WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**5171/19**
Applicant:	**Roby Agha**
Respondent:	**C & E Constructions Pty Ltd**
Date of Determination:	**19 December 2019**
Citation:	**[2019] NSWWCC 409**

The Commission determines:

1. The applicant sustained injury to his right shoulder on 25 March 2017 in the course of his employment with the respondent.

2. As a result of the injury sustained on 25 March 2019 the applicant developed consequential conditions in his left shoulder and cervical spine.

3. As a result of his cervical spine injury the applicant requires reasonably necessary treatment by way of bilateral carpal tunnel release surgery.

4. The Commission is not satisfied that the applicant suffered a consequential condition of his lumbar spine as a result of his accepted injuries. It follows that he is not entitled to payment of medical expenses of lumbar facet joint injections.

The Commission orders:

5. The respondent to pay the applicant's reasonably necessary medical expenses with respect to the carpal tunnel release proposed by Dr Marc Coughlan pursuant to section 60 of the *Workers Compensation Act 1987*.

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

Jill Toohey
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 JILL TOOHEY, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Mr Roby Agha was working as a builders labourer for C & E Constructions Pty Ltd (the respondent) on 25 March 2017 when he injured his right shoulder while lifting a bar fridge. The respondent accepted liability for his injury. In May 2017, Mr Agha underwent the first of a series of surgical procedures to his right shoulder for repair of a rotator cuff tear.

2. As a consequence of his injury, Mr Agha began favouring his left shoulder. An ultrasound in July 2017 revealed a partial tear in the left rotator cuff. The respondent accepted liability for a consequential injury to his left shoulder.

3. Around November 2017, Mr Agha developed pain in his neck and down his arms. Subsequently he developed adhesive capsulitis in the right shoulder and, in January 2018, he underwent further surgery. He continued to suffer pain in his neck, and he had numbness and tingling in his arms and hands. Ultimately, the respondent accepted liability for aggravation of a pre-existing cervical spine condition and, in August 2018, Mr Agha underwent a cervical spine fusion.

4. In early 2018, Mr Agha developed lower back pain. By November 2018, his lower back pain was worse. In February 2019, he underwent further surgery to his right shoulder. His treating surgeon, Dr Marc Coughlan, thought the symptoms in his arms and hands could be due to carpal tunnel syndrome. He arranged nerve conduction studies, for which the respondent accepted liability. The studies confirmed bilateral carpal tunnel syndrome.

5. In March 2019, Mr Agha underwent further surgery to his right shoulder. In April 2019, Dr Coughlan recommended bilateral carpal tunnel release and L4/5 facet joint injections to relieve his ongoing symptoms of arm pain and back pain.

6. By notices issued under section 78 of the *Workplace Injury Management and Workers Compensation Act 1998* on 7 May 2019 and 4 July 2019, the respondent denied liability to compensate Mr Agha for L4/5 facet joint injections and right-hand carpal tunnel release surgery. The respondent acknowledges that the notice should have referred to the claim for *bilateral* carpal tunnel release.

7. The present proceedings were commenced by an Application to Resolve a Dispute registered with the Commission on 3 October 2019 in which Mr Agha seeks compensation for medical expenses, being for L4/5 facet joint injections and bilateral carpal tunnel release surgery, resulting from injury to his right and left shoulders and cervical spine, and consequential injury to his lumbar spine.

ISSUES FOR DETERMINATION

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

   (a) whether the bilateral carpal tunnel syndrome and lumbar spine condition result from Mr Agha's accepted right and left shoulder, and cervical spine, injuries, and

   (b) if so, whether the proposed surgery and injections are reasonably necessary as a result of his injury.

PROCEDURE BEFORE THE COMMISSION

9. The parties attended a hearing on 2 December 2019. Mr Bruce McManamey of counsel appeared for Mr Agha. Mr Paul Barnes of counsel appeared for the respondent. 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

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

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

Oral evidence

11. There was no application to cross-examine Mr Agha or to adduce oral evidence.

FINDINGS AND REASONS

Mr Agha's evidence

12. Mr Agha provided a written statement of evidence dated 16 September 2019, a summary of which follows.

13. In 1994/5 Mr Agha was involved in a motor vehicle accident for which he received compensation. His lower back symptoms had completely resolved by the end of 1996. In 2003/4 he suffered a partial tear in his right shoulder while at the gym. His resulting symptoms had completely resolved by the end of 2004. He had no history of injury or symptoms in his neck or left shoulder before the workplace injury on 25 March 2017.

14. On 25 March 2017, immediately following the incident at work, Mr Agha attended at Westmead Hospital. He had an MRI, and on 29 March 2017 he saw Dr Desmond Bokor, orthopaedic surgeon, who advised he needed surgery for a torn rotator cuff in his right shoulder. Dr Bokor performed the surgery on 2 May 2017. A month later, Mr Agha still had significant pain and restricted movement in his right shoulder. On 17 July 2017, Dr Bokor reviewed him and attributed the persisting pain and stiffness to adhesive capsulitis.

15. Mr Agha states that, from the time of his initial injury, he began favouring his left shoulder and used it for all activities of daily living. As a consequence, he developed symptoms in his left shoulder. An ultrasound on 29 July 2017 disclosed subacromial bursitis and a partial thickness tear of the supraspinatus tendon.

16. On 25 September 2017, Dr Bokor recommended an ultrasound guided injection into his left shoulder. The insurer approved payment for the injection. On 6 November 2017, when his symptoms were persisting, Dr Bokor recommended a further injection into his left shoulder. The insurer approved payment for the second injection.

17. In early November 2017, Mr Agha began to experience pain and discomfort at the base of his neck, more marked on the left side. The pain radiated into both arms and hands and was associated with weakness, numbness and a burning sensation in his arms and hands. His general practitioner, Dr Emin, referred him for a CT scan of his cervical spine for which the insurer accepted liability. The CT scan was done on 12 December 2017. An MRI several days later revealed a partial thickness tear of the left rotator cuff.

18. On 20 December 2017, Dr Emin referred him to Dr Marc Coughlan, orthopaedic surgeon. The insurer accepted liability for the scans and the referral to Dr Coughlan.

19. After a further MRI of his right shoulder in January 2018, Dr Bokor recommended further surgery to his right shoulder to repair the capsulitis. The insurer accepted liability for the surgery which was performed in late January.

20. On 1 March 2018, Mr Agha saw Dr Coughlan and told him about persistent pain, more marked on the left, radiating into both arms and hands, and burning and numbness in his arms and hands. Dr Coughlan recommended bilateral injections into his cervical spine for which the insurer accepted liability.

21. In April 2018, Mr Agha was referred to a pain management clinic at Royal Prince Alfred Hospital. Around the same time Dr Coughlan requested he undergo a MRI. When he saw Dr Coughlan next, in May 2018, the pain in his neck, arms and hands, was deteriorating. Dr Coughlan advised a discectomy and fusion at C6/7 and a disc replacement at C5/6. After initially declining liability, the insurer accepted liability for the recommended surgery which was carried out in August 2018.

22. The surgery alleviated, but did not eradicate, the pain radiating from Mr Agha's cervical spine into his shoulders, arms and hands, and he continued to experienced numbness and burning in his arms and hands. In September 2018, Dr Coughlan recommended physiotherapy and an adjustable bed, both of which the insurer funded.

23. In early 2018, Mr Agha began to experience intermittent discomfort in his lumbar spine. By October 2018, his lower back symptoms had become constant, aggravated by sitting or lying for prolonged periods. By that time he had not worked for 18 months and had been completely inactive, spending the better part of each day sitting or lying down.

24. In February 2019, Dr Bokor performed arthroscopic debridement of the bursa of Mr Agha's right shoulder, and a regeneration collagen implant was inserted. On 19 February 2019, Mr Agha told Dr Coughlan of persisting pain radiating from his neck into his arms and hands, ongoing tingling and numbness in his hands and deteriorating lower back pain. Dr Coughlan suspected carpal tunnel syndrome and referred him for nerve conduction studies and a SPECT scan of his lower back. The insurer accepted liability for both.

25. On 3 April 2019, Dr Coughlan advised Mr Agha that the nerve conduction studies had confirmed carpal tunnel syndrome, and he recommended surgery. He also recommended injections into his lumbar spine at L4/5.

26. On 3 June 2019, Mr Agha saw Dr James Powell, orthopaedic surgeon, at the request of the insurer. Based on Dr Powell's opinion, the insurer declined liability for the surgery and injections recommended by Dr Coughlan.

27. Mr Agha says he experiences persisting pain, discomfort and restricted movement in his neck, radiating into his arms and hands, and tingling and numbness is both hands. He has significant lower back pain which is deteriorating and now radiating into his right leg. He wishes to have the surgery and injections recommended by Dr Coughlan.

Dr Coughlan

28. The documents before the Commission include letters and reports from Dr Coughlan, a number of which concern Mr Agha's accepted conditions alone and which it is not necessary to refer to here.

29. On 12 April 2018, Dr Coughlan reported to Dr Emin that Mr Agha continued to have "very significant headaches, arm pain and neck pain. His imaging showed bilateral osteochondral bars at C6/7 compressing the C7 nerve root." He suggested an updated MRI. On 24 May 2018, Dr Coughlan reported that Mr Agha "continued to have very significant ongoing bilateral arm pain [which] has become progressively worse over the course of time." At this point Dr Coughlan recommended the cervical spine surgery for which the respondent ultimately accepted liability.

30. On 11 June 2018, Dr Coughlan wrote to the respondent. He noted that the pain chart in the physiotherapy report (below) was not particularly clear but, from what he could make out, the pain and numbness went down from the shoulder area into the forearms and hands bilaterally, and Mr Agha described pain with burning sensation in the palmar aspects of both hands. Dr Coughlan said this "certainly could be consistent with a C6 and C7 radiculopathy" and he thought "his clinical symptoms of cervicogenic arm pain should be treated separately and distinctly from his surgery that he had for his shoulders and improvement or lack of improvement thereafter".

31. In a report on 6 August 2018 to Mr Agha's solicitors, Dr Coughlan said he had not volunteered "any significant radicular symptoms and he had no evidence of any severe arm pain" before the initial workplace injury.

32. On 12 September 2018, following the cervical spine surgery, Dr Coughlan reported to Dr Emin that, overall, Mr Agha was "coping very well and has noticed significant improvement in some of his symptoms particularly his arm pain."

33. The improvement was apparently short-lived because, on 15 February 2019, Dr Coughlan reported to Dr Emin that Mr Agha had "significant ongoing bilateral tingling and numbness in the hands." His Tinel's test was positive, and Dr Coughlan suspected he had "some degree of Double Crush Syndrome with concomitant Carpal Tunnel Syndrome." He suggested waiting several weeks while Dr Bokor performed further shoulder surgery after which he should consider doing Nerve Conduction Studies "just to look at the contribution of the carpal tunnels to his peripheral symptoms."

