WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

MATTER NO:	**6616/19**
APPLICANT:	**Guy Kenneth Buckley**
RESPONDENT:	**J B T Logistics Pty Ltd**
DATE OF DETERMINATION	**9 March 2020**
CITATION:	**[2020] NSWWCC 67**

The Commission determines:

1. The applicant sustained an injury to his right shoulder arising out of or in the course of his employment on 8 May 2016.

2. The applicant did not sustain an injury to his neck arising out of or in the course of his employment on 8 May 2016.

3. The applicant developed a consequential chronic pain condition in his right upper extremity as a result of the injury sustained to his right shoulder on 8 May 2016.

The Commission orders:

4. Award for the respondent in respect of the allegation of an injury to the applicant's neck on 8 May 2016.

5. I remit this matter to the Registrar for referral to an Approved Medical Specialist pursuant to section 321 of the *Workplace Injury Management and Workers Compensation Act 1998* for assessment of the whole person impairment of the applicant's right upper extremity due to a consequential condition (chronic pain) resulting from the injury sustained to the applicant's shoulder on 8 May 2016.

6. The documents to be reviewed by the Approved Medical Specialist are:

    (a) Application to Resolve a Dispute and attached documents, and
    (b) Reply and attached documents, excluding the report of Dr Reitner dated 17 January 2020.

7. Note:

    (a) The claim in respect of the whole person impairment of the right upper extremity (shoulder) and scarring (TEMSKI). The parties agree that the applicant has 12% whole person impairment of the right upper extremity (shoulder) and 1% whole person impairment for scarring (TEMSKI), for a combined total of 13% whole person impairment.

    (b) The Approved Medical Specialist is requested to include these agreed assessments in his Medical Assessment Certificate.

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

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 GLENN CAPEL, SENIOR ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Guy Buckley (the applicant) is 48 years old and commenced employment with J B T Logistics Pty Ltd (the respondent) as a truck driver in approximately 2010. His services were terminated in December 2017.

2. There is no dispute that the applicant injured his right shoulder on 8 May 2016 when he was in the process of unhooking a forequarter of beef that was suspended in his truck. Liability was accepted by Allianz Australia Workers Compensation (NSW) Ltd (Allianz). The claim was later transferred to AAI Ltd t/as GIO (the insurer). Weekly compensation and medical expenses have been paid, although precise details are unknown.

3. On 2 July 2019, the applicant's solicitor served a notice of claim on the insurer for lump sum compensation in respect of the right upper extremity (shoulder), cervical spine, and scarring (TEMSKI) due to injury sustained on 8 May 2016 pursuant to s 66 of the *Workers Compensation Act 1987* (the 1987 Act).

4. On 28 October 2019, the insurer issued a notice pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) disputing that the applicant had injured his cervical spine and that his employment was a substantial contributing factor to his condition.

5. The insurer advised that its qualified specialist, Dr Bosanquet, had not correctly assessed the applicant's whole person impairment, so in the circumstances, it was prepared to settle the lump sum claim in respect of 13% whole person impairment, based on the assessment provided by Dr Bodel in his report dated 10 April 2018. There was no response to this offer.

6. On 31 October 2019, the applicant's solicitor served a further notice of claim on the insurer for lump sum compensation in respect of the right upper extremity (shoulder), cervical spine, scarring (TEMSKI) and impairment caused by chronic pain due to injury sustained on 8 May 2016 pursuant to s 66 of the 1987 Act. The insurer determined the claim via an email on 31 October 2019, without issuing a further dispute notice.

7. By an Application to Resolve a Dispute (the Application) registered in the Workers Compensation Commission (the Commission) on 16 December 2019, the applicant claims lump sum compensation in respect of his right upper extremity (shoulder), cervical spine, scarring (TEMSKI) and impairment caused by chronic pain due to injury sustained on 8 May 2016.

PROCEDURE BEFORE THE COMMISSION

8. 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.

PRELIMINARY ISSUE FOR DETERMINATION

9. At the arbitration hearing, the applicant's counsel, Mr Tanner, objected to the admission into evidence of the report of Dr Reitner dated 17 January 2020, on the grounds that the respondent had not complied with the legislation.

10. Given that this took the respondent's counsel, Mr Barter, by surprise. Neither counsel proposed to make submissions regarding the doctor's report, so I granted the parties leave to file written submissions.

11. The respondent's submissions were received on 26 February 2020.The applicant's submissions were received on 4 March 2020.

SUBMISSIONS IN RESPECT OF THE PRELIMINARY ISSUE

12. Mr Barter submits that unlike s 74 of the 1998 Act, which was repealed by the 2012 amendments, s 78 of the 1998 Act does not specify the requirements of any notice to be given to a worker. Section 79 of the 1998 Act provides that the notice must contain a concise and readily understandable statement of the reasons for an insurer's decision and the relevant issues. It is not suggested this requirement has not been met in the dispute notice issued on 28 October 2019.

13. Mr Barter submits regulation 38 of the *Workers Compensation Regulation 2016* (the 2016 Regulation) requires service of any report relevant to the decision made by the insurer. In this matter, the only relevant reports were those of Dr Bosanquet, which were referred to and attached to the notices. Dr Reiter's report was not in existence and could not have been relevant to the insurer's decision. It was served on the same day of receipt and attached to the respondent's Reply.

14. Mr Barter submits that no objection was raised at the telephone conference on 23 January 2020. There was ample opportunity for the applicant to obtain medical evidence to address the report of Dr Reitner.

15. Mr Barter submits that the applicant was treated by specialist medical practitioners from three different specialties, namely Drs Kwa, Wu and Sui. He submits that Dr Reitner's report complies with regulation 44 of the 2016 Regulation, because her speciality fits within the descriptor of "Multidisciplinary Pain Management",like Dr Sui. The report is not excluded by any legislative or procedural requirement and that it would be contrary to procedural fairness to exclude it.

16. Mr Tanner submits that an insurer's obligations in relation to the provision of reports are set out in s 73 of the 1998 Act and regulation 41 of the 2016 Regulation. The obligation to provide a copy of a report applies to any report that is relevant to the claim or any aspect of the claim to which the decision relates, whether or not the report supports the reasons for the decision.

17. Mr Tanner submits that the insurer did not provide a copy of Dr Reiter's report to the applicant in accordance with these provisions. It follows that her report is inadmissible, does not constitute evidence in the current proceedings, and should not to be disclosed to the AMS.

18. Mr Tanner submits that the applicant has not been treated by a rheumatologist, and so the respondent should not be able to rely on a report from a rheumatologist, and there is no evidence that Dr Reiter is a pain management specialist.

REASONS IN RESPECT OF THE PRELIMINARY ISSUE

19. The obligations on an insurer who disputes liability are set out in s 73 and s 78 of the 1998 Act and Regulations 38 and 41 of the 2016 Regulation. Regulation 44 of the 2016 Regulation is also of relevance to this preliminary issue.

