WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **5408/19**
Applicant: **Gary Nilsson**
Respondent: **Wollongong City Council**
Date of Determination: **20 January 2020**
Citation: **[2020] NSWWCC 23**

The Commission determines:

1. The Application to Resolve a Dispute is amended in Part 4 to allege:

    (a) injury to the left shoulder on 1 October 2012;

    (b) injury to the left shoulder due to work tasks performed between September 2011 and December 2013;

    (c) injury to the cervical spine due to work tasks performed between September 2011 and December 2013, and/or

    (d) consequential condition in the cervical spine resulting from injury to the left shoulder.

2. Award for the respondent with respect to the claim pursuant to section 66 of the *Workers Compensation Act 1987*.

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

W Dalley
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 WILLIAM DALLEY, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

G Bhasin

Gurmeet Bhasin
Acting/ Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Gary Nilsson (Mr Nilsson/the applicant) was employed from time to time by Wollongong City Council (the Council/the respondent) as a casual labourer between mid-2011 and March 2014. On 1 October 2012 Mr Nilsson was performing work using a whipper snipper when he noticed painful symptoms in the left shoulder. Mr Nilsson reported the incident and continued working, expecting that the symptoms in the left shoulder would resolve. However, the left shoulder symptoms did not resolve and Mr Nilsson continued to experience pain in the left shoulder when performing his work.

2. Mr Nilsson last performed work for the respondent in December 2013. He was not offered further work and, apart from a few days performing traffic control work for a different employer at a construction site, he has not worked since.

3. Mr Nilsson continued to suffer symptoms in the left shoulder. Mr Nilsson underwent conservative treatment without lasting relief. In November 2014 the treating orthopaedic surgeon recommended arthroscopic rotator cuff repair. The respondent declined liability for that surgery and the surgery was eventually performed in January 2016 in the public system.

4. Mr Nilsson also complained of painful symptoms in his neck and investigations were carried out in mid-2015.

5. In proceedings commenced in the Commission in 2015 Mr Nilsson sought weekly payments and payment of treatment expenses. The respondent accepted liability for weekly payments for a closed period in respect of injury to the left shoulder which occurred on 1 October 2012. Weekly payments for the closed period were the subject of an award with the claim for treatment expenses being discontinued and settled by agreement between the parties.

6. Mr Nilsson was examined by Dr James Bodel, orthopaedic surgeon, at the request of Mr Nilsson’s solicitors on a number of occasions. Dr Bodel assessed Mr Nilsson as having 7% whole person impairment in respect of pathology in the cervical spine and 8% whole person impairment in respect of pathology in the left shoulder. The combined assessment was 14% whole person impairment.

7. A claim for lump-sum compensation pursuant to section 66 of the *Workers Compensation Act 1987* (the 1987 Act) was made by Mr Nilsson’s legal representatives. The Permanent Impairment Claim Form nominated the date of injury as 1 October 2012. The “body system affected by the injury” was “left shoulder”. The letter accompanying the claim form did not specify the nature and extent of the injury alleged but relied upon the report of Dr Bodel dated 20 July 2017.

8. The respondent disputed the claim. The respondent denied injury to the left shoulder or cervical spine due to gradual process (disease injury) and disputed the extent of impairment arising from injury to the left shoulder on 1 October 2012. The respondent also raised the issue of whether the claim had been duly made in respect of an allegation of a disease injury as well as disputing that employment was a substantial contributing factor to injury to the left shoulder by way of a disease process.

9. In a further dispute notice dated 4 October 2018 the respondent also disputed that Mr Nilsson suffered “any consequential/secondary condition in your cervical spine/neck as now alleged.”

10. Mr Nilsson's representatives filed an Application to Resolve a Dispute in the Commission alleging injury: "1/10/2012 (and nature and conditions of employment from September 2011 to December 2013)". The type of injury was nominated as "disease injury". The injury description was; "The applicant sustained injury to his left shoulder and neck while using a whipper snipper to cut long grass, as well as performing heavy and repetitive manual activities." The claim was for lump sum compensation pursuant to section 66 of the 1987 Act.

11. The respondent confirmed the denial of liability in accordance with its dispute notices and sought leave pursuant to section 289A(4) of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) to dispute "that the applicant's employment was the main contributing factor to the alleged injuries to the neck/cervical spine and left shoulder within the meaning of Section 4(b) of the Workers Compensation Act 1987".

ISSUES FOR DETERMINATION

12. At hearing the applicant was granted leave to amend the allegation of injury to add a claim, in the alternative, that the applicant suffered the onset of a pathological condition in the cervical spine as a consequence of injury to the left shoulder (whether that injury be a frank injury or a disease injury). A claim of that nature had been effectively disputed by the respondent in its further dispute notice dated 4 October 2018.

13. The dispute notices had effectively denied injury pursuant to section 4(b) of the 1987 Act and I was satisfied that leave was not required for the respondent to rely upon an issue of whether employment was the main contributing factor as this was a necessary condition for disease injury to be established.

14. The parties agree that the following issues (capable of resolution in the Commission) remain in dispute:

    (a) Did the applicant suffer an injury to his left shoulder due to the nature of the work tasks performed by him in the course of his employment with the respondent?

    (b) Did the applicant suffer an injury to his cervical spine due to the nature of the work tasks performed by him in the course of his employment with the respondent?

    (c) Did the applicant suffer the onset of a pathological condition in the cervical spine as a result of injury to the left shoulder in the course of his employment with the respondent?

PROCEDURE BEFORE THE COMMISSION

15. 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

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

    (a) Application to Resolve a Dispute and attached documents, and
    (b) Reply and attached documents.

Oral evidence

17. No application was made for the introduction of oral evidence or to cross examine any witness.

FINDINGS AND REASONS

The evidence

18. The relevant evidence is common to the determination of each of the issues and it is convenient to deal with the issues together. The respondent did not dispute that the applicant suffered an injury to his left shoulder on 1 October 2012, being an injury within section 4(a) of the 1987 Act.

Mr Nilsson.

19. A number of statements by Mr Nilsson were in evidence. In a statement dated 9 January 2015 (said to have been taken on 22 December 2014) Mr Nilsson detailed his employment by the Council. He said that he had been employed on a casual basis between 27 June 2011 and 14 March 2014. His last work had been performed with the Council "in the lead up to Christmas 2013." He said that he had not engaged in any other employment at that time.

20. Mr Nilsson said that prior to the commencement of his employment he had undergone a pre-employment medical and had disclosed a prior injury to his right shoulder unrelated to work which occurred in 1982. He said that he made a good recovery from that injury and up to that time had no ongoing complaints relating to the right shoulder.

21. After employment with the Council, Mr Nilsson said that he had had only four days' work for a different employer doing traffic control.

22. Mr Nilsson said that he had worked in a range of different roles for the Council, performing construction tasks, working on the asphalt truck, forming concrete work and working in parks and gardens.

23. Mr Nilsson described the injury that he suffered to his left shoulder. In 2012 he was using a whipper snipper equipped with handlebars when he felt pain in his left shoulder. He said that he assumed that the pain would settle.

24. Mr Nilsson described the operation of the whipper snipper saying that he was required to lift and raise it to cut high grass, thick grass or weeds. He explained why that action was necessary. Mr Nilsson said that he believed that he had reported the incident.

25. The painful symptoms did not diminish and Mr Nilsson continued to notice pain in the left shoulder while performing his work tasks. He noticed loss of strength and aching. He described the various activities which would produce painful symptoms in the left shoulder. Mr Nilsson said that he put up with the pain and continued to do his normal duties including using the whipper snipper. He said that he had not seen a doctor while still performing work for the Council.

26. Mr Nilsson said that he was no longer offered work in 2014 but noted that the symptoms in the left shoulder were worsening. He consulted a general practitioner, Dr Shah, in March 2014. After x-ray and ultrasound, he was referred to an orthopaedic surgeon, Dr Nouh, who arranged an MRI scan and recommended surgery. The Council declined liability for the surgery and, at the time of making that statement, Mr Nilsson was still awaiting surgery as a public patient.

27. In a statement dated 31 July 2015, Mr Nilsson stated that he had not received any payments of weekly compensation in respect of incapacity which he said related primarily to his left shoulder. Mr Nilsson said that he had always performed work of a physical nature and would be unable to perform the sort of work for which he was suited because of his injury.

28. Mr Nilsson noted that in January 2015, he had been subjected to strain on his right shoulder in an incident at a local club. He said that the right shoulder had been sore but a cortisone injection had provided some relief. He said there was no current suggestion of surgery for that shoulder. The left shoulder remained his main concern with ongoing symptoms. The right shoulder movements were effectively full but there was a restricted range of movement of the left shoulder which he felt was deteriorating. He said the stiffness and soreness in his arm was extending into his trapezius and his neck.

29. The next statement in time appears to have been taken on 10 November 2015, although it does not appear to have been signed until 15 January 2018. In that statement Mr Nilsson referred to a consultation he had with Dr Nouh who had explained the rationale for the proposed surgery. Mr Nilsson said he wished to undertake the surgery. He noted that he had completed a four-day period of work with a different employer performing traffic control duties. He said that he was still experiencing soreness in the left shoulder and ceased performing the work because he was not able to cope with it.

30. In his statement dated 21 November 2017, Mr Nilsson made observations with regard to his examination by Dr Smith on behalf of the respondent. He explained that he had not performed the actions requested by the independent medical expert as he felt they would cause pain. He reported his concerns to the respondent.

31. In a statement dated 5 December 2017, Mr Nilsson said that he had “no recollection of any prior problems with my neck before injuring my left shoulder”. He described the position in which he held his left arm to “minimise symptoms” and said, “over time, I noticed some soreness in around the area between my left shoulder and my neck as well as tightness into the left side of my neck.” He attempted to alleviate the pain by raising the arm. He said, “both of these postures tend to increase the tightness and soreness into the area between my left shoulder, my neck in the left side of my neck.”

32. With respect to his neck Mr Nilsson said:

> “Before and in particular, after the surgery, it became apparent that there was something not quite right with my neck. When I would try to turn my head a reasonable distance to the left, I would start to notice a soreness and started to turn my whole body rather than my neck. I started to notice that if I put my head back against the headrest, this would start to hurt my neck. There is a pain in my neck and in particular, on the left side of my neck as well as a muscle tension or tightness.”

33. Mr Nilsson said that his recovery from surgery had “not been ideal” and that he had had a cortisone injection in early 2017 to try and reduce some of the ongoing symptoms in the left shoulder. He said the range of movements remained poor. He had enrolled in a gym program with a view to trying to improve his fitness and the function in his left shoulder and neck. He said this program had been paid for by the respondent.

34. In a statement dated 15 January 2018, Mr Nilsson noted that Dr Nouh had performed a left shoulder reconstruction and rotator cuff tear in January 2016. He said surgery had been followed by conservative treatment including stretching. He was disappointed with the outcome from surgery and detailed the limitations on movement in his arm. He said, “I find that I tend to hold my neck tilted towards the left I have had some problems with this posture including a tightness in my neck.” He noted that he had a scan of the neck following the surgery. He said that he believed that the symptoms were due to “tightness and pain I experience when I attempt to stretch my body out to its normal posture.”

35. A claim form by Mr Nilsson received by the respondent on 10 October 2014 was in evidence. The claim form indicates that the affected parts of the body affected by injury was the left shoulder. The description of the injury is "whilst whipper snipping in a park I felt something go in my left shoulder". No date of injury was specified.

36. A Certificate of Determination in respect of proceedings in matter 4599 of 2015 in the Commission recorded an agreement between the parties for weekly payments for a limited period and an agreement as to medical expenses. The Application to Resolve a Dispute in those proceedings was in evidence. The injury relied upon at that time in those proceedings was injury on 1 October 2012 to the left shoulder, said to have been sustained "whilst using a whipper snipper to cut long grass. In doing so, he developed pain into his left shoulder."

37. A copy of Mr Nilsson's Permanent Impairment Claim Form was in evidence. The copy in evidence is undated but it appears to have been accompanied by a letter from Mr Nilsson's solicitors dated 31 July 2017. That letter nominated the date of injury as 1 October 2012. The claim form notes the affected body system as "left shoulder" and was accompanied by the report of Dr Bodel dated 20 July 2017.

38. A letter from Mr Nilsson's solicitors dated 6 June 2018 was in evidence. The letter refers to the claim for lump-sum compensation based on the report of Dr Bodel and notes "We write to confirm that the claim in relation to our client's neck [? is] made on the basis of a secondary or consequential injury as a secondary or consequential [? condition] to our client's left shoulder injury." A further report from Dr Bodel dated 4 June 2018 was enclosed. The respondent was asked to regard the letter as an amendment to the permanent impairment claim previously lodged.

39. An Application to Resolve a Dispute in proceedings 5845 of 2018 between the parties was in evidence. In that application Mr Nilsson alleged injury on 1 October 2012 "and nature and conditions of employment from September 2011 to December 2013". Injury was alleged to the left shoulder and neck with the description of injury:

> "The applicant sustained injury to his left shoulder while using a whipper snipper to cut long grass, as well as performing heavy and repetitive manual activities. The applicant underwent a left shoulder reconstruction including a rotator cuff repair in January 2016. As a result of left shoulder injury and subsequent surgery, the applicant has sustained a secondary or consequential injury to his neck."

