WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **2612/19**
Applicant: **Kalliroi Tsigounis**
Respondent: **Secretary, Department of Justice**
Date of Determination: **26 July 2019**
Citation: **[2019] NSWWCC 256**

The Commission determines:

Findings

1. The applicant developed a consequential condition in her left shoulder as a result of the right wrist injury on 20 January 2015.

2. The applicant has not established that she developed a consequential condition in her cervical spine as a result of the right wrist injury on 20 January 2015.

Orders

3. Award for the respondent in respect of the claim for a consequential condition in the applicant's cervical spine as a result of the right wrist injury on 20 January 2015.

4. The matter is remitted to the Registrar for referral to an Approved Medical Specialist for assessment or whole person impairment according to the following:

    (a) Injury on 20 January 2015 (date of injury)

    (b) Body System: Right Upper extremity (chronic pain); Left Upper Extremity (shoulder, consequential condition)

    (c) Documents to be provided to Approved Medical Specialist (with attachments unless excluded):

        (i) The Application to Resolve a Dispute, and
        (ii) The Reply.

5. The parties have liberty to apply within seven days regarding the form of the referral to the Approved Medical Specialist in relation to the right upper extremity.

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

Gerard Egan
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 GERARD EGAN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

L Golic

Lucy Golic
Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Kalliroi Tsigounis (the applicant) claims lump sum compensation for injuries sustained on 20 January 2015 during the course of her employment with Corrective Services New South Wales (Secretary, Department of Justice, hereinafter referred to as the respondent).

2. The primary injury the applicant sustained was to the right wrist. She brings a claim for lump sum compensation based on assessments of whole person impairment (WPI) in relation to the right upper extremity (40% WPI), left upper extremity (shoulder, 2% WPI) and cervical spine (5% WPI) based on assessments by orthopaedic surgeon Dr Peter Giblin in a report dated 25 July 2018.

3. There is no dispute concerning liability for and impairment arising out of the right upper extremity. However, the respondent disputes liability in respect of impairment assessed for the left upper extremity (shoulder) and the cervical spine. The applicant relies upon "conditions" in those body parts which are said to be consequential or secondary to the right wrist injury.

ISSUES FOR DETERMINATION

4. Accordingly, liability for the alleged secondary conditions in the left shoulder and the cervical spine require determination.

PROCEDURE BEFORE THE COMMISSION

5. The parties attended an arbitration in Sydney on 18 July 2019. 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.

6. Mr Petrie of counsel instructed by Mr Koutzoumis appeared for the applicant who was also present. Mr Baker of counsel instructed by Mr Guest appeared for the respondent.

EVIDENCE

Documentary evidence

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

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

Oral evidence

8. There was no application for cross-examination or oral evidence.

FURTHER BACKGROUND AND THE EVIDENCE

Applicant's statement dated 12 February 2019

9. In a statement, the applicant states that she commenced employment with the respondent in about December 2015 and during a tactical training exercise on 20 January 2016 she fell backwards, injuring her right arm and wrist trying to break the fall.

10. The applicant attended her general practitioner Dr Bashir Mahmood and investigations into the right wrist injury commenced. After failing to improve, Dr Mahmood referred the applicant to Dr Michael Dowd in June 2016.

11. She describes proceeding to wrist arthroscopy on 5 October 2016 and further surgery on 25 January 2017 by Dr Dowd which will be dealt with below. She describes persisting with conservative treatment such as physiotherapy, hydrotherapy and the intervention of a psychologist and pain management programs.

12. The applicant's statement, however, is non-instructive regarding the nature of the onset of the applicant's symptoms in her left upper limb or her neck. Nor does it provide any description of the activities the applicant did, or did not do as a result of her right-sided symptoms or surgeries. The sum total of the applicant's direct evidence, presumably prepared by her solicitors relevant to the onset of those symptoms is as follows:

> "I continue to suffer ongoing disability and discomfort in my right arm, my right wrist, my right shoulder and base of my neck.
>
> As a direct result of me relying upon my left arm to do almost all of my daily chores, my left arm has become very weak."

13. The last statement is merely an assertion of medical causation. In *Moon v Conmah Pty Limited* [2009] NSWWCCPD 134 (*Moon*), Roche DP was critical of the worker's evidence where he had suffered injury to his right shoulder and claimed compensation based on a consequential condition in his left shoulder, similar to this case. Roche DP said, at [22]:

> "Mr Moon's statement has been poorly drafted and is most unsatisfactory. The only evidence in it dealing with the issue that arises on appeal is paragraph seven, which states:
>
> > 'I have also developed over time symptoms in my left shoulder (due to my right shoulder injury), neck and back due to my work injuries.'
>
> One would have thought that, at a minimum, details would have been provided as to when the left shoulder symptoms commenced and in what circumstances. Mr Moon's statement should also have dealt with the nature and extent of the injuries to the right upper extremity and their impact on his use of his left shoulder. The failure to deal with these issues in Mr Moon's statement is unfortunate and unsatisfactory. As a result, it has been necessary to piece together Mr Moon's case from the medical histories".

Contemporaneous medical evidence

14. It appears that the applicant saw Dr Dowd on 19 July 2016 when significant difficulties with the right wrist persisted interfering with her daily activities and personal care such as toileting. He immediately flagged a right wrist diagnostic arthroscopy and sought permission from the respondent's insurer to proceed.

15. This occurred on 5 October 2016, when he diagnosed a complete rupture of the scapholunate ligament and extensive synovitis in the right wrist. He confirmed that she would need a secondary procedure and again requested further approval.

16. Although the report is not in evidence, it is apparent that the applicant also underwent a right shoulder ultrasound on 25 January 2016, very shortly after the accident. This is referred to in a medicolegal report of Dr Peter Giblin dated 25 July 2018 which will be dealt with below.

17. Dr Dowd performed the right scaphoidectomy and capitolunate fusion in the right wrist on 25 January 2017. In his next report in evidence, on 9 March 2017, Dr Dowd reported to Dr Mahmood that "it appears as though [the applicant] has possibly developed Complex Regional Pain Syndrome (CRPS)", which at that stage, involved her right hand.

18. She was referred by Dr Mahmood to Dr Peter Allan (unknown speciality) for this condition. There is no report by Dr Allan before me.

19. Dr Mahmood on 14 March 2017, certified the applicant (in a general medical certificate) as having "a work-related injury to her right wrist complicated with Complex Regional Pain Syndrome and she is unable to do her home duties and needs assistance for …"

20. On 4 April 2017, Carolyn Whitson, the applicant's hand therapist, noted amongst other her views that CRPS symptoms were present and that the applicant "reported left upper limb pain and carpal tunnel symptoms".

21. The existence of CRPS was confirmed by Dr Dowd in a report dated 6 April 2017 when he said she had "quite difficult Complex Regional Pain Syndrome". He reported no wrist movement and minimal finger movement, mottled appearance and pain. He said he would refer her to Dr Sushama Deshpande at Western Sydney Pain Centre for management.

22. On 4 August 2017, an ultrasound of the right shoulder apparently showed adhesive capsulitis (frozen shoulder), again referred to by Dr Giblin, but I have not been taken to that report in evidence. The existence of this pathology is not disputed by the respondent, but its relevance may lie in the extent of disability in the right upper limb in order to justifiably establish any consequential condition in the left upper limb.

23. On 15 August 2017, Dr Mahmood noted the results of the right shoulder ultrasound (frozen shoulder) and added that the applicant was "now having pain in her left shoulder as well". His referral to the radiologist reported "USS left shoulder: (frozen shoulder on right side and now having same symptoms on left)."

24. The left shoulder ultrasound was reported on 17 August 2017. The report concluded that there was biceps sheaf effusion and "subacromial/subdeltoid bursitis +++". Dr Mahmood arranged for an injection into the left shoulder for the bursitis after reviewing the ultrasound results. The applicant had previously had injections into the right shoulder which were of little benefit. Dr Mahmood noted this on 4 September 2017 and also noted the applicant was awaiting a left shoulder local injection.

25. On 7 September 2017, Dr Mahmood noted the applicant was to have hydrotherapy. He noted "Left shoulder pain possibly secondary to her right wrist injury …" He again noted that she would need a local injection in the left shoulder and noted physiotherapy and hydrotherapy would involve the left shoulder as well.

26. On 21 September 2017, Dr Dowd noted the right frozen shoulder even after a ganglion block injection. He noted the persistence of CRPS and continuation of "physio +++".

27. On 11 October 2017, Dr Dowd recorded "persistence of severe CRPS. Very stiff (elbow and shoulder)". He also noted that the "block did nothing" and that the applicant has "frozen shoulder in left and right". (Dr Dowd's emphasis.)

28. Problems continued over the following months. On 11 (or 21) December 2017, Dr Dowd noted that the applicant had two steroid injections for the left frozen shoulder with no help provided.

29. In a questionnaire response on 5 February 2018 to the respondent's insurer, Dr Mahmood stated that the right shoulder pain started first "then she started having left shoulder pain and stiffness. Restricted range of movement." He said the left shoulder was not as bad and "? Part of same process".

30. Bilateral shoulder symptoms continued. On 15 March 2018, Ms Whitson noted severe limited left shoulder movement compared to the right. She also noted that there was "intermittent stiffness and pain in her right shoulder, cervical spine, and thoracic area."

31. On 23 April 2018, Dr Mahmood noted left shoulder stiffness and pain persisting with some spasms on the left hand and fingers. There was persisting right wrist pain, tenderness and excessive sweating. He noted the applicant "needs cervical MRI scan" and arranged another ultrasound of the left shoulder. The reference to the radiologist concerning the cervical spine was "MRI scan – cervical spine (neck pain and stiffness radiated down to her left shoulder and left arm)".

32. The ultrasound of the left shoulder on 26 April 2018 again reported subacromial and subdeltoid bursitis.

33. The cervical spine MRI scan on 10 May 2018 reported widespread uncodiscarthrosis from C3/4 to C6/7 with posterior bulging with protrusions of the discs. There was foraminal narrowing and canal stenosis also.

34. Dr Mahmood reviewed the radiological findings on 22 May 2018. He said the MRI of the cervical spine showed "nothing serious" involving specialist review or local injection. In the left shoulder, he noted persistence of the bursitis and arthritis, again offering a local "HCS injection" and arranged it.

35. The contemporaneous medical evidence does not extend beyond May 2018, leaving the medicolegal reports to be dealt with below.

Forensic reports

36. I will deal with the forensic reports chronologically.

37. The respondent had the applicant examined by Dr Roger Rowe, orthopaedic surgeon on 13 September 2017 and a report of the same date is in evidence. Dr Rowe noted the initial incident on 20 January 2016 involving her right wrist and the intervention of Dr Dowd leading to the scaphoidectomy and capitolunate fusion in January 2017. He noted that after the operation the applicant wore a splint and a sling for a few weeks and then a moulded splint which she has worn on and off ever since. He then, without further elaboration, notes that on 21 August 2017 it appears that she had been given a stellate ganglion block into the neck for treatment of CRPS via a pain clinic specialist, Dr Deshpande (I have not been taken to any material from Dr Deshpande in evidence).

38. When reviewing her current symptoms, he noted the applicant said her right wrist had become progressively worse rather than better and she was never free of discomfort with constant aches. He noted relief for an hour to an hour and a half by taking tablets and some relief with hot and cold packs. He noted the applicant herself described developing "bilateral frozen shoulders as diagnosed on an ultrasound". He said that the symptoms in her right shoulder began about six weeks ago (which would make it early August 2017) and in the left shoulder about two weeks ago (early September 2017). Dr Rowe recorded the applicant reported that "both shoulders ache from time to time".

39. Dr Rowe recorded the applicant's description of her daily activity saying that she uses a chair in the shower and her husband had to help wash her. She could put on large loose clothing but her husband had to assist with her bra. She was able to wash some clothes but had the family hang them out. She could undertake basic cooking but was unable to peel vegetables, and could make coffee. She could do a bit of dusting with her left hand only, and undertook some minor tidying of the house.

40. I will not describe the detail of the examination of either forensic examiner as it appears that the applicant's presentation is markedly demonstrative (indeed, both Dr Rowe and Dr Giblin had difficulty obtaining a reliable and reproducible record of signs and symptoms). The applicant essentially demonstrated very little movement in the right arm (most joints). It is not clear whether Dr Rowe examined the left upper limb or the neck on his first examination at all.

41. He did, however, note without comment the left shoulder ultrasound report dated 18 August 2017 recording bursitis and effusion of the biceps sheaf.

42. Dr Rowe diagnosed a wrist injury and although he said there was "mention in some documents of CRPS" there was no evidence of that condition before him. He declined to assess assessment of impairment because he thought there may yet be some improvement given her attendance at the pain clinic.

43. The applicant's solicitor arranged examination by Dr Peter Giblin, orthopaedic surgeon on 25 July 2018. He noted the initial injury and the involvement of Dr Dowd leading to the surgeries. He recorded:

> "After the first operation, she developed a frozen right shoulder and had a two steroid injections, and then her neck became sore."

44. Curiously, after noting the further conservative treatment and medications, Dr Giblin records that the applicant had "a fall on 19 September" because of the drugs that she was on and they took her to Blacktown Hospital. "There were no fractures but both her shoulders had been sorer ever since".

45. Dr Giblin recorded the applicant's "main complaint is that her right arm is useless", wearing the splint to immobilise her right wrist. He continued:

> "She complains of sharp stabbing pains, aching, burning and pins and needles involving her entire right arm and she says that her neck is constantly stiff and sore.
>
> The left shoulder has become frozen and is too painful to move.
>
> She can still drive a motor vehicle if it is necessary.
>
> Around the house she describes herself as having severe problems in terms of her daily personal and household activities. There is a cleaning lady who comes in four hours every fortnight and her daughter assists with most other activities.
>
> At present, she said she cannot use her right arm for any functional activities and cannot sleep on it. She does not wear the wrist brace inside the house. …"

46. As noted above, the examination was problematic. Dr Giblin said the applicant would not let him move the right shoulder at all and any attempt at passive movement was resisted. The same occurred in the left elbow but he noted that the applicant was able to move her left elbow and shoulder in a fluid fashion "although through a diminished range of motion" during informal aspects of the examination. Dr Giblin noted the absence of typical CRPS signs such as temperature differences, radial pulses, sweating, or discolouration.

47. When examining the right upper limb (except for the right wrist), Dr Giblin noted that with "with some degree of encouragement and perseverance" exhibited a limited range of motion.

48. Dr Giblin noted the active range of motion in the cervical spine was also grossly limited in all directions with the presence of muscle spasm and tightening. He did not even assess tendon reflexes because he considered the applicant's allodynia was too severe to attempt.

49. Dr Giblin set out a long list of radiological investigations reviewed by him. In addition to the right wrist these involved the right shoulder including the ultrasound on 25 June 2016 and 4 August 2017. There was also left shoulder ultrasounds on 17 August 2017 and 26 April 2018. With the cervical spine, the only radiology was the MRI scan on 10 May 2018. He did not make any observations beyond that reported by the radiologists.

50. Dr Giblin's conclusions on diagnoses and causation was short and is set out as follows:

> "Based on her history and examination, she has the provisional diagnosis of a soft tissue injury to her right wrist, reasonably causally related to the subject injury of 20 January 2016, and then associated with compensatory and secondary injuries to her right shoulder, cervical spine and left shoulder."

51. He said that at the time of his examination the applicant's "right upper extremity has no functional value" and he was not satisfied that the left shoulder injury had stabilised.

52. Although Dr Giblin did not find any of the explicitly requirements for a diagnosis of CRPS based on the relevant assessment guidelines, he ultimately diagnosed Complex Regional Pain Syndrome concerning her "right upper extremity and cervical spine". He said:

> "The assessment process was complicated by some inconsistencies in relation to observed physical findings and complaints.
>
> I note the right upper extremity attracts 60% whole person impairment.
>
> I have made a geographic assessment that two-thirds of her right upper extremity is impaired which allocates 40% whole person impairment.
>
> I assign her a DRE 2 category to her cervical spine equating to 5% whole person impairment.
>
> I have not included activities of daily living on the basis that her restrictive functions are pertinent to her right arm injury."

53. In combination, these assessments produced 43% whole person impairment WPI. As noted, he deferred assessment in relation to "the left shoulder injury".

54. Dr Giblin examined the applicant again on 30 April 2019. He said there was no material change in that the applicant was still off work, had no further surgery, and was undergoing symptomatic management. He noted the continuing attendance at the pain clinic every two months with regularly changing medication.

55. He recorded the applicant as still complaining of “almost complete loss of function of her right upper extremity as well as pins and needles and sharp stabbing pain radiating down her left arm from her neck”.

56. Again, there was no active movement of the right upper limb joints and passive movement was vigorously resisted.

57. Again, Dr Giblin noted no trophic changes in the nail beds of the right hand, no dorsal oedema on the hand, no colour changes and no temperature differences in the right upper limb.

58. On the left, the applicant claimed “trigger fingers” but he could find no evidence of this on examination. “With some minor active resistance” he found a full range of motion in the left elbow, forearm, wrist, fingers and thumbs. Sensory testing to light touch was normal.

59. He said, “Repeated attempts to examine the range of motion of the left shoulder were not successful” but he could find no asymmetry in shoulder girdle muscles in terms of bulk.

60. For the left shoulder however, he noted the finding of bursitis in the ultrasounds in April 2018 and a further ultrasound of 11 April 2019 (not in evidence) which he said also reported ongoing bursitis features. On this basis, and in light of the difficulties that he had examining the limb, he assessed 2% WPI for the left upper limb based on a diagnosis of persisting bursitis.

61. Dr Giblin did note a previous injury disclosed to him in both examinations involving the right side of her neck and right shoulder in July 2005. He said a claim was “made and settled”, but she returned to work thereafter running a café and a Greek restaurant for some years with a described “full and uneventful recovery”.

62. Dr Rowe then re-examined the applicant on 19 September 2018 at the request of the respondent. He noted, in addition to the pain clinic, the applicant had also more recently attended a hand specialists, Dr Yee for a second opinion. There is no evidence from Dr Yee before me. There is mention of studies to investigate carpal tunnel syndrome but she had not been back to see him, so that potentiality has not been fully explored.

63. There was ongoing physiotherapy twice a week which was said to relieve tension in her neck and shoulders for a short period.

64. Ongoing complaints included right wrist ache at all times and no movement “whatsoever” in any of the hand, wrist or fingers. She described not using the right hand “for anything”. She also said there was no movement to the right shoulder and right elbow.

65. On the left, the shoulder is described as “sore and stiff”. Dr Rowe recorded the applicant saying that her left shoulder symptoms “were noted around six or seven months after the injury”, although the first recorded note of her left-sided symptoms appears to have been in March 2017 by Ms Whitson. He noted the applicant’s self-attribution of the left shoulder symptoms to overuse but Dr Rowe said, “in fact she has been doing next to nothing since the injury”.

66. In the neck, there was stiffness and ache intermittently, associated with headache.

67. Again, Dr Rowe recorded the applicant’s description of her daily activities with her daughter helping her to shower and dress, doing “all of the washing, cooking and most of the cleaning” with the additional assistance of a paid cleaner once a week for two hours. She could drive but preferred not to. He said the applicant attends a hairdresser “twice per week” to wash her hair because she could not wash it on her own.

68. On examination, again there were recorded significant difficulties. She would not demonstrate any movement of the hand or wrist or right shoulder. There was extremely limited movement of the right elbow. No symptoms or CRPS were observed by Dr Rowe.

69. On the left, he said there was no abnormality in the left hand, wrist or elbow. In the left shoulder, he said there was no local tenderness and no painful arc. Movements were variable and an average reduction in movement of the shoulder.

70. In the neck, he noted movements limited to about one half and reflexes were only able to be tested in the left arm.

71. Dr Rowe again concluded that there was an injury to the right wrist but he could find no evidence of CRPS. Because of the total loss of function demonstrated by the applicant in the right upper limb, he declined to assess impairment.

72. Dr Rowe accepted there was "presumably some cervical spondylosis given her years" but although discomfort from time to time may occur, there was no evidence to relate it to the injury or any evidence "that it is secondary to her right wrist injury".

73. He accepted that it may be possible for a frozen right shoulder to occur secondary to the original injury but was unsure whether it was present or not. He said it was "difficult to relate the left side in any way to the subject injury" without elaboration.

74. In all, he concluded:

> "It can be seen from my comments above, that it is my assessment that her neck and left shoulder symptoms are not secondary or consequential to the right arm injury."

SUBMISSIONS

75. Both counsel made submissions and I thank them for their assistance in guiding me through the material before me relevant to the remaining issues.

76. During submissions, I raised the comments made by Deputy President Roche in *Moon* regarding the inadequacy of the lay evidence.

Applicant's submissions

77. Mr Petrie for the applicant brought me through a concise chronology of contemporaneous evidence which I have attempted to reproduce above, so I will not repeat it. For the left shoulder, the applicant's submissions based on that contemporaneous evidence were that: there was an initial right wrist injury; this resulted in two surgical procedures, following which within about a month there was development of right sided complex regional pain symptoms which went on to become "severe" as described by Dr Dowd; within months of the completion of the surgery, the applicant was complaining of the onset of left upper limb symptoms – primarily the shoulder; by August 2017 there was the establishment of a frozen right shoulder; within one month there was the establishment of a "frozen left shoulder" and the general practitioner opined that it was possibly secondary to the right shoulder injury.

78. For the cervical spine, Mr Petrie conceded that the onset of symptoms has not been contemporaneously recorded until April 2018 and then in context of symptoms in the left hand and fingers. He said he could put it no higher than the summary opinion expressed by Dr Giblin set out above.

79. Mr Petrie conceded that Dr Giblin was not extensive in his explanation of the causal relationship between the initial injury and the right-sided symptoms to the left shoulder and cervical spine. He pointed out, however, that he clearly identified that it was a "compensatory or secondary injury" in both the cervical spine and left shoulder. Mr Petrie submitted that Dr Rowe, although he said he did not consider the left-sided neck symptoms to be related to the right injury, he did not consider the concept of compensatory use of the left upper limb (while it was still functional) for what was a severely disabled right upper limb, and he did not investigate or explain the relationship between cervical symptoms (or the absence) to the injury at all.

80. In relation to any criticism of the absence of any contemporaneous description of the activities of the applicant, and the evidence suggesting that the applicant was indeed very inactive (potentially relevant to the question of whether the left arm was used at all and in the context of the allegation of over-compensatory use), Mr Petrie pointed out that there is no suggestion of left arm symptoms until a couple of months after the final surgery, being of onset in March 2017. It is noted that the observations by Dr Rowe and the description he obtains as to the activities the applicant undertakes are well after that onset of left arm symptom and he described the situation where the applicant's disability had been compounded by bilateral activities as opposed to her activities resulting from her right upper limb injuries during the first year or so of her troubles following injury.

81. In relation to the fall referred to by Dr Giblin, he concedes that that seems to be rather strange but notes that Dr Giblin does not rely upon it for his conclusion in any event, referring to the left shoulder symptoms as being "compensatory". Further Dr Giblin merely said that the shoulders became "sorer" indicating that there was already the onset of the left shoulder symptoms in any event at the time of the alleged fall (if it occurred).

Respondent's submissions

82. Mr Baker, for the respondent submitted in general terms that the applicant does not put forward the requisite evidentiary material to demonstrate that the applicant, in fact, overused her the left upper limb. This undermines any expert conclusions based on that assumption.. Particularly he notes the total absence of any such evidence in the statement, as I have already noted above.

83. He submits that Dr Mahmood's evidence of the relationship of causal connection between left and right shoulders rises no higher than possibility and the applicant is required to establish the condition on the basis of probabilities.

84. Mr Baker said Dr Giblin's report is undermined by a number of matters. First, he noticed that the applicant reported a frozen right shoulder and her neck became sore very soon after the first operation. This is clearly not borne out on the contemporaneous evidence.

85. Secondly, Dr Giblin recorded that the applicant had a fall in December 2017 making both shoulders "sorer". Again, there is no contemporaneous evidence suggesting the fall, and there is no direct evidence from the applicant disclosing the nature of it. Clinical notes of Dr Mahmood on 21 December 2017 refer to persistent symptoms without any reference to a fall at all.

86. In relation to the left arm symptoms generally (as I understand it, in contrast to the left shoulder itself) Mr Baker submits that the general practitioner noted the pain was radiating from the neck into the left arm and arranged for an MRI scan in April 2018. He noted the generalised degenerative changes on the MRI scan which are conceded would possibly explain any symptoms complained of, but it does not establish a relationship to the original injury.

87. Mostly, Mr Baker was critical of the absence of any evidence of a description of the nature of the onset of the applicant's symptoms in either the left upper extremity or the neck. He notes the descriptions by the applicant indicate a severely debilitated woman who undertakes very little activity. He notes the description by Dr Rowe, culminating in his opinion that the applicant undertakes virtually no activities at all, and in the absence of any description of such activity in which the applicant used her left arm to compensate for her right arm injury, I would not be satisfied that the factual basis for a "compensatory" injury as concluded by Dr Giblin has been established.

88. As a result, Dr Giblin's opinion is undermined, and I would prefer the opinions of Dr Rowe both in relation to the left shoulder and the cervical spine.

89. Mr Baker noted the absence of any evidence from Dr Yee, who the applicant had recently seen in relation to a possible diagnosis of carpal tunnel, or of treating pain specialist, Dr Deshpande.

FINDINGS AND REASONS

90. It is clear that a finding of the compensable nature of a consequential condition must be determined in favour of the worker before that assessment of impairment from that condition can be referred to an Approved Medical Specialist (AMS) for assessment of impairment. This is the determination of "liability" required by s 293(3)(a) and s 321(4)(a) of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act).

91. It is common ground that the applicant need not establish an "injury" to the left shoulder and neck as required by s 4 of the *Workers Compensation Act 1987* (the 1987 Act)).

92. In *Kumar v Royal Comfort Bedding Pty Ltd* [2012] NSWWCCPD 8 (*Kumar*), Roche DP (at [55]) held that it was not necessary to establish that there was "significant pathology" in his shoulder, only that the proposed surgery was reasonably necessary as a result of the back injury on 19 March 2009. Mr Kumar's employer submitted that a finding of a consequential back condition by the Arbitrator was "not supported by reasoned opinion or change in pathology". His Honour rejected that submission, saying (at [136]), that the worker "did not have to show that the altercation caused a pathological change in his back, such as to support a s 4 injury".

93. That is, a diagnosis of pathology is not required for the applicant to succeed: *JR & DI Dunn Transport Pty Ltd v Wilkinson* [2015] NSWWCCPD 38, Keating J at [134]; *Trustees of the Roman Catholic Church for the Diocese of Parramatta v Brennan* [2016] NSWWCCPD 23; *Arquero v Shannons Anti Corrosion Engineers Pty Ltd* [2019] NSWWCCPD 3, Wood DP at [140].

94. Similarly, while the timing of contemporaneous complaint may be important when determining whether an injury has been established, the onset of a consequential condition may occur some time after the initial injury. However, the facts of each case will determine the importance of the time of onset.

The left shoulder

95. In this case, I accept the applicant's described timeline in submissions has been established: there was an initial right arm injury (wrist); this resulted in two surgical procedures, following which within about a month there was development of complex regional pain symptoms which went on to become "severe" as described by Dr Dowd; surgery to the right wrist in January 2017; the development of left shoulder symptoms by August 2017, during which time the applicant continued with gross symptoms in the right arm and a frozen right shoulder was diagnosed; within one month there was the establishment of a "frozen left shoulder".

96. The lack of lay evidence regarding the applicant's activities and the nature of and overuse or reliance upon the left arm (or neck) is unsatisfactory. However, when considering the probable use of the left arm, I also note Roche DP's comments in *Moon*, where he said of the probable effects of an injured arm on the contralateral limb, at [49]:

> "The connection between the left shoulder symptoms and the right shoulder injury – the overuse of the left shoulder as a result of restrictions in the right shoulder – is, in the circumstances of the present case, so obvious that it requires no further explanation by the medical experts (*Sydneywide Distributors Pty Ltd v Red Bull Australia Pty Ltd* [2002] FCAFC 157 at [88]- [89])."

97. Dr Rowe has assumed that the applicant has been almost totally inactive, and therefore the left arm has not been used, let alone overused. I accept, based on the chronology, that the left arm would obviously have been used in preference to the right until the left arm also became sore. This would have been through 2016 and 2017 after the surgery, leading to the first recorded onset of left shoulder problems by Ms Whitson in March 2017. Dr Rowe said that the symptoms in her right shoulder began about six weeks ago (which would make it early August 2017) and in the left shoulder about two weeks ago (early September 2017). I accept that the assumptions of the time of onset of left sided symptoms by Dr Rowe are incorrect and his assumptions contemplate the applicant's disability after bilateral problems existed.

98. I am satisfied and I find that the applicant probably did use her left arm excessively during 2016 and 2017 to protect the right wrist. I make this finding, despite an apparent incorrect assumption by Dr Giblin, that she developed a frozen right shoulder "after the first operation", which does not seem to be borne out by the contemporaneous evidence.

99. Dr Rowe accepted that it may be possible for a frozen right shoulder to occur secondary to the original injury but was unsure whether it was present or not. Although identification of pathology is not necessary, I am satisfied that the ultrasound findings of frozen shoulder in August 2017 undermine Dr Rowe's scepticism of the existence of adhesive capsulitis at any time, even though his findings at the time may have caused him to doubt the applicant's presentation at examination. When Dr Rowe concluded that it was "difficult to relate the left side in any way to the subject injury", he did so without elaboration.

100. In addition, I accept the conclusion by Dr Giblin, despite its brevity, that the condition in the left shoulder was "compensatory to", or resulted from, the right wrist injury. Although expressed as a possibility, short of probability, I also accept Dr Mahmood's view, that it was "secondary to" the wrist injury.

101. Causation is a question of fact: *March v E & MH Stramare Pty Ltd* [1991] HCA 12;171 CLR 506 per Mason CJ at [16]. It falls to be determined on a simple common sense test in accordance with *Kooragang Cement Pty Limited v Bates* (1994) 35 NSWLR 452; 10 NSWCCR 796 (*Kooragang*). I must feel actual persuasion of the occurrence or existence of the fact in issue before it can be found: *NOM v* DPP [2012] VSCA 198 at [124]. See also Dixon J in *Briginshaw v Briginshaw* [1938] HCA 34; 60 CLR 336

102. The Court of Appeal in *Nguyen v Cosmopolitan Homes* [2008] NSWCA 246 (*Nguyen*) summarised the approach as follows:

> "(1) A finding that a fact exists (or existed) requires that the evidence induce, in the mind of the fact-finder, an actual persuasion that the fact does (or at the relevant time did) exist;

(2) Where on the whole of the evidence such a feeling of actual persuasion is induced, so that the fact-finder finds that the probabilities of the fact's existence are greater than the possibilities of its non-existence, the burden of proof on the balance of probabilities may be satisfied;

(3) Where circumstantial evidence is relied upon, it is not in general necessary that all reasonable hypotheses consistent with the non- existence of a fact, or inconsistent with its existence, be excluded before the fact can be found; and

(4) A rational choice between competing hypotheses, informed by a sense of actual persuasion in favour of the choice made, will support a finding, on the balance of probabilities, as to the existence of the fact in issue." (at [55])

103. I am sufficiently persuaded that the left shoulder condition results from the right wrist injury.

104. As already noted, and pointed out by Mr Baker, Dr Giblin records that the applicant had "a fall on 19 September" because of the drugs that she was on, both her shoulders to be "sorer ever since". I am not dissuaded that this note implicates the fall as a causative factor, or undermines the effect of the over-reliance by the applicant upon her left arm. There is no contemporaneous record of any such fall in the general practitioner notes, or in Dr Dowd's records. Indeed, there is no evidence from the applicant herself that she was the subject of a fall in late 2017. In any event, Dr Giblin does not suggest that the fall has caused any of the subsequent problems, other than to perhaps increase the symptoms. There is an implicit acceptance that the symptoms already existed at the time of the fall, and there is no suggestion that the causal chain between the work related right-sided injury and the development of the left shoulder symptoms has been severed. Looked at another way, the principles regarding the question of causation in relation a consequential condition are set out above (*Kumar*). It is the general law approach to causation.

105. A condition can have multiple causes by events over a long period: *St George Leagues Club Ltd v Wretowska* [2013] NSWWCCPD 64 at [110]; *Mercer; ACQ Pty Ltd v Cook* [2009] HCA 28; and *ACQ Pty Ltd v Cook* [2009] HCA 28; 237 CLR 656 at [25] and [27] amongst others. Thus, the presence or suspicion of other factors implicated in the cause does not exclude a finding of causation: *March,* Mason CJ (at 509).

106. I also note Dr Giblin's record of previous injury to the right side of the applicant's neck and right shoulder in July 2005. In the applicant's direct evidence, however, she said that prior to commencement of employment with the respondent she had "not suffered any injuries in any employment or at any other time" and specifically said that she had "never made any previous claims for compensation or damages". It is noted that this statement is in February 2019. In contrast, Dr Giblin said a claim was "made and settled", but she returned to work thereafter running a café and a Greek restaurant for some years with a described "full and uneventful recovery". There is no suggestion on the evidence that there were any significant ongoing problems from that injury

107. