WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **1643/20**
Applicant: **Andrew John Green**
Respondent: **Bayside EQ t/as NJ Johnston and NP Johnson**
Date of Determination: **1 July 2020**
Citation: **[2020] NSWWCC 216**

The Commission determines:

1. The applicant suffers with injury to his right upper extremity (elbow) arising out of or in the course of employment with the respondent on 15 February 2018.

2. The applicant suffers with consequential conditions of the right upper extremity and left upper extremity (shoulder) as a result of injury arising out of or in the course of employment with the respondent on 15 February 2018.

3. Award for the respondent in respect of the allegation of injury to the cervical spine and lumbar spine arising out of or in the course of employment with the respondent.

4. The applicant suffers with a secondary psychological injury as a result of physical injury arising out of or in the course of employment with the respondent on 15 February 2018.

5. Respondent to pay the applicant weekly payments of compensation at the rate of $787.66 from 19 January 2020 to date pursuant to section 37 of the *Workers Compensation Act 1987* with such payments to continue in accordance with the provisions of the *Workers Compensation Act 1987.*

6. General order pursuant to section 60 of the *Workers Compensation Act 1987* that the respondent pay the applicant's reasonably necessary medical and related treatment expenses for treatment of the consequential conditions of the right upper extremity and left upper extremity (shoulder) as a result of injury arising out of or in the course of employment with the respondent on 15 February 2018.

7. General order pursuant to section 60 of the *Workers Compensation Act 1987* that the respondent pay the applicant's reasonably necessary medical and related treatment expenses for surgical procedures of the right carpal tunnel syndrome release and left shoulder rotator cuff repair as a result of injury arising out of or in the course of employment with the respondent on 15 February 2018.

8. General order pursuant to section 60 of the *Workers Compensation Act 1987* that the respondent pay the applicant's reasonably necessary medical and related treatment expenses for treatment of the secondary psychological injury as a result of physical injury arising out of or in the course of employment with the respondent on 15 February 2018.

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

Grahame Edwards
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 GRAHAME EDWARDS, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Sufian

Abu Sufian
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

Background

1. Mr Andrew John Green (the applicant) claims weekly payments of compensation pursuant to s 37 of the *Workers Compensation Act 1987* (the 1987 Act) from 19 January 2020 as well as medical and related treatment expenses pursuant to s 60 of the 1987 Act as a result of suffering injury to his right elbow arising out of or in the course of his employment with Bayside EQ t/as NJ Johnston and NP Johnston (the respondent).

2. The respondent operates a piggery at Tyagarah located in the Northern Rivers Region of New South Wales.

3. Mr Green was employed by the respondent as a farm hand/manager. He commenced employment with the respondent in October 2017.

4. The respondent does not dispute Mr Green suffered injury to his right elbow from recurrent blows to it while manoeuvring pigs and performing manual duties in the course of his employment. Mr Green said he did not suffer a "specific injury" but developed pain in his right elbow while undertaking manual labour activities.

5. On 19 March 2018, Mr Green stopped work due to pain and immobility in his right elbow. He consulted his general practitioner, Dr de Campos Silva of the Tintenbar Medical Centre (nominated treating doctor), who diagnosed olecranon bursitis. The elbow condition did not settle, and Mr Green was referred to the Lismore Base Hospital.

6. On 4 April 2018, Mr Green underwent a surgical procedure at the Lismore Base Hospital by Dr Freihaut in the form of a right elbow olecranon bursitis excision.

7. On 7 April 2018, Mr Green was discharged from hospital and returned to the care of his general practitioner.

8. On 12 April 2018, the respondent terminated Mr Green's employment.

9. On 20 April 2018, Dr de Campos Silva issued a medical certifying Mr Green unfit for work from 4 April 2018 to 4 May 2018 noting the date of injury as 15 February 2018.

10. The parties have accepted the date of injury to the right elbow as 15 February 2018.

11. On 1 May 2018, Mr Green was reviewed by a rehabilitation provider (pinnacle rehab) on referral from the respondent.

12. On 11 May 2018, Mr Green underwent a workplace assessment by "pinnacle rehab" who reported that pre-injury duties of cleaning, feeding and checking stock were suitable in accordance with restrictions from 28 May 2018.

13. On 15 May 2018, the respondent accepted provisional liability for the injury to the right elbow.

14. In May 2018, Mr Green obtained employment with an entity styled "Novaskill", independently of "Pinnacle rehab", as a field officer mentoring trainees. This job required a lot of driving which Mr Green said aggravated his elbow condition.

15. Mr Green was referred to Dr Henschke, orthopaedic surgeon, for review of weakness in the right arm and ulnar nerve symptoms.

16. On 22 August 2018, Dr Henschke reported to the nominated treating doctor that there was some paraesthesia in the ulnar nerve distribution in the hand and some wasting at the hypothenar eminence with the possibility of residual ulnar nerve entrapment following the right olecranon bursitis, and possibly some formation of scar tissue in the area.

17. On 2 October 2018, Mr Green underwent nerve conduction studies by Dr Bonev, neurologist, at the rooms of Prof Corbett on the Gold Coast.

18. Dr Henschke referred Mr Green to Dr Prodger, orthopaedic surgeon, for review and surgical intervention in the form of an ulnar nerve release because Dr Henschke operated only in the public hospital system.

19. On 26 October 2018, Dr Prodger reported to Dr Henschke that Mr Green had symptoms of ulnar nerve compression since excision of the infected olecranon bursa and a positive "Tinel's test" over the right ulnar nerve in the cubital tunnel, confirming that the recent nerve conduction studies showed a focal right ulnar neuropathy at the elbow.

20. On 27 November 2018, Mr Green underwent a right ulna nerve compression release by Dr Prodger at St Vincent's Hospital Ballina.

21. The respondent accepted liability for the surgical procedure of the right ulnar nerve compression release.

22. Mr Green said that following the ulnar nerve compression release he began to experience pain in his back, neck and left shoulder. He said he received physiotherapy treatment for his back on referral from his general practitioner and underwent three injections to his left shoulder.

23. On 21 January 2019, Dr Prodger reported to Dr de Campos Silva that the ulna symptoms remained the same seven weeks post the right ulnar nerve release.

24. Dr Prodger also reported that Mr Green complained of left shoulder pain, which he attributed to overuse of the left upper limb due to the limited use of his right arm since the injury, and that a hydro cortisone injection and local anaesthetic injection had made no difference to the shoulder symptoms.

25. On 6 February 2019, Mr Green commenced right hand rehabilitation at the Gold Coast Hand Therapy in Ballina. He underwent four to six sessions.

26. On 11 February 2019, Mr Green underwent further nerve conduction studies by Dr Bonev.

27. On 13 February 2019, Dr Prodger reported to Dr de Campos Silva that the repeat ulnar nerve study showed persistent focal ulnar neuropathy, and that the ulnar nerve release made no difference to symptoms of constant paraesthesia in the ulnar nerve distribution of the right hand, and that there was tenderness around the elbow, recommending an ulnar nerve transposition.

28. On 21 February 2019, Mr Green underwent a right ulnar nerve transposition for progressive nerve compression neuropathy of the right ulnar nerve by Dr Prodger at St Vincent's Private Hospital Ballina.

29. The respondent accepted liability for the surgical procedure of the right ulnar nerve transposition.

30. On 5 March 2019, Dr Prodger reported to Dr de Campos Silva that the surgery was difficult, finding the ulnar nerve was encased in a thick and florid scar in the cubital tunnel, and that he translocated the nerve to a sub muscular position.

31. Dr Prodger also reported that Mr Green was suffering with a lot of hand stiffness, advising to use the hand as much as possible.

32. Dr Prodger opined that Mr Green was developing signs of complex regional pain syndrome of the right upper limb, which needed aggressive physiotherapy and hand therapy.

33. On 21 March 2019, Dr Prodger reported to Dr de Campos Silva that the operation wound was healing but there was no change in the thenar eminence.

34. Dr Prodger also reported that Mr Green complained that his left shoulder and back were "troublesome".

35. On 23 April 2019, Dr Prodger reviewed Mr Green, reporting that the right upper limb symptoms remained the same with persistent elbow pain, medial pain and paraesthesia and anaesthesia in the right ring finger; and there was persistent muscle wasting in the hypothenar and eminence of the first dorsal interosseous space.

36. On 6 June 2019, Mr Green underwent further nerve conduction studies by Dr Bonev which revealed carpal tunnel syndrome at the right wrist. Dr Bonev recommended that surgical carpal tunnel release needed to be considered.

37. On 31 October 2019, Mr Green was assessed by Dr Doig, independent medical examiner, at the request of the respondent.

38. On 12 November 2019, Dr Doig reported that the infected olecranon bursa at the dominant right elbow had resolved and there was no incapacity for work as a result of the elbow injury; and that the other medical conditions of the cervical spine, lumbar spine and left shoulder were unrelated to the olecranon bursitis.

39. On 25 November 2019, Dr Prodger sought approval from the insurance scheme agent for surgical procedures in the form of a left rotator cuff repair and a right carpal tunnel release, providing an estimation of the cost for the procedures.

40. On 27 November 2019, the insurance scheme agent issued a notice pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) declining liability for weekly payments of compensation and medical expenses with weekly payments to cease on 18 January 2020.

