WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **2967/10**
Applicant: **Wendy Michelle Ellis**
Respondent: **P & A Fiumara & Sons Pty Limited**
Date of Determination: **19 November 2019**
Citation: **[2019] NSWWCC 370**

The Commission determines:

1. The applicant did not suffer an injury to the cervical spine on 8 February 2017 within the meaning of section 4(a) of the *Workers Compensation Act 1987*.

The Commission orders:

2. Award for the respondent in relation to the claimed injury to the cervical spine on 8 February 2017.

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

Date of injury:	8 February 2017.
Body System:	Right upper extremity (right shoulder) and right lower extremity (right knee and right ankle).
Method of Assessment:	Whole Person Impairment.

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

   (a) Application to Resolve a Dispute dated 18 June 2019 and attached documents;

   (b) Reply dated 10 July 2019 and attached documents.

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

Anthony Scarcella
Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OFANTHONY SCARCELLA, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Ms Wendy Michelle Ellis, is a 51-year-old woman who was employed by P & A Fiumara & Sons Pty Limited (the respondent) as a baker.

2. On 8 February 2017, at the respondent's premises, Ms Ellis alleges that she entered the respondent's bakery cool room to retrieve some sourdough, slipped on the wet floor and injured her cervical spine, lumbar spine, right shoulder, right knee and right ankle.

3. On 19 March 2019, Ms Ellis submitted a permanent impairment claim pursuant to section 66 of the *Workers Compensation Act 1987* (the 1987 Act) in respect of the alleged injuries to her spine (cervical spine), right upper extremity (right shoulder), right lower extremity (right knee and right ankle).[1]

4. On 26 June 2019, the respondent issued a Dispute Notice pursuant to section 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) disputing injury to the cervical spine; disputing that the accepted injuries to the right upper extremity (right shoulder), right lower extremity (right knee and right ankle) exceeded the threshold in section 66(1) of the 1987 Act; and also disputing the claim in relation to the cervical spine due to the failure to give notice of the injury and failure to make a claim for compensation in accordance with sections 254 and 261 of the 1998 Act respectively.[2]

5. The Application to Resolve a Dispute (ARD) dated 18 June 2019 was registered in the Commission.

6. The Reply dated 10 July 2019 was received in the Commission.

ISSUES FOR DETERMINATION

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

    (a) whether Ms Ellis suffered an injury to her cervical spine on 8 February 2017 within the meaning of sections 4(a) and 9A of the 1987 Act, and

    (b) whether Ms Ellis is entitled to lump sum compensation within the meaning of section 66 of the 1987 Act.

Matters previously notified as disputed

8. The issues in dispute were notified in a Dispute Notice pursuant to section 78 of the 1998 Act dated 26 June 2019.

Matters not previously notified

9. No other issues were raised.

PROCEDURE BEFORE THE COMMISSION

10. The parties attended a conciliation conference/arbitration in Wagga Wagga on 1 October 2019. Mr Josh Beran of counsel appeared for Ms Ellis and Mr Charlie Street of counsel appeared for the respondent.

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[1] Application to Resolve a Dispute (ARD) at pages 244-246.
[2] Reply at pages 19-24.

11. During the conciliation phase the parties agreed as follows:

    (a) the respondent no longer pressed the issues raised in its section 78 Dispute Notice dated 26 June 2019 relating to sections 254 and 261 of the 1998 Act.

12. 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

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

    (a) ARD dated 18 June 2019 and attached documents, and
    (b) Reply dated 10 July 2019 and attached documents.

Oral evidence

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

AN ANALYSIS OF THE EVIDENCE

Ms Wendy Michelle Ellis

15. In evidence, there is a statement by Ms Ellis dated 16 April 2019. I will now refer to the relevant parts of Ms Ellis' statement.

16. On 22 January 2015, Ms Ellis commenced her employment as a baker with the respondent.

17. Ms Ellis provided a detailed description of her duties as a baker with the respondent.[3]

18. On 8 February 2017, Ms Ellis commenced her shift with the respondent at 2.00 am, as usual. At about 2.30 am she entered the bakery cool room to retrieve some sourdough. The cool room compressor overflow hose had spilt water onto the floor of the cool room. As she walked into the cool room, she slipped on the wet floor and injured her right knee, right ankle, right shoulder, neck and lower back. She immediately reported the accident to Fred and Anna Fiumara, the owners of the business.

19. On 8 February 2017, Ms Ellis was conveyed by ambulance to Leeton Hospital, where she underwent morphine injections and was kept under observation for a few hours prior to being discharged.

20. On 9 February 2017, Ms Ellis consulted her general practitioner, Dr Tatiana Pavlovskaya at the Leeton Family Clinic. She was referred for x-rays.

21. Following the incident on 8 February 2017, Ms Ellis was unfit for work for about four weeks. Thereafter, she returned to work with the respondent on selected duties. She was still experiencing pain in her lower back, neck, right wrist, right knee and right shoulder.

[3] ARD at page 248 at [9].

22. On 13 April 2017, Ms Ellis again consulted Dr Pavlovskaya, who prescribed her pain-relieving medication and referred her to Dr Matthew Howard, Orthopaedic Surgeon.

23. In April 2017, Dr Howard administered a steroid injection into Ms Ellis' right shoulder.

24. On 28 August 2017, Ms Ellis resigned from her employment with the respondent because she "could not handle the workload due to my injuries."[4]

25. On 14 December 2017, Ms Ellis commenced casual employment with Suzanne Grae, Wagga Wagga.

26. On 14 March 2018, Dr Howard administered a nerve block to Ms Ellis' right shoulder, which failed to provide much relief.

27. On 15 June 2018, Ms Ellis underwent a nerve root injection in her neck.

28. On 26 July 2018, Ms Ellis underwent a cortisone injection into her neck, which did not provide much benefit.

29. On 24 August 2018, Ms Ellis resigned from her employment with Suzanne Grae, Wagga Wagga.

30. On 24 August 2018, Dr Howard discharged Ms Ellis from his care as he was unable to offer any further assistance.

31. On 27 August 2018, Ms Ellis commenced full-time employment with Hills Motor Group, Wagga Wagga.

32. Ms Ellis underwent a regime of physiotherapy which provided some relief. She takes Nurofen for pain relief twice per day during the working week because it does not interfere with her driving. She takes Endone for pain relief on weekends.

33. Ms Ellis stated that, in relation to her daily tasks, she experiences difficulties with interrupted sleep; walking, sitting or standing for prolonged periods; walking on uneven surfaces; and descending and ascending stairs; squatting and kneeling; mowing the lawn and tending to the garden; washing her car; pushing and pulling objects; opening jars; carrying out normal work duties; carrying out normal domestic duties; vacuuming and mopping floors; ironing; making the bed; undertaking tasks requiring the use of both arms; driving; lifting weighty objects; reaching overhead; and continuing pain and a restricted range of movement in her lower back, neck, right knee and right shoulder. In addition, her social activities and handcraft hobbies have been curtailed due to the ongoing pain and discomfort.

Worker's Injury Claim Form

34. In evidence, there is a Worker's Injury Claim Form dated 12 February 2017 which was completed and signed by Ms Ellis.[5]

35. The Claim Form recorded the injury/condition and body parts affected in the incident on 8 February 2017 as being the right ankle, right knee, lower back, right shoulder and wrist. There was no reference to Ms Ellis' neck.

36. The claim form recorded the circumstances of the injury as having occurred when Ms Ellis slipped on water on the floor and fell, whilst getting sourdough out of the bakery cool room on 8 February 2017 at 2.30 am.

[4] ARD at page 249 at [28].
[5] ARD at pages 9-12.

Ms Ellis' treatment providers

37. In evidence, there are Ms Ellis' clinical records produced by Leeton Family Clinic[6] and Ms Ellis' clinical records produced by Dr Matthew Howard, Orthopaedic Surgeon.[7] There are also various certificates, referral letters and reports by Ms Ellis' treatment providers in evidence. I will now refer to the relevant parts of those documents.

38. Ms Ellis' Leeton Family Clinic records commence with an entry on 31 October 2002. The last surgery consultation entry is on 9 October 2017. The records were transferred to Junee Medical and Dental Centre in or about April 2018. Ms Ellis' Junee Medical and Dental Centre clinical records are not in evidence.

39. Contained within Ms Ellis' Leeton Family Clinic records are 13 WorkCover NSW - Certificates of Capacity (Certificates of Capacity), which were issued by general practitioners in that practice in relation to the work-related accident on 8 February 2017.[8] The first Certificate of Capacity was dated 9 February 2017. The last Certificate of Capacity was dated 10 November 2017. None of those 13 Certificates of Capacity referred to a neck injury or neck pain. The Certificates of Capacity dated 9 February 2017, 14 February 2017 and 22 February 2017, rather unhelpfully, provided a diagnosis of work-related injury as "musculoskeletal" and the description of how the injury related to work simply as "happened at work". Most of the remaining Certificates of Capacity made reference, in one way or another, to injuries to the right shoulder, right wrist, right ankle, back and chronic pain. The descriptions of the relationship of the injuries to work mostly referred to a fall at work with an outstretched arm on 8 February 2017.

40. In evidence, there is a Certificate of Capacity issued Dr Awad, General Practitioner of Junee dated 11 June 2018 in relation to the work-related accident on 8 February 2017.[9] The Certificate of Capacity referred to right shoulder pain due to a partial tear of the subscapularis, distal supraspinatus tendinosis and bursitis. It did not refer to neck pain or a neck injury.

41. In evidence, there is a Certificate of Capacity issued by Dr Wahba, General Practitioner of Junee dated 14 September 2018 in relation to the work-related accident on 8 February 2017.[10] The Certificate of Capacity referred to right shoulder pain due to a partial tear of the subscapularis, distal supraspinatus tendinosis and bursitis. It did not refer to neck pain or a neck injury.