20. Section 73 of the 1998 Act provides:

> "**73 Insurer to provide copies of reports to worker** (cf former s 93E)
>
> (1) The regulations may make provision for or with respect to requiring an insurer to provide a worker, a worker's legal representative or any other person with a copy of a specified report, or a report of a specified kind, obtained by the insurer in relation to a claim by the worker.
>
> (2) Without limiting subsection (1), the kind of reports to which the regulations under this section can apply include investigators' reports, rehabilitation providers' reports and reports of assessments under section 40A (Assessment of incapacitated worker's ability to earn) of the 1987 Act.
>
> (3) If an insurer fails to provide a copy of a report as required by the regulations under this section—
>
> (a) the insurer cannot use the report to dispute liability to pay or continue to pay compensation or to reduce the amount of compensation to be paid and cannot use the report for any other purpose prescribed by the regulations for the purposes of this section, and
> (b) the report is not admissible in proceedings on such a dispute before the Commission, and
> (c) the report may not be disclosed to an approved medical specialist or an Appeal Panel in connection with the assessment of a medical dispute under Part 7 of Chapter 7."

21. Sections 78 of the 1998 Act provides:

> "**78 Insurer to give notice of decisions**
>
> (1) An insurer must give notice in accordance with this Division of any decision of the insurer—
>
> (a) to dispute liability in respect of a claim or any aspect of a claim, or
> (b) to discontinue payment to a worker of weekly payments of compensation, or reduce the amount of the compensation.
>
> (2) Notice of a decision of an insurer involving both a liability dispute and a discontinuation or reduction of weekly compensation may be combined into a single notice (subject to any provision of the Workers Compensation Guidelines requiring separate notices to be given).
>
> (3) The requirement to give notice of a decision to discontinue payment to a worker of weekly payments of compensation does not affect any limitation on weekly payments of compensation under Division 2 of Part 3 of the 1987 Act."

22. Regulation 38 of the 2016 Regulation provides:

> **"38 Notice of insurer decisions**
>
> (1) A notice under section 78 of the 1998 Act of an insurer's decision to dispute liability in respect of a claim or any aspect of a claim (except in connection with a work injury damages matter), or to discontinue or reduce the amount of weekly payments of compensation, is to contain the following information—

(a) a statement identifying all the reports and documents submitted by the worker in making the claim for compensation, and by the employer in connection with the claim,

(b) a statement identifying all the reports of the type to which clause 41 applies that are relevant to the decision, whether or not the reports support the reasons for the decision,

(c) a statement advising that a copy of a report required to be provided by the insurer under clause 41(3) (except as provided by clause 41(5) or (6)) accompanies the notice,

(d) details of the procedure for requesting a review of the decision,

(e) a statement to the effect that the worker can seek advice or assistance from the worker's trade union organisation, from an Australian legal practitioner, from the Independent Review Officer or from any other relevant service established by the Authority,

(f) the contact details for the Independent Review Officer,

(g) the street address and the email address of the Registrar of the Commission,

(h) a summary, in the approved form, of the effect of the decision, the worker's rights of review, the procedure for requesting a review and the legal and other services that may be available to the worker to provide advice or assistance in relation to the dispute.

(2) If the notice relates to a decision to discontinue weekly payments of compensation, the insurer must give a copy of the summary referred to in subclause (1)(h) to any current employer of the worker who is liable to pay the compensation (except in circumstances where the compensation is paid by the insurer)."

23. Regulation 41 of the 2016 Regulation provides:

"**41 Access to certain medical reports and other reports obtained by insurer**

(1) This clause applies to the following types of reports that an employer or insurer has in the employer's or insurer's possession—

(a) medical reports, including medical reports provided pursuant to section 119 (Medical examination of workers at direction of employer) of the 1998 Act,
(b) certificates of capacity,
(c) clinical notes,
(d) investigators' reports,
(e) workplace rehabilitation providers' reports,
(f) health service providers' reports,
(g) reports obtained by or provided to an employer or insurer that contain information relevant to the claim on which a decision to dispute liability is made.

(2) This clause applies to the following decisions of an employer or insurer relating to an injured worker—

(a) a decision to dispute liability in respect of a claim, or any aspect of a claim (in circumstances requiring the insurer to give the worker a notice under Division 3 of Part 2 of Chapter 4 of the 1998 Act),

(b) a decision to discontinue payment, or to reduce the amount of weekly benefits (in circumstances requiring the insurer to give the worker a notice under Division 3 of Part 2 of Chapter 4 of the 1998 Act),
(c) a decision on the review under section 287A of the 1998 Act of a decision described in paragraph (a) or (b) that confirms the original decision.

(3) For the purposes of sections 73(1) and 126(2) of the 1998 Act, if an employer or insurer makes a decision to which this clause applies, the employer or insurer must provide a copy of any relevant report to which this clause applies to the worker, as an attachment to a notice under Division 3 of Part 2 of Chapter 4 of the 1998 Act or section 287A of the 1998 Act, as the case may be, except where the report has already been supplied to the worker and that report is identified in a statement under clause 38(1)(d).

(4) The obligation in this clause to provide a copy of a report applies to any report that is relevant to the claim or any aspect of the claim to which the decision relates, whether or not the report supports the reasons for the decision…."

24. Regulation 44 of the 2016 Regulation restricts the number of medical reports that can be admitted into evidence. It provides:

"**44 Restrictions on number of medical reports that can be admitted**

(1) In any proceedings on a claim or a work injury damages threshold dispute in relation to an injured worker, only one forensic medical report may be admitted on behalf of a party to proceedings.

(2) A report referred to in subclause (1) must be from a specialist medical practitioner with qualifications relevant to the treatment of the injured worker's injury.

(3) Where the injury has involved treatment by more than one specialist medical practitioner, with different qualifications, then an additional forensic medical report may be admitted from a medical practitioner with qualifications in that specialty.

(4) In this clause—

forensic medical report, in relation to a claim or dispute—
(a) means a report from a specialist medical practitioner who has not treated the worker and that has been obtained for the purpose of proving or disproving an entitlement, or the extent of an entitlement, in respect of the claim or dispute, and
(b) includes a medical report provided by a specialist medical practitioner in respect of an examination of the injured worker pursuant to section 119 of the 1998 Act, and
(c) does not include a report from a specialist medical practitioner who has not treated the worker and that has been obtained for the purpose of proving or disproving an entitlement, or the extent of an entitlement, in respect of another claim or dispute."

25. It is true that the provisions in s 78 of the 1998 Act differ from those that were contained in s 74 of the 1998 Act, which was repealed in 2012. However, the requirements of any dispute notice are contained in regulation 38 of the 2016 Regulation, in particular, regulations 38(1)(a) and 38(1)(b).

26. Section 73 of the 1998 Act empowers the making of regulations regarding the provision of various reports and other documents by an insurer to a worker. Regulations 38 and 41 of the 2016 Regulation are such regulations and they provide that it is mandatory for an insurer to provide copies to a worker of such documents identified in the regulations as an attachment to a dispute notice.

27. The failure to provide copies of the reports and documents to a worker makes them inadmissible in any proceedings, and the insurer is not able to rely on these reports in a dispute before the Commission. This has been confirmed in a number of Presidential decisions, such as *Ingham's Enterprises Pty Ltd v Thoroughgood*[1] and *Chown v Tony Madden Refrigeration Transport Limited*[2].