41. The respondent also declined liability for medical and related treatment expenses pursuant to s 60 of the 1987 Act.

42. In May 2020, Mr Green elected to undergo the left shoulder rotator cuff repair and carpal tunnel release in the public hospital system under Dr Prodger.

Proceedings

43. The applicant lodged an Application to Resolve a Dispute (the Application) dated 25 March 2020.

44. The applicant particularised the claim for weekly payments from 16 January 2020, subsequently amended to 19 January 2020, pursuant to s 37 of the 1987 Act and future medical expenses for the proposed surgical procedures in the form of left shoulder rotator cuff repair and the right carpal tunnel release as recommended by Dr Prodger as well as physiotherapy, hand rehabilitation and further consultations with his treating psychologist, Ms Patricia Grant.

45. The applicant particularised the injury details as follows:

"**Type of injury**	aggravation, acceleration or exacerbation of deterioration of disease
Date of Injury	15/02/2018
Date of compensation Claim	15/02/2018
Place of injury	Respondent's workplace
Injury description	Olecranon Bursitis, right infected olecranon bursa, right elbow, right wrist, cervical and lumbar spine, consequential right shoulder injury capsulitis rotator cuff tear, consequential right carpal tunnel syndrome, consequential aggravation of cervical and lumbar spine condition, secondary psychological condition adjustment disorder."

46. The respondent lodged its Reply to Application to Resolve a Dispute (the Reply) dated 15 April 2020.

47. The respondent, in addition to the declinature of liability outlined in the s 78 notice, particularised the following issues in dispute in its reply:

"**Any other issues**	1. The Respondent disputes that the worker suffered injuries to his cervical spine, lumbar spine, either shoulder or right wrist in the course of his employment with the Respondent, or alternatively as a result of the injuries sustained to his right elbow. 2. The Respondent disputes that any alleged secondary psychological condition resulted in the course of his employment with the Respondent, or alternatively as a result of the right elbow injury."

48. On 22 April 2020, I held a telephone conference with the parties. Mr Harrison represented the applicant and Mr Murray represented the respondent in the interests of the insurance scheme agent. Mr Green was in attendance was a representative of the insurance scheme agent, Ms Malone.

49. The applicant conceded there was a typographical error in the injury description section of the Application and that reference to right shoulder should be the left shoulder.

50. The respondent maintained its declinature of liability in respect of the surgical procedures of the left shoulder rotator cuff repair and the right carpal tunnel release, and the body parts particularised in the Application except for injury to the right elbow which it submits the effects of the injury have resolved, and that the applicant is not incapacitated for work as a result of the right elbow injury.

51. The applicant confirmed that the proceedings would be conducted on the basis he suffered injury to his right elbow, right wrist, cervical spine, and lumbar spine in the course of employment and/or consequential conditions of the right wrist, cervical spine, lumbar spine and left shoulder as a result of injury to the right elbow.

ISSUES FOR DETERMINATION

52. The parties agree the following issues remain in dispute:

    (a) Injury to the right upper extremity, lumbar spine, cervical spine and left upper extremity (shoulder) arising out of or in the course of employment within the meaning of s 4 of the 1987 Act.

    (b) Consequential conditions of the right upper extremity, lumbar spine, cervical spine and left upper extremity (shoulder) resulting from injury to the right elbow.

    (c) Whether the employment concerned was a substantial contributing factor to the injury within the meaning of s 9A of the 1987 Act.

    (d) Whether the applicant suffered a secondary psychological injury as a result of a physical injury.

    (e) Whether the surgical procedures in the form of right carpal tunnel release and left shoulder rotator cuff repair were reasonably necessary as a result of injury within the meaning of s 60 of the 1987 Act.

    (f) Claim for medical expenses, past and future, including claim for psychological counselling and consultations with the treating psychologist.

    (g) Entitlement to weekly payments of compensation from 19 January 2020.

PROCEDURE BEFORE THE COMMISSION

53. The parties attended a conciliation conference/arbitration hearing conducted via telephone on 3 June 2020 because of the Covid 19 social distancing regulations. 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.

54. The arbitration hearing was sound recorded.

55. Mr Brazel of counsel instructed by Mr Harrison represented the applicant who was in attendance.

56. Mr Grimes of counsel instructed by Mr Stiles represented the respondent in the interests of the insurance scheme agent.

57. Ms Huang, representative of the insurance scheme agent, was also in attendance.

EVIDENCE

Documentary evidence

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

    Applicant

    (a) Application and attached documents, and

(b) Application to Admit Late documents dated 5 May 2020.

Respondent

(a) Reply and attached documents.

Oral evidence

59. No application was made by either party to adduce oral evidence. No application was made by the respondent to cross-examine the applicant.

Applicant's submissions

60. Mr Brazel provided written submissions entitled: "Outline of Written Submission", dated 1 June 2020.

61. The applicant's submissions are summarised as follows:

(a) The respondent accepts the applicant suffered injury to his right elbow arising out of or in the course of employment.

(b) The applicant commenced work with the respondent in October 2017 and developed pain in his right elbow over a period of time, suffering direct blows to the back of it.

(c) The surgical procedures to the right elbow did not result in a good outcome.

(d) The nerve condition study was as a consequence of the treatment for the olecranon bursectomy resulting from the injury to the right elbow.

(e) The applicant suffered consequential conditions of the right wrist and left shoulder as a result of the injury to the right elbow.

(f) The applicant aggravated his neck and lower back in the course of employment with the respondent.

(g) The applicant suffered a secondary psychological injury as a result of his physical injury.

(h) The applicant relies upon the principles of *Kooragang Cement Pty Ltd v Bates*[1] (*Kooragang*) and *Rail Services Australia v Dimovski & Anor*[2] discussed by Deputy President Roche in *Moon v Conmah Pty Ltd*[3] that what is required is a common sense evaluation of the causal chain or causal link between the consequential conditions and the injury.

(i) The applicant did not have any nerve symptoms prior to the bursectomy, which is supported by the clinical records of the nominated treating doctor.

(j) The applicant was referred by the respondent to a rehabilitation provider following the first surgical procedure.

(k) The applicant was referred to Dr Henschke because of complaints about weakness in the right arm and ulnar nerve symptoms.

[1] (1994) 35 NSWLR 452 at 462F; 10 NSWWCR 796
[2] [2004] NSWCA 267
[3] [2009] NSWWCCPD 134 at [45]-[46] and [51]

(l) EMG study undertaken by Dr Bonev on 2 October 2018[4] revealed an absent right ulna sensory nerve action and focal right ulnar mononeuropathy at the right elbow.

(m) The applicant had ulnar symptoms with muscle wasting with significant ulnar entrapment at the elbow as confirmed by Dr Henschke[5] resulting in right ulnar nerve compression release by Dr Prodger on 27 November 2018.

(n) The right ulnar nerve release did not relieve the symptoms with the applicant undergoing a right ulnar nerve transposition on 21 February 2019.

(o) Dr Prodger said the surgery was difficult because the ulnar nerve was encased in a thick and florid scar in the cubital tunnel[6].

(p) Dr Williams (nominated treating doctor – Tintenbar Medical Centre) noted sensory losses.[7]

(q) Dr Chang, consulted neurosurgeon, recorded a history of the applicant experiencing tingling and numbness along the ulnar aspect of the right arm, hand and the little finger and the ring finger since the olecranon bursectomy.[8]

(r) Dr Prodger provides the causal link on the question of causation of the onset of the ulnar nerve compression syndrome symptoms and the olecranon bursectomy as result of the injury to the right elbow.[9]

(s) The applicant underwent the right carpal tunnel release and left shoulder rotator cuff repair in late May 2020.

(t) The Commission would be satisfied of a causal link between the conditions of the carpal tunnel syndrome and the right ulna nerve as a result of the injury to the right elbow.[10]

(u) There is a causal link or connection between the right elbow injury and the need for the right ulna nerve compression release (the second operation – 27 November 2018), and the right ulna nerve transposition (the third operation – 21 February 2019).

(v) The applicant suffers with a consequential condition of the left shoulder caused by overuse of the left arm because the right upper limb has been affected by the nerve compression syndrome resulting from the right elbow injury.[11]

(w) The applicant complained to Dr Prodger about his left shoulder and low back when he consulted him on 21 March 2019.[12]

(x) Dr Prodger observed there was muscle wasting in the thenar eminence, and there was mild wasting in the hypo thenar eminence compared to the left.[13]

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[4] Application – pp 36-37
[5] supra – p 29
[6] Application – p 16
[7] Reply – pp 42-43
[8] Application – p 216
[9] supra – p 222
[10] supra – p 219
[11] supra at 10
[12] supra – p 195
[13] supra at 12

(y) The applicant complained to his nominated treating doctor about his left shoulder from overuse[14].

(z) The right wrist carpal tunnel is as a result of the ulna nerve complications caused by the elbow injury, confirmed by Dr Prodger.

(aa) The applicant acknowledges he suffered a previous injury to his right wrist requiring plating of a fractured radius and fixation of a fractured scaphoid.

(bb) Dr Doig's opinion that the medical conditions (ulnar nerve, median nerve, carpal tunnel syndrome, and left shoulder) are not related to the infected olecranon bursa is not the test for causation of consequential conditions resulting from injury.

(cc) The test is a common sense evaluation of the causal link between the consequential conditions and the injury.

(dd) Dr Doig's opinion should not be accepted.

(ee) The applicant suffers with a secondary psychological injury as a result of his physical injury.

(ff) The applicant presented to Dr de Campos Silva on 25 May 2018 with symptoms of depression and anxiety.[15]

(gg) The applicant was referred by Dr de Campos Silva to Patricia Grant, psychologist, on 7 February 2019, who diagnosed him to be suffering with an Adjustment Disorder as a result of his injury.[16]

(hh) Further consultations with the nominated treating doctors for psychological injury are recorded in the clinical notes dated 2 January 2019, 2 February 2019 and 6 March 2019[17].

(ii) Ms Grant believes the applicant requires further psychotherapy treatment for his psychological injury.[18]

(jj) The applicant has no capacity for work and claims weekly payments from 19 January 2020.

(kk) The applicant claims medical and related treatment expenses and the cost of the surgery undertaken for the left shoulder rotator cuff repair and the right carpal tunnel syndrome release.

(ll) The applicant also claims medical and related treatment expenses for his psychological injury.

[14] Reply – pp 38
[15] Reply – p 32
[16] Application – pp 212-213
[17] Reply – pp 39-41
[18] Application – p 211

Respondent's submissions

62. The respondent's submissions are summarised as follows:

(a) The applicant bears the onus of establishing injury on the balance of probabilities in that the Commission feels an actual persuasion of the existence of that fact.[19]

(b) The applicant has not discharged his onus.

(c) The applicant's case is based upon an inaccurate history.

(d) The applicant's credit is in issue.

(e) There are no forensic reports from independent medical examiners qualified by the applicant.

(f) The initial injury was to the right elbow and the history provided to the general practitioner was immobility in the elbow.[20]

(g) The general practitioner diagnosed right elbow olecranon bursitis on 19 March 2018, certifying the applicant unfit to 3 April 2018, and fit for suitable duties from 4 April 2018 to 26 November 2018.

(h) The applicant alleges he was terminated on 12 April 2018.[21]

(i) The general practitioner recorded on 10 May 2018 that the right elbow had a full range of movement and there was nil pain and nil swelling.[22]

(j) The general practitioner recorded on 23 May 2018 that there was a full range of movement in the right elbow with nil pain and nil swelling.

(k) The condition of the right elbow as a result of the injury had resolved by the time the applicant was seen by his general practitioner on 23 May 2018.

(l) The applicant obtained employment with "Novaskill" in May 2018.

(m) The applicant said his right elbow was aggravated by driving.[23]

(n) The consequential conditions came on at a much later time caused by subsequent employment.

(o) The applicant's credit is in issue in terms of accepting the history provided to the nominated treating doctors.

(p) The opinion on causation is based on the history provided by the applicant.

(q) The applicant said at paragraph 7 of his statement that he never previously injured his right arm or left shoulder.

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[19] *Nguyen v Cosmopolitan Homes* [2008] NSCA 246 at [44]-[48]
[20] applicant's statement – Application – p 2 at [13]
[21] supra at [17]-[18]
[22] Reply – p 31
[23] supra – 21 at [19]

(r) The applicant also alleges at paragraph 34 of his statement that at no stage prior to his employment with the respondent did he have any symptoms in his left shoulder or lumbar spine.

(s) The applicant also told the respondent's independent medical examiner that his general health had been good.

(t) The applicant's history is not correct.

(u) There was no disclosure about injury to the lumbar spine, the left shoulder and psychological problems as recorded by the general practitioner in the clinical notes between 2010 and 2014.[24]

(v) The applicant consulted his general practitioner on 7 March 2014 for depression.[25]

(w) The general practitioner recorded on 1 July 2016 under the heading "issues":

"back
Shoulder
pain in buttock and hip
recurrently lose feeling, and fall due to back pain, recurrent sharp pain
Pain in shoulders with sleeping".[26]

(x) The general practitioner recorded on 4 July 2016 complaints about back pain, and bilateral shoulder pain for two years, getting progressively worse.

(y) The general practitioner discussed with the applicant that his injuries are wear and tear of many years of manual labour.

(z) The applicant consulted his general practitioner on 8 November 2016 complaining of swollen glands on the left side of the neck.[27]

(aa) On 15 December 2016, the applicant was seen by his general practitioner for stress, and said he felt depressed.[28]

(bb) The applicant has had significant psychological problems leading up to 2016.

(cc) The applicant's pre-existing conditions of the lumbar spine, left shoulder, neck and psychiatric problems were not disclosed to the nominated treating doctors and the respondent's independent medical examiner.

(dd) The Commission should treat the applicant's evidence with caution in accepting that he suffered consequential conditions resulting from the injury to the right elbow.

(ee) While Dr Bonev advised that surgical carpal tunnel release needs to be considered, no opinion as to the causation of the median nerve symptoms was given.[29]

(ff) The applicant relies upon the opinion of Dr Prodger.

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[24] Reply – pp 7-20
[25] supra – p 21
[26] Reply – pp 23-24
[27] supra – p 25
[28] supra – pp 26-27
[29] Application – pp 159-160

(gg) Dr Prodger provided no opinion about causation of the carpal tunnel syndrome and the left rotator cuff repair when seeking approval for the proposed surgeries.[30]

(hh) Dr Williams did not provide an opinion on causation of the right carpal tunnel syndrome.[31]

(ii) The opinion of Dr Williams that the symptoms occurred after the initially infected right olecranon bursitis should not be accepted because he said, to his knowledge, he did not think the injuries were as a result of any pre-existing condition or injury.

(jj) There is no causal link between the consequential conditions and the injury to the right elbow.

(kk) Any further problems with the right elbow were caused by work with another employer.

(ll) Dr Doig could not provide any anatomical or scientific explanation for acceptance of the secondary conditions because he suffers from primary idiopathic osteo-arthritis of the cervical spine; pre-existing partial tear of the supraspinatus tendon at the left shoulder and a carpal tunnel syndrome at the right wrist.

(mm) Dr Williams' WorkCover medical certificate dated 7 January 2020[32] certifying the applicant with no capacity for work assumes the right arm was injured at work.

(nn) Reports from the nominated treating doctors and WorkCover certificates of incapacity do not assist the applicant with respect to the consequential conditions or psychological treatment.

(oo) Dr Prodger provided his report dated 4 March 2020[33] as an expert witness answering questions asked by the applicant's solicitor but does not say what history he obtained upon which he based his opinion.

(pp) In answer to question four, Dr Prodger merely accepts the applicant's statement of him attributing the left shoulder pain to overuse of his left arm while his right arm was recovering from surgery, but said he was unable to directly relate the partial thickness supraspinatus tear and his left shoulder symptoms directly to the infected olecranon bursa.

(qq) In answer to question five, Dr Prodger was unable to directly relate the development of symptoms and signs of carpal tunnel syndrome to the accepted infected olecranon bursa.

(rr) In answer to question 11, Dr Prodger agreed with Dr Doig's opinion that the cervical and lumbar spines and the left shoulder are unrelated to the infected right olecranon bursa.

(ss) Dr Prodger was not provided with any prior history with respect to the cervical spine, lumbar spine and left shoulder.

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[30] supra – p 173
[31] supra – p 212
[32] Application – p 40
[33] supra – p 222

(tt) The Commission would have difficulty accepting the applicant's evidence.

(uu) Dr Williams was given no prior history of psychological problems.

(vv) The applicant's prior psychological problems as recorded in the clinical records were not disclosed by him in his statement of evidence before the Commission.

(ww) The applicant's nominated treating doctors did not have a fair climate upon which to base their opinions.

(xx) The applicant did not give Dr Prodger a history of his previous back, cervical and left shoulder problems.

(yy) The clinical records disclose that the applicant had bilateral problems with the left shoulder for two years prior to the right elbow injury.

(zz) The Commission should accept Dr Doig's opinion that the conditions of the cervical spine, lumbar spine, left shoulder and right carpal syndrome are unrelated to the right elbow injury for the reasons he gave.

(aaa) Dr Prodger provided no opinion whether the proposed surgery of right carpal tunnel release and left shoulder rotator cuff repair were reasonably necessary as a result of injury.

(bbb) The Commission should accept Dr Doig's opinion that the applicant is fit for his pre-injury duties with respect of his olecranon bursa condition, which had fully resolved by 23 May 2018 when seen by his general practitioner.

(ccc) The applicant has the capacity to perform the duties set out in his resume[34] such as a customer service officer, delivery driver, accounts manager, and office duties.

(ddd) The applicant is not totally incapacitated for work as a result of his right elbow injury.

(eee) Any incapacity for work is as a result of the unrelated medical conditions as opined by Dr Doig.

Applicant's submissions in reply

63. The applicant's submissions in reply are summarised as follows:

(a) The applicant acknowledges that the onus of establishing the consequential conditions is upon him.

(b) The respondent's submission that the applicant failed to provide an accurate history to the nominated treating doctors is a "red herring".

(c) Dr Doig was provided with the clinical records of the medical practice of the applicant's general practitioner.

[34] Application – pp 7-10

(d) The applicant presented to his general practitioner on 10 May 2018 with muscle wasting and weakness in the right arm following the olecranon bursectomy and was referred to Dr Henschke, and subsequently to Dr Prodger.

(e) There is no history of psychological problems recorded in the clinical notes of the Tintenbar Medical Centre after 2016.

(f) The nerve conduction studies performed by Dr Bonev on 12 June 2019 confirmed sensory impairment in the right ulnar nerve distribution and the right median nerve conduction as well as right carpal tunnel syndrome.

(g) Dr Prodger is of the opinion that the surgery to the left shoulder and the right carpal tunnel syndrome are reasonably necessary as a result of injury because he sought approval to undertake the proposed surgery.[35]

(h) Dr Prodger reported that the applicant almost immediately after the olecranon bursitis surgery developed ulna nerve compression symptoms, and that the onset of the nerve compression syndrome symptoms was attributable to the first operation being the drainage of the infected olecranon bursa.

(i) Dr Prodger provides the causal link between the right carpal tunnel syndrome and the injury[36].

(j) Ms Grant, treating psychologist, has seen the applicant 20 times since she first assessed him on 7 February 2019.[37]

(k) Ms Grant diagnosed the applicant to be suffering with an Adjustment Disorder as a result of the injury, which has had a significant impact upon his mental health.

(l) Dr Doig has not appreciated what is required to establish a causal link between the consequential conditions and the olecranon bursitis, ignoring the chronology of complaints to the nominated treating doctors.

(m) Dr Doig conceded that on-going dysaesthesia on the ulnar border could take many months to resolve.

(n) The applicant was referred to Dr Henschke because the right arm symptoms did not resolve.

FINDINGS AND REASONS

Issue 1 – Did the applicant suffer consequential conditions of the right ulnar nerve and the right median nerve as a result of injury to the right elbow?

64. Mr Green said he did not have any sensory nerve distribution problems in his right arm prior to the injury to the right elbow. He said that he developed numbness and paraesthesia in his right arm after the olecranon bursitis excision.[38]

[35] supra – p 173
[36] supra – p 219
[37] Application – p 210
[38] Applicant's statement – Application – p 2 at [7] and [20]

65. The clinical records of the Tintenbar Medical Centre show that Mr Green has been consulting this practice since 2013.

66. Mr Green suffered a previous injury to his right wrist requiring plating of a fractured radius and fixation of a fractured scaphoid. The history of the fractured radius is recorded in the clinical records under the heading: "Inactive Past History".[39]

67. The clinical records show the first consultation was on 8 April 2013 for back complaints as a result of a work injury on 10 November 2011.

68. While Mr Green consulted various medical practitioners at the Tintenbar Medical Centre for his back pain, bilateral shoulder pain, depression and other medical conditions; there is no record of complaints about the right elbow, right wrist, right hand or nerve sensory distribution in the right arm prior to the right elbow injury.

69. Mr Green first consulted Dr de Campos Silva about his right elbow on 19 March 2018. The clinical notes record: "Some pain and immobility in Right elbow. Constantly knocking it in confined spaces at work. Some heat and selling?>fluid".[40]

70. On 4 April 2018, Dr de Campos Silva referred Mr Green to the Lismore Base Hospital because of an infected right olecranon bursitis.

71. On the same date, Mr Green underwent a right olecranon bursectomy by Dr D Freihaut. Mr Green upon discharged was returned to the care of his general practitioner.

72. Mr Green was reviewed by Dr de Campos Silva on 20 April 2018, 3 May 2018 and 10 May 2018.

73. Dr de Campos Silva found on examination at the consultation on 10 May 2018, there was a full range of movement of the right elbow and nil pain and swelling.

74. Mr Green was reviewed by Dr de Campos Silva on subsequent dates of 23 and 25 May and 8 and 27 June 2018.

75. The first recorded complaint about paraesthesia in the right arm was made on 27 June 2018. Dr de Campos Silva referred Mr Green to the fracture clinic at Lismore Base Hospital for review by a surgeon.

76. Mr Green was reviewed by Dr Henschke, orthopaedic surgeon, at the fracture clinic.

77. On 22 August 2018, Dr Henschke[41] reported to the Tintenbar Medical Centre the following:

> "It has now been four months since his operation and Andrew is generally progressing well, however he does describe some weakness of the right upper limb in addition to some ulnar nerve symptoms. The weakness is readily explained by the fact that he has been using his right upper limb far less than he normally would as he has recovered. With regard the ulnar nerve symptoms these present as some paraesthesia in the ulnar nerve distribution in the hand and some wasting at the hypothenar eminence. **It is possible that there might be some residual ulnar nerve entrapment following the right olecranon bursitis and possibly some formation of scar tissue in the area**. (emphasis not in original)"

[39] Reply – p 13
[40] supra – p 27
[41] Application – p 28

78. Dr Henschke referred Mr Green for nerve conduction studies at the rooms of Prof Corbett on the Gold Coast.

79. Dr Bonev, neurologist, reported to Dr Henschke on 2 October 2018[42] that there was sensory impairment in the right ulnar nerve distribution, returning Mr Green to Dr Henschke for future management.

80. Dr Bonev recorded the following history:

> "Constant numbness and tingling in the medical aspect of the right hand for approximately 6 months post olecranon bursectomy; symptoms associated with right intrinsic hand weakness and Green states that he cannot even open a jar at present."

81. Dr Bonev was of the opinion that Mr Green was suffering with "focal right ulnar mononeuropathy at the elbow".

82. Dr Henschke saw Mr Green on 24 October 2018 and reported to the Tintenbar Medical Centre on the same day[43] that the nerve conduction studies confirmed "significant nerve entrapment at the elbow", recommending surgery because of the severity of the symptoms and muscle wasting.

83. Dr Henschke referred Mr Green to Dr Prodger because he operated only in the public hospital system.

84. Dr Prodger reported to Dr Henschke on 26 October 2018[44] that examination revealed a positive "Tinel's" test over the right ulnar nerve in the cubital tunnel with wasting in the first dorsal interosseous on the right and reduced power in the first interosseous on the right compared to the left, and mild subjective alteration in the sensation in the ulnar nerve distribution of the right hand.

85. Dr Prodger recommended that Mr Green undergo an ulnar nerve compression release.

86. On 27 November 2018, Mr Green underwent right ulnar nerve compression release by Dr Prodger at St Vincent's Private Hospital Ballina. The compressed ulnar nerve around the medial epicondyle was released.[45]

87. Mr Green did not have a good outcome from the ulnar nerve compression release reporting to Dr Prodger that the release made no difference to his symptoms of constant paraesthesia in the ulnar nerve distribution of his right hand and tenderness around the elbow.[46]

88. Mr Green underwent further conduction studies by Dr Bonev on 11 February 2019. Dr Bonev reported as follows:[47]

> "Ongoing numbness and tingling in medial aspect of right hand associated with sense of weakness in right hand; symptoms have apparently worsened since right ulnar release in October, 2018.
>
> …

[42] supra – p 36
[43] supra – p 29
[44] Application – p 34
[45] supra – p 30 – operation report dated 27 November 2018 – Application – p 32
[46] report of Dr Prodger dated 13 February 2019 – Application – p 19
[47] Application – p 20

Examination: (emphasis in original)

- Weakness and wasting of right ulnar-innervated hand muscles
- Normal upper-limb deep tendon reflexes bilaterally
- Sensor impairment in right ulnar never distribution
- Tinel's sign from right ulnar nerve at the retrocondylar groove

Summary of Neurophysiological Findings: (emphasis in original)

- **Absent right ulnar sensory nerve action potential and abnormal right ulnar motor nerve-conduction velocities in the 'across-elbow' segment, confirmed with 'inching' studies – these findings show mild deterioration compared to his pre-surgical study performed in October 2018.**
- **Normal right median, superficial radial and median antebrachial cutaneous sensory nerve-conduction velocities.**"

89. Dr Prodger wrote to Dr de Campos Silva on 13 February 2019[48] advising he offered Mr Green an ulnar never transposition because of constant paraesthesia in the ulnar distribution of the right hand and tenderness around the elbow.

90. On 21 February 2019, Mr Green underwent a right ulnar nerve transposition by Dr Prodger at the St Vincent's Private Hospital Ballina.[49]

91. Dr Prodger reported to Dr de Campos Silva on 5 March 2019[50] that the ulnar nerve transposition surgery was very difficult. Dr Prodger found the ulna nerve was "encased in a thick scar in the cubital tunnel", requiring the nerve to be translocated to a sub muscular position.

92. Dr Prodger was concerned Mr Green might be developing complex regional pain syndrome in his right hand, recommending "aggressive physiotherapy and hand therapy".

93. Dr Prodger reviewed Mr Green on 23 April 2019[51] recording that the symptoms in the right upper limb remained much the same with persistent elbow pain, paraesthesia and anaesthesia in the right ring finger, and persistent muscle wasting in the hypothenar and eminence of the first dorsal interosseous space.

94. Mr Green continued with right hand therapy, reporting to Dr Williams at the Tintenbar Medical Centre on 1 May 2019 that he was "back to where was before the second operation".[52]

95. Dr Williams referred Mr Green for further nerve conduction studies by Dr Bonev which were carried out on 12 June 2019.

96. Dr Bonev reported upon the nerve conduction studies as follows:[53]

"**Impression:** (emphasis in original)

- **Persistent focal right ulnar neuropathy at the elbow – these findings show mild improvement, compared to his pre-surgical study performed in February 2019.**
- **Right carpal tunnel syndrome.**

[48] supra – p 19
[49] supra – p 18
[50] supra – p 16
[51] supra – p 12
[52] Reply – p 42
[53] Application – p 159

Presenting complaints Related to Current Referral (emphasis in original)

- Ongoing and progressively worsening numbness and tingling in medial aspect of right hand associated with sense of weakness in right hand and medial forearm; symptoms have apparently worsened since right ulnar transposition surgery in February 2019; patient also reports intermittent numbness and tingling in lateral 3 digits of right hand, worse with excessive us of the hands.

…

Examination: (emphasis in original)

- Weakness and wasting of right APB and ulnar-innervated hand muscles
- Normal upper-limb deep tendon reflexes bilaterally
- Sensory impairment in right ulnar nerve distribution
- Tinel's sign from right ulnar nerve at the retrocondylar groove

Summary of Neurophysiological Findings: (emphasis in original)

- Absent right ulnar sensory nerve action potential and abnormal right ulnar motor nerve-conduction velocities in the 'across-elbow, segment, confirmed with "*inching*" studies
- **Moderate right median nerve conduction-delay at the carpal tunnel, confirmed by *"inching"* studies** [emphasis not in original]
- Normal right superficial radial and medical antebrachial cutaneous sensory nerve action potentials.

Comments and Recommendations: (emphasis in original)

- **Surgical carpal tunnel release needs to be considered, as the median symptoms have become notable** (emphasis not in original)"

97. On 23 July 2019, Dr Prodger[54] wrote to Dr Williams reporting that Mr Green still gets symptoms along the ulna border of the forearm into his right and little finger with weakness in the right hand, and over time has involved more of his whole hand and just not the ulnar nerve distribution.

98. Dr Prodger noted Mr Green had developed symptoms of carpal tunnel syndrome on the right wrist which involves the median nerve. Dr Prodger said:

> "I have seen Andrew today. He is now five months post right ulna nerve transposition. His ulna nerve symptoms have really only changed marginally at best. He still gets symptoms along the ulna border of his forearm into his ring and little finger. He still has weakness in his right hand but this over time has involved more of his whole and hand and not just the ulna nerve distribution. He is still very tender around the scar over his proximal medial forearm. He has symptoms every day and every night in his right upper limb.
>
> **Over time Andrew has developed symptoms of carpal tunnel on the right which involves the median nerve. It is not uncommon for nerve compression syndromes to result in other nerve compression syndromes in the same upper limb and this appears to have happened overtime with Andrew** (emphasis not in original).

[54] Application – p 219

> I would recommend a right carpal tunnel release. His right upper limb function needs to be maximised and he is now having functional limitations due to the right carpal tunnel syndrome compounding the functional limitations from the right ulna nerve symptoms.
>
> **It is my opinion that these two conditions are linked by virtue of compensation of other parts of his hand leading to a second nerve compression syndrome in his right upper limb** (emphasis not in original)".

99. On 25 November 2019, Dr Prodger[55] wrote to the insurance scheme agent seeking approval to perform the carpal tunnel release surgery, which was declined on the issuing of the s 78 notice.

100. Mr Green relies upon the principle of *Kooragang* to establish on the balance of probabilities on a common sense evaluation of the causal chain that he suffered consequential conditions of sensory loss and impairment of the ulnar and median nerves as a result of the injury to the right elbow.

101. The Commission has considered and explained the difference between an "injury" and a condition that has resulted from an injury in a number of Presidential decisions.[56]

102. In considering the difference between an "injury" and a condition that has resulted from an "injury", the Commission has consistently applied the principles in *Kooragang*.

103. Deputy President Roche in *Bouchmouni* at [65]-[66] said:

> "It may been that if an 'injury' sets in train a series of events then, if the chain is unbroken and provides the relevant causative explanation for the incapacity or impairment, compensation is payable (though, in the case of a claim for compensation for permanent impairment, the payment is dependent upon an assessment by an Approved Medical Specialist. That does not mean that the condition that provides the relevant causative explanation for the incapacity or impairment is an 'injury'.
>
> The fact that the worker in *Kooragang* died from a heart attack did not mean that the attack was an 'injury'. It meant that, on the facts of that case, there was an unbroken chain of causation between the back injury and death. In words, the heart attack (and death) resulted from the back injury."

104. When the symptoms of the consequential condition developed is not determinative[57].

105. The respondent submitted the symptoms in the right arm developed at a later time caused by subsequent employment with "Novaskill".

106. The relevant question is not when those symptoms started, or what the worker was doing at the time, but whether the symptoms resulted from the right elbow injury.[58]

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[55] supra – p 173

[56] *Moon v Conmah Pty Ltd* [2009] NSWWCCPD 134 (*Moon*) at [43], [45] and [50];
Superior Formwork Pty Ltd v Livaja [2009] NSWWCCPD 158 at [122];
Cadbury Schweppes Pty Ltd v Davis [2011] NSWWCCPD 4 (*Davis*) at [28]-[32] and [39]-[42*];*
North Coast Area Health Service v Felstead [2011] NSWCCPD 51 at [84];
Australian Trainseeship System v Turner [2012] NSWWCCPD 4 (*Turner*) at [28]- [29] and [61];
Kumar v Royal Comfort Bedding Pty Ltd [2012] NSWWCCPD 8 at [35]-[49] and [61]), and recently by Deputy President Roche in *Bouchmouni v Bakhos Matta t/as Western Red Services* [2013] NSWWCCPD 4 (*Bouchmouni*) at [52]-[76].

[57] *Turner* at [61]

[58] Ibid

107. It appears the respondent relied upon Mr Green's evidence that his work mentoring trainees with "Novaskill" involved a lot of driving which aggravated his right elbow condition to make this submission.

108. There is no evidence that the sensory impairment in the right ulnar nerve distribution and the right median nerve conduction-delay at the carpal tunnel of the right wrist was caused by driving or duties undertaken while working for "Novaskill".

109. Mr Green relies upon the opinions of Drs Henschke and Prodger as to the causal link between the impairments in the right ulnar nerve distribution and the median nerve, supported by the nerve conduction studies performed by Dr Bonev, and the injury to the right elbow.

110. Dr Henschke found on examination when he first assessed Mr Green in August 2018 that there were ulnar nerve symptoms of paraesthesia in the ulnar nerve distribution in the hand and some wasting at the hypothenar eminence.

111. Dr Henschke found it is possible that there might be some residual ulnar nerve entrapment following the right olecranon bursectomy, and possibly some formation of scar tissue in the area.

112. While Dr Henschke opined there might be some residual ulnar nerve entrapment following the right olecranon bursectomy, the Commission can determine a scenario regarded by expert medical witnesses as being possible to be made out on the balance of probabilities having regard to the whole of the evidence.[59]

113. Dr Henschke's opinion that there may be some scar tissue in the area of the ulnar nerve entrapment was confirmed by Dr Prodger when he performed the right ulnar nerve transposition.

114. Dr Prodger found the ulnar nerve was "encased in thick scar in the cubital tunnel", requiring the nerve to be translocated to a sub muscular position.

115. I accept Mr Green's evidence that the surgical procedures of the right ulnar nerve compression release and the ulnar nerve transposition did not improve the sensory impairment symptoms in his right arm and hand.

116. The nerve conduction studies undertaken by Dr Bonev on 12 June 2019 confirmed not only persistent focal right ulnar neuropathy at the elbow but revealed moderate right median nerve conduction-delay at the carpal tunnel at the right wrist requiring consideration by Dr Prodger to perform a carpal tunnel release.

117. Dr Prodger said the symptoms of carpal tunnel on the right wrist involving the median nerve, confirmed by the nerve conduction studies by Dr Bonev on 12 June 2019, developed over time.

118. On the question of the casual link between development of the median nerve sensory impairment of the right carpal tunnel and the impaired ulnar nerve distribution, Dr Prodger opined that these two conditions are linked by virtue of compensation of other parts of the hand leading to a second nerve compression syndrome in the right upper limb**.**

119. Dr Prodger further opined that it is not uncommon for nerve compression syndromes to result in other nerve compression syndromes in the same upper limb.

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[59] *Tubemakers of Australia Limited v Fernandez* (*Fernandez*) (1976) 50 ALJR 720

120. Dr Prodger's opinion about the causal link between the sensory impairment of the median nerve and the impaired ulnar nerve was provided to the current general practitioner, Dr Williams, in the context of a report from the specialist treating doctor and not provided as a forensic opinion for litigation purposes.

121. Dr Doig was unable to provide any anatomical or scientific explanation with respect to acceptance of the secondary conditions of the impaired ulnar and median nerves as a result of the olecranon bursectomy.

122. Dr Doig was asked to assess whether the request by Mr Green for approval of surgical procedures of right carpal tunnel release and left rotator cuff repair related to the accepted injury to the right elbow.

123. In my view, Dr Doig did not consider whether there was an unbroken causal link between the infected olecranon bursitis and the sensory impaired ulnar and median nerves when he opined there was no anatomical or scientific explanation for those consequential conditions.

124. I agree with Mr Brazel's submission that Dr Doig did not consider the evaluation of the causal chain between the consequential conditions of the impaired ulnar and median nerves resulting from the olecranon bursectomy unlike Drs Henschke and Prodger.

125. Dr Doig did not provide reasons for concluding that the carpal tunnel syndrome at the right wrist was unrelated to the injury to the right elbow except to state he was unable to "provide a scientific explanation" for the right carpal tunnel release as a result of the infected olecranon bursa.

126. Dr Doig did not consider whether the olecranon bursectomy caused the ulnar nerve impairment and formation of scar tissue in that area as found by Dr Prodger in the cubital tunnel while performing the ulnar nerve transposition.

127. The respondent submitted that Dr Prodger's opinion on causation cannot be accepted because in answer to a question from Mr Green's solicitor said he was unable "to directly relate" the development of symptoms and signs of carpal tunnel syndrome to the infected olecranon bursa.

128. The solicitor's letter to Dr Prodger is not in evidence but in any event the doctor provided reasons for the causal link between the development of the carpal tunnel syndrome and the ulnar nerve compression syndrome in his report to Dr Williams dated 23 July 2019.[60]

129. I accept Dr Henschke's opinion that the "significant nerve entrapment at the elbow", confirmed by the nerve conduction studies, was likely to have been caused by the olecranon bursitis.

130. I accept Dr Prodger's opinion that the onset of the ulnar nerve compression syndrome symptoms was attributable to the olecranon bursectomy being drainage of an infected olecranon bursa.[61]

131. I also accept Dr Prodger's opinion that it is not uncommon for nerve compression syndromes to result in other nerve compression syndromes in the same upper limb.

132. Drs Henschke and Prodger had a fair climate upon which to base their opinions as to the causal link of the ulnar nerve and median nerve impairments with the infected olecranon bursitis.[62]

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[60] Application – p 219
[61] report of Dr Prodger dated 4 March 2020 – Application – p 222
[62] *Paric v John Holland (Constructions) Pty Ltd* (*Paric*) [1987] HCA 58; 59 ALJR 844

133. I accept Mr Brazel's submission that the infected olecranon bursitis requiring excision resulted in sensory loss of the ulnar nerve distribution resulting in the median nerve impairment and the carpal tunnel syndrome at the right wrist.

134. I feel an actual persuasion of the existence of the unbroken causal link or nexus between the infected olecranon bursitis and the ulnar nerve entrapment at the elbow as opined by Dr Henschke, and the median nerve impairment resulting in the carpal tunnel syndrome at the right wrist as opined by Dr Prodger. As Dr Prodger opined it is not uncommon for nerve compression syndromes to result in other nerve compression syndromes in the same upper limb.

135. I find on the balance of probabilities that Mr Green suffers with the consequential conditions of ulnar nerve and median nerve impairment with causation of the carpal tunnel syndrome at the right wrist resulting from the median nerve impairment as a result of the injury to the right elbow.

136. The parties made no submissions whether the employment concerned was a substantial contributing factor to the right elbow injury, presumably because liability had been accepted; the question for determination being whether the consequential conditions of the ulnar and median nerve sensory impairments resulted from the right elbow injury and causation of the carpal tunnel syndrome.

Issue 2 – Did the applicant suffer injury to the cervical spine and lumbar spine arising out of or in the course of employment with the respondent?

137. The allegation that Mr Green suffered injury to his cervical and lumbar spine was prosecuted on two bases:

    (a) arising out of or in the course of employment, and/or

    (b) consequential condition resulting from the injury to the right elbow.

138. Mr Brazel conceded in his written submissions that it "may be more difficult to relate to the employment" that Mr Green suffered an "aggravation of his back and neck pain".

139. Mr Brazel made no submission that Mr Green suffered a consequential condition of his cervical and lumbar spines as a result of injury to the right elbow.

140. Mr Green's evidence is that he developed pain in his cervical and lumbar spines "at approximately the same time that I experience [d – sic] left shoulder pain." He said: "I believe my back pain developed from using my body differently when trying to do minor tasks".[63]

141. Mr Green also said that he had no symptoms in his back prior to the right elbow injury.[64]

142. Dr Prodger reported to Dr de Campos Silva on 21 March 2019[65] that Mr Green complained his left shoulder and low back were "troublesome". No history was recorded by Dr Prodger as to the onset of the low back pain.

143. Mr Green relies upon the opinion of Dr Prodger that the work with the respondent aggravated pre-existing degenerative changes in his cervical and lumbar spines.[66]

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[63] Application – p 4 at [33]
[64] supra at [34]
[65] supra – p 14
[66] Application to Admit Late Documents – applicant – report of Dr Prodger dated 4 March 2020 – answer to question 6

144. Dr Prodger noted MRI imagining showing degenerative changes at multiple levels of the cervical and lumbar spines.

145. It appears Dr Prodger provided his opinion on the question of causation of aggravation of degenerative changes in the cervical and lumbar spines as a result of the work with the respondent in response to a question from Mr Green's solicitor. The solicitor's letter is not in evidence.

146. I agree with Mr Grimes' submission that Dr Prodger did not have the correct history[67] or a proper foundation upon which to base his opinion to reach his conclusion[68] that the work with the respondent aggravated the degenerative changes as revealed by the MRI imagining in the cervical and lumbar spines.

147. I also agree with Mr Grimes' submission that Dr Prodger had not been provided with Mr Green's extensive history of low back pain as revealed by the clinical records of the Tintenbar Medical Centre.

148. The initial consultation at the medical practice with Dr Rogers on 8 April 2013 was about back pain with a history recorded that Mr Green injured his back in a work incident on 10 November 2011 when a trolley, holding an 80 kilogram gas bottle which he was pushing, fell into a hole.[69]

149. The medical practice's clinical records show numerous attendances for back pain over the years from 2013 to 2016.

150. Mr Green attended upon Dr Rogers on 4 July 2016 complaining about low back pain across the sacrum, buttock and hip as well as other body parts. Dr Rogers recorded there was a long discussion with Mr Green about his injuries due to wear and tear over many years of manual labour.[70]

151. The first post-injury record about the back was not made until 10 October 2018, which related to a "lower back pigmented mole".[71]

152. The first recorded post-injury complaint about back pain was the consultation with Dr Leahy on 1 February 2019.[72]

153. Mr Brazel's concession that it might be difficult to establish that the work with the respondent aggravated the degenerative changes in the cervical spine and lumbar spine was, in my view, a proper concession because the evidence as to causation of current back complaints as a result of work with the respondent is remote.

154. I am unable to accept Dr Prodger's opinion that the work with the respondent aggravated degenerative changes in the cervical and lumbar spines because it was not based upon a correct history or a proper foundation to reach the conclusion he did especially when Mr Green's statement provides no evidence of neck and back pain while undertaking work tasks with the respondent.

155. Dr Prodger may have reached a different conclusion if he had a proper foundation upon which to base his opinion as to causation of Mr Green's current back complaints.

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[67] *Parcic*
[68] *Makita (Australia) Pty Ltd v Sprowles* [2001] NSWCA 305; 52 NSWLR 705 at [85]; *Hancock v East Coast Timber Products Pty Ltd* [2011] NSWCA 11 at [77] and [83] and *Adler v Australian Securities and Investments Commission* [2003] NSWCA 131 at [63]
[69] Reply – p 14
[70] supra – p 25
[71] supra – p 36
[72] supra – p 40

156. Mr Green's evidence that he developed back pain at approximately the same time he experienced pain in his left shoulder, and his belief that his "back pain developed from using my body differently when trying to do minor tasks", is remote and the speculative view of a lay person not supported by the medical evidence.

157. I do not feel the actual persuasion of the existence of a fact that the work tasks undertaken by Mr Green in the course of employment with the respondent aggravated, accelerated, exacerbated or deteriorated degenerative changes in the cervical and lumbar spines as revealed by the MRI scan.

158. I find that Mr Green did not suffer injury to his cervical spine and lumbar spine arising out of or in the course of employment with the respondent.

159. I find that Mr Green did not suffer consequential conditions of the cervical spine and lumbar spine as a result of injury to the right elbow.

160. I proposed to make an award in favour of the respondent for the alleged injury to the cervical spine and lumbar spine.

Issue 3 – Did the applicant suffer a consequential condition of the left shoulder as a result of injury to the right elbow?

161. The applicant submits he suffers with a consequential condition of the left shoulder as a result of overuse of the left arm resulting from injury to the right elbow, relying upon the principles of *Kooragang* to establish on a common sense evaluation the casual chain or link between the left shoulder condition and the injury.

162. The applicant further submits that the sensory disturbance and impairment of the ulnar and median nerves as a result of the injury resulting in muscle wasting and weakness in the right arm, and the median nerve impairment resulting in the carpal tunnel syndrome at the right wrist, resulted in him overusing his left arm because of weakness and loss of use of the right arm resulting in the left shoulder condition.

163. The respondent submits Mr Green's credit is in issue because he failed to provide a history of previous bilateral shoulder pain to the nominated treating specialists, telling Dr Doig that his general health was good.

164. The respondent referred to the clinical records of the Tintenbar Medical Centre in support of its submission as to the applicant's credit and failure to disclose a history of attendances upon his general practitioners for bilateral shoulder complaints.

165. The respondent submits Dr Prodger merely relied upon the history of Mr Green that he overused his left arm to compensate for the loss of use of the right arm resulting in problems with his left shoulder, and that Mr Green's evidence should be treated with caution.

166. The respondent, in support of its submission that Dr Prodger could not relate the left shoulder condition to the right elbow injury, referred to Dr Prodger's report dated 4 March 2020[73] where he said: "I am not able to directly link these conditions (referring to the back, left shoulder and right carpal tunnel syndrome symptoms) with the original condition of an infected olecranon bursa"; and similarly he was unable to attribute the partial tear in the supraspinatus tendon to the injury.

[73] Application to Admit Late Documents – applicant – p 7 – question 6.

167. The respondent also referred to the report of Dr Prodger dated 2 September 2019[74] where he opined that the left shoulder symptoms and pathology of a large partial thickness tear of the supraspinatus tendon and clinically frozen shoulder is most likely related to many years of heavy work, including heavy overhead work, in manual labour occupations leading up to his right arm injury.

168. Mr Green relies upon the opinion of Dr Prodger that he suffers with a consequential condition of the left shoulder as a result of the injury to the right elbow and the subsequent sensory loss and impairment of the ulnar and median nerves resulting in carpal tunnel syndrome at the right wrist.

169. The respondent relies upon the opinion of Dr Doig that the left shoulder condition is unrelated to the olecranon bursitis because Dr Doig was unable to provide a scientific explanation for the proposed left shoulder rotator cuff repair as a result of the infected olecranon bursa.

170. The clinical records of the Tintenbar Medical Centre show Mr Green attended upon Dr Rogers on two occasions – 1 July 2016 and 4 July 2016 – for complaints about bilateral shoulder pain.

171. The respondent submitted that Dr Rogers noted at the consultation on 4 July 2016[75] the applicant's injuries were "wear and tear of many years of manual labour".

172. The consultation with Dr Rogers on 1 and 4 July 2016 was in regard to back pain and pain across the sacrum and buttock, noting that Mr Green was unable to sleep because of bilateral shoulder pain and back pain ongoing for two years, and getting progressively worse.

173. The first consultation recorded about the left shoulder after the injury was made on 20 November 2018[76], seven days before the second operation in the form of the right ulnar nerve compression release.

174. Mr Green was referred for an x-ray and ultrasound of his left shoulder because he was complaining of pain in the left shoulder and upper arm.

175. While Dr Prodger said he was unable to "directly link" the left shoulder condition with the "original accepted condition of an infected olecranon bursa" and "attribute the partial thickness tear in the supraspinatus to the 'original injury'", he found:

> "It is clear however Mr Green did need to use his left upper limb more during his recovery from the right upper surgery which may have aggravated this pre-existing condition".

176. I accept Dr Prodger's opinion expressed in his report dated 2 September 2019 that the cause of the large partial thickness tear of the supraspinatus tendon resulted from heavy labour work over many years.

177. However, the determinative question is whether the overuse of the left arm compensating for the lack of use of the right arm resulting from the injury aggravated the pre-existing shoulder pathology.

[74] Application – p 217
[75] Reply – pp 24-25
[76] Supra – pp 37-38

178. Mr Green had undergone three surgical procedures, the first being the olecranon bursectomy, the second being the right ulnar nerve compression release and the third being the right ulnar nerve transposition prior to the commencement of proceedings in the Commission. He underwent further surgical procedures in late May 2020 for the right carpal tunnel syndrome release and the left shoulder rotator cuff repair.

179. The medical evidence establishes that there was muscle wasting and weakness in the right arm and hand as a result of the injury.

180. Mr Green's evidence about loss of use of the right arm and hand, sensory loss and nerve distribution dysfunction is independently and overwhelmingly supported by the medical evidence including observations on clinical examination by the nominated treating doctors and the respondent's independent medical expert.

181. I have found that the sensory loss and impairment of the ulnar and median nerves resulted from the injury to the right elbow for reasons given under the heading "Issue 1" above.

182. The clinical records refer to bilateral shoulder pain and unable to sleep provided to Dr Rogers on two occasions in July 2016.

183. Mr Green's complaints about left shoulder pain from overuse of his left arm because of the right arm condition are supported by referral for an x-ray and ultrasound by Dr Turner on 20 November 2018, and complaints to Dr Prodger.

184. Dr Turner in the subsequent consultation on 30 November 2018 noted: "muscle wasting and weakness in right arm".

185. Drs Henschke, Prodger and Bonev referred to sensory loss of the ulnar and median nerves, muscle wasting and weakness in the right arm and hand throughout the series of reports provided to the nominated treating doctors.

186. Dr Doig's clinical examination revealed positive provocation tests for carpal tunnel syndrome with thenar wasting on the right and a weak abductor pollicis breveis muscle, and that Mr Green had a positive "Froment's" sign and weak intrinsic muscles, consistent with on-going ulnar nerve impairment.

187. In my view, Dr Doig has not considered the causal link or chain between the aggravation of the left shoulder pathology resulting from overuse of the left arm due to the impaired condition of the right arm, including the carpal tunnel syndrome, during the recovery period following ulnar nerve compression and transposition surgical procedures as considered by Dr Prodger.

188. I am satisfied that Mr Green relied upon his left arm to perform his activities of daily living to compensate for the lack of use of his right arm caused by sensory loss and impairment of the ulnar and median nerves resulting in muscle wasting and weakness as a result of the injury aggravating the pre-existing pathology of a partial tear of the supraspinatus tear in the left shoulder resulting in a clinical frozen shoulder as found by Dr Prodger.

189. Dr Prodger reported to Dr Williams on 23 July 2019 that there were ongoing symptoms of impingement in the left shoulder, which has failed conservative treatment including physiotherapy and subacromial steroid injections, and that the left shoulder condition has "likely resulted from compensation of using his left upper limb while his right upper limb has been affected by the nerve compression syndrome".[77]

[77] Application – p 214

190. While Dr Prodger's opinion as to aggravation of the pre-existing pathology in the left shoulder by the need to use the left arm during recovery from the surgical procedures is on the basis of possibility as opined in his report dated 4 March 2020[78], I am satisfied that possibility is made out on the balance of probabilities having regard to the whole of the evidence.[79]

191. I find that Mr Green suffered a consequential condition of the left upper extremity (shoulder) as a result of injury to the right elbow.

Issue 4 – Was the employment concerned a substantial contributing factor to the injury within the meaning of s 9A of the 1987 Act?

192. Mr Brazel and Mr Grimes made no submission whether the employment concerned was a substantial contributing factor to the injury; presumably because injury to the right elbow has been accepted by the respondent.

193. I am satisfied on balance that the work tasks performed by Mr Green in the course of employment with the respondent were "real and of substance"[80], and there was a causative element or causal connection between the employment and the injury.[81]

194. The consequential conditions of the ulnar nerve, the median nerve, the carpal tunnel syndrome at the right wrist, and the left shoulder resulted from the injury. The question of causation and the causal link or causal connection between those conditions and the injury were determinative in accordance with the principles of *Kooragang* as discussed by Deputy President Roche in *Bouchmouni*.

Issue 5 – Did the applicant suffer a secondary psychological injury as result of physical injury within the meaning of s 65A of the 1987 Act?

195. Mr Green's evidence is that the injury and the consequential conditions of right upper extremity and his left upper extremity (shoulder) resulting from the injury have impacted upon him psychologically.[82]

196. Mr Green said that at times he experiences low mood, lack of motivation and becomes angrily easily.

197. Mr Green was referred by Dr Rocha of the Tintenbar Medical Centre to Ms Grant, psychologist, for counselling and treatment of his psychiatric condition.

198. Ms Grant first consulted with Mr Green on 7 February 2019, and since that time has seen him on 20 occasions. Treatment has taken the form of psychotherapy to help Mr Green adjust and to assist him with pain management and incapacity as a result of his injury and consequential conditions resulting from injury.

199. Ms Grant diagnosed Mr Green to be suffering with Adjustment Disorder, which is a recognisable psychiatric condition within DSM IV, as a result of his injury in the course of employment with the respondent.

200. Ms Grant opined in her report dated 14 January 2020[83]that Mr Green requires further psychotherapy for treatment of his psychiatric condition.

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[78] Application to Admit Late Documents – applicant – p 7 – answer to question 6
[79] *Fernandez*
[80] *Badawi v Nexon Asia Pacific Pty Ltd t/as Commander Australia Pty Ltd* [2009] NSWCA 324; 75 NSWLR 503 at [80]-[81]
[81] *Taylor v PJM Building Management Pty Ltd* [2013] NSWCCPD 52 at [59] and *Super Retail Group Services Pty Ltd v Uelese* [2016] NSWWCCPD 4
[82] Application – p 6 at [49]
[83] supra – pp 210-211

201. The respondent submitted that Mr Green did not disclose his previous history of complaints and treatment for pre-existing psychiatric conditions as recorded in the clinical notes of the Tintenbar Medical Centre.

202. While Mr Green consulted general practitioners at the Tintenbar Medical Centre of psychiatric conditions between 3 March 2014 and 15 December 2016, those consultations were unrelated to the physical injury suffered with the respondent.

203. Consultation with Dr de Campos Silva on 25 May 2018 was for mood stability. Dr de Campos Silva made Mr Green aware of psychological therapy when "depression/Anxiety flares up".

204. The next recorded psychiatric consultation was 2 January 2019 when Mr Green consulted Dr Rocha at the Tintenbar Medical Centre requesting referral to a psychologist: "as he feels work injuries have affected him psychologist [sic]".

205. I am satisfied that the referral by Dr Rocha to Ms Grant for psychological treatment was as a result of the physical injury to the right elbow and the consequential conditions resulting from the injury.

206. Mr Green had undergone two surgical procedures, the olecranon bursectomy and the right ulnar nerve compression prior to referral to Ms Grant, and at a time when Dr Prodger was recommending ulna nerve transposition because of little or no improvement in the sensory loss nerve distribution resulting in muscle wasting and loss of function of the arm and hand.

207. I find the referral to Ms Grant and treatment of his psychiatric condition was as a result of the physical injury with the respondent.

208. I find on the balance of probabilities that Mr Green suffers with a secondary psychological injury as a result of the physical injury to the right elbow and the consequential conditions resulting from the injury.

Issue 6 – Are the surgical procedures of right carpal tunnel syndrome release and left shoulder rotator cuff repair reasonably necessary as a result of injury within the meaning of s 60 of the 1987 Act?

209. The respondent submits Dr Prodger provided no opinion whether the proposed surgery of right carpal tunnel syndrome release and left shoulder rotator cuff repair were reasonably necessary as a result of injury within the meaning of s 60 of the 1987 Act.

210. The applicant submits Dr Prodger provided his opinion that the proposed surgery of the right carpal tunnel syndrome release and the left shoulder rotator cuff repair were reasonably necessary as a result of injury when he wrote to the insurance scheme agent seeking approval to undertake the surgery.

211. The nerve conduction studies performed by Dr Bonev on 12 June 2019 identified right carpal tunnel syndrome. Dr Bonev commented:[84]

> "ongoing and progressively worsening numbness and tingling in the medial aspect of right hand associated with sense of weakness in right hand and medial forearm; symptoms have apparently worsened since right ulnar transposition surgery in February 2019; patient also reports intermittent numbness and tingling in lateral 3 digits of right hand, worse with excessive of the hands."

[84] Application – p 159

212. Dr Bonev reported that "*inching*" studies confirmed moderate right median nerve conduction-delay at the carpal tunnel; recommending surgical carpal tunnel release needs to be considered because the median nerve symptoms have become more notable.

213. Dr Prodger reported to Dr Williams on 23 July 2019[85] the results of the nerve conduction studies, recommending right carpal tunnel release because the right upper limb function needed to be maximised as there were functional limitations due to the carpal tunnel syndrome, and that surgical management was the next step for the right upper limb nerve compression syndrome to deal with the carpal tunnel syndrome.

214. Also, in the same report, Dr Prodger reported that Mr Green was suffering with "ongoing symptoms in the left shoulder which has failed conservative measures, particularly physiotherapy and subacromial steroid injections", and he "may well be heading down the surgical path for his left shoulder as well".

215. On 23 November 2019, Dr Prodger wrote to the insurance scheme agent seeking approval for the proposed surgery of "Left Rotator Cuff Repair + Right Carpal Tunnel Release", providing an estimated cost of the surgery.[86]

216. Declinature for the proposed surgery was based upon Dr Doig's opinion that the left shoulder condition was unrelated to the injury.

217. While Dr Doig commented upon an MRI scan of the left shoulder revealing a large partial thickness tear of the supraspinatus tendon and his physical examination found restricted movement in both shoulders, he proffered no opinion whether the surgery should be undertaken or whether the surgery was reasonably necessary.

218. Dr Doig confirmed the nerve conduction studies of 12 June 2019 revealed compression of the median nerve at the right carpal tunnel, and his physical examination found "positive provocation tests for carpal tunnel syndrome with thenar wasting on the right and a weak abductor pollicis brevis muscle", but proffered no opinion whether the surgery should be undertaken or whether the surgery was reasonably necessary.

219. I accept Dr Prodger's opinion, supported by the nerve conduction study confirming right carpal tunnel syndrome and the clinical findings on examination by Drs Bonev, Prodger and Doig, that the right carpal tunnel release is reasonably necessary as a result of injury because all other conservative measures have failed; surgery is appropriate and has the potential effectiveness of relieving the symptoms of the carpal tunnel syndrome.[87]

220. I also accept Dr Prodger's opinion that Mr Green suffers with impingement of the left shoulder, clinically a frozen shoulder, and a large partial thickness tear of the supraspinatus tendon confirmed by MRI scan[88], aggravated by overuse of the left arm to compensate for impaired function of the right arm, that conservative treatment, including physiotherapy and subacromial steroid injections, have failed and that the appropriateness and potential effectiveness of the surgery is to relieve the symptoms to obtain function of the left upper extremity.

221. I find that the proposed surgery of right carpal tunnel release as recommended by Dr Prodger is reasonably necessary as a result of injury within the meaning of s 60 of the 1987 Act.

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[85] supra – p 214
[86] Supra – p 173
[87] *Diab v NRMA Ltd* [2014] NSWWCCPD 72 at 88
[88] report of Dr Prodger dated 2 September 2019 – Application – p 217

222. I find that the proposed left shoulder rotator cuff repair as recommended by Dr Prodger is reasonably necessary as a result of injury within the meaning of s 60 of the 1987 Act.

223. Mr Brazel informed me that the right carpal tunnel release and left shoulder rotator cuff repair were undertaken by Dr Prodger in the last week of May 2020.

224. I propose to make a general order pursuant to s 60 of the 1987 Act that the respondent pay the applicant's reasonably necessary medical and related treatment expenses in respect of the surgical procedures of right carpal tunnel release and left shoulder rotator cuff repair undertaken by the nominated treating specialist as a result of those consequential conditions resulting from the injury.

225. I also propose to include in the general order pursuant to s 60 that the respondent pay the applicant's reasonably necessary medical and related treatment expenses for treatment of the consequential conditions of the right upper extremity and left upper extremity (shoulder) resulting from the injury.

Issue 7 – Is the applicant entitled to past and future medical and related expenses for treatment of his secondary psychological injury pursuant to s 60 of the 1987 Act?

226. As I have found Mr Green suffers with a secondary psychological injury, accepting the opinion of the treating psychologist, I agree with Mr Brazel's submission that Mr Green is entitled to payment of medical and related treatment expenses for counselling and psychotherapy of his psychological injury.

227. I propose to make a general order pursuant to s 60 of the 1987 Act that the respondent pay the applicant's reasonably necessary medical and related treatment expenses for treatment of his secondary psychological injury resulting from the physical injury.

Issue 8 – Is the applicant entitled to weekly payments of compensation from 19 January 2020 pursuant to s 37 of the 1987 Act?

228. The applicant submits he has no capacity for work from 19 January 2020 because of the consequential conditions of the sensory disturbance and impairment of the ulnar and medial nerves resulting in right carpal tunnel syndrome as well as the consequential condition of his left shoulder.

229. The respondent submits the Commission should accept Dr Doig's opinion that Mr Green is fit for his pre-injury duties because the right olecranon bursitis had fully resolved by 23 May 2018 as found by the general practitioner.

230. The respondent further submits that Mr Green is not totally incapacitated for work, and that he has the capacity to perform suitable duties such as a customer service officer, delivery driver, accounts manager or office duties as set out in his resume.

231. The respondent's submissions were based upon the opinion of Dr Doig that the consequential conditions of the sensory loss and impairment of the ulnar and median nerves as well as the tunnel carpal syndrome and the left shoulder were unrelated to the right elbow injury.

232. I have not accepted Dr Doig's opinion for reasons I have given under "Issue 1" and "Issue 3" above.

233. I agree with Mr Brazel's submission that the applicant has no capacity for work from 19 January 2020 for the following reasons:

    (a) poor outcome from the surgical procedures of the right ulnar nerve release and the right ulnar nerve transposition;

    (b) sensory loss and impairment of the ulnar and median nerves resulting in muscle wasting;

    (c) symptoms along the ulnar border of the forearm into the ring and little finger;

    (d) loss of use of the right arm and hand as a result of sensory nerve disturbance of the ulnar and median nerves;

    (e) carpal tunnel syndrome at the right wrist involving the median nerve;

    (f) left shoulder impingement;

    (g) clinically frozen left shoulder;

    (h) aggravation of partial tear of the supraspinatus tendon in the left shoulder;

    (i) aggravation of degenerative changes in the left shoulder, and

    (j) recovery from surgical procedures of right carpal tunnel release and left shoulder rotator cuff repair.

234. Mr Green underwent the carpal tunnel release and arthroscopy of the left shoulder in the last week in May 2020. The operative findings are unknown but allowing for a period of recovery, including physiotherapy and a rehabilitation programme, Mr Green will have no capacity for work for the foreseeable future, remaining under the care of his nominated treating doctors.

235. Mr Green's nominated treating doctors have issued approved WorkCover medical certificates certifying no capacity for work from 19 June 2019[89] with the last certificate in evidence issued on 4 March 2020.[90]

236. I find that Mr Green has had no capacity for work as a result of his injury and consequential conditions resulting from injury since 19 January 2020 to date with such incapacity continuing.

237. The parties agree the pre-injury average week earnings were $984.58.[91]

238. Mr Green is entitled to weekly payments of compensation at the prescribed rate pursuant to s 37 of the 1987 Act from 19 January 2020 to date with such payments to continue in accordance with the provisions of the 1987 Act.

[89] Application – pp 107-114
[90] Application to Admit Late Documents – applicant – p 6
[91] Application – p 171