42. On 9 February 2017, the Leeton Family Clinic records disclosed that Ms Ellis consulted Dr Noormohideen, who recorded that she had sustained a fall at work when she slipped on water in a bakery and landed on her "bottom".[11] On examination, Dr Noormohideen noted that Ms Ellis was tender in the right paraspinal region and requested imaging of her lumbosacral spine and right wrist. He prescribed Ms Ellis Prednisolone tablets, Panadeine Forte tablets and Diazepam tablets. No complaints of right shoulder pain, neck pain or right knee pain were recorded. Dr Noormohideen issued the unhelpfully vague Certificate of Capacity referred to above, which simply described the injury as musculoskeletal and having happened at work.

43. On 9 February 2017, Ms Ellis underwent an x-ray of her right wrist and lumbosacral spine by Dr Freilich, Radiologist on the referral of Dr Noormohideen.

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[6] ARD at pages 39-168.
[7] ARD at pages 169-235.
[8] ARD at pages 113-152.
[9] ARD at pages 252-254.
[10] ARD at pages 31-33.
[11] ARD at page 44.

44. On 14 February 2017, the Leeton Family Clinic records disclosed that Ms Ellis consulted Dr Noormohideen, who recorded that she was still tender in the area of her lower back. He requested a CT scan of Ms Ellis' lumbosacral spine and issued another Certificate of Capacity. No complaints of right wrist pain, right shoulder pain, neck pain or right knee pain were recorded.

45. On 14 February 2017, Ms Ellis underwent a CT scan of her lumbosacral spine by Dr Tan, Radiologist on the referral of Dr Noormohideen.

46. On 16 February 2017, the Leeton Family Clinic records disclosed that Ms Ellis consulted Dr Noormohideen, who recorded that the lumbar CT scan detected no abnormality. He noted that Ms Ellis was only taking Panadol and Nurofen occasionally. He recommended a coordinated return to work with suitable duties to be arranged by the respondent after 22 February 2017. No complaints of right wrist pain, right shoulder pain, neck pain or right knee pain were recorded.

47. On 22 February 2017, the Leeton Family Clinic records disclosed that Ms Ellis consulted Dr Noormohideen, who recorded that Ms Ellis still had some pain; was not and did not want to take any medication regularly; and that she was to return to work on modified duties. Dr Noormohideen issued another Certificate of Capacity. No complaints of right wrist pain, right shoulder pain, neck pain, right knee or right ankle pain were recorded. In fact, the doctor did not even mention Ms Ellis' lower back and merely referred to "some pain".[12] Also on 22 February 2017, Dr Noormohideen responded to questions raised by the respondent's then insurer and referred to Ms Ellis' lower back and, in particular, sacral pain as well as the right wrist.[13]

48. On 3 March 2017, the Leeton Family Clinic records disclosed that Ms Ellis consulted Dr Pavlovskaya, who recorded that Ms Ellis had sustained a fall one month previously on an outstretched arm and that her foot had become inverted in the fall. She recorded complaints of pins and needles; a burning feeling in the right shoulder; a swollen, painful and burning sensation in the right ankle. Dr Pavlovskaya observed an antalgic gait. The reason for the consultation was recorded as "shoulder injury".[14] Dr Pavlovskaya requested diagnostic imaging of Ms Ellis' right ankle and right shoulder. She prescribed Ms Ellis Prednisolone tablets, Panadeine Forte tablets and Naprosyn tablets. No complaints of right wrist pain, neck pain, back pain or right knee pain were recorded. Dr Pavlovskaya issued a Certificate of Capacity, which referred to the lumbosacral spine, right ankle, right shoulder and right wrist.[15]

49. On 16 March 2017, Ms Ellis underwent an x-ray of her right shoulder and right ankle by Dr Kodur, Radiologist.[16] On the same date, Ms Ellis underwent ultrasounds of her right shoulder and right ankle by Dr Kodur.[17]

50. On 27 March 2017, the Leeton Family Clinic records disclosed that Ms Ellis consulted Dr Pavlovskaya, who discussed the results of the x-rays and ultrasounds of her right shoulder and right ankle.[18] Dr Pavlovskaya injected Ms Ellis' right shoulder with Celestone and Marcaine. No complaints of right wrist pain, neck pain, back pain or right knee pain were recorded. A Certificate of Capacity was issued, which referred to the lumbosacral spine, right ankle, right shoulder and right wrist.[19]

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[12] ARD at page 44.
[13] Reply at pages 1-4.
[14] ARD at page 43.
[15] ARD had pages 141-143.
[16] Reply at page 5.
[17] Reply at page 6.
[18] ARD at page 43.
[19] ARD at pages 138-140.

51. On 13 April 2017, the Leeton Family Clinic records disclosed that Ms Ellis consulted Dr Pavlovskaya, who recorded that Ms Ellis had an accident at work where she hurt all of her right side; she still experienced pain in her shoulder; the recent ultrasound disclosed bursitis; the Celestone and Marcaine injection into the right shoulder had provided some relief but she still experienced pain and pins and needles in her fingers.[20] No complaints of right wrist pain, neck pain, back pain or right knee pain were recorded. Dr Pavlovskaya issued a Certificate of Capacity, which referred to the lumbosacral spine, right ankle, right shoulder and right wrist.[21] She referred Ms Ellis to Dr Matthew Howard, Orthopaedic Surgeon. The referral letter to Dr Howard repeated the information recorded in the clinical records. [22]

52. On 4 May 2017, Ms Ellis consulted Dr Howard, whose consultation record noted a fall in February at work on her right side with shoulder pain, back pain and pins and needles in the fingers.[23] On 8 May 2017, Dr Howard reported back to Dr Pavlovskaya that Ms Ellis' back pain was settling but her right shoulder was very painful. Whilst physiotherapy settled some of the symptoms, her shoulder range of motion remained restricted. He recommended that she continue with physiotherapy but recommended an MRI scan of her right shoulder.[24] Dr Howard did not record any complaints of right wrist pain, neck pain, right knee pain or right ankle pain.

53. On 18 May 2017, the Leeton Family Clinic records disclosed that Ms Ellis consulted Dr Pavlovskaya, who recorded that Ms Ellis still had pain in her shoulder, back and ankle. She also noted Ms Ellis' complaints that she had too much to do with her right arm and this caused her to cry from pain. There was a hostile attitude at work, and she found it difficult to sleep. Dr Pavlovskaya considered that she required counselling and referred her to Ms Kathryn Munro, Psychologist. No complaints of right wrist pain, neck pain, back pain or right knee pain were recorded. Dr Pavlovskaya also issued a Certificate of Capacity, which referred to the lumbosacral spine, right ankle, right shoulder, right wrist, chronic pain and minor depression.[25]

54. On 18 May 2017, Ms Ellis underwent a right shoulder MRI scan by Dr Tan, Radiologist on the referral of Dr Howard.[26]

55. On 26 May 2017, Ms Ellis consulted Dr Howard, who reported back to Dr Pavlovskaya that he had reviewed the recent right shoulder MRI scan which demonstrated no obvious cuff tearing. He reinjected Ms Ellis' right shoulder with steroids in the hope that such intervention would make "a big difference to her".[27]

56. On 7 June 2017, Ms Ellis consulted Ms Munro. On 13 June 2017, Ms Munro reported back to Dr Pavlovskaya.[28] In her report, Ms Munro noted that Ms Ellis fell in the bakery predominantly on her right side, hurting her right shoulder and wrist on 8 February 2017. No reference was made to Ms Ellis' neck.

57. On 11 July 2017, the Leeton Family Clinic records disclosed that Ms Ellis consulted Dr Pavlovskaya, who recorded that Ms Ellis' shoulder was "good"[29] and that she would like to go back to work but with a different employer. No complaints of right wrist, neck pain, back pain or right knee pain were recorded. Dr Pavlovskaya issued a Certificate of Capacity,

[20] ARD at page 42.
[21] ARD at pages 135-137.
[22] ARD at page 22.
[23] ARD at page 226.
[24] ARD at page 224.
[25] ARD at pages 132-134.
[26] ARD at page 68.
[27] ARD at page 221.
[28] ARD at pages 92-93.
[29] ARD at page 41.

which referred to the lumbosacral spine, right ankle, right shoulder, right wrist, chronic pain and major depression.[30]

58. On 21 July 2017, Ms Ellis consulted Dr Howard, who reported back to Dr Pavlovskaya that Ms Ellis' right shoulder was settling down and he repeated a steroid injection. He was convinced that she did not require surgery and that she should continue with physiotherapy. Dr Howard did not record any complaints of right wrist pain, neck pain, right knee pain or right ankle pain.[31]

59. On 10 August 2017, the Leeton Family Clinic records disclosed that Ms Ellis consulted Dr Pavlovskaya, who recorded that Ms Ellis still had pain in her right shoulder on and off. She prescribed Ms Ellis Panadeine Forte tablets. No complaints of right wrist, neck pain, back pain or right knee pain were recorded. Dr Pavlovskaya issued a Certificate of Capacity, which referred to the lumbosacral spine, right ankle, right shoulder, right wrist and chronic pain.[32]

60. On 12 September 2017, the Leeton Family Clinic records disclosed that Ms Ellis consulted Dr Pavlovskaya, who recorded that Ms Ellis attended in relation to her shoulder injury. She was referred to Mr Aaron Miles and prescribed Naprosyn SR tablets. No complaints of right wrist, neck pain, back pain or right knee pain were recorded. Dr Pavlovskaya issued a Certificate of Capacity, which referred to the back, right ankle, right shoulder, right wrist and chronic pain.[33]

61. On 15 September 2017, Ms Ellis consulted Dr Howard whose consultation record noted that she had resigned from work; she was consulting a physiotherapist (Mr David Pattison) twice a week; and that she had a painful right shoulder. On 18 September 2017, he reported back to Dr Pavlovskaya that Ms Ellis was improving somewhat and that the change in physiotherapist had made a big difference. He recommended the continuation of a non-operative pathway and was hopeful that her symptoms would settle. Dr Howard did not record any complaints of right wrist pain, neck pain, right knee pain or right ankle pain.