34. In the same report, Dr Coughlan said he did not think Mr Agha required surgery for his lumbar spine but it would be prudent to get a SPECT scan to see whether he had "any significant facetogenic inflammation particularly at L2/3 or whether it is primarily a discogenic issue."

35. The bone scan on 27 February 2019 demonstrated "moderate arthritic changes in the sacroiliac joints. Moderate facet joint arthritis present at L4/5 on the right Moderate discovertebral degenerative change at L2/3 on the right and L3/4 on the left associated with osteophyte formation."

36. On 27 March 2019, Dr Coughlan reported to Dr Emin that Mr Agha had "significant ongoing axial back pain and neck pain". He did not think urgent surgery was necessary and said he preferred to err on the side of conservative treatment. On 13 April 2019, he reported that Mr Agha's paraesthesia in his right arm seemed to have become slightly worse after the shoulder surgery. His Tinel's test is positive and nerve conduction studies had confirmed carpal tunnel syndrome bilaterally. Given his ongoing paraesthesias and numbness in the hand, and that this was affecting Mr Agha's quality of life, he had suggested a carpal tunnel release on the right hand side.

37. With respect to Mr Agha's lumbar spine, Dr Coughlan said:

> "… I have reassured him that the SPECT Bone scan only confirms L4/5 facet arthropathy and no significant other pain generators.

I [sic] would be worthwhile doing facet blocks at the same time whilst be is anaesthetised for his CTS. I have requested authorisation [for both]".

38. On 10 May 2019, Dr Coughlan responded to questions from the respondent. He confirmed the diagnosis of bilateral carpal tunnel syndrome. He said:

> "2. The relationship between the original work injury and his arm paraesthesia. is that since the incident Mr Roby [sic] has reported severe pain and paraesthesia in both his neck and shoulders. These symptoms have been evidence since the initial injury despite surgical treatments, however, they have worsened since the most recent surgery on his shoulder.
>
> 3. It Is difficult to comment on other possible causes however it is reasonable to assume that the work injury caused Mr Roby's pain and paraesthesia as onset occurred at time of injury."

39. On 3 August 2019, Dr Coughlan reported to Dr Emin that the "significant neuropathic symptoms" down Mr Agha's right hand side were continuing, and were a "combination of residual radicular dysfunction and also some degree of Carpal Tunnel Syndrome". He said:

> "The main value of doing a carpal tunnel release is also to see how much of his symptoms are emanating from local pathology and how much is emanating from significant residual or ongoing radicular dysfunction.
>
> [….] He is having ongoing local back pain and we have discussed the option of facet blocks as per our previous discussion."

40. In a report to Mr Agha's solicitors on 28 August 2019, Dr Coughlan said the proposed L4/5 facet joint injections and the right hand carpal tunnel release were reasonably necessary given his ongoing symptoms of axial back pain and arm pain and were "related to the injuries he sustained in his cervical spine and shoulders" on 25 March 20I7. He said:

> "These symptoms have been in part precipitated by the injuries sustained to his cervical spine and shoulders. He had previously not complained of severe axial back pain and the significant right sided arm pain came on after his injuries. Obviously there are normal age related constitutional factors that would predispose him to certain issues, but the onset of the symptoms were precipitated or came on after his injuries."

41. In a follow-up report on 4 September 2019, Dr Coughlan said Mr Agha's chronic back pain was "in part a consequence of the injuries he sustained to his cervical spine and shoulders: and his "inactivity as a result of those injuries could also be reasonably considered as a contributing factor."

Physiotherapy report

42. An Independent Physiotherapy Consultant report on 28 May 2018 detailed Mr Agha's symptoms following the injury at work, including the onset of neck pain around November 2017. A body chart, completed by Mr Agha, was used to map the location of symptoms. The copy in the documents is not entirely clear but shows areas of pain, pins and needles and/or numbness in the head, neck and shoulders, and shooting down the arms into the hands.

43. The report states that Mr Agha described shooting pains down both arms, sometimes occurring for no known reason, and a burning sensation in the palmar aspect of both hands. He also reported numbness in palmar aspect of both hands, and pins and needles in both upper limbs extending down into the hands. Active ranges of motion of the neck, shoulders, elbows and wrists were assessed

44. There is no indication on the chart of symptoms or in the body of the report, to symptoms in the lumbar spine.

Dr Powell

45. Dr Powell saw Mr Agha for assessment on 3 June 2019 and reported on 13 June 2019. He was provided with documents including CT, MRI and bone scans, and reports from Dr Coughlan. He took a detailed history including the extensive investigations and procedures since Mr Agha's initial injury. He refers to an earlier report dated 8 January 2019, a copy of which does not appear in the documents, but which it appears dealt only with Mr Agha's accepted shoulder and cervical spine injuries.

46. Dr Powell noted that Mr Agha started to develop neck pain around October or November 2017, initially at the sides, with the pain moving left and right, and becoming more frequent over subsequent months. He recorded that Mr Agha then started to develop intermittent feelings of tingling and numbness going down the right arm from the shoulder down to the hand and palm, and later to the left, which gradually became more frequent and were now constant with a burning sensation in both palms.

