the impression of "very minor radial tunnel signs" at that time. He also thought there was 'thoracic biomechanics likely amplifying pain". This clinical picture remained Mr Robinson's description on numerous examinations and records thereafter.

65. Dr Ruthnam also identified radial tunnel symptoms, quite early.

66. The applicant himself, in his statement, which in this respect was not altered in any way by the oral evidence, said that the initial symptoms (that is the right elbow) got worse with time while he continued work, and that "over the next few months my symptoms became worse and I then started to develop paraesthesia effecting both hands and more so on the right". This would suggest that the onset of any hand or wrist complaint did not occur until several months after the injury. This is a significant factor when I am asked to determine the direct cause or link between the frank injury and the onset of the pathology sought to be treated. I am not dealing with a situation where the condition is a secondary or consequential condition. Nor has the applicant presented a case to the effect that the subsequent work following the injury was a contributor to the development of his hands and wrist pathology.

67. On the basis of the electrical studies and the ultimate acceptance by Dr Marshal of the diagnostic corroboration of those symptoms, I am satisfied that the applicant probably does have bilateral carpal tunnel syndrome.
68. Whilst Dr Marshall somewhat belatedly connects the Carpal Tunnel Syndrome to the fall (especially on the right side), he does not explain with sufficient clarity what the clinical picture was at any time during his care.

69. Clearly however, at the early presentations, the symptoms were consistent with radial tunnel involvement, but he does not say what the symptoms were. Relevantly, these symptoms were that there was pain "up the arm and then down towards the hand area", and in April 2018, that the applicant "mentioned a little bit of numbness, possibly down in the hand area, but he is not very clear and specific where that is and how often". He later said the applicant had "some features that could be explained by radial tunnel syndrome". One would have thought that closer questioning was required, given that he was still then working with an impression of radial tunnel syndrome.

70. In September 2018, following the discovery of the carpal tunnel condition Dr Marshall expressed surprise that the insurer denied funding for treatment "because Michael certainly did mention his hand numbness he was getting at the very first presentation and I was alarmed enough to suspect carpal tunnel in which we ordered a carpal tunnel test". This not consistent with Dr Marshall's historical reports. He suspected radial tunnel involvement when referring the applicant for electrical tests. Inference that can be readily made is that radial tunnel symptoms may involve hand numbness, and that the symptoms are not the same as median nerve entrapment as in carpal tunnel syndrome.

71. After the electrical studies, Dr Marshall medico-legally explains that the applicant had "classic clinical features of numbness and paraesthesia in his fingers that are particularly worse at night time, clinical symptoms then accepted as consistent with carpal tunnel syndrome.

72. Nevertheless, the matter may still possibly have been clarified by more focused medicolegal opinion, given the delay in the onset (probably of months) of the paraesthesia as described by the applicant himself, and the lack of comparison of the relevant radial nerve symptoms with median nerve symptoms. However, this did not occur.

73. On the basis of this analysis by the applicant's expert, I am left to assume the precise presenting symptoms (thought by three separate practitioners to indicate radial tunnel syndrome), and marry those with whatever symptoms Dr Marshall later accepts to be consistent with the early presentation. On the face of the documents, even with favourable inferences, I am unable to do so without becoming the expert myself.

74. Also of minor but not determinative significance, and a reason for the clarification I sought from the applicant's legal representative regarding whether the applicant's reliance was only on the frank injury as the cause, is Dr Marshall's clinical report in September 2018, where he opined that "one could assume that all the extra work and lifting he was doing with his left hand while his right elbow recovered could have exacerbated carpal tunnel features on the left side".

75. The issue that causes me greatest difficulty is the question of whether or not that pathology is the result of the injury to the hands and arms (or a direct result of the elbow injury (reminding myself a secondary condition is not claimed)). Dr Marshall was clearly focused on the right lateral epicondyle initially and for some time thereafter. Clinically, however, he identified potential radial tunnel involvement. That much can be accepted clinically.

76. When he referred the applicant for electrical studies in May 2018 for investigation of the Radial Tunnel Syndrome, at no time does Dr Marshall explain the nature of the symptoms and signs which lead him to conclude that there was potential radial tunnel involvement. Similarly, he does not explain why, on the basis of the electrical studies only, he is able to rely on the complaints of the applicant's hand symptoms as confirming that diagnosis, when the median nerve had never been mentioned before the electrical studies.

77. This, in my view, is a matter for expert evidence and the applicant has not gathered that evidence to present to the Commission. Although the Commission is an expert Tribunal, it is not for me to declare knowledge of, or investigate the symptoms and signs relevant to Radial Tunnel Syndrome, and compare that with similarly self-sourced symptoms and signs for Carpal Tunnel Syndrome. It is also not for me, even if I were to do that, to compare and contrast the clinical signs for each pathology in order to explain Dr Marshall's apparent oversight of the carpal tunnel presentation from early on. Because that presentation is a matter upon which Dr Marshall heavily relies, I am unable to accept his retrospective explanation of the causal chain.

78. I consider each of the following equally plausible: the applicant suffered carpal tunnel injury in the incident (albeit, with delayed onset of symptoms); he developed the condition due to events after the injury, or as a consequence of the injury to the elbow; or he simply developed the condition idiopathically. That is insufficient to discharge the onus: *Luxton*; *Flounders.*

79. Mr Hanrahan points to a medical certificate on 19 March 2018 in which Dr Ruthnam makes the comment: "avoid repetitive pronation supination – wrist activities". The difficulties with this are that the diagnosis in that certificate remains of right lateral epicondylitis, and Dr Ruthnam's clinical notes do not support any connection to the carpal tunnel at that time. Presumably wrist pronation and supination is an activity affected by lateral epicondylitis as well. The note does not address the difficulty in distinguishing radial tunnel problems from carpal tunnel problems.

80. I do not accept that the clinical records are, "riddled with errors", although I note the caution required when relying upon them. The difficulty is, if errors exist, the applicant has not requested the doctors to rectify them.

81. Mr Hanrahan's submission that the need for the treatment still "results from" the elbow injury and if it be necessary, the employment fall is still a substantial contributing factor to the carpal tunnel syndrome cannot be accepted. It was not the case the applicant presented. The case was of a direct injury to the wrists in the form of carpal tunnel syndrome. In any event, Dr Marshall's hope that addressing the carpal tunnel syndrome may also remedy the elbow is mere conjecture.

82. I would note that I am not critical of the applicant not mentioning hand symptoms early. He has been open about that in his own evidence. The symptoms did not appear until some time after injury.

83. Because Dr Marshall is, in essence, the only expert providing any explanation as to the cause of the pathology as a result of the accident, it follows that I do not accept the applicant has discharged his onus and there will be an award for the Respondent.

SUMMARY

84. There is an Award for the respondent with respect to the Applicant's claim for injury to the right and left wrists in the form of bilateral carpal tunnel syndrome.

85. There is an Award for the respondent with respect to the claim for proposed bilateral carpal tunnel release.