40. In those proceedings, a claim was made for lump sum compensation pursuant to section 66 of the 1987 Act in respect of injury to the left shoulder and a consequential condition in the cervical spine. Those proceedings were discontinued at hearing.

Wollongong Medical Centre.

41. Clinical records from the Wollongong Medical Centre were in evidence. The notes cover attendances by Mr Nilsson on a number of general practitioners in that practice between 31 October 2008 and 13 December 2013.

42. Mr Nilsson was last seen in that practice on 13 December 2013 by Dr Siddiqui with complaints of shortness of breath, "twinges" in the chest and other medical problems. There is no reference to the left shoulder or neck at that consultation nor in any earlier consultation at that practice.

Dr Hitesh Shah, General Practitioner

43. Mr Nilsson is recorded as having first consulted Dr Shah on 13 March 2014. The general practitioner recorded "new patient here, on meds for bp and anxiety/depression, had routine bloods three weeks ago." No reference is made to any injury.

44. Dr Shah saw Mr Nilsson again on 27 March 2014. The reason for visit this described "anxiety/depression, hypertension, glaucoma, iron deficiency." No mention is made of any injury. Further consultations in April, May and June 2014 record general health concerns. On 24 July 2014 the general practitioner noted:

> "many issues – has been taking alcohol in excess recently, had a fight on Monday night after drinks, had a fall also, injury around right eye, top of head, lower back, pain at the sites, getting better, does not want any pain meds – no loc [loss of consciousness] convulsions, vomiting – no generalised headache or eye symptoms."

On examination the doctor noted bruising and tenderness to the head. Among other observations he recorded "neck move (sic) – normal".

45. On 10 September 2014, the general practitioner noted other health concerns and recorded "injury left shoulder 12 months ago, since pain on movements and lifting weight on ant [anterior] aspect, no other sym [symptoms]." An x-ray of the shoulder was requested. The results of the x-ray and ultrasound were explained in consultation a week later. The general practitioner advised referral to an orthopaedic surgeon but Mr Nilsson declined as the pain was "not bad" at that time. The general practitioner recorded "left supraspinatus tendon tear".

46. Mr Nilsson requested referral to a specialist in October 2014 as the left shoulder pain was becoming worse. A referral to Dr Nouh was given and medication prescribed. Mr Nilsson again consulted Dr Shah on 27 October 2014. He noted that Mr Nilsson had been seen by Dr Nouh and an MRI scan ordered.

47. On 15 December 2014, the general practitioner noted that the Council had declined the workers compensation claim and the proposed shoulder operation had been postponed. At the next consultation on 30 December 2014 Dr Shah noted that Mr Nilsson was continuing to have problems with the left shoulder and had consulted a solicitor.

48. On 13 February 2015, Dr Shah noted "pain and limited move [sic] of the right shoulder since mid-January since police handcuffed him, no pain at rest, no other sym [symptoms]". On examination Dr Shah found limited movement in the right shoulder and ordered an ultrasound examination. On 26 February 2015 the general practitioner explained the results of the right shoulder ultrasound which showed a right supraspinatus tendon tear.

49. Dr Shah saw Mr Nilsson on 13 March 2015 to provide a medical certificate in respect of the left supraspinatus tendon tear and on 20 March 2015 he noted that Mr Nilsson had seen the orthopaedic surgeon in relation to his right shoulder. On 2 April 2015 the general practitioner requested an ultrasound guided steroid injection of the right shoulder.

50. At consultation on 2 June 2015, Mr Nilsson was noted to be still on the waiting list for his left shoulder surgery.

51. On 9 July 2015, Dr Shah recorded that Mr Nilsson was attending for an unrelated matter. The general practitioner noted "also pain in cx [scil cervical] spine region, more on neck move [sic], no pain in arms, no neuro sym." On examination Dr Shah noted "mild tender whole cx spine, neck move – full". An x-ray was requested.

52. Mr Nilsson attended Dr Shah again on 9 July 2015, when the results of the x-ray were noted as "cervical spondylosis". A GP plan was put in place and, on consultation two days later, physiotherapy was suggested. The following consultations relate to other health matters.

53. Following receipt of the x-ray report Dr Shah recommended physiotherapy and referral was made.

54. Subsequent consultations in 2015 deal with other medical issues but note that Mr Nilsson remained on the waiting list for the left shoulder surgery. On 26 November 2015 Dr Shah noted; "patient was first seen for left shoulder issues on 10/9/14 and had injury 12 months before that date."

55. On 29 January 2016, Dr Shah noted that Mr Nilsson had undergone left shoulder surgery one week previously and was attending for wound dressing.

56. Subsequent attendances note management of the left shoulder following surgery as well as other general health issues. Continuing problems with the left shoulder were noted in May 2017 and again in August 2018. There does not appear to be any reference to neck symptoms following the surgery in January 2016.

57. The general practitioner's notes include a copy of the left shoulder ultrasound (17 September 2014) which showed "medium full size thickness tear involving the anterior peripheral insertion of the supraspinatus tendon."

58. The report of the ultrasound of the right shoulder (23 February 2015) was reported as showing "a medium-size, full thickness tear of the supraspinatus tendon." The result of the MRI examination of the right shoulder was also in evidence confirming the full thickness tear of the supraspinatus. The report of the ultrasound-guided right subacromial bursa injection was also in evidence.

59. The report dated 9 July 2015 of the x-ray of the cervical spine was reported as showing:

> "moderate degenerative disc disease at the C5/6 level, minimal changes at other levels. Facet joint sclerosis is evident particularly at the C3/4 level. There is no bony foraminal stenosis. There is mild cervical tilt to the left. No cervical ribs or other significant anomaly detected."

The clinical history was given as "pain and tenderness".

60. A copy of a letter dated 14 October 2014 from Dr Shah to the Council was in evidence. Dr Shah said that Mr Nilsson had come to see him on 10 September 2014 "with history of injury to left shoulder about 12 months ago while doing manual work for Council. His symptom is pain on anterior aspect of left shoulder on movement and on lifting weight with left hand." Dr Shah could not comment on causation or relation to work. He noted that Mr Nilsson had only started to attend Dr Shah's practice in March 2014.

61. Other results of tests and referral letters related to other conditions were in evidence and do not appear relevant to the current issue.

Dr Fred Nouh, Orthopaedic Surgeon

62. A series of reports by the treating orthopaedic surgeon, Dr Nouh, were in evidence. On 10 November 2014 Dr Nouh reported to Dr Shah that the MRI scan of the left shoulder confirmed a supraspinatus muscle tear with subacromial bursitis. Dr Nouh recommended arthroscopic rotator cuff repair.

63. A letter from Dr Nouh to Council requested approval for arthroscopic rotator cuff repair of the left shoulder noting that Mr Nilsson had failed conservative treatment. Dr Nouh recorded:

> "From the history given by the patient, I do believe that the patient's employment is a substantial contributing factor to the current condition and the need for surgery. The surgery will hopefully alleviate the patient's symptoms and assist them [sic] in returning to their [sic] preinjury duties."

64. On 17 November 2014, in answer to a request for further information by the Council Dr Nouh said that he believed there was a relationship between Mr Nilsson's condition and his employment with the Council stating "repetitive heavy manual labour lifting at work would be a contributor to his rotator cuff tear. Shoulder cuff tears/impingement could be caused by repetitive strain on the rotator cuff muscles and is not necessarily always related to a specific incident."

65. On 22 November 2014, Dr Nouh reported to Dr Shah confirming a history of pain in the left shoulder secondary to a rotator cuff tear. He noted that the pain had been present "for almost 18 months" and that Mr Nilsson: "puts it down to heavy manual labour work with Wollongong Council." He said; "there was no specific incident which caused his pain, he does feel the pain was related to his work where at the time he was doing repetitive movements in heavy lifting. His pain has progressively gotten worse and so far he has had no treatment for it." Dr Nouh recommended ultrasound guided cortisone injection and an MRI scan.

66. Dr Nouh saw Mr Nilsson again on 9 March 2015 in regard to the right shoulder which he said had "recently become quite symptomatic with pain and weakness". Dr Nouh noted that Mr Nilsson was on the waiting list for left shoulder surgery but he said that Mr Nilsson "feels his right shoulder has become much more severe in terms of pain."

67. Dr Nouh noted global restriction in range of movement due to pain. Ultrasound of the shoulder showed a full thickness supraspinatus muscle tear which he said measured up to 2 cm in length as well as a subacromial bursitis.

68. An email dated 26 November 2014 from Dr Nouh's secretary reported that Dr Nouh had reviewed documents supplied by Council including an employment description. Dr Nouh did not agree that the main factor was degenerative changes commensurate with age and said, "Shoulder cuff tears/impingement could be caused by repetitive strain on the rotator cuff muscles during his employment with Wollongong City Council."

69. The MRI scan recommended by Dr Nouh was reported on 7 November 2014 as showing a complex partial tear within the anterior portion of the supraspinatus tendon. There was no full thickness/complete tear and no retraction of the tendon and no atrophy of the supraspinatus muscle.

70. An ultrasound examination of the left shoulder performed on 17 September 2014 and that of the right shoulder reported on 24 February 2015 were both reported as showing "a medium full size full thickness tear of the supraspinatus tendon."

71. The MRI scan of the right shoulder was reported on 20 March 2015 as showing:

"• Capsuloligamentous thickening with oedema within the axillary recess, posterior capsule and anterior inferior capsule suggests a glenohumeral joint capsulitis. Clinical correlation is recommended.

• High-grade bursal surface and full thickness tear of the anterior fibres of the supraspinatus at the footprint, collectively measuring 9 mm in AP dimension.

• Background of moderate supraspinatus tendinosis.

• Mild fatty infiltration of the muscle tendon junction of supraspinatus.

• Mild tendinosis of the long head of biceps tendon laterally within the rotator interval.

• Mild bony spurring of the undersurface of the acromion at the insertion of the coraco-acromial ligament.

- Mild thickening of the coraco-acromial ligament."

Dr James Bodel, Orthopaedic Surgeon.

72. Mr Nilsson was examined by Dr Bodel for the purposes of a medicolegal report, initially on 12 May 2015. Dr Bodel noted a history of employment with the Council in work which involved "concreting, jack hammering, the engineer's department, maintenance, asphalting and tar patching and truck driving and also using ride on lawnmowers and whipper snippers." He noted "gradual onset of left shoulder girdle pain -? October 2012."

73. Dr Bodel recorded that Mr Nilsson reported the onset of left shoulder pain while using a whipper snipper to cut long grass in about October 2012. The shoulder had not recovered and deteriorated over time. Dr Bodel reported that the left shoulder pain and become unbearable by September 2014 and Mr Nilsson had consulted Dr Shah who had organised investigations which had revealed a full thickness tear of the anterior aspect of the supraspinatus tendon.

74. Dr Bodel noted the results of the MRI scan of 6 November 2014 and the recommendation by Dr Nouh for arthroscopic subacromial decompression and repair of the rotator cuff. Dr Bodel noted that Dr Nouh had also seen Mr Nilsson with respect to the right shoulder which he said was an unrelated matter.

75. Dr Bodel reported that Mr Nilsson remained on the public waiting list for surgery and had not worked since he had been put off by the Council in March 2014, having last worked in December 2013. Dr Bodel said, "He has a certificate however indicating that he does not have to apply for work at the moment because of the ongoing problems with his shoulders and also with his neck."

76. Dr Bodel recorded Mr Nilsson's complaints which included "left-sided neck pain". Dr Bodel recorded the respective ranges of motion in the shoulders, noting that there was impingement in both shoulders and definite adhesive capsulitis on the right-hand side but not on the left-hand side. Range of movement was measured as more restricted on the left.

77. Dr Bodel reported "This gentleman has pain and stiffness in the region of the left shoulder caused by the work injury using the whipper snippers." The nature of the injury was "significant rotator cuff pathology with a full thickness tear of the anterior aspect of the supraspinatus tendon". He said that there was a "direct causal link between the episode of injury that occurred in October 2012 based on the history that he gives and he gives no history of any other accident or injury involving the left shoulder." Dr Bodel also stated:

    > "Based on the history and the clinical findings there is a direct causal link between the nature and conditions of his work Wollongong City Council and the development of the rotator cuff injury to the left shoulder. It has probably arisen as a result of a primary cause but also may be due in part to an aggravation acceleration exacerbation and deterioration caused by the nature of work in general."

78. The report dated 20 July 2012 Dr Bodel said that he had again examined Mr Nilsson, noting that he had undergone surgery in late 2015. He summarised Mr Nilsson's injuries:

    > "- Gradual onset of left shoulder girdle pain – October 2012;
    >
    > - Injury to the neck;
    >
    > - Consequential injury to the right shoulder following an assault."

79. Dr Bodel recorded the history on this occasion; “This gentleman reports that he began to develop minor aches and pains in the neck and left shoulder at work over the years.” He noted the heavy work performed by Mr Nilsson which he said required “fairly strenuous activities with the neck and both shoulders”. Dr Bodel recorded; “He developed minor aches and pains but in about October 2012 the pain in the left shoulder became more acute, particularly when using a whipper snipper. He was cutting long grass at that time.”

80. Dr Bodel reported that there had been a steady deterioration over time with the left shoulder and neck becoming increasingly troublesome. He recorded that Mr Nilsson was eventually put off work in late 2013 because of “deteriorating function and an inability to do the heavy work.”