28. In this matter, the respondent did not provide a copy of the report of Dr Reitner to the applicant as an annexure to a notice issued pursuant to s 78 of the 1998 Act. This makes the report inadmissible in accordance ss 73 and 78 of the 1998 Act and regulations 38 and 41 of the 2016 Regulation.

29. Regulation 44 of the 2016 Regulation also causes issues for the respondent. The respondent qualified Drs Bosanquet, an orthopaedic specialist, and Dr Reitner, a rheumatologist. The applicant has only been treated by general practitioners, an orthopaedic surgeon, a specialist anaesthetist and a pain management specialist, but not a rheumatologist, so the report of Dr Reitner does not comply with regulations 44(1) and 44(2). To allow the admission of the report in these proceedings would be prejudicial to the applicant and this outweighs the prejudice that the respondent might suffer. I would also question the probative value of the report in any event, as Dr Reitner did not examine the applicant.

30. In these circumstances, the respondent is unable to rely on the report of Dr Reitner dated 17 January 2020 and it will not be admitted into evidence.

ISSUES FOR DETERMINATION

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

    (a) whether the applicant injured his cervical spine on 8 May 2016 – s 4 and 9A of the 1987 Act, and

    (b) quantification of the applicant's entitlement to lump sum compensation – s 66 of the1987 Act.

32. During the conciliation conference, the parties advised that there was no dispute in respect of the assessment of the applicant's claim for whole person impairment of the right upper extremity (shoulder) and scarring (TEMSKI), so it was not necessary for the Approved Medical Specialist (AMS) to provide as assessment.

33. Further, the claim for whole person impairment due to chronic pain was a matter for an AMS, consistent with the principles discussed in *Elsworthy v Forgacs Engineering Pty Ltd*[3]*.*

[1] [2013] NSWWCCPD 29.
[2] [2005] NSWWCCPD 159.
[3] [2017] NSWWCC 64.

EVIDENCE

Documentary evidence

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

    (a) Application and attached documents;

    (b) Reply and attached documents, excluding the report of Dr Reitner dated 17 January 2020

Oral evidence

35. Neither party sought leave to adduce oral evidence or cross examine any witnesses.

REVIEW OF EVIDENCE

Applicant's statement

36. In his statement dated 22 August 2019, the applicant indicated that on 8 May 2016, he was making a delivery of a large piece of meat which was hanging from a piece of rope through its ribcage and was attached to an overhead hook inside the truck. He stated:

> "While in the back of the truck, I squatted at the knees to get the forequarter off the floor of the truck. I did not bend at the waist.
>
> As I was about to drop the beef onto my right shoulder, I felt a popping sensation. The forequarter was so heavy I did not get it up onto my shoulder. I was in immediate pain and could not move my right arm at all due to pain and numbness".

37. The applicant stated that his offsider completed the deliveries and he consulted Dr Chan the next day. He was referred to Dr Kwa, who performed an arthroscopic subacromial decompression and repair of a torn rotator cuff on 4 August 2016. In January 2019, he was given a ketamine infusion by Dr Wu.

38. The applicant stated that he continued to suffer from pain in his neck, right shoulder and right arm. He also had weakness and tingling in his right arm and hand. He was taking various forms of medication for his pain.

Clinical notes and reports of Kendal Street Medical Service

39. The clinical notes of the Kendal Street Medical Centre commence on 10 May 2016 and conclude on 2 October 2018.

40. On 10 May 2016, Dr Chan recorded that the applicant had right shoulder pain for a few days that he described as "? work related from heavy lifting". He suspected that the applicant had tendinopathy.

41. Dr Chan referred the applicant for x-rays and an ultrasound on 12 May 2016. These tests showed degenerative changes in the applicant's right AC joint, full thickness tears of the supraspinatus and subscapularis tendons and bursitis. The doctor referred the applicant to Dr Kwa and provided him with medical certificates. Certificates were also issued by Drs Jones and Kamal.

42. In October 2016, it was noted that the applicant was performing light duties. On 21 November 2016, Dr Chan recorded that the applicant's right shoulder pain was better following his surgery.

43. The applicant had x-rays and an ultrasound on 16 January 2017. These tests showed evidence of degenerative changes in his right AC joint and tendinopathy in the supraspinatus tendon.

44. On 10 February 2017, Dr Downton recorded that the applicant had experienced minimal improvement in the past few months. She noted that the applicant had been working on light duties since 27 October 2016 for normal hours. He was not taking any medication, but he was receiving rehabilitation and physiotherapy, and he was performing regular exercises.

45. On 1 March 2017, Dr Downton reported that Dr Kwa suspected that the applicant's bursitis and capsulitis was causing overhead lifting restrictions, and that he advised against any return to lifting or meat carving.

46. Dr Downtown developed a GP Management Plan and recorded detailed consultation notes on 13 March 2017 and 10 April 2017. She advised that there was no real change in the applicant's condition. A vocational assessment had suggested that the applicant had the capacity to undertake a number of sedentary occupations.

47. On 5 May 2017, Dr Downton attended the applicant's workplace and was shown a variety of light jobs that could be offered to the applicant. She agreed that he could undertake various light packing and supervisory duties. The applicant commenced these duties and the doctor recorded that he was coping during subsequent consultations.

48. On 3 July 2017, Dr Downton recorded that the applicant had a frozen right shoulder and a reduced range of motion. He had pain extending from his shoulder up to the right side of his neck.

49. On 15 August 2017, Dr Downton recorded that the applicant had nerve entrapment symptoms and significant pain extending to the right side of his neck. The doctor questioned whether the applicant was developing Chronic Regional Pain Syndrome (CRPS).

50. On 12 September 2017, Dr Downton recorded that the applicant had ceased work because his employer could no longer provide him with suitable duties. A CT scan showed some thinning of the subscapularis tendon and the possibility of a fill thickness tear of the long head of biceps tendon. The applicant also complained of paraesthesia affecting his left arm.

51. On 10 October 2017, Dr Downton noted that the applicant had carpal tunnel syndrome, which might be compensatory, and a frozen shoulder. She sought an opinion on causation from Dr Kwa.

52. On 6 March 2018, Dr Downton recorded that the applicant had attended a pain clinic and he had occasional paraesthesia in his right hand and arm. The applicant continued to attend the surgery for certificates on a monthly basis throughout 2018.There was no reported improvement in his right shoulder condition.

53. There are numerous referral letters from Dr Downton in evidence, but they only refer to the applicant's frozen right shoulder and possible CRPS.

54. In a report dated 4 January 2018, Dr Downton advised that the applicant had a globally reduced range of motion secondary to pain in the right shoulder, with symptoms of hyperalgesia and allodynia that fluctuated in intensity. His services had been terminated by the respondent due to his inability to participate usefully in any work activities because of his frozen right shoulder.

55. In her report dated 31 August 2018, the doctor recorded that the applicant was still suffering from significant pain and impaired function in his right shoulder. She complained that there had been no active involvement by the current rehabilitation provider and Allianz had not provided any assistance regarding the management of the applicant's injury.

Clinical notes and reports of Dr Kwa

56. The clinical notes of Dr Kwa include a series of his medical reports and some reports from the applicant's physiotherapist.

57. In his initial report dated 17 June 2016, Dr Kwa recorded the following history of the circumstances of injury:

> "His right shoulder was injured at work around six weeks ago. He was flicking a forequarter of beef onto his shoulder when he felt something tear in the right shoulder. Since then he has had severe pain and difficulty moving the right shoulder. He denies any previous problems nor injuries. He has had no treatment. He has been off work since".

58. Dr Kwa recorded that all right shoulder movements were painful, and it was difficult to assess the full range of movement due to muscle guarding. The doctor noted that there was a full range of neck movements but movements to the left and right caused pain radiating from the neck down over both shoulders.

59. Dr Kwa suspected that the applicant had suffered an acute right rotator cuff tear from his work duties. The doctor referred the applicant for a CT arthrogram on 4 July 2016, which showed a partial thickness tear of the scapularis tendon and a dislocation of the biceps.

60. Dr Kwa recommended that the applicant have surgery and an arthroscopic acromioplasty, subacromial decompression, subscapularis interarticular repair and a subpectoralis biceps tenodesis was performed on 4 August 2016 at the Dudley Private Hospital.

61. In a report dated 16 August 2016, Dr Kwa noted that the applicant had minimal pain and the doctor was happy for him to resume light duty employment.

62. Although the physiotherapist expressed some concerns, Dr Kwa recommended that the applicant continue to have physiotherapy. In a report dated 4 November 2016, Dr Kwa agreed that the applicant seemed to be developing CRPS and psychological issues following his surgery. He suggested that Dr Chan should consider a referral for further treatment for depression, anxiety and chronic pain.

63. In a report dated 11 November 2016, Dr Kwa suggested that the applicant restrict his work activities to a 2kg weight limit and that he continue with physiotherapy.

64. On 10 January 2017, Dr Kwa reported that the applicant was having trouble abducting his arm and he felt a clunking sensation in the shoulder. His shoulder pain radiated down the anterior aspect of his arm. He was currently doing supervisory duties.

65. Dr Kwa referred the applicant for x-rays and an ultrasound on 16 January 2017. These tests showed degenerative changes in the right AC joint, supraspinatus tendonitis and bursal bunching.

66. In a report dated 21 February 2017, Dr Kwa noted that the applicant's shoulder was still painful, and he had difficulty lifting. The doctor stated the applicant still had bursitis and impingement, which he felt would settle with time. He recommended that the applicant continue with physiotherapy strengthening programme and he was optimistic of a return to truck driving in the future.

67. On 25 July 2017, Dr Kwa reported that the applicant's shoulder was no better and the right shoulder pain radiated up the right side of his neck. He had difficulty lifting his arm and he had burning sensation around the shoulder. The applicant claimed that he sometimes had swelling and a bluey discoloration over his forearm and numbness and tingling extending to his hand. He is currently working on light duties and he was not taking any medication.

68. Dr Kwa advised that the applicant presented with significant pain and dysfunction of the right shoulder due to a lack of musculo control rather than adhesive capsulitis. He referred the applicant for a CT arthrogram and recommended that he have steroid injections, but the applicant declined.

69. Dr Kwa stated that the applicant's symptoms of altered sensation in a glove and stocking distribution up to the elbow, in the absence of obvious muscle wasting and a Tinel's sign, did not suggest carpal tunnel syndrome.

70. A CT arthrogram was performed on 9 August 2017 which disclosed similar findings to the arthrogram performed in July 2016. There was some thinning of the subscapularis tendon with minor articular surface irregularity reflecting the previous tear, and the possibility of a full thickness tear of the long head of the biceps.

71. An EMG was performed on 29 September 2017. This showed evidence of a right median nerve lesion in the wrist consistent with carpal tunnel syndrome. There was no other upper limb abnormality.

72. In his final report dated 31 October 2017, Dr Kwa noted that the applicant's condition had remained the same, with pain in his shoulder and sometimes over the top radiating up the side of the neck to just behind his ear. The applicant had pins and needles over his upper arm and down towards the elbow, with occasional pins and needles in his right hand.

73. Dr Kwa commented that there was no obvious evidence in the arthrogram to explain the locking and clicking sensation in the applicant's shoulder. He thought that most of the pins and needles related to his shoulder, rather than carpal tunnel syndrome, although he might have mild symptoms.

74. Dr Kwa stated that the pain radiating to the side of the applicant's neck may be related to his AC joint. He recommended a trial of steroid and local anaesthetic injections into the AC joint. Nevertheless, the applicant admitted that his shoulder condition was better than it was before his operation. The doctor advised against further surgery and recommended multidisciplinary pain management treatment.

Reports of Mr Gilham

75. The reports from the physiotherapist Mark Gilham, describe the nature of the treatment that was provided to the applicant following his right shoulder surgery. In his report dated 9 October 2016, Mr Gilham advised that he was concerned about some clunking around in the applicant's shoulder and extreme pain to light touch. On 1 November 2016, Mr Gilham advised that the applicant was developing CRPS. In later reports, he noted that he applicant's condition was improving.

76. On 15 February 2017, Mr Gilham reported that the applicant seemed to have developed adhesive capsulitis which had remained in a stable phase. He recommended that the applicant continue to perform his stretching exercises.

77. In a report dated 18 July 2017, Mr Gilham recorded that the applicant's shoulder condition was deteriorating in terms of the range of movement. He had also developed symptoms of carpal tunnel syndrome in his right hand.

Reports of Dr Sui and Dr Wu

78. Dr Sui, rehabilitation specialist, reported on 19 March 2018. She recorded that the applicant injured his right shoulder in May 2016 after flicking a forequarter of beef onto his right shoulder. She noted that he was diagnosed with full thickness right rotator cuff tear and had a surgical repair in August 2016. He was diagnosed with a frozen shoulder in June 2017 and with carpal tunnel syndrome in September 2017.

79. Dr Sui reported that the applicant had on-going right shoulder pain, in the front and over the top of the shoulder radiating up the side of the neck to just behind the ear. There was significant allodynia in the right shoulder area and the applicant was unable to tolerate light touch. The right arm seemed to be slightly darker than the left.

80. Dr Sui diagnosed CRPS. She recommended the use of anti-neuropathic pain medications, but the applicant was reluctant to take any oral medication.

81. Dr Wu reported on 30 October 2018. He recorded that the applicant had injured his right shoulder and had surgery in August 2016. His pain improved for three to six months, but it had returned. The pain was situated predominantly in the right shoulder and was made worse with any movement of the shoulder. The pain was persistent and fluctuated in intensity. There were also episodes of swelling, discolouration of the skin, and paraesthesia and numbness in the right arm. The applicant had declined to take medication. There were no complaints in relation to the neck.

82. Dr Wu thought that it was likely that the applicant had CRPS of his right shoulder. He recommended that the applicant have a Ketamine infusion, together with inpatient intensive physical therapy and nerve blocks to facilitate rehabilitation. The applicant was unsure whether to have this treatment.

Reports of Dr Bodel

83. Dr Bodel reported on 10 April 2018. He recorded that the applicant was unloading a forequarter of beef on 8 May 2016 when he sustained injury. The usual method was to swing the beef up as it hung from the hook and move underneath it either on the left or right side. The doctor noted that "He did this manoeuvre and dropped the heavy forequarter on to his right shoulder. He was aware of an immediate onset of whole arm pain and numbness".