62. On 6 October 2017, Mr David Pattison, Physiotherapist reported back to Dr Pavlovskaya thanking her for referring Ms Ellis for right neck/shoulder and left lower back management. Mr Pattison stated that he was pleased to report that Ms Ellis was making great progress to date and that her right shoulder dysfunction */* upper limb neurodynamic tension had improved to show nil neurodynamic tension. He also noted that treatment of her tight cervical spine had assisted in this regard.[34]

63. On 9 October 2017, the Leeton Family Clinic records disclosed that Ms Ellis consulted Dr Pavlovskaya, who recorded that Ms Ellis complained of pain in her shoulder. She prescribed Panadeine Forte tablets. No complaints of right wrist, neck pain, back pain or right knee pain were recorded. Dr Pavlovskaya issued a Certificate of Capacity, which referred to the back, right ankle, right shoulder, right wrist and chronic pain.[35]

64. On 17 October 2017, Mr Pattison wrote to Dr Howard.[36] Mr Pattison reported that Ms Ellis had continued with regular physiotherapy over the past two to three months with good effect on the management of her right shoulder and her left lumbar spine. He noted that:

[30] ARD pages 125-127.
[31] ARD at page 214.
[32] ARD at pages 122-124.
[33] ARD at pages 119-121.
[34] ARD at page 80.
[35] ARD at pages116-118.
[36] ARD at page 211.

> "She has had a tough week this week and unfortunately has had a mild setback with an increasing neck and shoulder tension."[37]

He prescribed an ongoing home exercise program.

65. On 18 October 2017, Ms Ellis consulted Dr Howard, whose consultation record noted that Ms Ellis' shoulder movement was better, although, there was some pain, but it had improved with physiotherapy.[38] On 23 October 2017, Dr Howard reported back to Dr Pavlovskaya that Ms Ellis was slowly improving with physiotherapy and approaching the stage where she could return to work. Dr Howard discharged Ms Ellis from his care.[39] Dr Howard did not record any complaints of right wrist pain, neck pain, back pain, right knee pain or right ankle pain.

66. On 9 November 2017, Mr Pattison reported to Dr Pavlovskaya that Ms Ellis had suffered a setback in her progress following prolonged sitting in a car trip to Wollongong. He increased her upper limb and lumbopelvic strengthening exercises and expected improvement over the next three to four weeks.[40]

67. On 10 November 2017, the Leeton Family Clinic records disclosed that Ms Ellis consulted Dr Pavlovskaya, who recorded that Ms Ellis continued with physiotherapy and that her range of shoulder motion had improved, as had her strength. No complaints of right wrist, neck pain, back pain or right knee pain were recorded. Dr Pavlovskaya issued a Certificate of Capacity, which referred to the back, right ankle, right shoulder, right wrist and chronic pain.[41]

68. Ms Ellis moved to Junee and her Leeton Family Clinic records were transferred to Junee Medical and Dental Centre in or about April 2018.

69. On 14 February 2018, Ms Ellis underwent a right shoulder ultrasound by Dr Lee on the referral of Dr Wahba, which demonstrated enthesopathy of the subscapularis tendon insertion with flattening suggestive of mild chronic tear and subacromial bursitis.[42]

70. On 26 February 2018, Ms Ellis consulted Dr Howard, who reported back to Dr Wahba, General Practitioner of Junee Medical and Dental Centre, that Ms Ellis was still experiencing a lot of trouble with her shoulder and that the situation had not really progressed. He remained convinced that there was no significant cuff tear, but her pain was not settling. He noted that she was working casually. He recommended a suprascapular nerve block.[43]

71. On 14 March 2018, Ms Ellis underwent an ultrasound guided injection of Celestone and Marcaine into her right suprascapular nerve by Dr Matthew Richardson.[44]

72. On 5 April 2018, Mr Pattison wrote to Dr Howard advising that Ms Ellis had continued with physiotherapy following her recent nerve block injection in mid-March 2018 and reported a slight, but not significant, reduction in pain. Mr Pattison observed:

> "Treatment of cervical mobilisations / transverse mobilisations had an immediate effect on her shoulder AROM. Flexion and abduction both improved 10-15° with less pain.

[37] ARD at page 211.
[38] ARD at page 210.
[39] ARD at page 209.
[40] ARD at page 75.
[41] ARD at pages 113-115.
[42] ARD at pages 17-18.
[43] ARD at page 204.
[44] ARD at page 201.

> Overall, I believe Wendy has an ongoing shoulder /cuff weakness issue given the chronic nature of her injury, however her cervical spine is also playing a significant part. Would she benefit from further investigations of her cervical spine / ulnar nerve roots to further assist her shoulder management?"[45]

73. On 5 April 2018, Ms Ellis consulted Dr Howard, whose consultation record noted that she was still experiencing pins and needles.[46] On 11 April 2018, Dr Howard reported back to Dr Wahba that the suprascapular nerve block did not really make a lot of difference, which possibly suggested that her shoulder was not necessarily the major issue. He referred to the letter by Mr Pattison dated 5 April 2018 which suggested that Ms Ellis' neck may be the issue. In this regard, Dr Howard stated: "… I think this is possibly a reasonable option." Dr Howard then commented as follows:

> "I think we should cover our bases and make sure we have not missed anything of significance. We do not seem to be really addressing the issue I must admit with looking at Miss Ellis's [sic] shoulder. Perhaps the neck is a problem."[47]

Dr Howard recommended that Ms Ellis undergo an MRI scan of the cervical spine and tentatively agreed with Mr Pattison that it would be worthwhile excluding formal nerve compression with nerve conduction studies as well.

74. On 24 April 2018, Ms Ellis underwent an MRI scan of her cervical spine by Dr Stephenson on the referral of Dr Howard.[48] The clinical notes in the report referred to right shoulder pain and queried neck pathology. Dr Stephenson described the findings of degenerative joint disease in the following terms:

> "C2/3: Left facet DJD. No neural compression.
>
> C3/4: Reduced disc hydration, minor left facet DJD. No neural compression.
>
> C4/5: Minor reduction in disc height and hydration. No neural compression.
>
> C5/6: Reduced disc height and hydration, uncovertebral DJD. As a result, there is anterior indentation of the thecal sac partly effacing CSF, without causing cord deformity and only mildly narrowing the C6 subarticular recesses and neural foramina. Neural compression unlikely.
>
> C6/7: Reduced disc height and hydration, a focal disc extrusion to the left of the midline posteriorly extending for a very short distance below the level of the disc space, focally indenting the thecal sac. Neural compression unlikely."[49]

75. On 31 May 2018, Ms Ellis underwent median and ulnar nerve conduction studies by Dr Martin Jude, Consultant Physician Neurologist on the referral of Dr Howard. Dr Jude concluded that there was a right median neuropathy at the right wrist, consistent with carpal tunnel syndrome of mild to moderate severity. There was no neurophysiological evidence of an ulnar neuropathy at the wrist or elbow and that proximal conduction was normal in the right median and ulnar nerves.[50]

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[45] ARD at page 197.
[46] ARD at page 199.
[47] ARD at page 196.
[48] ARD at page 190.
[49] ARD at page 190.
[50] ARD at pages 184.

76. On 15 June 2018, Ms Ellis consulted Dr Howard with her cervical spine MRI scan. He noted changes around the neural foramina at the C6 level and thought it would be reasonable to inject it due to her marked neck pain. He thought it prudent to arrange an MRI scan of her right cuff.[51] Dr Howard referred Ms Ellis for an interventional radiology and steroid injection under guidance in the right C6 perineural nerve root. The clinical history provided in the referral referred to right sided nerve symptoms and some C6/7 changes on cervical spine MRI.[52]

77. On 6 July 2018, in response to the respondent's then insurer, Dr Howard provided a report.[53] Referring to the finding in Ms Ellis' MRI scan dated 24 April 2018, Dr Howard opined that, whilst disc compression was not definite, there were some changes at the C6/7 level on the right side. In relation to the question as to how the C6 pathology related to the acute trip and fall on 8 February 2017, he explained that Ms Ellis had always complained of shoulder pain and that his and the physiotherapist's attempts to resolve it non-operatively, only had variable success. It was only when the physiotherapist raised the suggestion of neck pathology that the question was asked. Hence the reason for obtaining the MRI scan of the cervical spine. Dr Howard opined:

> "There can be an overlap between neck pathology and shoulder pain. On the basis that the shoulder interventions have not been totally successful it is possible that the cervical spine is to blame. This is why I am requesting an injection in this area to see whether this solves Miss Ellis' pain as at least a diagnostic manoeuvre.
>
> … I do not think that the injection is required for constitutional or aging factors. I believe that this is related to her current situation following her workplace accident and will assist me in her ongoing management regarding this."[54]

78. On 7 July 2018, Ms Ellis underwent an MRI scan of her right shoulder by Dr Stephenson, who reported on 11 July 2018, that he found equivocal evidence of a small interstitial tear between the deep part of the supraspinatus tendon posteriorly and the overlying more superficial infraspinatus tendon fibres, where those two tendons intermingle. There was a tiny interstitial tear in the mid-substance of the subscapularis. There was tendinosis in the long head of the biceps tendon in the rotator interval.[55]

79. On 26 July 2018, Ms Ellis underwent a CT guided right C6 perineural cortisone injection by Dr Duncan on the referral of Dr Howard. Dr Duncan reported the clinical indications as right-sided nerve symptoms; some right C6/7 changes on cervical spine MRI. There was no immediate complication in the procedure.[56]

80. On 23 August 2018, Ms Ellis consulted Dr Howard, who reported back to Dr Wahba that the CT guided right C6 perineural cortisone injection was not of much benefit and that he did not believe that he had any other treatment to offer. Dr Howard reported that Ms Ellis had not undergone the nerve conduction studies recommended by him. This was not correct, as those studies were conducted by Dr Jude on 31 May 2018. He felt that Ms Ellis may have to live with some discomfort, and he did not believe that it was worthwhile investigating any further. He noted that the right shoulder MRI scan did not reveal any substantial cuff damage. He discharged Ms Ellis from his care.[57]

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[51] ARD at page 183.
[52] ARD at pages 185-186.
[53] ARD at pages 176-177.
[54] ARD at pages 176-177.
[55] ARD page 175.
[56] ARD at page 173.
[57] ARD at page171.

81. On 6 September 2018, Mr Pattison reported to Dr Wahba that Ms Ellis' last physiotherapy treatment took place on 20 August 2018. At that time, she informed him that she had obtained employment and that she was concerned about not being able to continue with treatment due to her work commitments. She advised Mr Pattison that her pain had settled a little and that her primary pain was in her lumbar spine, although, her shoulder was still sore. He also reported that in the week preceding 6 September 2018, he had received an email from Ms Ellis advising that she was enjoying her new job and that it was a great challenge as there was still much to learn. She requested that her working hours be increased to 5.5 hours per day with the removal of all driving restrictions so that she could complete her job. In view of the fact that Ms Ellis appeared to be tolerating and enjoying her new employment and requested an increase in her working hours, he was going to leave her physiotherapy treatment on hold.[58]

Dr James Bodel, Orthopaedic Surgeon

82. On 27 February 2019, Ms Ellis consulted Dr James Bodel, Orthopaedic Surgeon at the request of her lawyers.

83. In evidence, there is a report by Dr Bodel dated 28 February 2019.[59] I will now refer to the relevant parts of that report.

84. In the early part of his report, Dr Bodel summarised Ms Ellis' injuries as being to the neck; the right shoulder and arm; the lower part of the back; the right knee and the right ankle.

85. Dr Bodel reported the history relating to the subject injury taken from Ms Ellis as follows:

> "This lady states that she had a slip and fall event at the IGA Superstore in Leeton, on 8 February 2017. She states that she had walked into the cool room to get something when she inadvertently slipped on spilled water inside the cool room. She indicates that the cooling unit has an overflow pipe which unfortunately drains into a bucket which is inside the cool room. It was a 10-litre bucket that overflowed and there was water on the floor. She slipped and fell very heavily, landing on her right hand side, and suffering the injuries down the right side as I have indicated. She could not get up. She states that often she is in the store on her own but fortunately the cleaners were there at the time that she fell, and they came and investigated and immediately rang the ambulance."[60]

86. Dr Bodel provided a summary of the treatment received by Ms Ellis following the accident on 8 February 2017, which was, in the main, consistent with the evidence. He noted that Ms Ellis found her general practitioner not very supportive and very little was done by way of investigations. Eventually, a CT scan was performed due to some concern of a disc bulge and later, an MRI scan was performed on Ms Ellis' lower back and neck. The main focus of investigation then became the right shoulder. Dr Bodel also noted that Ms Ellis stated that she had not experienced any prior problems with her neck or back. However, he noted that Ms Ellis sustained a fall about 12 months ago and has suffered with vertigo since the work related injury and had a fall at home. She aggravated her pain but did not suffer any fractures.

87. Dr Bodel recorded Ms Ellis' neck related complaints as right-sided neck pain and shoulder girdle pain on the right side; prolonged head down posture can aggravate the pain; and pain at the base of the neck.

[58] ARD at page 28.
[59] ARD at pages 236-243.
[60] ARD at page 237.

88. Dr Bodel reported that Ms Ellis' formal physiotherapy had ceased, and she remained under the care of her general practitioner. He noted that she finds local heat and Nurofen helpful. She takes Panadeine Forte at the end of the day and on rare occasions, Oxycontin.

89. On examination, of Ms Ellis' cervical spine, Dr Bodel observed tenderness in the trapezius muscles at the base of the neck on the right; a reduced range of neck flexion, extension and rotation in all directions (most restricted on rotation to the left); some asymmetry of neck movement; no clinical signs of radiculopathy; reflexes present and equal; and no objective signs of sensory loss in the dermatomal distribution in the right upper limb.

90. Dr Bodel had the benefit of viewing Ms Ellis' MRI scan of the cervical spine dated 24 April 2018 and the radiologist's report relating to it. In relation to the scan, Dr Bodel commented that it demonstrated evidence of some degenerative disc disease at C4/5, C5/6 and C6/7 without neural compression at any level. However, there was some mild narrowing of the subarticular recess at the C5/6 level on the right. There was no definite nerve root compromise.

91. Having reviewed the documents provided to him, Dr Bodel observed:

> "I see no specific treatment offered to her for the neck and back apart from the physiotherapy which she did at Wagga Wagga Physiotherapy and Sports Injury Centre. There is a report from David Pattison, the physiotherapist, in regard to this but the focus was mostly in the region of the right shoulder."[61]

92. In response to the question posed as to whether Ms Ellis suffered frank injuries on 8 February 2017 or injuries as a result of the nature and conditions of her employment, Dr Bodel opined as follows:

> "This lady had a slip and fall event at her workplace at the IGA Superstore in Leeton, on 08 February 2017. As a result of that she has suffered an injury to the neck and right shoulder and arm, the lower back and the right knee and right ankle."[62]

93. Dr Bodel also opined that Ms Ellis continued to suffer pain and stiffness in the neck, right shoulder, right arm, lower back, right knee and right ankle as a consequence of the incident on 8 February 2017 and that work was a substantial contributing factor to her ongoing complaints.

94. Dr Bodel viewed Ms Ellis' prognosis as guarded due to the little improvement experienced in the two years following the accident.

95. Dr Bodel went on to assess Ms Ellis' permanent impairment in relation to her cervical spine, lumbar spine, right upper extremity and right lower extremity.

Dr Vijay Panjratan, Orthopaedic Surgeon

96. On 28 May 2019, Ms Ellis consulted Dr Vijay Panjratan, Orthopaedic Surgeon at the request of the respondent's lawyers.

97. In evidence, there is a report by Dr Panjratan dated 7 June 2019.[63] I will now refer to the relevant parts of that report.

[61] ARD at page 241.
[62] ARD at page 241 at [1].
[63] Reply at pages 9-18.

98. Dr Panjratan referred to a list of documents reviewed by him in the preparation of his report.[64] Included in the list of documents referred to was Ms Ellis' cervical spine MRI scan report by Dr Stephenson dated 24 April 2018.

99. Dr Panjratan provided a general history which confirmed the date of the subject injury, Ms Ellis' occupation and current work status,[65] which were, in the main, consistent with the evidence. Dr Panjratan referred to the body parts involved for assessment as being the right ankle, right knee, right shoulder and low back. He did not refer to the cervical spine. He noted:

> "She is also claiming the right wrist which has not [sic] included."[66]

100. Dr Panjratan took the following history of injury from Ms Ellis:

> "On 08/02/2017 she was getting dough out of the cool room and slipped on water in the cool room and fell backwards. She put her hand out to stop from falling herself [sic] and hurt her right wrist, lower back. The right leg went under the left leg. This happened around 2:30 in the morning. One of the cleaners was around who saw her and called for an ambulance. She was transported to Leeton Hospital."[67]

101. Dr Panjratan provided a summary of the treatment received by Ms Ellis following the accident on 8 February 2017, which was, in the main, consistent with the evidence. He referred to a cervical MRI scan on 15 June 2018 as demonstrating some changes around the neural foramina around C6. It would appear that the date 15 June 2018 is a typographical error and that, in fact, Dr Panjratan was referring to Dr Stephenson's cervical MRI scan dated 24 April 2018, which was reviewed by Dr Howard in consultation with Ms Ellis on 15 June 2018.

102. Dr Panjratan reported on the present condition of Ms Ellis' right shoulder, lower back, right knee and right ankle.[68] He did not report on the present condition of Ms Ellis' cervical spine.

103. Dr Panjratan reported his findings on examination of Ms Ellis' right shoulder, low back, right ankle and right knee.[69] He made no reference to the cervical spine.

104. Dr Panjratan referred to the medical imaging relating to Ms Ellis' right shoulder and right ankle. He made no reference, at that point, to the medical imaging relating to the cervical spine or lumbar spine. He referred to a report by Mr Patterson, Physiotherapist [presumably, meaning Mr Pattison] dated 20 June 2018.

105. In relation to Ms Ellis' cervical spine, Dr Panjratan stated:

> "Although I did not examine the neck however when I observed her, she moved her neck normally. There was no neck complaint."[70]

106. In response to the question posed as to whether Ms Ellis injured her neck on 8 February 2017, Dr Panjratan reply as follows:

> "I do not believe she injured her neck on 08/02/2017. She mentioned the wrist to me but did not make any mention of the neck."[71]

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[64] Reply at pages 9-10.
[65] Reply at page 10.
[66] Reply at page 11.
[67] Reply at page 11.
[68] Reply at page 13.
[69] Reply at page 14.
[70] Reply at page 16 at [2].
[71] Reply at page 16 at [3].

107. When referring to the assessment of permanent impairment, Dr Panjratan stated:

> "The ankle, knee, cervical and lumbar spine do not attract any impairment as there is no abnormality."[72]

SUBMISSIONS

108. The parties made oral submissions at the arbitration hearing which were sound recorded. The sound recording is available to the parties.

Ms Wendy Michelle Ellis' submissions

109. Ms Ellis' submissions, through her counsel, Mr Beran, may be summarised as follows:

(a) The respondent's section 78 Dispute Notice dated 26 June 2019 places sections 4 and 9A in dispute in relation to the cervical spine and submissions will be limited to the dispute in relation to the cervical spine.

(b) Ms Ellis' evidentiary statement described the circumstances of the work-related injury at the respondent's premises on 8 February 2017 and stated that the injuries she suffered included her neck. She described the medical treatment she had received following 8 February 2017. She stated that she continues to experience moderate pain and discomfort in her lower back, right knee, right wrist, neck and right shoulder.