47. Dr Powell noted the cervical fusion carried out by Dr Coughlan in August 2018 and that there was little change in Mr Agha's symptoms following the surgery. He noted that Mr Agha had recently had a CT scan to determine if there was any difficulty with the disc replacement, and that he was to be reviewed by Dr Coughlan the following week. He noted the nerve conduction studies had revealed "right carpal tunnel syndrome" and that Dr Coughlan had recommended an operation.

48. Dr Powell recorded that Mr Agha had constant pain in his neck, and "permanent numbness in the upper limbs going down to his palms on both sides, more marked on the right." Recently, he had an episode of feeling like there was "motor" inside the right palm which lasted for some time. He noted the results of the nerve conduction studies and that Dr Coughlan had recommended surgery. He noted that Mr Agha had no previous injuries or before the onset of symptoms in late 2017.

49. With respect to Mr Agha's lumbar spine, Dr Powell noted he had no previous injuries or symptoms before October or November 2018; the pain came on spontaneously and started to radiate down his legs, particularly the right. He then developed intermittent feelings of numbness down the right leg and, some months later, symptoms in the left, though the right remained worse. He noted that Dr Coughlan had found "some facet joint trouble pressing on a nerve" and had recommended an injection.

50. Dr Powell noted that the bone scan on 27 February 2019 showed "moderate uptake in the sacroiliac joints and right L4/5 facet", and "moderate uptake" at L2/3 to the right and L3/4 to the left. He noted that the nerve conduction studies reported "mild bilateral change … that may have C6/7 radicular basis". The MRI on 2 February 2019 showed degenerate changes from L1/2 to L4/5, most marked at L2/3, with a small posterior disc protrusion but no indication of neural involvement.

51. Having taken a detailed history and examination, Dr Powell provided responses to a series of questions. As to the diagnosis of Mr Agha's "right wrist/hand" symptoms and low back pain, he said:

> "It is difficult to provide a specific diagnosis with respect to the right hand/wrist symptoms. The symptoms are principally sensory involving the palm and fingers on the volar and dorsal surfaces, corning on spontaneously.
>
> Nerve conduction studies have shown a conduction defect across the wrist.

Distribution of symptoms and description does not suggest carpal tunnel syndrome as a primary entity and given that Mr Agha has known pathology in the neck for which he has had surgical intervention, the symptoms he complains of are most likely to arise from the cervical region.

Positive nerve conduction studies do not Indicate a specific diagnosis and have to be interpreted in clinical context. False positives are common particularly with individuals of solid build and with increasing age.

In the lumbar region, Mr Agha has been found to have multilevel lumbar spondylosis and this is the most likely source of his symptoms."

52. As to whether Mr Agha's work had been a substantial contributing factor to his wrist and back injuries, Dr Powell said it was not. He said Mr Agha had not worked since the time of the initial incident involving his left [sic] shoulder, some years ago. He said wrist symptoms "do not arise from shoulder injury, which was focal to rotator cuff tendons on the opposite side", and Mr Agha's lumbar spondylosis was "constitutional in nature and part of his general tendency towards degenerate connective tissue changes." He suffered no injury to the back, and the injury to the shoulder had no effect on his lumbar region, directly nor indirectly.

53. To a question whether there was a causal link between the "recently diagnosed wrist and back symptoms", Dr Powell replied there was not. He said Mr Agha has multilevel degenerative disease which is "constitutional in nature and part of his general tendency to connective tissue degenerative disease which is reflected at other regions such as in his shoulder and neck." He said the wrist symptoms are principally sensory and not associated with his lumbar spine. The source of these symptoms "may be neurologic in relation to his neck, and the only association between his neck pathology and his lumbar pathology is that it is part of his degenerate disease process."

54. Dr Powell said the spondylitic disease in the lumbar region was of longstanding. The injury to his left [sic] shoulder had no effect on the lumbar spine, directly nor indirectly, "apart from the underlying degenerate pathology being the same (and this is pre-existing)." He said there was "no indication that Mr Agha has right carpal tunnel syndrome, based upon his symptoms in distribution and onset" and it was unlikely that carpal tunnel release would have any effect on his symptoms "as they are not due to local disease." With respect to the lumbar spine injection, Dr Powell said whether they would help him symptomatically was between Mr Agha and his treating doctor, but the need to consider them did not arise from any aspect of his work, directly nor indirectly.

The applicant's submissions

55. Mr McManamey submits that Mr Agha has undergone a significant regime of treatment for his accepted injuries to his right and left shoulders and his cervical spine. In respect of his wrists, the medical evidence shows that symptoms in the arms and wrists have been a feature of his condition from very early on after his initial injury, and formed part of the reason for the decision to perform the disc fusion in his cervical spine. The symptoms in his lumbar spine were of later onset, in early 2018, becoming worse by October that year, by which stage he had not worked for 18 months and had been inactive, spending the better part of each day either sitting or lying down.

56. Mr McManamey submits that, by February 2019, Mr Agha was complaining of persistent pain in his neck, and symptoms into the arms and hands, persisting tingling and numbness in the hands, and deteriorating lower back pain. At that point, Dr Coughlan suspected bilateral carpal tunnel syndrome and referred him also for a bone scan of the lumbar spine. The respondent accepted liability for both investigations.

57. On 13 April 2019, Dr Coughlan confirmed that the Tinel's test was positive, and the nerve conduction studies confirmed the bilateral carpal tunnel syndrome. Given the ongoing paraesthesias and numbness in the right hand, he proposed right side carpal tunnel release. He confirmed his view of the relationship of the arm injury to the original work injury in his report on 10 May 2019. In particular, Mr Agha had reported severe pain and paraesthesia in his neck and shoulders since the initial injury, and his arm symptoms had deteriorated after the recent shoulder surgery. Dr Coughlan thought it reasonable to assume the work injury caused the pain and paraesthesia.

58. Dr Coughlan revisited the question of causation of the carpal tunnel syndrome on 3 August 2019 in which he said the main value of doing a carpal tunnel release was to see how much of Mr Agha's symptoms was emanating from local pathology and how much from significant residual or ongoing radicular dysfunction.

59. Mr McManamey submits that the totality of Dr Coughlan's opinion is that the proposed carpal tunnel release serves two purposes: to treat the bilateral carpal tunnel syndrome, and also to determine on the right hand side whether there was residual radiculopathy from the neck condition being masked by the carpal tunnel syndrome. On that view, Mr McManamey submits, it could be considered as diagnostic and treatment of the neck, and this is significant when considering Dr Powell's opinion.

60. Mr McManamey submits that it is unclear precisely what examination Dr Powell carried out with respect to the carpal tunnel syndrome. He took histories of the right and left shoulders, neck and lumbar spine, and the symptoms in each. He found abnormalities on both sides. He does not seem to have performed expressly, or commented on, the common Tinel's sign test. When he comes to an opinion, Dr Powell says it is difficult to provide a specific diagnosis with respect to the right hand/wrist symptoms but distribution of symptoms and description did not suggest carpal tunnel "as a *primary* entity" (emphasis added). Moreover, given the known pathology in his neck, the symptoms Mr Agha complained of were "most likely to arise from the cervical region." In so saying, Dr Powell can only be referring to the accepted cervical spine condition, there being no other cervical spine condition.

61. Mr McManamey submits that, at least in respect of symptoms on the right side, Dr Powell, like Dr Coughlan, thinks there may be a combination of two conditions, a significant part of which are in fact from the neck, which is why he addressed the question whether the carpal tunnel syndrome was a primary condition. Dr Powell does not address whether it was a secondary condition, and he does not really address the left side. Examination of Dr Powell's reasons show they support Dr Coughlan's second reason for doing the carpal tunnel release, which is diagnostic, to determine any contribution of the neck. Further, while he refers to false positives, Dr Powell does not say that is what has occurred here. Finally, Mr McManamey submits, Dr Coughlan has the advantage of being the treating surgeon.

62. With respect to the lumbar spine, Mr McManamey says Mr Agha's claim is not that the degenerative condition was caused by the original injury. Rather, he has given evidence about when he first noticed symptoms, at which time he had been inactive for a considerable period. Dr Coughlan reported on 15 February 2019 that he had been complaining of "very significant back pain since he has been inactive with chronic pain", and he seems to accept this was the context in which the pain occurred. He was satisfied of the connection, and that inactivity as a result of those injuries could also be considered a contributing factor.

63. There is no argument that Mr Agha has lumbar spondylosis which is constitutional in nature. However, Mr McManamey submits, Dr Powell has addressed the wrong question in saying that he suffered no *injury* to his back. Whether the underlying condition was aggravated by the injury itself is not the question. Rather Dr Powell should have addressed whether the injury to the shoulder and neck and their consequences played a part in the onset of the symptoms when they occurred.

The respondent's submissions

64. Mr Barnes submits that Mr Agha's claim falls short of what is required in a claim of consequential injury. For Mr Agha to prove his case for consequential loss, he must show in terms of the mechanism, how the linkage can be made between the conditions for which the insurer is liable and the claimed consequential conditions.

65. Mr Barnes submits that Dr Coughlan does not fully identify the process by which the consequential injuries are said to be linked to the initial injuries.

66. Turning to Dr Coughlan's reports, Mr Barnes submits that it was not until 15 February 2019 that he notes complaints of back pain. None of his reports prior to that date indicate complaints of lower back pain, even though Mr Agha says he had been experiencing symptoms from early 2018. Dr Coughlan's report of his review of Mr Agha on 19 November 2018, after Mr Agha says his back pain had worsened, makes no reference to the lumbar spine.

67. Mr Barnes submits that the physiotherapist's report makes no reference to any lumbar condition, and it is not indicated on the pain chart. Mr Barnes acknowledges that the report is dated 21 May 2018, and that Mr Agha claims that his symptoms were intermittent to start with and worsened around October 2018. Nevertheless, there is an absence of references in the reports to the lumbar spine. Dr Boesel, Interventional Pain Specialist, whom Mr Agha first saw on 19 June 2018, also makes no mention of lumbar spine pain.

68. Mr Barnes submits that Dr Coughlan bases the relationship between the carpel tunnel syndrome and lower back pain on the fact that both came after the initial injury but neither came on for some time after the initial injury, and Dr Coughlan fails to establish a causal link between the injury and onset of the symptoms and how they relate. He is uncertain as to the real cause of the carpal tunnel syndrome and says the main value in the proposed surgery is to determine the origin of the symptoms, whether related to the neck or locally.

69. Dr Coughlan says both treatments are reasonably necessary as a result of the accepted injuries but say only that symptoms have been in *part* precipitated by the injuries to cervical spine and shoulders. While he says Mr Agha had not previously complained of pain, and the onset of symptoms followed the initial injury, he fails to explain how were they precipitated or what gave rise to them. In this case, there is a paucity of evidence and Dr Coughlan fails show how the symptoms arose.