84. Dr Bodel reported that the applicant was able to drive, but his offsider completed the remaining deliveries. He saw his local doctor, was referred to Dr Kwa and he had an arthroscopic subacromial decompression and repair of a torn rotator cuff on 4 August 2016. He returned to work on light duties, but he continued to experience significant pain and disuse in his right upper limb. He ceased work in mid-2017, and he was terminated on 29 December 2017. He had not been able to return to work elsewhere.

85. The applicant complained of pain, stiffness and locking in his right shoulder. He was unable to push, pull, lift or use the arm overhead. He had weakness of grip strength and diffuse numbness and tingling in the whole of the right arm. On examination, the doctor observed generalised wasting in the right shoulder girdle, a restricted range of motion, tenderness in the trapezius muscles at the base of the neck on the right hand side and a reduced range of neck flexion, extension and rotation in all directions.

86. Dr Bodel diagnosed a rotator cuff tear and to the right shoulder and a soft tissue traction type injury to the neck and right shoulder on 8 May 2016. The applicant had ongoing pain and stiffness in the neck, the right shoulder and the arm, and marked functional disability in the right shoulder. He stated that the applicant was unfit for all work and he assessed 7% whole person impairment of the cervical spine and 11% whole person impairment of the right upper extremity (shoulder), for a total of 17% whole person impairment.

87. In a supplementary report dated 11 September 2018, Dr Bodel advised that when he examined the applicant, he found no major signs consistent with a diagnosis of CRPS. He suggested that any assessment of impairment be deferred until the applicant's condition had stabilised.

88. Dr Bodel explained that the mechanism of injury was that the applicant took the weight of a heavy forequarter of beef on his shoulder. This force created a downward force on the shoulder causing a traction injury on the brachial plexus and the cervical spine. Accordingly, he was satisfied that the applicant's neck was injured in the incident.

89. Dr Bodel re-examined the applicant on 1 May 2019. On this occasion, the doctor reported a different history of the mechanism of injury. The doctor recorded that the applicant "was about to drop the forequarter of beef onto the shoulder, he felt a painful popping sensation and he never did actually drop the beef onto the shoulder. The injury occurred before he took the weight on his shoulder. He felt a painful popping sensation as he swung it forward".

90. Dr Bodel reported that the applicant's shoulder was very painful after the operation and in fact his shoulder was worse. He had been left with very significant pain in the neck, right shoulder and arm with numbness and tingling in his fingers. There were also periods where the arm was cold and bluish, and he was unable to use it. There was a suggestion that he had CRPS.

91. The applicant's complaints were similar to those noted during the doctor's previous examination. On examination, the doctor tenderness in the trapezius muscles at the base of the neck on the right side and a reduced range of neck flexion, extension and rotation in all directions., particularly on rotation to the right. There was asymmetry of neck movement and a restricted range of shoulder movement on the right side, which was worse than before.

92. Dr Bodel diagnosed a significant rotator cuff injury to the region of the right shoulder and a probable disc injury in the cervical spine as a result of the injury on 8 May 2016. There was no comment regarding CRPS.

93. Dr Bodel assessed 7% whole person impairment of the cervical spine and 12% whole person impairment of the right upper extremity (shoulder) and 1% whole person impairment due to scarring (TEMSKI), for a total of 19% whole person impairment.

Reports of Dr Bosanquet

94. Dr Bosanquet reported on 28 June 2018. He recorded that the applicant would pick up a beef forequarter by pushing it up the wall where it was hanging from an overhead strap and then flick it onto his right shoulder. When he did this, he felt a burning pain and a pop in the shoulder, together with pain and stiffness in his neck. He eventually had a rotator cuff repair, which improved his range of movement, but he had ongoing pain and he was unable to move his arm above shoulder height.

95. The applicant complained of constant pain in the right shoulder and the right arm going into the fingers and the right side of his neck. He experienced swelling in the hand and colour changes in his hand which became darker and mottled. He had paraesthesia, numbness and burning in the arm radiating into his neck.

96. Dr Bosanquet noted that the applicant complained of pain on touching, hyperaesthesia in the shoulder extending into the right side of the neck, and there was a restricted range of movement. His right arm was sweating at the end of the examination and his right hand was purple and swollen. Neck movements were reduced and caused strong pain in the right shoulder.

97. Dr Bosanquet diagnosed a right rotator cuff injury and CRPS. He was not satisfied that there was any injury to the applicant's cervical spine and that the applicant had reached maximum medical improvement. He declined to provide an assessment of whole person impairment.

98. Dr Bosanquet provided further reports on 24 September 2019 and 9 October 2019. He recorded a different history, namely that "he put the forequarter up against the wall where it was hanging from an overhead string and he would normally then flick it on to his shoulder. On this occasion, but he was unable to do this as he felt a burning pain and a pop in the right shoulder".

99. Dr Bosanquet noted that the applicant had constant pain in his right shoulder and right arm radiating into the fingers and up into the right side of his neck. There was reduced strength and the applicant had noticed swelling in the hand with colour changes. He experienced paraesthesia, numbing and burning in the whole arm radiating to his neck.

100. On examination, the doctor observed marked allodynia through the whole of the right arm and extending up the shoulder into the right side of his neck. Neck and shoulder movements were restricted, and supination of the right elbow caused severe pain radiating up into the right side of the neck. There were marked colour changes in his right arm.

101. Dr Bosanquet diagnosed a rotator cuff tear and CRPS affecting the right upper limb. He stated that the applicant's employment was the substantial contributing factor to the current diagnosis. Given the presence of pre-existing degenerative changes in the applicant's AC joint which caused subacromial bursitis and possible impingement, he considered that a 10% deduction was warranted. He assessed 29% whole person impairment due to chronic pain in accordance with Table 13.22 on page 342 of AMA5. He confirmed there had been no injury to the applicant's cervical spine.

APPLICANT'S SUBMISSIONS

102. Mr Tanner submits that there is no dispute that the applicant injured his right shoulder on 8 May 2016. Dr Bodel recorded that the applicant had dropped the 4kg forequarter of beef onto his right shoulder and experienced pain and numbness in his whole arm. A similar history was recorded by Dr Bosanquet.

103. Mr Tanner submits that Dr Bodel noted that the applicant had generalised wasting in the right shoulder girdle, tenderness in the trapezius muscles at the base of the neck on the right hand side and a reduced range of neck flexion, extension and rotation. The doctor diagnosed a soft tissue traction type injury to the neck and the applicant had on-going pain. There was no explanation for his symptoms of pain, restriction of movement and stiffness other than the subject injury.

104. Mr Tanner submits that in his report dated 11 September 2018, Dr Bodel explained that the mechanism of injury where the applicant took the weight of a heavy forequarter of beef on his shoulder created a downward force on the shoulder thereby causing a traction injury. There was no dispute that there was a downward force.

105. Mr Tanner submits that in his report dated 1 May 2019, Dr Bodel noted that the applicant had on-going and significant pain in his neck, and there is no explanation other than the incident. The doctor diagnosed a probable disc injury and he stated that there was a direct causal link between the injury and the applicant's complaints.

106. Mr Tanner submits that according to Dr Bosanquet, the applicant had pain radiating into his neck. There is reference to referred pain in the clinical notes, but Dr Bodel indicated that the applicant's pain was situated in the neck. Neck movements caused pain, and this identified pathology in the neck, not radiating pain.

107. Mr Tanner submits that Dr Bosanquet provided one line answers to questions regarding the applicant's neck injury. He made bold assertions without engaging with the circumstances of injury and the applicant's version of his injury. The doctor noted that there had been no radiological tests, but the applicant still had neck pain which Dr Bodel identified as being due to a soft tissue injury. Dr Bosanquet did not challenge Dr Bodel's opinion and he recorded a history of the onset of pain and stiffness in the applicant's neck at the time of the incident.

108. Mr Tanner submits that Dr Bosanquet recorded that that flexion and extension were 50% of normal and rotation and lateral bending was 25% of normal. Therefore, there was a significant reduction in the applicant's ability to flex and bend his neck and the source of this restriction was the force of the beef carcass on his right shoulder. The doctor only considered radiating pain and not neck pathology.

109. Mr Tanner submits that the clinical notes focus on treatment of the applicant's right shoulder and it has been confirmed in numerous cases in the Commission that focus on the most acute injury does not mean that other injuries were sustained. One can be satisfied on the basis of the opinion of Dr Bodel that the applicant injured his neck.

110. In reply, Mr Tanner submits that there is no evidence that suggests that the applicant's age, weight and long work history were responsible for his neck symptoms. In his report dated 17 June 2016, Dr Kwa recorded a history that the applicant denied suffering any other injuries. There is no evidence of any event after 8 May 2016 that caused the sudden onset of neck problems.

111. Mr Tanner submits that Dr Bosanquet recorded a limited range of motion and the applicant explained the system of work. It was unclear from the applicant's statement whether he placed the forequarter on his shoulder, or whether it was nowhere near it. The applicant suffered a shoulder injury as a result of significant force. There was no evidence to the contrary.

RESPONDENT'S SUBMISSIONS

112. Mr Barter submits that the mechanism of injury is not consistent with the applicant's statement and the histories recorded by Dr Bosanquet and Dr Bodel in his last report. Another explanation for the applicant's neck symptoms could be the nature of the work performed where he placed strain on his neck when moving the forequarters of meat. The applicant's injury was not sustained in that manner. The applicant's age, weight and a long history of manual work might be alternative causes of his neck pain.

113. Mr Barter submits that according to the applicant's statement, he was about to drop the forequarter onto his shoulder when he suffered his shoulder injury. He did not get the carcass onto his shoulder. There was reference to any neck injury in the notes of the treating doctors.

114. Mr Barter submits that the first reference to a neck injury was in the report of Dr Bodel, but he recorded that the applicant had placed the forequarter on his shoulder. Dr Bosanquet reported that the applicant was pushing the forequarter up when he felt pain in his shoulder, and he experienced pain and stiffness in his neck. This history was recorded two years after the incident.

115. Mr Barter submits that there were no contemporaneous complaints of neck pain, but a temporal link is not the only test. In his statement, the applicant indicated that he had continuing neck symptoms, but he did not say when they started. If he had made complaints to his treating doctors, he might have been referred for diagnostic tests, but none were undertaken. The applicant was examined by a general practitioner, orthopaedic surgeon and pain management specialist, but there was no record of any complaints.

116. Mr Barter submits that Dr Kwa did not refer to radicular symptoms from the neck. Dr Wu looked at an alternative cause of the applicant's pain and diagnosed CRPS of the right shoulder.

REASONS

Did the applicant injure his cervical spine? – s 4 and 9A of the 1987 Act

117. Section 4 of the 1987 Act defines injury as follows:

> "In this Act-
>
> ***Injury***-
>
> (a) means personal injury arising out of or in the course of employment,
>
> (b) includes a disease injury, which means:
>
> (i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and
>
> (ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, and
>
> (c) does not include (except in the case of a worker employed in or about a mine) a dust disease, as defined by the Workers' Compensation (Dust Diseases) Act 1942, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined".

118. In order to be satisfied that an injury has occurred, there must be evidence of a sudden or identifiable pathological change: *Castro v State Transit Authority (NSW)*[4], or as stated by Neilson CCJ in *Lyons v Master Builders Association of NSW Pty Ltd* [5], "the word 'injury' refers to both the event and the pathology arising from it".

119. The issue of causation must be determined based on the facts in each case. The accepted view regarding causation was set out in *Kooragang Cement Pty Ltd v Bates*[6] where Kirby J stated:

> "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 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 common sense 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."

[4] [2000] NSWCC 12; 19 NSWCCR 496.
[5] (2003) 25 NSWCCR 422, [429].
[6] (1994) 35 NSWLR 452; 10 NSWCCR 796 (*Kooragang*), [463].

120. The applicant alleges that he injured his neck on 18 May 2016 when he was in the process of lifting a 4 kg forequarter of beef. Therefore, he relies on a personal injury in terms of s 4(a) of the 1987 Act. The applicant bears the onus of proof to establish that he sustained a neck injury.

121. In *Department of Education & Training v Ireland*[7], President Keating considered the principles regarding the discharge of the onus of proof. He stated:

> "The principles relevant to the discharge of the onus of proof were discussed in *Nguyen v Cosmopolitan Homes* [2008] NSWCA 246 (16 October 2008) ('*Nguyen*') where McDougall J (McColl and Bell JJA agreeing) said at [44]–[48]:
>
> '44. A number of cases, of high authority, insist that for a tribunal of fact to be satisfied, on the balance of probabilities, of the existence of a fact, it must feel an actual persuasion of the existence of that fact. See Dixon J in *Briginshaw v Briginshaw* (1938) 60 CLR 336. His Honour's statement was approved by the majority (Dixon, Evatt and McTiernan JJ) in *Helton v Allen* (1940) 63 CLR 691 at 712.
>
> 45. Dixon CJ put the matter in different words, although to similar effect, in *Jones v Dunkel* (1959) 101 CLR 298 at 305 where his Honour said that '[t]he facts proved must form a reasonable basis for a definite conclusion affirmatively drawn of the truth of which the tribunal of fact may reasonably be satisfied'. Although his Honour dissented in the outcome of that case, the words that I have quoted were cited with approval by the majority (Stephen, Mason, Aickin and Wilson JJ) in *West v Government Insurance Office of NSW* (1981) 148 CLR 62 at 66. See also Stephen J in *Girlock (Sales) Pty Limited v Hurrell* (1982) 149 CLR 155 at 161–162, and Mason J (with whom Brennan J agreed) in the same case at 168.
>
> 46. It is clear, in particular from *West* and *Girlock*, that the requirement for actual satisfaction as to the occurrence or existence of a fact is one of general application, and not limited to cases where the fact in question, if found, might reflect adversely on the character of a party or witness.
>
> 47. In *Malec v JC Hutton Pty Limited* (1990) 169 CLR 638 Deane, Gaudron and McHugh JJ said at 642-643:
>
> > 'A common law court determines on the balance of probabilities whether an event has occurred. If the probability of the event having occurred is greater than it not having occurred, the occurrence of the event is treated as certain; if the probability of it having occurred is less than it not having occurred, it is treated as not having occurred.'
>
> 48. On analysis, I think, what their Honours said is not inconsistent with the requirement that the tribunal of fact be actually persuaded of the occurrence or existence of the fact before it can be found. On their Honours' approach, what is required is a determination of the respective probabilities of the event's having occurred or not occurred. There is nothing in that analysis to suggest that the determination in favour of probability of occurrence should not require some sense of actual persuasion.'"[8]

[7] [2008] NSWWCCPD 134 (*Ireland*).
[8] *Ireland*, [89].

122. Therefore, in order for the applicant to discharge the onus that he sustained an injury in the incident on 8 May 2016, I "must feel an actual persuasion of the existence of that fact".

123. According to the applicant's statement, he was about to drop the beef onto his shoulder when he felt a popping sensation, so he did not actually lift the forequarter onto his shoulder. He claimed that he had immediate pain and could not move his arm due to pain and numbness. He did not identify the location of the pain and he did not suggest that he had injured his neck.

124. Later in his statement, the applicant advised that he continued to suffer from pain in his neck, right shoulder and right arm, together with weakness and tingling in his right arm and hand. Therefore, the applicant's statement is largely unhelpful as he did not mention a neck injury or identify when his neck pain commenced.

125. Unfortunately, a notice of injury, the applicant's claim form and the employers report of injury form are not in evidence. These documents may have provided contemporaneous evidence of the alleged neck injury.

126. A major concern for the applicant is the absence of any record of a neck injury or complaints of symptoms in the applicant's neck in the clinical notes of the treating doctors.

127. The importance of contemporaneous evidence in the form of clinical notes and medical reports was identified by President Keating in *Ireland*, where the first record of a back injury was three years after the subject fall.

128. The Court of Appeal in decisions such as *Davis v Council of the City of Wagga Wagga*[9], *Nominal Defendant v Clancy*[10], *King v* Collins[11]and *Mastronardi v State of New* South *Wales*[12] has cautioned against placing too much weight on the clinical notes of treating doctors, given their primary concern was treatment. In the Court's view, the notes rarely, if ever, represented a complete record of the exchange between a busy doctor and the patient. These decisions have been cited with approval by Deputy President Roche in the Commission in *Winter v NSW Police Force*[13]*.*

129. However, in this matter, one could not be satisfied that the treating doctors did not record a proper account of the applicant's complaints at the various consultations. The entries made by Dr Downton are particularly detailed and some entries cover more than one page.

130. On 10 May 2016, only two days after the incident, Dr Chan recorded that the applicant only had right shoulder pain following an episode of heavy lifting. The precise circumstances of the injury were not recorded. Significantly, the applicant was only referred for x-rays and an ultrasound of his right shoulder. One would have expected that he would have had some tests on his neck, if he had in fact sustained a neck injury as alleged.

131. The x-rays and ultrasound showed degenerative changes in the applicant's right AC joint and supraspinatus and subscapularis tendon tears.

132. Dr Downton took over the applicant's treatment in early 2017. She did not record any history of a neck injury or any complaints of neck pain. On 3 July 2017 and 15 August 2017, the doctor reported that the applicant had a frozen right shoulder and nerve entrapment symptoms. The applicant also had pain extending from his shoulder up to the right side of his

[9] [2004] NSWCA 34 (*Davis*).
[10] [2007] NSWCA 349 (*Clancy*).
[11] [2007] NSWCA 122 (*Collins*).
[12] [2009] NSWCA 270 (*Mastronard*i).
[13] [2010] NSWWCCPD 12 (*Winter*).

neck. These are the first references to the neck, but the symptoms were not localised in the neck and radiated from the applicant's right shoulder.

133. In October 2017, Dr Downton suspected that the applicant had carpal tunnel syndrome, and this was later confirmed by EMG studies. In March 2018, the doctor recorded that the applicant had occasional paraesthesia in his right hand and arm, but it was not suggested that these symptoms were related to any pathology in the applicant's cervical spine.

134. Significantly there is no reference to any neck injury or symptoms in the numerous referral letters and the reports completed by the doctor in 2018. The doctor only referred to the applicant's right shoulder symptoms.

135. Certificates were issued by Drs Chan, Kamal and Downton, but these are not in evidence, so whether the general practitioners identified a neck injury is unknown.

136. The applicant gains no support for his alleged neck injury from Dr Kwa. He recorded a history that the applicant was injured when he was flicking a forequarter of beef onto his shoulder and felt something tear in the right shoulder. There was no mention of any neck injury or neck pain. It is unclear from this history whether the applicant had actually placed the forequarter on his shoulder or was in the process of doing so.

137. According to Dr Kwa, the applicant had severe pain and restriction of movement in his shoulder, but there was a full range of neck movements but movements to the left and right caused pain radiating from the neck down over both shoulders. This would seem to suggest the existence of some neck pathology, but Dr Kwa did not comment on the significance of these symptoms or consider that they warranted further radiological investigation.

138. Dr Kwa provided a series of reports in 2016 and early 2017. There was no record of any neck symptoms and there was no further mention of any symptoms radiating from the neck to the shoulders. Any radiation or impingement symptoms came from the right shoulder.

139. On 25 July 2017, Dr Kwa reported that the applicant's right shoulder pain radiated up the right side of his neck. A similar complaint was made to Dr Downton at around this time. The doctor initially thought that the applicant did not have carpal tunnel syndrome, but he later seemed to change his opinion after the EMG study. Nevertheless, he felt that most of the problem stemmed from the shoulder.

140. In his last report dated 31 October 2017, Dr Kwa again reported that the applicant had shoulder pain radiating up the side of the neck to just behind the ear. This history is similar to that noted by Dr Sui.

141. Dr Kwa felt that most of the pins and needles related to the applicant's shoulder condition. The doctor explained that the pain radiating to the side of the applicant's neck might be related to his AC joint.

142. The reports of Mr Gilham contain no reference of any neck injury or symptoms. He only referred to the applicant's right shoulder injury and carpal tunnel syndrome. There is no suggestion that he provided any treatment for neck symptoms.

143. Similarly, Drs Sui and Wu focussed on the applicant's right shoulder symptoms and there were no histories of a neck injury or complaints of pain centred in or radiating out from the neck. They diagnosed CRPS of the right shoulder.

144. Dr Sui recorded a history that the applicant injured his right shoulder after flicking a forequarter of beef onto his right shoulder. This suggests that the applicant told her that the carcass came into contact with his right shoulder.

145. Therefore, there is no history of a neck injury or symptoms originating in the applicant's neck in the evidence of Dr Chan, Dr Downton, Dr Kwa and Mr Gilham. Even allowing for the principles discussed in *Davis*, *Collins*, *Clancy*, *Mastronardi* and *Winter*, one would have expected at least one of these clinicians to record a history of a neck injury or consider a referral for diagnostic tests if the applicant's neck pain was a severe as he alleges.

146. Little assistance is provided by the opinion of Dr Bosanquet on the question of causation, because he merely said that there was no neck injury without providing an explanation. His conclusion that there was no injury to the applicant's neck represents a mere "ipse dixit". Nevertheless, his reports are of assistance regarding the history and the nature of the applicant's complaints.

147. The history recorded by Dr Bosanquet in his initial report seems to suggest that the applicant actually lifted the carcass onto his right shoulder when he experienced a burning pain and a pop in the shoulder, as well as pain and stiffness in his neck. Such a history regarding immediate neck pain and stiffness in not recorded in any of the material from the treating doctors, and is inconsistent with the applicant's statement.

148. Dr Bosanquet also reported a history of pain in the right shoulder and arm going into the fingers and the right side of his neck and he noted paraesthesia, numbness and burning in his arm extending into the right side of the neck. This history and the complaints are not consistent with symptoms radiating from the neck. Although the doctor noted that neck movements were reduced and caused strong pain in the right shoulder, he was not satisfied that there was any injury to the applicant's cervical spine.

149. Dr Bosanquet recorded a different history in his subsequent reports, namely the applicant was unable to flick the forequarter onto his shoulder as he felt a burning pain and a pop.

150. Dr Bosanquet again noted that the applicant's right shoulder pain, paraesthesia, numbness and burning radiated up into the right side of his neck rather than starting in the neck and radiating to his shoulder and arm. He observed that neck and shoulder movements were restricted, and supination of the right elbow caused severe pain radiating up into the right side of the neck, rather than in the opposite direction. The doctor again discounted the possibility of a neck injury.

151. It is true that Dr Bosanquet recorded a restricted range of movement in the applicant's neck, but he did not attribute this to any neck injury and in any event, his history only identified pain radiating from the shoulder and not the reverse.

152. The history recorded by Dr Bodel in his initial report, namely that the applicant felt pain in his right shoulder when he dropped the carcass onto his shoulder, is inconsistent with the applicant's statement. Further, the doctor did not record any history of a neck injury and only recorded tenderness in the trapezius muscles at the base of the neck and a reduced range of neck flexion, extension and rotation in all directions. He did not illicit the cause of these symptoms.

153. According to Dr Bodel, the applicant suffered a traction type injury to the shoulder and neck because he took the weight of the forequarter on his shoulder, and this caused a traction injury to the brachial plexus and the cervical spine. One can readily understand this conclusion based on the history that the doctor recorded. However, this history does not accord with the applicant's statement and the history recorded in the later reports.

154. In his later report, Dr Bodel recorded that the applicant had not actually dropped the beef onto his shoulder, but he took the weight on his shoulder. The doctor did not describe a traction injury or how the applicant's neck was affected.

155. The doctor again recorded details of the applicant's neck symptoms that included pain, tenderness in the trapezius muscles at the base of the neck, asymmetry of neck movement and a reduced range of motion. He diagnosed a probable cervical disc injury instead of a soft tissue injury, but he did not explain the change in his opinion or the mechanism of the neck injury in light of the different history.

156. Although Mr Tanner submits that there is no explanation for the applicant's symptoms of pain, restriction of movement and stiffness other than the subject injury, the treating doctors have recorded no history of any neck injury and the applicant has not undergone any diagnostic tests. The symptoms recorded by the treating doctors, who have all seen the applicant on a regular basis, seemed to start in the right shoulder, extend to the base of the neck and radiate up the neck to behind the applicant's right ear.

157. Dr Kwa, the only treating specialist, explained that these symptoms could be related to the pathology in the applicant's AC joint, so there is another possible explanation for the applicant's symptoms in the absence of a history of another injury.

158. It is well-established law that an expert's medical opinion is of limited probative value in the overall assessment of the issues if it is based upon an inaccurate history[14]. This affects the weight to be given to the reports of Dr Bodel, where he identified a different mechanism of injury in hi slats report and he has not explained how this impacted on his original opinion.

Conclusion

159. The applicant alleges that he injured his neck in the incident on 8 May 2016. He relies on a statement completed more than three years after the incident. He did not refer to a neck injury, he failed to give details regarding the onset, nature and duration of his neck pain. Further, he gave no explanation why he did not mention his neck pain to his treating doctors and physiotherapist. He merely stated that he continued to experience neck pain. Therefore, the applicant's statement is unconvincing and is not persuasive.

160. The history recorded by Drs Bodel and Bosanquet in their initial reports did not mirror the applicant's statement. Dr Bodel did not even record a history of a neck injury, but he merely noted some symptoms that he attributed to a soft tissue traction injury. Such a conclusion was based on an incorrect history.

161. I am satisfied that the applicant did not report an injury to his neck to any of his treating doctors despite having on-going treatment for his shoulder injury, and this places in doubt the reliability of his evidence. Further, Dr Bodel has not provided a satisfactory explanation for his opinion on causation after he was provided with the correct history. In those circumstances, his opinion carries no weight on the basis of the principles in *Hancock*, *Paric* and *Makita*.

162. According to *Ireland*, in order for the applicant to discharge the onus that he sustained a hernia injury in the incident on 3 May 2014, I "must feel an actual persuasion of the existence of that fact".

[14] [2001] NSWCA 305; (2001) 52 NSWLR 705 (*Makita*); *Hancock v East Coast Timbers Products Pty Ltd* [2011] NSWCA 11 (*Hancock*); and *Paric v John Holland (Constructions) Pty Ltd* [1985] HCA 58 (*Paric*).

163. In the circumstances, I am not satisfied that the applicant has discharged the onus of establishing that he injured his cervical spine arising out of or in the course of his employment on 8 May 2016. Accordingly, there will be an award for the respondent in respect of this alleged injury.

Quantification of whole person impairment

164. I will remit this matter to the Registrar for referral to an AMS pursuant to s 321 of the 1998 Act for assessment of the whole person impairment of the applicant's right upper extremity due to a consequential condition (chronic pain) resulting from the injury sustained to the applicant's shoulder on 8 May 2016.

FINDINGS

165. The applicant sustained an injury to his right shoulder arising out of or in the course of his employment on 8 May 2016.

166. The applicant did not sustain an injury to his neck arising out of or in the course of his employment on 8 May 2016.

167. The applicant developed a consequential chronic pain condition in his right upper extremity as a result of the injury sustained to his right shoulder on 8 May 2016.

ORDERS

168. Award for the respondent in respect of the allegation of an injury to the applicant's neck on 8 May 2016.

169. I remit this matter to the Registrar for referral to an AMS pursuant to s 321 of the 1998 Act for assessment of the whole person impairment of the applicant's right upper extremity due to a consequential condition (chronic pain) resulting from the injury sustained to the applicant's shoulder on 8 May 2016.

170. The documents to be reviewed by the AMS are:

    (a) Application to Resolve a Dispute and attached documents, and
    (b) Reply and attached documents, excluding the report of Dr Reitner dated 17 January 2020.

171. Note:

    (a) The claim in respect of the whole person impairment of the right upper extremity (shoulder) and scarring (TEMSKI). The parties agree that the applicant has 12% whole person impairment of the right upper extremity (shoulder) and 1% whole person impairment for scarring (TEMSKI), for a combined total of 13% whole person impairment.

    (b) The AMS is requested to include these agreed assessments in his Medical Assessment Certificate.