(c) The history of injury taken by Dr Panjratan was that, on 8 February 2017, Ms Ellis was getting dough out of the cool room and slipped on water in the cool room and fell backwards. She put her hand out to stop herself from and hurt her right wrist, lower back. The importance of that history of the mechanism of injury was that Ms Ellis put her hand out to stop herself from falling. She also injured her shoulder and one can infer from that there was some neck involvement by the impact of the outstretched arm onto the neck.

(d) Ms Ellis did not include an injury to her neck in the injury details section in the Worker's Injury Claim Form dated 12 February 2017. The claim form did disclose that Ms Ellis injured her right ankle, right knee, lower back, right shoulder and wrist when she slipped on water and fell in the respondent's bakery cool room whilst retrieving some sourdough. On that basis, the respondent cannot succeed on the section 9A issue raised, namely, that employment was not a substantial contributing factor.

(e) Ms Ellis' Leeton Family Clinic clinical records show that she attended her general practitioner on 9 February 2017 and reported a slip and fall at work landing on her "bottom" and complained of tenderness in her right paraspinal region. Less than a month later, on 3 March 2017, the clinical records show that Ms Ellis was complaining of pins and needles in her upper limbs. The general practitioner did not make the link of injury to Ms Ellis' cervical spine as being a cause of the pins and needles. This specialised tribunal would recognise that pins and needles can be symptoms of pathology in the cervical spine.

(f) The evidence demonstrates that the focus of treatment to Ms Ellis' injuries was to her right shoulder for some period of time. That is not uncommon in workplace injuries, where the predominant pain and symptoms are treated first and everything else is left by the wayside until the predominant pain and symptoms can be excluded.

[72] Reply at page 17.

(g) In a referral letter by Dr Pavlovskaya to Dr Howard, Orthopaedic Surgeon dated 13 April 2017, the former noted that Ms Ellis still had pain and pins and needles in her fingers.

(h) On 8 May 2017, Dr Howard noted that Ms Ellis had a fall at work on 8 February 2017 injuring her entire right side. He noted some back pain had a very painful shoulder. Dr Howard focused his assessment and treatment on Ms Ellis' right shoulder for a period of time. Such treatment focus continued until the physiotherapist identified symptoms as coming from Ms Ellis' cervical spine.

(i) On 6 October 2017, Mr Pattison, Physiotherapist referred to his ongoing management of Ms Ellis' right neck/shoulder and left lower back. He reported that her right shoulder dysfunction/upper limb neurodynamic tension had improved, and that treatment of her right cervical spine had assisted in this regard. So, as early as October 2017, Ms Ellis was receiving treatment to her cervical spine and that such treatment was alleviating her symptoms. On 17 October 2017, Mr Pattison reported an increase in Ms Ellis' neck and shoulder tension. On 5 April 2018, Mr Pattison reported to Dr Howard that treatment of Ms Ellis' cervical mobilisations / transverse mobilisations had an immediate effect on her shoulder range of motion and that her cervical spine was also playing a significant part. He thought she would benefit from further investigations of her cervical spine / ulnar nerve roots to further assist her shoulder management.

(j) On 11 April 2018, Dr Howard reported that the suprascapular nerve block undergone by Ms Ellis made little difference and that this probably suggested that her shoulder was not the major issue. He referred to Mr Pattison's recent report to him noting that the neck may be the issue and conceded that perhaps Ms Ellis' neck as a problem. Dr Howard referred Ms Ellis for a cervical MRI scan.

(k) On 24 April 2018, Ms Ellis underwent an MRI scan of her cervical spine which identified pathology. On 15 June 2018, Dr Howard reviewed the MRI scan and noted some right C6/7 changes. On 19 June 2018, Dr Howard commented on the changes noted in the cervical spine MRI scan around the neural foramina around C6 level. He thought it reasonable to inject this as she had quite marked neck pain.

(l) On 6 July 2018, Dr Howard reported to the respondent's insurer that whilst disk compression at the C6 was not definite, there were some changes on the right side at this level. He opined that there can be an overlap between neck pathology and shoulder pain and that it was possible that the cervical spine was to blame. Dr Howard did not think that the injection he was proposing was required for constitutional or ageing factors. He believed that it related to her current situation following her workplace accident and that it would assist him in her ongoing management. Essentially, Dr Howard, the treating orthopaedic surgeon, is saying that the C6 nerve root symptoms were a direct result of Ms Ellis' workplace accident on 8 February 2017.

(m) On 28 February 2019, Dr Bodel took a history relating to Ms Ellis' injury. The history provided included that Ms Ellis found that her initial general practitioner was not very supportive and that very little was done in the way of investigations. The main focus of investigation became the right shoulder. Dr Bodel noted that Ms Ellis had no prior problems with her neck. So, there was no other cause for the C6 nerve root symptoms identified by Dr Bodel or in any of the other evidence. Dr Bodel reported that Ms Ellis complained of right sided neck pain. Such complaint was consistent with Ms Ellis falling on her right side and the mechanism of injury. On physical examination, Dr Bodel observed a reduced range of neck flexion, extension and rotation in all directions. Importantly,

Dr Bodel had seen the actual MRI scan of Ms Ellis' cervical spine. He had access to both the scan and the report.

(n) Dr Bodel opined that as a result of the work-related slip and fall event in the workplace on 8 February 2017, Ms Ellis had suffered an injury to her neck, right shoulder, right arm, lower back, right knee and right ankle. He noted continuing pain in her neck and assessed Ms Ellis as having a DRE Cervical Category II level of assessable impairment.

(o) Both Dr Howard and Dr Bodel confirmed an injury to Ms Ellis' cervical spine.

(p) The only evidence opining no injury to Ms Ellis' cervical spine came from Dr Panjratan in his report dated 7 June 2019. Dr Panjratan had access to Ms Ellis' cervical spine MRI scan report but not the scan and referred to it. Importantly, and absolutely fatal to the opinions contained in Dr Panjratan's report is that he did not examine the neck. He observed her to move her neck normally. That is not a formal examination. It is on this basis that Dr Panjratan provided his opinion that Ms Ellis did not injure her neck on 8 February 2017. Such opinion is flawed and there was no fair climate within which to provide that opinion. The opinion should be rejected.

(q) The initial focus of investigation on Ms Ellis' right shoulder was the reason for the delay in the diagnosis and treatment of the C6 nerve root symptoms.

The respondent's submissions

110. The respondent's submissions, through its counsel, Mr Street, may be summarised as follows:

(a) The Worker's Injury Claim Form dated 12 February 2017 signed by Ms Ellis and declared to be true and correct, made no reference to an injury to the neck.

(b) Ms Ellis' evidentiary statement dated 16 April 2019 provided a comprehensive history and included a statement that on 8 February 2017 she slipped on the wet cool room floor and injured her right knee, right ankle, right shoulder, neck and lower back. Such statement is inconsistent with what was recorded in the Worker's Injury Claim Form. The latter document is the most compelling piece of evidence.

(c) Dr Panjratan's report dated 7 June 2019 under the heading "Body Part Involved" listed certain body parts and the list did not include the cervical spine.

(d) The respondent rejects that Dr Panjratan's evidence in relation to his examination of Ms Ellis is fatal to its case. The respondent submits that it is fatal to Ms Ellis' case, in that, it is recorded by Dr Panjratan that there was no neck complaint by her. Dr Panjratan reported that he did not believe that Ms Ellis injured her neck on 8 February 2017. He noted that she mentioned the wrist to him but that she did not make any mention of her neck. This is a question of fact. Ms Ellis, if she so chose, could have adduced evidence to the contrary. She did not.

(e) The Worker's Injury Claim Form dated 12 February 2017 made no reference to pain in Ms Ellis' neck and she made no complaint of pain in her neck to Dr Panjratan. It is submitted that, on that basis, the Commission can find that there was no injury to Ms Ellis' neck. Further, throughout Ms Ellis' early clinical history, until the physiotherapists report dated 6 October 2017, there was no reference to the neck in the recorded consultations.

(f) It is not clear on the face of Mr Pattison's report dated 6 October 2017, despite the fact that it is the first reference to the cervical spine, that the issue of the neck was raised on the complaint of Ms Ellis. The report does not say that Ms Ellis complained of pain in the neck.

(g) Similarly, Dr Howard's report dated 11 April 2018 did not say that Ms Ellis complained of pain in the neck.

(h) There was no direct evidence of Ms Ellis having given an account to her treating medical practitioners that she had injured her neck on 8 February 2017.

(i) The MRI scan of Ms Ellis' cervical spine dated 24 April 2018, came about after Dr Howard decided to investigate the issues about the neck raised by the physiotherapist. The MRI report described the findings of degenerative joint disease.

(j) Dr Bodel recorded the history relating to the injury. On examination, he observed a reduced range of neck flexion, extension and rotation in all directions. Such finding on examination was consistent with the MRI scan report, but it is also perfectly consistent with a degenerative condition, not necessarily a frank injury. Dr Bodel opined that Ms Ellis sustained a frank injury following a slip and fall event at her workplace on 8 February 2017 and that she suffered an injury to the neck, right shoulder, arm, lower back, right knee and right ankle. Dr Bodel's report is inconsistent with the claim form completed by Ms Ellis and the claim form is inconsistent with her evidentiary statement. The reference to pins and needles in Ms Ellis' Leeton Family Clinic clinical records was not picked up by Dr Bodel as a link to the cervical spine and the incident on 8 February 2017. If it were so important, one would have thought that Dr Bodel would have dealt with it.

(k) Ms Ellis may have some continuing pain in her neck region as a result of what has been revealed in the MRI scan. However, the Commission cannot be satisfied on balance that it was as a result of the incident on 8 February 2017.

(l) The Commission cannot draw an inference that there was some neck involvement because Ms Ellis fell with an outstretched arm. If that was, in fact, what happened, one would have expected it to have been recorded in the Worker's Injury Claim Form dated 12 February 2017 completed by Ms Ellis and in subsequent consultations with treatment providers.