70. Mr Barnes submits that the vague nature of Dr Coughlan's opinion is insufficient. Dr Coughlan says he believes Mr Agha's lower back symptoms are in *part* a consequences of the accepted injuries, and that his inactivity as a result of those injuries *could* be considered contributory. The question is by what mechanism or process did he suffer any consequential losses.

71. In contrast, Dr Powell conducted a full body examination, and did an extensive review of documents including reports from Dr Coughlan. Mr Barnes acknowledges that, ideally, Dr Powell would have had reports later than April 2019 available to him but, he submits they would make little difference as there is a paucity of information in Dr Coughlan's reports in any event.

72. Without conceding the issue, Mr Barnes indicated he did not propose to spend much time on the question of reasonableness of the proposed treatment. As far as the reasonableness of the proposed treatment, Mr Barnes acknowledges that Dr Powell accepts that treatment for the lumbar spine is a matter for Mr Agha and his doctor, at least as to reasonableness, and the same can be said of the carpal tunnel release.

73. In conclusion, Mr Barnes submits, Mr Agha's evidence falls short of what is required to prove the claim and ought to fail on both conditions.

Reply

74. In reply, Mr McManamey submits that it is not correct to say the onset of symptoms came sometime after the initial injury. Mr Agha's evidence is that the onset of symptoms in the arms, hands and wrists, came shortly after the initial injury and were part of the reason the respondent accepted liability for the cervical spine condition.

Consideration

75. The principles relevant to a claim for consequential condition were described in *Moon v Conmah Pty Ltd*[1] in which DP Roche determined that, in a claim for consequential loss to another part of the body, a worker is not required to prove "injury" within the meaning of section 4 of the *Workers Compensation Act 1987*. The worker need only establish that a consequential condition *results from* an accepted injury.

76. Deputy President Roche confirmed this approach in *Kumar v Royal Comfort Bedding Pty Ltd*[2], where he said:

> "By asking if Mr Kumar has suffered a s 4 injury to his right shoulder, the Arbitrator erred in his approach and asked the wrong question. This error affected his approach to the medical evidence and his conclusion. Mr Kumar's claim was always, as the respondent has conceded on appeal, that the right shoulder condition, and the need for surgery, resulted from the accepted back injury. It was not necessary for him to prove that he suffered a s 4 injury to his right shoulder."

77. In *Murphy v Allity Management Services Pty Ltd*[3] DP Roche summarised the onus a claimant bears when alleging the existence of a consequential condition. He said at [58]:

> "[Ms Murphy] only has to establish, applying the commonsense test of causation (*Kooragang Cement Pty Ltd v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796), that the treatment is reasonably necessary 'as a result of' the injury (see *Taxis Combined Services (Victoria) Pty Ltd v Schokman* [2014] NSWWCCPD 18 at [40]–[55]). That is, she has to establish that the injury materially contributed to the need for the surgery (see the discussion on the test of causation in *Sutherland Shire Council v Baltica General Insurance Co Ltd* (1996) 12 NSWCCR 716)."

78. This approach was also confirmed by Deputy President Snell in *Trustees of the Roman Catholic Church for the Diocese of Parramatta v Brennan*[4], where he observed:

> "The above do not suggest any need that a finding of a consequential condition necessarily involves the identification of pathology. It is sufficient to find (if the evidence supports it) a condition that results from an employment injury. I accept the respondent's submission that it is sufficient to find a consequential condition, pathology need not necessarily be identified. In *Kumar,* the relevant finding was based on the existence of symptoms."

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[1] *Moon v Conmah Pty Ltd* [2009] NSWWCCPD 134
[2] *Kumar v Royal Comfort Bedding Pty Ltd* [2012] NSWWCCPD 8
[3] *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49
[4] *Trustees of the Roman Catholic Church for the Diocese of Parramatta v Brennan* [2016] NSWWCCPD 23

79. The "common sense test of causation" was described by Kirby P in *Kooragang Cement Pty Limited v Bates*[5] as follows:

> "The result of the cases is that each case where causation is in issue in a workers compensation claim, must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase 'results from', is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent death of injury or death, will not, of itself, be sufficient to establish that such incapacity or death 'results from' a work injury. What is required is a commonsense evaluation of the causal chain. As the early cases demonstrate, the mere passage of time between a work incident and subsequent incapacity or death, is not determinative of the entitlement to compensation. In each case, the question whether the incapacity or death 'results from' the impugned work injury (or in the event of a disease, the relevant aggravation of the disease), is a question of fact to be determined on the basis of the evidence, including, where applicable, expert opinions."

Is carpal tunnel release surgery reasonably necessary as a result of Mr Agha's work injury?

80. The evidence shows that Mr Agha began experiencing neck pain around the end of 2017, with pain radiating down his arms and into his hands. Throughout 2018, the symptoms down his arms and into his wrists and hand, and deteriorated. By February 2019, he was complaining of persistent pain in his neck, symptoms in his arms and hands, and persisting tingling and numbness in the hands. Dr Coughlan's suspicion of bilateral carpal tunnel syndrome was confirmed by nerve conduction studies. Dr Coughlan noted in August 2018 that Mr Agha had no history of radicular symptoms or arm pain before the injury on 25 March 2017.

81. Dr Coughlan has the benefit of being Mr Agha's treating doctor over an extended period, and having reviewed him several times. He recommended cervical spine injections in May 2018 after Mr Agha developed pain in his neck, arms and hands, becoming progressively worse. In June 2018, he thought the burning sensation in Mr Agha's palms "certainly could be consistent with a C6 and C7 radiculopathy" and that "his clinical symptoms of cervicogenic arm pain" should be treated separately from the surgery for his shoulders. He clearly considered there was a link between the cervical spine and the hand/wrist condition.

82. In April 2019, after confirmation of the carpal tunnel syndrome, and that ongoing paraesthesias and numbness in his hands were affecting Mr Agha's quality of life, Dr Coughlan suggested a carpal tunnel release on the right hand side. In May 2019, he stated his view that his symptoms had been evident since the initial injury despite surgical treatments but worsened since the recent surgery on his shoulder. While it was difficult to comment on other possible causes, he thought it reasonable to assume that the work injury caused Mr Roby's pain and paraesthesia "as onset occurred at time of injury."

83. Mr Barnes submits, correctly, that Mr Agha's evidence is not that his neck, arm and hands symptoms occurred at the time of the initial injury. His evidence was they came on around November 2017 and deteriorated throughout 2018 and 2019. However, I think reading Dr Coughlan's many reports in totality shows that he relied on more than just contemporaneous onset for his opinion as to the relationship to Mr Agha's cervical spine. For example, he also noted there were no symptoms prior to the initial injury. He reasoned that the onset of symptoms "were precipitated or came on after his injuries" (that is, not necessarily at the same time as the initial injury). He noted likely radicular dysfunction and thought they may be due to a combination of residual radicular dysfunction and also some degree of carpal tunnel syndrome.

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[5] *Kooragang Cement Pty Limited v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796

84. There is evidently some uncertainty in Dr Coughlan's mind as to the source of Mr Agha's hand/wrist symptoms because he said in his report of 3 August 2019 that the "main value" of doing a carpal tunnel release was to see how much of his symptoms were coming from local pathology and how much from significant residual or ongoing radicular dysfunction. I accept Mr McManamey's submission that it may be considered as both diagnostic and treatment of the neck. I do not think its diagnostic purpose undermines Dr Coughlan's opinion of the distinct possibility of a relationship to the accepted cervical spine condition.

85. Although he reaches a different conclusion, Dr Powell tends to lend support to Dr Coughlan's opinion. He acknowledges that it is difficult to provide a specific diagnosis with respect to the right hand/wrist symptoms. He, too, thinks there may be a combination of conditions at play but he goes on to say the symptoms Mr Agha complained of were "most likely to arise from the cervical region."

86. I accept Mr McManamey's submission that Dr Powell addressed the wrong question in saying that the carpal tunnel syndrome was not a *primary* condition. He does not address whether it was secondary to the accepted cervical spine condition.

87. Considering in particular that Dr Coughlan has the benefit of being the treating specialist and has reviewed Mr Agha several times before and after successive surgery and treatment, and considering that Dr Powell did not address the question directly, I prefer Dr Coughlan's opinion that the need for the carpal tunnel release results from the accepted cervical spine condition. Insofar as there is any uncertainty, I do not think it undermines the conclusion that, in all the circumstances, it is reasonably necessary treatment as a result of the accepted cervical spine condition.

Did Mr Agha suffer a consequential injury to his lumbar spine?

88. Mr Agha must provide sufficient evidence for me to be satisfied that the pain in his lumbar spine results from one or more of his accepted injuries.

89. Mr Agha's evidence is that he began to experience "intermittent discomfort" in his lumbar spine in early 2018, approximately 12 months after the initial injury. By October 2018, his lower back symptoms had become constant. He states they were "aggravated by sitting or lying for prolonged periods". By that time he had not worked for 18 months and had been "completely inactive". The treatment he had undergone since his injury meant he had spent "the better part of each day sitting or lying down".

90. I have no reason to doubt the truthfulness of Mr Agha's statement that he had spent prolonged periods of inactivity but it is of limited assistance. It is not clear what he meant by sitting or lying for prolonged periods, or what activity he undertook at other times. It is reasonable to infer from the work he did previously that he was relatively active before his injury, and I accept that he had periods of relative inactivity following surgery and associated treatment. However, Mr Agha is not in a position to assess whether his degenerative condition was in fact aggravated by sitting or lying down for prolonged periods, or whether it was for some other reason.

91. More importantly, I am not satisfied that Mr Agha's claim of consequential injury to his lumbar spine finds sufficient support in Dr Coughlan's reports.

92. In February 2019, when Dr Coughlan first mentioned the lumbar spine pain, he thought it would be prudent to get a SPECT scan to see whether Mr Agha had "any significant facetogenic inflammation particularly at L2/3 or whether it is primarily a discogenic issue." The subsequent bone scan demonstrated moderate arthritic and degenerative changes at several levels. As the treating doctor, he may have seen no need to comment on causation at that point.

93. On 27 March 2019, Dr Coughlan reported to Dr Emin, noting Mr Agha's "significant ongoing axial back pain and neck pain". At that point he did not think urgent surgery was necessary and preferred conservative treatment. His report of 13 April 2019 to Dr Emin is largely concerned with the confirmation of carpal tunnel syndrome and the proposal for carpal tunnel release. He said he had reassured Mr Agha that the bone scan "only confirms L4/5 facet arthropathy and no significant other pain generators." He then says he thinks it would be "worthwhile" doing facet blocks at the same time Mr Agha was anaesthetised for the carpal tunnel release. I do not think any inference as to causation can be drawn from that statement. It is possible that Dr Coughlan thought no more than better to undergo one anaesthetic than two.

94. Apart from the fact that he sought authorisation from the insurer for both procedures. nothing in Dr Coughlan's reports suggests a connection between the accepted injuries and the lumbar spine condition. In his report of 3 August 2019, he states only that Mr Agha was having "ongoing local back pain" and they had discussed the option of facet blocks.

95. The first specific reference to any causal connection is in Dr Coughlan's report of 28 August 2019 in which he said the ongoing symptoms of axial back pain and arm pain and were "related to the injuries he sustained in his cervical spine and shoulders". He said the symptoms had been

> "in part precipitated by the injuries sustained to his cervical spine and shoulders. He had previously not complained of severe axial back pain and the significant right sided arm pain came on after his injuries. Obviously there are normal age related constitutional factors that would predispose him to certain issues, but the onset of the symptoms were precipitated or came on after his injuries."

96. The basis for the connection drawn by Dr Coughlan appears to be that the lumbar spine symptoms came on after the accepted injuries. He does not given more than a temporal explanation. He does not say what it was about the accepted injuries that led to the development of the lower back condition.

97. In his follow-up report on 4 September 2019, Dr Coughlan restated his opinion that Mr Agha's chronic back pain was "in part" a consequence of the accepted injuries. He went on to say that his inactivity as a result of those injuries "could also be reasonably considered as a contributing factor."

98. As I understand Mr Barnes' submission, in saying "could" be a contributing factor, Dr Coughlan raised no more than the possibility of a connection, and that is not enough to prove the claim.

99. It can be that if expert evidence suggests a possible view then, after examining the lay evidence, a tribunal may decide that it is the probable view: *EMI (Australia) Ltd v Bes* [1970] 2 NSWR 238 (*Bes*); *Tubemakers of Australia Limited v Fernandez* (1976) 50 ALJR 720; *Woolworths Limited v Christopher-Coates* [2014] NSWWCCPD 14. In *Bes* Herron CJ said at [242]:

> "Medical science may say in individual cases that there is no possible connection between the events and the death, in which case of course, if the facts stand outside an area in which common experience can be the touchstone, then the judge cannot act as if there was a connection. But if medical science is prepared to say that it is a possible view, then in my opinion the judge after examining the lay evidence may decide that it is probable."

100. In my view, Dr Coughlan has not sufficiently disclosed his reasoning for me to be satisfied that he thought inactivity materially contributed to Mr Agha's lower back condition. I do not think his statement that it "could also be considered a contributing factor" can be understood as putting the connection higher than a possibility. Dr Coughlan has not adequately explained the significance, if any, of the pre-existing degenerative condition, or how inactivity contributed to Mr Agha's lumbar condition. He had not provided a satisfactory explanation of the relevant causal mechanism. In my view, a fair reading of his reports puts the connection no higher than a possibility. Without more, I am not satisfied the connection is probable.

101. For completeness I would add that Mr Barnes submits that Mr Agha did not complain of lumbar back symptoms until approximately 12 months after his initial injury. However, I do not think it necessarily follows from the fact that Mr Agha did not complain of lower back pain until late 2018 that his condition was not due to inactivity as a result of his accepted injuries. The problem with Dr Coughlan's reports is the lack of sufficiently clear explanation of the connection.

102. Dr Powell's opinion has its own difficulties. There is no argument with his view that Mr Agha has multilevel degenerative disease which is constitutional in nature. However, Dr Powell said only that the spondylitic disease was longstanding and the injury to his left shoulder had no effect on the lumbar spine, either directly or indirectly. Much of the rest of his opinion was directed to answering questions as to the relationship between the carpal tunnel syndrome and the lumbar spine. Mr Barnes frankly acknowledged that the reason for those questions is unclear.

103. I accept Mr McManamey's submission that, in saying that Mr Agha suffered no *injury* to his back, Dr Powell addressed the wrong question. The question was whether the accepted injuries played a part in the onset of the symptoms when they occurred. It also would have been helpful had Dr Powell had the opportunity to comment on Dr Coughlan's later reports where he refers to Mr Agha's inactivity, but he did not. However, deficiencies in Dr Powell's report do not lead to uncritical acceptance of Dr Coughlan's opinion.

104. Considering all of the evidence, I am not satisfied that Mr Agha's lumbar spine condition resulted from one or more of his accepted injuries. It follows that the need for spinal block injections does not result from his accepted injuries.

SUMMARY

105. For these reasons, I find:

(a) Mr Agha applicant sustained injury his right shoulder on 25 March 2017 in the course of his employment with the respondent to which his employment was a substantial contributing factor.

(b) As a result of the injury sustained on 25 March 2019 Mr Agha developed consequential conditions in his left shoulder and cervical spine.

(c) As a result of his cervical spine injury Mr Agha requires reasonably necessary treatment by way of bilateral carpal tunnel release surgery.

(d) I am not satisfied that Mr Agha suffered a consequential condition of his lumbar spine as a result of his accepted injuries.

106. The respondent to pay Mr Agha's reasonably necessary medical expenses with respect to the carpal tunnel release proposed by Dr Marc Coughlan pursuant to section 60 of the *Workers Compensation Act 1987.*