81. Dr Bodel again noted the course of treatment from September 2014 onward and the results of the various scans. Mr Nilsson reported that he was disappointed with the outcome of surgery. He said that Mr Nilsson had been assessed by Dr Nouh with regard to his neck and that he had eventually had an injection into the subacromial space of the left shoulder which had helped the neck but not the shoulder.

82. The right shoulder symptoms had improved and pain was reported primarily in the region of the left shoulder. There was also pain at the base of the neck on the left-hand side and on head down posture or use of the left arm overhead.

83. Dr Bodel said, “There is in my view a direct causal link between the nature and conditions of his work and the injury to the neck in the left shoulder.” He commented:

> “The work he was doing was always very physical work. This included the sledge hammering, jack hammering, tire patching, driving trucks and using wheelbarrows. The nature and conditions of work in particular is in my view the main substantial contributing factor to the neck and shoulder injury.”

84. Dr Bodel assessed Mr Nilsson as having 7% whole person impairment in respect of pathology in the cervical spine and 8% whole person impairment in respect of pathology in the left shoulder with a combined assessment of 14% whole person impairment.

85. Dr Bodel provided a supplementary report on 4 June 2018. Dr Bodel was provided with the statements prepared by Mr Nilsson. Dr Bodel reported:

> “I note initially her symptoms concentrated on an area of the region of the left shoulder in about October 2012. He later developed a consequential condition in the region of the right shoulder and also the neck which came on gradually over time by way of aggravation, acceleration, exacerbation and deterioration of a disease process, being the degenerative disc disease in the cervical spine and the rotator cuff pathology in the right shoulder.
>
> I confirm that the local doctor’s continuation notes confirm that the first record of the complaint about the neck was in about July 2015 which was about six months after his surgery on the left shoulder.”

86. Dr Bodel commented:

> “This gentleman did give a history when I examined him of the gradual onset of neck and shoulder girdle pain. I confirm the documentation that you have provided indicating that his neck pain came on gradually, particularly after he had had his shoulder surgery on the left-hand side.”

He added “as I have indicated in my original report of 20 July 2017, I always considered that this gentleman’s neck complaint is a consequential condition associated with the left shoulder injury and the surgery.”

87. Dr Bodel examined Mr Nilsson again on 29 April 2019. He reported that Mr Nilsson had last worked for the Council in December 2013. He noted the types of tasks performed by Mr Nilsson which Mr Nilsson referred to as “fairly strenuous”. He said the activities had aggravated Mr Nilsson’s neck and shoulders.

88. Dr Bodel noted that “In October 2012, he [Mr Nilsson] had developed more significant pain in the left shoulder. This was a more acute onset of symptoms while using a whipper snipper. He was cutting long grass at the time.” Mr Nilsson had continued work, thinking that he had simply pulled a muscle. Dr Bodel recorded that Mr Nilsson put up with the pain and had received “minimal treatment”. However, he had deteriorated and “began developing increasing neck pain as well”. In late 2013 Dr Bodel had been forced to cease work due to increasing pain. Dr Bodel again noted that Mr Nilsson had sought treatment from his general practitioner in September 2014 when the pain in the left shoulder became unbearable. Investigations had shown full thickness tear of the supraspinatus tendon.

89. Dr Bodel noted that x-rays of the cervical spine had shown degenerative disc disease at C5/6 and that Mr Nilsson had had another injection into the left shoulder but had not had any specific treatment for the neck.

90. Mr Nilsson reported that he was undertaking physiotherapy and an exercise program with an exercise physiologist but his shoulders were getting worse. Mr Nilsson had also reported a further injury to the right shoulder when he had fallen over at home.

91. Dr Bodel felt that the neck pain and right shoulder girdle pain had developed “as a consequential condition of the circumstances associated with the nature and conditions of work in general”. He reported that Mr Nilsson developed adhesive capsulitis in both shoulders, right worse than the left. Examination of the respective range of motion in the shoulders disclosed restriction of movement.

92. After review of the documentation Dr Bodel said: “I note various statements taken from Mr Nilsson dating back to 2015. His had a gradual onset of symptoms of the neck and both shoulders, initially the left worse than the right, as a result of the nature and conditions of work in general.” Dr Bodel noted the comments by Mr Nilsson as to the position which he held his left arm. He did not feel that this was a contributing factor to any of pathology which he felt was “present in the circumstances that has arisen as a result of the nature and conditions of his work in general.”

93. Dr Bodel discounted the posture of the left arm as a contributory factor and said, “He does have a disease process of gradual onset in the neck and both shoulders and workers been an aggravation, acceleration, exacerbation and deterioration of that disease process over time.”

94. Dr Bodel assessed whole person impairment in the left arm at 8% and in the right shoulder as 7%. He combined this with an assessment of 7% whole person impairment in respect of the cervical spine to give a total whole person impairment of 20%.

Dr Kim Edwards, Surgeon.

95. Mr Nilsson was examined by Dr Kim Edwards at the request of the Council on 7 November 2014. Dr Edwards recorded a history of work as a labourer with the onset of the problem in the left shoulder “approximately 18 months or two years ago”. Mr Nilsson had noticed a sharp pain in the left shoulder but had continued working. Mr Nilsson had explained that he had not sought treatment because he feared it might jeopardise his employment.

96. Dr Edwards noted that Mr Nilsson had last worked with the Council in December 2013. Since that time, he had had only four days casual work with another employer.

97. Dr Edwards noted the results of the MRI scan of the left shoulder. Dr Edwards noted that Mr Nilsson had no record of any particular incident or injury and had not sought medical attention until September 2014 with regard to the left shoulder.

98. On examination Dr Edwards noted limitation of movement besides impingement. He agreed with the diagnosis of left shoulder supraspinatus tear. Dr Edwards felt that the condition in the left shoulder was unconnected with employment. He said, "his description of the incidents occurring at work are not convincing."

99. Dr Edwards examined Mr Nilsson again on 17 July 2015. He noted the previous examination and recorded that Mr Nilsson was now complaining of "extreme" pain in the neck which Mr Nilsson said been present for the last five or six months. He also noted complaints of right shoulder symptoms which Mr Nilsson said were unrelated to work. Dr Edwards also recorded "he then said it was because he uses his right arm more than his left."

100. Dr Edwards considered the "Parks Labour Analysis" with respect to Mr Nilsson's employment, noting that "approximately 80% of the day was mowing or using a whipper snipper." Dr Edwards considered the weight of the whipper snipper and the manner of its use. He said that he did not accept that this type of activity would cause a rotator cuff tear. He did not consider the nature and conditions of Mr Nilsson's employment to be a substantial contributing factor to his condition.

Dr Anthony Smith, Orthopaedic Surgeon.

101. Mr Nilsson was examined by Dr Anthony Smith at the request of the Council on 7 September 2017. Dr Smith recorded that Mr Nilsson had a "work incident" in October 2012 noting that Mr Nilsson could not recall the date exactly. Dr Smith recorded a history:

> "He was working for the Wollongong Council in a casual job and was whipper snippering shrubbery and he developed pain in his left shoulder. I enquired as to where the pain was that he said he could not recall but it was in the shoulder. There was no other pain."

102. Mr Nilsson reported the surgery in the left shoulder in January 2016. Dr Smith reported that Mr Nilsson said: "Before the operation, the pain was all about the left shoulder, left shoulder was weak and it was stiff. There were no other symptoms apart from the pain and stiffness".

103. Mr Nilsson had said "the operation did not really fix the pain and the neck was part of the problem. He had tingling in all the digits of the left hand and pain running down the arm all the time. He has learned to put up with that. The symptoms occurred six months or so after the operation."

104. Dr Smith considered the results of the investigations of the left shoulder including the ultrasound report and MRI examinations and the report of Dr Bodel dated 19 May 2015. Dr Smith concurred with Dr Bodel's opinion regarding Mr Nilsson's left shoulder problems which he said, "has probably arisen as a result of the primary cause". Dr Smith however discounted employment as a cause and thought it more likely that pathology was attributable to the assault. He felt the activity with the whipper snipper was unlikely to cause a rotator cuff disease but noted that rotator cuff disease could be "aggravated by quite trivial activity".

105. Dr Smith felt that Mr Nilsson probably had degenerative disc disease in the neck which was degenerative in origin and not related to work. He did however state:

> "I have stated above that the use of a whipper snipper would be an unlikely mechanism of injury regarding his rotator cuff disease. He could easily have been having some symptoms from time to time for many years prior to 2014 because of exacerbation to his cervical degenerative disease and/or his rotator cuff disease."

106. With respect to the neck, Dr Smith reported: “His cervical degenerative disease is likely to produce occasional neck pain with or without shoulder pain on one side or the other, from time to time whether he works or whether he does not no matter what work he engages in.” He assessed 5% whole person impairment in respect of the cervical spine which he said was unrelated to employment.

107. Dr Smith examined Mr Nilsson again on 16 August 2018. Dr Smith noted that he had been provided with the reports of Dr Bodel dated 20 July 2007 [sic – 2017] and 4 June 2018. In relation to the neck symptoms noted by Dr Bodel, Dr Smith said that “Mr Nilsson suggested that the neck became a problem because he was protecting his left shoulder from 2012 onwards.” He noted the complaint of neck pain to the general practitioner in July 2015 “six months following his left shoulder surgery”.

108. Dr Smith also had Mr Nilsson’s statement dated 22 December 2014. He noted the history set out in that statement with the onset of pain for the first time in 2012 whilst doing whipper snipper activities. Dr Smith noted the subsequent statement which dealt with the incident in which Mr Nilsson suffered injury to his right shoulder. Dr Smith noted that in the statement dated 15 January 2018 Mr Nilsson had reported the onset of pain in the area between the left shoulder and neck following the surgery.

109. Dr Smith noted the x-ray of the neck performed on 9 July 2015. Dr Smith was of the opinion that “the symptoms emanate from his cervical degenerative disease and not his left shoulder rotator cuff disease.” He felt the assault at the club was a more likely cause than the use of a whipper snipper.

110. Dr Smith was of the opinion that there was no relationship between Mr Nilsson’s cervical degenerative disease in his rotator cuff disease “apart from the fact that he has pain referred to his neck into the left shoulder.” The problems were unrelated to employment with the Council.

Submissions

111. Counsel for the applicant submitted that the issues had to be decided on an overall view of the evidence which established on the balance of probabilities that Mr Nilsson had suffered injury to his left shoulder not only because of an injurious event on 1 October 2012, but also because of the heavy work that he had performed over time of his employment with the respondent.

112. Counsel submitted that it was probable that the heavy work performed would have resulted in injury to the cervical spine but this could also have occurred as a consequence of the injury to the left shoulder. The applicant had not had left shoulder or neck problems prior to his employment with the respondent. Dr Smith, qualified for the respondent, acknowledged that work could have aggravated cervical symptoms.

113. Counsel for the applicant submitted that it was not unlikely that some event had occurred to aggravate the cervical spine at the time of the left shoulder surgery or subsequently. Dr Bodel was satisfied that there was a causal link between employment and the condition in the cervical spine.

114. Counsel for the respondent submitted that Dr Bodel had relied on an incorrect history. His various opinions as to causation and his reliance on an incomplete history meant that no significant weight could be accorded to his opinions as variously expressed.

115. There was no evidence of injury to the neck at work. The earliest reference to the neck was in mid-2015. The earlier examination had shown “normal neck movements” in the general practitioner’s notes.

116. The opinion of Dr Bodel as to a consequential origin for the neck condition should not be accepted as Dr Bodel had provided no basis for his opinion nor provided any explanation as to how he had reached that conclusion which was at variance with his earlier opinion.

Discussion and findings.

117. The respondent accepts that Mr Nilsson suffered injury to his left shoulder in October 2012 in the course of his employment but disputes that that injury gives rise to any ongoing impairment.

118. The respondent disputes that Mr Nilsson suffered injury to his left shoulder due to a process of gradual onset or by way of aggravation of a pre-existing disease condition. However, it is common ground that Mr Nilsson's claim for lump-sum payment pursuant to section 66 of the 1987 Act cannot succeed unless impairment arising from the cervical spine is established as resulting from employment whether as an injury or a consequential condition. It is therefore convenient to examine the issue of causation of the cervical pathology to ascertain whether the applicant has established that the pathology in the cervical spine is either caused by the work tasks performed in the course of his employment with the Council or as a consequence of the injury to the left shoulder.

119. In *Department of Education and Training v Ireland*[1] Keating P said:

> "[89] The principles relevant to the discharge of the onus of proof were discussed in *Nguyen v Cosmopolitan Homes* [2008] NSWCA 246 (16 October 2008) ('Nguyen') where McDougall J (McColl and Bell JJA agreeing) said at [44]-[48]:
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> '44. A number of cases, of high authority, insist that for a tribunal of fact to be satisfied, on the balance of probabilities, of the existence of a fact, it must feel an actual persuasion of the existence of that fact. See Dixon J *in Briginshaw v Briginshaw* [1938] HCA 34; (1938) 60 CLR 336. His Honour's statement was approved by the majority (Dixon, Evatt and McTiernan JJ) in *Helton v Allen* [1940] HCA 20; (1940) 63 CLR 691 at 712.
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> 45. Dixon CJ put the matter in different words, although to similar effect, in *Jones v Dunkel* [1959] HCA 8; (1959) 101 CLR 298 at 305 where his Honour said that '[t]he facts proved must form a reasonable basis for a definite conclusion affirmatively drawn of the truth of which the tribunal of fact may reasonably be satisfied'. Although his Honour dissented in the outcome of that case, the words that I have quoted were cited with approval by the majority (Stephen, Mason, Aickin and Wilson JJ) in *West v Government Insurance Office of NSW* [1981] HCA 38; (1981) 148 CLR 62 at 66. See also Stephen J in *Girlock (Sales) Pty Limited v Hurrell* [1982] HCA 15; (1982) 149 CLR 155 at 161 – 162, and Mason J (with whom Brennan J agreed) in the same case at 168.
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> 46. It is clear, in particular from West and Girlock, that the requirement for actual satisfaction as to the occurrence or existence of a fact is one of general application, and not limited to cases where the fact in question, if found, might reflect adversely on the character of a party or witness.
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> 47. In *Malec v JC Hutton Pty Limited* [1990] HCA 20; (1990) 169 CLR 638 Deane, Gaudron and McHugh JJ said at 642-643:

[1] [2008] NSWWCCPD 134

> "A common law court determines on the balance of probabilities whether an event has occurred. If the probability of the event having occurred is greater than it not having occurred, the occurrence of the event is treated as certain; if the probability of it having occurred is less than it not having occurred, it is treated as not having occurred."
>
> 48. On analysis, I think, what their Honours said is not inconsistent with the requirement that the tribunal of fact be actually persuaded of the occurrence or existence of the fact before it can be found. On their Honours' approach, what is required is a determination of the respective probabilities of the event's having occurred or not occurred. There is nothing in that analysis to suggest that the determination in favour of probability of occurrence should not require some sense of actual persuasion'."

120. In a frequently cited passage, Kirby P said in *Kooragang Cement v Bates*[2];

> "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 the 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 to work at the subsequent death or injury will not, of itself be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a common sense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between the work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation".

121. Applying that reasoning to the evidence, I could not be satisfied that Mr Nilsson suffered injury to his cervical spine/neck as result of work tasks that he performed with the Council, nor could I be satisfied that Mr Nilsson developed a condition in the cervical spine as a result of injury to the left shoulder.

Injury to the cervical spine

122. In answer to the applicant's submission that the nature of the work performed by Mr Nilsson was likely to have given rise to an injury to the cervical spine, the respondent submitted that the fact that employment was capable of causing injury was "not to the point"[3]. The applicant was required to prove, on the balance of probabilities, that the pathology in the cervical spine had in fact been caused by employment tasks which Mr Nilsson had performed.

123. I am satisfied the evidence establishes that Mr Nilsson completed employment tasks with the respondent up to December 2013. In that period there was no report of injury to the neck. He did not seek medical treatment while employed for injury to his neck or shoulder.

124. When Mr Nilsson was examined on 24 July 2014 by Dr Shah with respect to injuries suffered in a fight which involved injury to the head and lower back, Dr Shah had noted that, on examination, Mr Nilsson's neck movement was "normal".

125. The first complaint of injury to a treating doctor appears to have been on 9 July 2015, more than 18 months after Mr Nilsson had last worked for the Council. Dr Shah noted complaint of pain in the cervical spine with no neurological symptoms but for movement of the neck. He did not record any history relating to the onset of those symptoms.

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[2] (1994) 35 NSWLR 452; (1994) 10 NSWCCR 796 (at 810)
[3] Per Keating P in *Mannie v Bauer Media Pty Ltd* [2016] NSWWCCPD 47 at [87]

126. The reports of Dr Nouh do not assist with regard to causation of the pathology demonstrated on x-ray in Mr Nilsson's neck. Although Dr Nouh saw Mr Nilsson on a number of occasions he did not record any complaints of cervical pain or pain in the neck.

127. In his report in May 2015, Dr Bodel noted that Mr Nilsson "has a certificate however indicating that he does not have to apply for work at the moment because of ongoing problems with his shoulders and also with his neck." No such certificate was in evidence and the records of Dr Shah and the Wollongong Medical Centre do not contain any reference to such a certificate. The reference to the neck in Dr Bodel's report from May 2015 is the first record of complaint of neck pain to a medical practitioner. Dr Bodel did not address the cause of the neck symptoms in that report.

128. Mr Nilsson, in his claim form received by the Council in October 2014, refers only to a specific injury to the left shoulder; "whilst whipper snipping in a park I felt something go in my left shoulder". There is no mention of the neck in that form. The Permanent Impairment Claim Form refers only to injury to the left shoulder but does attach the report of Dr Bodel dated 20 July 2017 which notes complaints of "minor aches and pains in the neck and left shoulder at work over the years" with steady deterioration over time with the left shoulder and the neck becoming increasingly troublesome.

129. In his report of 20 July 2017 Dr Bodel said; "there is in my view a direct causal link between the nature and conditions of his work and the injury to the neck in the left shoulder." Dr Bodel described the nature of the work performed which he said included "sledge hammering, jack hammering, tar patching, driving trucks and using wheelbarrows". Dr Bodel was of the opinion, in that report, that "the nature and conditions of work in particular is in my view the main substantial contributing factor to the neck and shoulder injury."

130. I infer from that report that Dr Bodel regarded work tasks as having given rise to (or aggravating) pathology in the neck.

131. After he was provided with further material included in the statements of Mr Nilsson Dr Bodel reported in June 2018:

> "I note initially his symptoms concentrated on an area of the region of the left shoulder in about October 2012. He later developed a consequential condition in the region of the right shoulder and also the neck which came on gradually over time by way of aggravation, acceleration, exacerbation and deterioration of a disease process, being the degenerative disc disease in the cervical spine and the rotator cuff pathology in the right shoulder."

132. Dr Bodel noted the first record of the complaint about the neck to the treating doctors was in July 2015. He commented that the documentation provided indicated that the neck pain "came on gradually, particularly after he had his shoulder surgery on the left-hand side." He said, "I always considered that this gentleman's neck complaint is a consequential condition associated with the left shoulder injury and the surgery."

133. Although Dr Bodel says that he has always been of the opinion that the neck condition was consequential upon the left shoulder injury, it is difficult to reconcile that view with the report of 20 July 2017. I infer that Dr Bodel has changed his mind.

134. In his more recent report dated 2 June 2019 Dr Bodel said; "I note various statements taken from Mr Nilsson dating back to 2015. He has had gradual onset of symptoms in the neck and both shoulders, initially the left worse than the right, as result of the nature and conditions of work in general." He felt that the posture of the left arm following surgery did not contribute to the underlying pathology.

135. The report of June 2019 indicates that Dr Bodel has again changed his mind and was again of the view that there was an injury to the cervical spine due to work tasks performed by Mr Nilsson with the Council.

136. I have considered whether Dr Bodel's use of the word "consequential" is intended to convey that the pathology was a consequence of work tasks but this does not fit the context with the reference to the shoulder surgery.

137. The reports of Dr Bodel are inconsistent and to a degree contradictory. The absence of any reference to the neck in the clinical records weighs heavily against symptoms in the neck having been present from and after December 2013. The statement by Dr Bodel that Mr Nilsson "was eventually put off work in late 2013 because of deteriorating function and an inability to do the heavy work" is not supported by the evidence. If this were the case then it would be extremely unlikely that Mr Nilsson would not have sought treatment at that time.

138. Mr Nilsson's statement dated 9 January 2015 does not refer to any symptoms in the neck. In his statement dated 31 July 2015 Mr Nilsson referred to stiffness and soreness in the left arm extending into the trapezius and his neck.

139. In his statement dated 5 December 2017 Mr Nilsson said: "Before and in particular, after the surgery, it became apparent that there was something not quite right with my neck. When I would try to turn my head a reasonable distance the left, I would start to notice a soreness and started to turn my whole body rather than my neck." The surgery took place in January 2016. The inference is that the symptoms in the neck were not present when Mr Nilsson ceased work for the respondent.

140. The general practitioner's notes record normal neck movement upon examination in July 2014 following injuries received by Mr Nilsson in a fight. On 10 September 2014 the general practitioner noted the history of injury to the left shoulder "12 months ago" and complaints of pain on movement and on lifting of weights but with no other symptoms.

141. The conclusion I draw from this evidence is that Mr Nilsson first noticed the onset of symptoms in his neck at some time in 2015 and more than a year after he left the employment of the respondent. I could not be satisfied on that evidence that Mr Nilsson established on the balance of probabilities that the work tasks he had performed had injured his neck or aggravated a pre-existing degenerative condition in the neck.

Cervical spine condition resulting from injury to the left shoulder

142. I am not satisfied that a causal connection has been established between the injury to the left shoulder and the onset of symptoms in Mr Nilsson's cervical spine.

143. In his statement dated 5 December 2017 Mr Nilsson provided a detailed description of the posture in which he would hold his left arm to minimise symptoms in the left shoulder. He said, "over time, I noticed some soreness in around the area between my left shoulder and my neck as well as tightness into the left side of my neck." He said that he would raise his left arm upwards to relieve muscle tightness and to minimise the pain. He said these postures tended to increase the tightness and soreness "into the area between my left shoulder, my neck in the left side of my neck." He also noted that he would hold his head tilted to the left.

144. Mr Nilsson said that, particularly after surgery, he noted that turning the neck caused pain as well as raising his head against the headrest in a car.

145. In his statement dated 15 January 2018, Mr Nilsson again said that he held his neck tilted to the left and had problems with this posture including tightness in the neck. He said "in more recent times, my doctors have organised to scan with respect my neck. I have only done this since the surgery and believe it is because of the tightness and pain I experience when I attempt to stretch my body out to its normal posture."

146. Counsel for the respondent correctly pointed to Dr Bodel's error with regard to the date of the left shoulder surgery which he thought had been performed in January 2015 rather than 2016. The first record of complaint about the neck predated the surgery.

147. Dr Bodel felt that the neck pain had come on gradually "particularly after he had had his shoulder surgery on the left-hand side". He said that he had always considered Mr Nilsson's neck complaints to be a consequential condition associated with the left shoulder injury and the surgery.

148. Dr Bodel's opinion in this regard does not accord with his earlier report nor with his most recent report in June 2019. His error with regard to the date of surgery also serves to reduce the weight to be given to the opinion in that report.

149. There is no intuitive connection between injury to the left shoulder and the onset of symptoms in the neck as might be the case if it were a case of onset of symptoms in a contralateral limb. While it is understandable that injury to one shoulder might lead to the onset of the condition in the other shoulder due to unfamiliar use of the opposite shoulder, there is no such connection suggested in the present case.

150. The reports of Dr Bodel do not cast any light on the mechanism by which either the injury to the left shoulder or the surgery may have resulted in the neck symptoms. Dr Bodel does not explain how he relates the cervical symptoms to injury to the left shoulder when there is similar pathology present in the right shoulder.

151. I accept Dr Bodel's opinion that there is no connection between the posture in which Mr Nilsson held his left arm and the pathology in the neck. Dr Bodel specifically considers the detailed observations made by Mr Nilsson and firmly rejects that hypothesis.

152. The history taken by Dr Smith was of neck symptoms having developed following the operation. The clinical notes and Dr Bodel's report of May 2015 show that in fact complaints of neck pain predated the operation. Dr Smith in any event felt that the pathology in the neck was unrelated to employment. I accept that Mr Nilsson informed Dr Smith that "the neck became a problem because he was protecting his left shoulder from 2012 onward" but it does not appear that Dr Smith accepted that hypothesis and it is comprehensively rejected by Dr Bodel.

153. The history Dr Edwards obtained when he saw Mr Nilsson in July 2015, six months before the left shoulder surgery, was of extreme pain in the neck present for the last five or six months. That history would be consistent with the inference that I have drawn from the clinical notes of onset of neck pain in 2015.

154. No medical practitioner provides an explanation as to the proposed causal link between the onset of symptoms in the neck and injury to the left shoulder. Counsel for the applicant submitted that is often the case that surgery results in unintended effects to other parts of the body. That is not an unreasonable hypothesis but it is unsupported by evidence and the circumstances are not such as to suggest a causal connection, either with respect to the posture or other symptoms flowing from the left shoulder injury or from the surgery.

155. The evidence falls short of establishing, on the balance of probabilities, a causal link between left shoulder injury and the pathology in the cervical spine. There is no "common sense" connection such as might be thought to be present in a complaint of a consequential condition in a contralateral limb due to overuse or unfamiliar use and I am not persuaded that a causal link has been established.

Conclusion

156. The applicant has not established, on the balance of probabilities, either injury to the cervical spine in the course of employment with the respondent nor the onset of a consequential condition in the cervical spine resulting from injury to the left shoulder.

157. I am satisfied that no basis exists for inclusion of impairment in the cervical spine in the assessment of whole person impairment resulting from injury in the course of employment with the respondent. The applicant did not dispute that, if the cervical spine was not included in the assessment, then the applicant could not demonstrate impairment greater than 10% and was therefore unable to satisfy the threshold in section 66(1) of the 1987 Act.

158. Although it was argued at hearing, it is unnecessary to consider whether the injury to the left shoulder included any proportion due to work tasks performed while the applicant was employed by the respondent. The assessment of whole person impairment in the left shoulder upon which Mr Nilsson's claim was based was made by Dr Bodel on the assumption that the pathology was due to employment, whether by a frank incident and/or because of work tasks performed. That assessment falls below the statutory threshold and the claim for lump-sum compensation cannot be maintained.

159. There will be an award for the respondent with respect to the claim pursuant to section 66 of the 1987 Act.