(m) Dr Howard's report to the respondent's insurer dated 6 July 2018 should be read as a whole. The question posed by the insurer is how the C6 pathology is related. Dr Howard does not explain how the pathology is related to the incident on 8 February 2017. There is no reasoning revealed leading to the ultimate conclusion that it was related to her current situation following her workplace accident. The opinion carries no weight in those circumstances, and it comes more than a year after the incident. The report is of no assistance to the Commission.

(n) The respondent did not wish to make any submissions in relation to section 9A of the 1987 Act.

Ms Ellis' submissions in reply

111. Ms Ellis' submissions in reply may be summarised as follows:

(a) The respondent raised as an issue the fact that the original claim form did not list the neck as being injured. Workers are not expected to know the exact nature and extent of their injuries at the time of initial notification: *Warwick Hobart trading as Terry White Chemists v Pietrzak*[73] (*Pietrzak*).

(b) Dr Panjratan's findings on examination were of fact, not opinion. However, his opinion was based on those facts. He did not conduct an examination of the neck. Hence, Dr Panjratan's opinion is flawed.

(c) The clinical records in evidence do not reveal any prior history of neck complaints. They identify no intervening injuries. They identify no alternate cause of the symptoms in Ms Ellis' neck.

(d) In relation to Dr Howard's report to the respondent's insurer dated 6 July 2018, it is agreed that the reasoning process was not totally elucidated. It was a simple report to the insurance company to answer certain questions, not an expert's report. The insurer could have asked for further reasons from Dr Howard.

(e) There are two orthopaedic surgeons supporting an injury to Ms Ellis' cervical spine (Dr Howard and Dr Bodel).

The respondent's submissions in reply

112. The respondent's submissions in reply may be summarised as follows:

(a) Dr Panjratan's findings on examination were of fact. The fact was one of no complaint of neck pain.

(b) The submission that Dr Howard's report dated 6 July 2018 was a simple report to the insurer to answer certain questions, not an expert's report and that insurer could have asked for further reasons from Dr Howard, reverses the onus. Ms Ellis bears the onus of proving injury.

(c) In relation to the submission that there was no evidence of an alternate cause of the symptoms in Ms Ellis' neck, there is an alternate cause, namely, the degenerative condition in the cervical spine.

Ms Ellis' further submissions in reply

113. Ms Ellis' further submissions in reply may be summarised as follows:

(a) There were complaints of neck pain made to the physiotherapist and the treating orthopaedic surgeon.

(b) There is no evidence that an alternate cause of the symptoms in Ms Ellis' neck, is the degenerative condition in her cervical spine. That was counsel for the respondent's interpretation of the cervical spine MRI report. Such submission should be discounted.

[73] *Warwick Hobart trading as Terry White Chemists v Pietrzak* [2006] NSWWCCPD 315 at [56].

114. After some discussion with the parties following the conclusion of oral submissions, I made the following directions for written submissions:

> "1. The respondent is to lodge and serve by 15 October 2019 a list of references to the clinical records in evidence supporting its oral submissions in relation to the applicant's alleged injury to her cervical spine made at the arbitration hearing on 1 October 2019.
>
> 2. The applicant is to lodge and serve by 22 October 2019 any written submissions in reply.
>
> 3. At the conclusion of the time allowed for submissions the dispute will be determined 'on the papers'."

The respondent's written submissions

115. The respondent's written submissions in the form of a schedule of relevant references in the clinical records in evidence were undated and entered into the Commission's file on 16 October 2019. I have referred to those references in the analysis of the evidence above.

Ms Ellis' written submissions in reply

116. Ms Ellis' written submissions in reply were dated 22 October 2019 and entered into the Commission's file on 24 October 2019. The submissions may be summarised as follows:

> (a) The respondent's schedule of documents supports the position expressed by the Ms Ellis at arbitration, in that, it was not until the treating physiotherapist identified symptomology in her neck, that the neck began to be treated and diagnosed. It was only after further repeated suggestions by Mr Pattison that Ms Ellis' neck was actively looked at by Dr Howard, her treating specialist.
>
> (b) After Mr Pattison's initial reference to Ms Ellis' neck, the neck is increasingly reported in the medical documents, as identified by the schedule, culminating in the multiple records of Dr Howard.
>
> (c) Workers are not expected to know the exact nature and extent of their injuries at the time of initial notification: *Pietrzak.*
>
> (d) Ms Ellis is a person with no medical knowledge. She relied on her treating practitioners to diagnose the injuries sustained in the incident on 8 February 2017. The fact that the diagnosis was delayed by an essentially disinterested general practitioner, should not prejudice her, especially in circumstances where a diagnosis has now been made by multiple orthopaedic surgeons.

FINDINGS AND REASONS

117. I have carefully considered the evidence and the oral and written submissions made by the parties.

118. The relevant legislation and legal principles are outlined below.

119. Section 4 of the 1987 Act provides:

> "In this Act:
>
> 'injury':
>
> (a) means personal injury arising out of or in the course of employment,

(b) includes a 'disease injury', which means:

(i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and

(ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, and

(c) does not include (except in the case of a worker employed in or about a mine) a dust disease, as defined by the *Workers' Compensation (Dust Diseases) Act* 1942, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined."

120. The onus of establishing injury falls upon Ms Ellis and the standard of proof is on the balance of probabilities, meaning that I must be satisfied to a degree of actual persuasion or affirmative satisfaction: *Department of Education and Training v Ireland*[74] (*Ireland*) and *Nguyen v Cosmopolitan Homes*[75] (*Nguyen*).

121. The issue of causation must be based and determined on the facts in each case. In the NSW workers compensation jurisdiction, the long accepted view regarding causation was set out in *Kooragang Cement Pty Ltd v Bates*[76] (*Kooragang*). In *Kooragang*, in perhaps the most commonly cited passage on causation, Kirby P said:

> "The result of the cases is that each case where causation is in issue in a workers compensation claim, must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from', is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent death or injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a commonsense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation. In each case, the question whether the incapacity or death 'results from' the impugned work injury (or in the event of a disease, the relevant aggravation of the disease), is a question of fact to be determined on the basis of the evidence, including, where applicable, expert opinions. Applying the second principle which Hart and Honoré identify, a point will sometimes be reached where the link in the chain of causation becomes so attenuated that, for legal purposes, it will be held that the causative connection has been snapped. This may be explained in terms of the happening of a novus actus. Or it may be explained in terms of want of sufficient connection. But in each case, the judge deciding the matter, will do well to return, as McHugh JA advised, to the statutory formula and to ask the question whether the disputed incapacity or death 'resulted from' the work injury which is impugned."[77]

122. The High Court of Australia, in *Comcare v Martin*[78] (*Martin*), considered the extent to which one can rely on a common sense evaluation of the causal chain test referred to in *Kooragang*. *Martin* involved the definition of injury under section 5A in the *Safety,*

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[74] *Department of Education and Training v Ireland* [2008] NSWWCCPD 134.
[75] *Nguyen v Cosmopolitan Homes* [2008] NSWCA 246.
[76] *Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796.
[77] *Kooragang Cement Pty Ltd v Bates* (1994) 10 NSWCCR 796 at 810.
[78] *Comcare v Martin* [2016] HCA 43.

Rehabilitation and Compensation Act 1988 (the SRC Act). The High Court of Australia's conclusion commences with a caution concerning the use of the "common sense" test:

> "Causation in a legal context is always purposive. The application of a causal term in a statutory provision is always to be determined by reference to the statutory text construed and applied in its statutory context in a manner which best effects its statutory purpose. It has been said more than once in this Court that it is doubtful whether there is any 'common sense' approach to causation which can provide a useful, still less universal, legal norm. Nevertheless, the majority in the Full Court construed the phrase 'as a result of' in s 5A(1) as importing a 'common sense' notion of causation. That construction, with respect, did not adequately interrogate the statutory text, context and purpose.[79]

123. As I understand it, when referring to applying "common sense", Kirby, P in *Kooragang* was not suggesting that it be applied "at large" or that issues were to be determined by "common sense" alone but by a careful analysis of the evidence. Therefore, the legislation must be interpreted by reference to the terms of the statute and its context in a fashion that best effects its purpose. Such a concept is not new. Sections 4(b), 9A and 11A of the 1987 Act contain specific requirements and the provisions need to be interpreted using standard principles of interpretation. This does not mean that the common sense approach has no place in the application of the legislation to the facts of the case.

124. In *Kirunda v State of New South Wales (No 4)*[80] (*Kirunda*), Snell DP stated:

> "In *Kooragang Cement Pty Ltd v Bates* Kirby P said that causation 'is a question of fact to be determined on the basis of the evidence, including, where applicable, expert opinions'.[81] A finder of fact, dealing with issues of causation, is entitled to 'have some recourse' to 'the sequence of events and commonsense'.[82] However, where an 'issue lies outside the realm of common knowledge and experience' it 'falls to be determined by reference to expert medical evidence'.[83] In *Lithgow City Council v Jackson* the plurality said, of a finding on causation:
>
> > 'That proposition is not self-evident. To establish it would call for more than the application of 'commonsense' or the court's experience of ordinary life. The proposition turns on an inference from the nature of the respondent's injuries to their probable cause. That inference could only be drawn in the light of expert medical evidence.'"[84]

125. In order to establish that a "personal injury" has been suffered within the meaning of section 4(a) of the 1987 Act, Ms Ellis must establish, on the balance of probabilities, that there has been a definite or distinct "physiological change" or "physiological disturbance" in the cervical spine for the worse which, if not sudden, is at least, identifiable: *Kennedy Cleaning Services Pty Ltd v Petkoska*[85] (*Kennedy*) and *Military Rehabilitation and Compensation Commission v May*[86] (*May*). The word "injury" refers to both the event and the pathology arising from it: *Lyons v Master Builders Association of NSW Pty Ltd*[87] (*Lyons*). While pain may be indicative of such physiological change, it is not itself a "personal injury".

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[79] *Comcare v Martin* [2016] HCA at [42].
[80] *Kirunda v State of New South Wales (No 4)* [2018] NSWWCCPD 45 at [136].
[81] (1994) 35 NSWLR 452, 464B..
[82] *Hevi Lift (PNG) Ltd v Etherington* [2005] NSWCA 42; 2 DDCR 271, [89] (per McColl JA, Mason P and Beazley JA agreeing).
[83] *Tubemakers of Australia Ltd v Fernandez* (1976) 50 ALJR 720, 724E (per Mason J, Barwick CJ and Gibbs J agreeing).
[84] *Lithgow City Council v Jackson* [2011] HCA 36; 244 CLR 352; 281 ALR 223; 85 ALJR 1130, [66] (*Jackson*).
[85] *Kennedy Cleaning Services Pty Ltd v Petkoska* [2000] HCA 45.
[86] *Military Rehabilitation and Compensation Commission v May* [2016] HCA 19.
[87] *Lyons v Master Builders Association of NSW Pty Ltd* (2003) 25NSWCCR 496.

126. *Castro v State Transit Authority*[88] (*Castro*) provides a useful review of the authorities and makes it clear that what is required to constitute "injury" is a "sudden or identifiable pathological change". In *Castro*, a temporary physiological change in the body's functioning (atrial fibrillation: irregular rhythm of the heart), without pathological change, did not constitute injury.

127. *Zickar v MGH Plastic Industries Pty Ltd*[89] highlighted that a worker can rely on injury simpliciter despite the existence of a disease. The High Court of Australia held that the presence of a disease did not preclude reliance upon that event as a personal injury. The terms "personal injury" and "disease" are not mutually exclusive categories. A sudden identifiable physiological (pathological) change to the body brought about by an internal or an external event can be a personal injury and the fact that the change is connected to an underlying disease process does not prevent the injury being a personal injury: *North Coast Area Health Service v Felstead*.[90]

128. I now turn to the application of the relevant legislation and the legal principles referred to above to the available evidence in this matter, bearing in mind that Ms Ellis bears the onus of establishing her case on the balance of probabilities.

129. The analysis of the evidence above discloses some inconsistencies between the evidence of Ms Ellis and the medical records; and even between the medical records themselves, particularly in relation to the claimed injury to Ms Ellis' cervical spine. I have drawn attention to some of the vague, unhelpful and inconsistent entries in Ms Ellis' Leeton Family Clinic records and the absence of recorded complaints of symptomology in relation to the cervical spine.

130. Whilst I have no reason to doubt Ms Ellis' credibility, I have concerns about the reliability of her evidence regarding her cervical spine. I will now refer to those concerns.

131. Ms Ellis' statement was completed with the assistance of her lawyer on 16 April 2019, more than two years after the work-related incident. The value of contemporaneous evidence has been repeatedly endorsed by the courts.

132. In *Onassis and Calogeropoulos v Vergottis*[91], Lord Pearce said of documentary evidence:

> "It is a truism, often used in accident cases, that with every day that passes the memory becomes fainter and the imagination becomes more active. For that reason, a witness, however honest, rarely persuades a Judge that his present recollection is preferable to that which was taken down in writing immediately after the accident occurred. Therefore, contemporary documents are always of the utmost importance."

133. More recently, in *Watson v Foxman*,[92] the McLelland CJ in Equity said:

> " … Human memory of what was said in a conversation is fallible for a variety of reasons, and ordinarily the degree of fallibility increases with the passage of time, particularly where disputes or litigation intervene, and the processes of memory are overlaid, often subconsciously, by perceptions or self-interest as well as conscious consideration of what should have been said or could have been said. All too often what is actually remembered is little more than an impression from which the plausible details are then, again often subconsciously, constructed. All of this is a matter of human experience."[93]

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[88] *Castro v State Transit Authority* [2000] NSWCC 12; (2000) 19 NSWCCR 496.
[89] *Zickar v MGH Plastic Industries Pty Ltd* [1996] HCA 31; 187 CLR 310.
[90] *North Coast Area Health Service v Felstead* [2011] NSWWCCPD 51 at [77].
[91] *Onassis and Calogeropoulos v Vergottis* [1968] 2 Lloyd's Rep 403 at 431.
[92] *Watson v Foxman* (1995) 49 NSWLR 315.
[93] *Watson v Foxman* (1995) 49 NSWLR 315 at 319.

134. Histories in medical records are often used to attack the credit of a worker. Reference is made either to a failure to mention relevant matters, or a description in a medical record which is different to what the worker now says in evidence. Care should be taken when considering such evidence, not to place too much weight on the clinical notes of treating doctors, given their primary concern with treatment. Experience demonstrates that busy doctors sometimes misunderstand, omit or incorrectly record histories of accidents or complaints by a patient, particularly in circumstances where their concern is with the treatment or impact of an obvious frank injury: *Davis v Council of the City of Wagga Wagga*[94]; and applied in *King v Collins*[95] and *Mastronardi v State of New South Wales*[96].

135. The caution referred to above was confirmed by Roche DP in *Winter v NSW Police Force*[97] as follows: The caution referred to above was confirmed by Roche DP in *Winter v NSW Police Force*[98] as follows:

> "It is important to remember that clinical notes are rarely (if ever) a complete record of the exchange between a patient and a busy general practitioner. For this reason, they must be treated with some care (*Nominal Defendant v Clancy* [2007] NSWCA 349; *Davis v Council of the City of Wagga Wagga* [2004] NSWCA 34; *King v Collins* [2007] NSWCA 122 at [34-36])."[99]

136. I acknowledge that caution must be taken when relying upon clinical records. I have exercised caution in this regard and considered all the evidence in coming to my findings.

137. In describing the mechanism of her slip and fall on 8 February 2017 in her own evidentiary statement, Ms Ellis did not refer to falling with an outstretched right arm or to putting her right hand out to stop herself from falling. Such description was not included in the Worker's Injury Claim Form Ms Ellis completed and signed on 12 February 2017. The history of injury recorded by Dr Noormohideen, Ms Munro, Dr Howard and Dr Bodel did not include such description. Dr Noormohideen took a history of Ms Ellis having slipped on water and fallen at work in a bakery, landing on her "bottom". Ms Munro took a history of falling in the bakery on her right side. Dr Howard took a history of a fall at work on her right side. Dr Bodel took a history of a slip and fall event in the cool room at work, landing very heavily on her right-hand side. On 3 March 2017, Dr Pavlovskaya took a history of a fall on an outstretched arm and that her right foot had become inverted with the fall. Dr Panjratan took a history of slipping on water in the cool room, falling backwards, putting her hand out to stop herself from falling and her right leg going under her left leg.

138. As pointed out by Ms Ellis' counsel, Mr Beran, in submissions, Dr Panjratan was the medical practitioner who recorded the most detailed history of the mechanism of the slip and fall. The description provided to Dr Panjratan is consistent with Ms Ellis landing on her "bottom", as described to Dr Noormohideen. It is also consistent with falling on her right side, as described to Dr Howard, Dr Bodel and Ms Munro. It is consistent with the injuries to Ms Ellis' right wrist, right shoulder, right knee and right ankle. However, I disagree with Ms Ellis' submission that, by accepting such description of the mechanism of the slip and fall, I can infer that Ms Ellis injured her cervical spine on 8 February 2017. Such inference is not self-evident. To establish it would call for more than the application of 'commonsense' or the Commission's experience of ordinary life. The proposition turns on an inference from the nature of Ms Ellis' symptomatology and pathology to their probable cause. Such inference could only be drawn in the light of expert medical evidence: *Kirunda* and *Jackson*. I will refer to the expert evidence later.

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[94] *Davis v Council of the City of Wagga Wagga* [2004] NSWCA 34.
[95] *King v Collins* [2007] NSWCA 122.
[96] *Mastronardi v State of New South Wales* [2009] NSWCA 270.
[97] *Winter v NSW Police Force* [2010] NSWCCPD 12.
[98] *Winter v NSW Police Force* [2010] NSWCCPD 12.
[99] *Winter v NSW Police Force* [2010] NSWCCPD at [183].

139. Having carefully considered all the evidence relating to the mechanism of Ms Ellis' slip and fall event at the respondent's premises on 8 February 2019, I am satisfied and find that Ms Ellis slipped on water in the respondent's cool room, fell backwards, put her hand out to stop herself from falling and on landing, her right leg went under her left leg.

140. In relation to the alleged injury to Ms Ellis' cervical spine, there is a lack of contemporaneous evidence of complaints of symptoms.

141. Ms Ellis' evidentiary statement dated 16 April 2019, provided a briefer description of the mechanism of her slip and fall on 8 February 2017 than she did to Dr Panjratan at the time she consulted him. Thereafter, she simply stated that, as a result of the incident, she injured her right knee, right ankle, right shoulder, neck and lower back. In her evidentiary statement, Ms Ellis did not specify when she noticed the onset of pain in her neck, nor did she describe the nature of the symptoms in her neck. However, she did state that four weeks after 8 February 2017, she returned to work with the respondent and was still experiencing pain in her lower back, neck, right wrist, right knee and right shoulder. As to her current condition, Ms Ellis stated that she continued to experience moderate pain and discomfort in her lower back, right knee, right wrist, neck and right shoulder.

142. In the Worker's Injury Claim Form dated 12 February 2017, Ms Ellis recorded the injury/condition and body parts affected in the incident on 8 February 2017 as being the right ankle, right knee, lower back, right shoulder and wrist. There was no reference to her neck. The respondent submitted that the claim form was a compelling piece of evidence in this regard. I do not accept that it is as compelling on its own as the respondent submitted. It is but one piece of evidence I have taken into account together with the rest of the evidence before me.

143. Ms Ellis submitted that workers are not expected to know the exact nature and extent of their injuries at the time of initial notification: *Pietrzak*. The principle espoused in *Pietrzak* was in the context of section 254 of the 1998 Act, where Roche DP stated:

> "The term 'injury' in the 1998 Act means 'personal injury arising out of or in the course of employment'" (section 4 1998 Act). In the context of section 254 'injury' means 'injurious event', not the pathology said to have resulted from the injurious event. A worker is not expected to know the exact nature and extent of his injury at the time of initial notification. Any other interpretation of 'injury' in this section would lead to the unsatisfactory situation of a worker who gives notice of an upper back strain being barred from claiming compensation in the event that medical investigations subsequently reveal that he or she in fact sustained a lumbar disc injury. There may well be arguments about causation, but provided the evidence supported a connection between the injurious event and the subsequently discovered lumbar disc lesion, the worker would not be barred from recovering compensation because he or she did not initially give 'notice of injury' for the correct body part."[100]

144. The issue here in relation to the alleged injury to the cervical spine is one of causation, that is, whether there is evidence supporting a connection between the injurious event and the alleged injury to the cervical spine.

145. Between 9 February 2017 and 22 February 2017, Ms Ellis consulted Dr Noormohideen, whose treatment and investigations focussed on her lumbosacral spine and, to a lesser extent, her right wrist. He arranged for Ms Ellis to undergo an x-ray of her right wrist and an x-ray and CT scan of her lumbosacral spine. Dr Noormohideen did not record any complaints of neck symptoms by Ms Ellis in any of the consultations on 9 February 2017, 14 February 2017, 16 February 2017 or 22 February 2017.

[100] *Warwick Hobart trading as Terry White Chemists v Pietrzak* [2006] NSWWCCPD 315 at [56].

146. On and from 3 March 2017, Ms Ellis came mainly under the care of Dr Pavlovskaya until the former moved to Junee. Ms Ellis submitted that on 3 March 2017, Dr Pavlovskaya recorded complaints of pins and needles in Ms Ellis' upper limbs and that, whilst the doctor did not make the link of injury to the cervical spine as being the cause of the pins and needles, the Commission, as a specialist tribunal, would recognise that pins and needles can be symptoms of pathology in the cervical spine. I do not agree with the submission that Dr Pavlovskaya recorded complaints of pins and needles in Ms Ellis' upper limbs at this consultation. The clinical records referred only to "pins and needles" and a burning sensation in the right shoulder. There was no reference to the upper limbs. There was no complaint of neck symptoms. In a referral letter to Dr Howard dated 13 April 2017, Dr Pavlovskaya referred to pins and needles in the fingers. There was no reference to the upper limbs. There was no complaint of neck symptoms recorded.

147. Dr Pavlovskaya, Dr Howard and Mr Pattison focussed on the treatment of Ms Ellis' right shoulder for a significant period of time. This was not surprising as there was no record in the Leeton Family Clinic records of Ms Ellis having complained of symptoms in her neck. The Certificates of Capacity did not refer to a neck injury or neck symptoms.

148. The first reference to the neck is found in Mr Pattison's report to Dr Pavlovskaya dated 6 October 2017, where he referred to treatment of the "right neck/shoulder". He described great progress having been made, noting that he had treated Ms Ellis' tight cervical spine, which had assisted in the improvement of her condition.

149. On 26 February 2018, Ms Ellis consulted Dr Howard, who reported that Ms Ellis was still experiencing a lot of trouble with her shoulder and that the situation had not really progressed. He remained convinced that there was no significant cuff tear, but her pain was not settling. He recommended a suprascapular nerve block. The latter procedure was performed on 14 March 2018 and Ms Ellis reported a slight, but not significant reduction in pain to Mr Pattison shortly thereafter.

150. It was not until Mr Pattison's report to Dr Howard dated 5 April 2018, that Mr Pattison expressed the opinion that Ms Ellis' cervical spine was playing a significant part in her ongoing shoulder/cuff weakness. He recommended further investigations of her cervical spine and ulnar nerve roots to further assist her shoulder management. Dr Howard felt that, as treatment to date did not seem to be addressing the issue, perhaps the cervical spine was the problem. He referred Ms Ellis for an MRI scan of her cervical spine and for median and ulnar nerve conduction studies.

151. Dr Howard explained to the respondent's insurer that there can be an overlap between neck pathology and shoulder pain and that on the basis shoulder interventions had not been totally successful, it was possible that the cervical spine was to blame. Dr Howard's request for the insurer's approval to proceed with the right C6 perineural nerve root injection was based on his opinion that, because of the possible overlap referred to above, it was related to her current condition following her workplace accident and would assist with her ongoing management.

152. The median and ulnar nerve conduction studies, conducted on 15 June 2018, concluded that there was a right median neuropathy at the right wrist, consistent with carpal tunnel syndrome of mild to moderate severity. On the evidence, Dr Howard appeared to be unaware of the nerve conduction study findings. Such findings could explain the sensation of pins and needles in Ms Ellis' fingers. The MRI scan of Ms Ellis' cervical spine on 15 June 2018, as interpreted by Dr Howard, noted changes around the neural foramina at the C6 level and he felt it reasonable to inject it because of her then marked neck pain. He also opined that, whilst disc compression was not definite, there were some changes at the C6/7 level on the right side.

153. On 26 July 2018, Ms Ellis underwent a CT guided right C6 perineural cortisone injection. On 23 August 2018, Ms Ellis consulted Dr Howard, who reported that the CT guided right C6 perineural cortisone injection was not of much benefit and that he did not believe that he had any other treatment to offer and made no arrangements for her to consult him again.

154. Mr Pattison felt that Ms Ellis' cervical spine was playing a significant part in her ongoing shoulder/cuff weakness. Dr Howard opined that it was possible that the cervical spine was to blame after reviewing the cervical MRI scan, which demonstrated evidence of some degenerative disc disease at C4/5, C5/6 and C6/7 without neural compression; and mild narrowing of the subarticular recess at C5/6 on the right. However, the CT guided right C6 perineural cortisone injection was not of much benefit. I do not accept Ms Ellis' submission that, essentially, Dr Howard opined that the C6 nerve root symptoms were a direct result of the workplace incident on 8 February 2017. Dr Howard thought it possible that the neck was to blame and felt it reasonable to inject the right C6 in such circumstances because of the potential overlap between neck pathology and shoulder pain. Not surprisingly for a treating specialist, Dr Howard did not fully engage with the causation issue.

155. Ms Ellis consulted Dr Panjratan on 28 May 2019. Dr Panjratan did not believe that Ms Ellis injured her cervical spine in the workplace incident on 8 February 2017. However, Dr Panjratan admitted to not having examined Ms Ellis' cervical spine. He merely observed that she moved her neck normally. I cannot understand why Dr Panjratan did not examine Ms Ellis' cervical spine, as it was clearly within the instructions with which he was provided. Accordingly, I do not give any weight to his opinion that Ms Ellis did not injure her cervical spine. Nevertheless, Dr Panjratan was clear that Ms Ellis did not complain of neck symptoms during the consultation. Ms Ellis did not produce any evidence to the contrary despite having ample opportunity to do so. Dr Panjratan referred to the body parts involved for assessment as being the right ankle, right knee, right shoulder and lower back. He also made reference to Ms Ellis claiming the right wrist.

156. Dr Bodel summarised Ms Ellis' injuries as being to the neck; the right shoulder and arm; the lower part of the back; the right knee and the right ankle. Dr Bodel did not record as part of the history of injury, the version Ms Ellis was promoting in submissions and which was accepted by me, namely, that she slipped on water in the respondent's cool room, fell backwards, put her hand out to stop herself from falling and on landing, her right leg went under her left leg. Dr Bodel did not make reference to the pins and needles in Ms Ellis' fingers.

157. Dr Bodel opined that, on 8 February 2017, Ms Ellis experienced a slip and fall event at her workplace and, as a result, suffered injuries to the neck, right shoulder, arm, lower back, right knee and right ankle and that work was a substantial contributing factor to her ongoing complaints. However, Dr Bodel does not provide the reasoning behind reaching such opinion.

158. Rule 15.2(3) of the Workers Compensation Commission Rules 2011 provides that "evidence based on speculation or unsubstantiated assumptions is unacceptable." Further, it is well established in the authorities such as *Paric v John Holland (Constructions) Pty Ltd*[101] (*Paric*); *Makita (Australia) Pty Ltd v Sprowles*[102] (*Makita*); *South Western Sydney Area Health Service v Edmonds*[103] (*Edmonds*); and *Hancock v East Coast Timbers Products Pty Ltd*[104] (*Hancock*); that there must be a "fair climate" upon which a doctor can base an opinion. Whilst it is accepted that a doctor does not need to provide elaborate or detailed explanations for his conclusion, one needs more than a mere "ipse dixit" (an assertion without proof) and that seems to be precisely what Dr Bodel has done in this matter.

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

159. Accordingly, having considered the whole of the evidence, I am not satisfied on the balance of probabilities, to a degree of actual persuasion or affirmative satisfaction, that Ms Ellis has established that there was a definite or distinct physiological change or disturbance in her cervical spine for the worse which, if not sudden, was at least identifiable, arising out of or in the course of her employment with the respondent on 8 February 2017.

160. Accordingly, I find that Ms Ellis did not suffer an injury to the cervical spine on 8 February 2017 within the meaning of section 4(a) of the 1987 Act.

SUMMARY

161. Ms Ellis did not suffer an injury to the cervical spine on 8 February 2017 within the meaning of section 4(a) of the 1987 Act.

162. Award for the respondent in relation to the claimed injury to the cervical spine on 8 February 2017.

163. The matter is remitted to the Registrar for referral to an Approved Medical Specialist for assessment pursuant to the 1998 Act as follows:

Date of injury:	8 February 2017.
Body System:	Right upper extremity (right shoulder) and right lower extremity (right knee and right ankle).
Method of Assessment:	Whole Person Impairment.

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

    (a) ARD dated 18 June 2019 and attached documents;

    (b) Reply dated 10 July 2019 and attached documents.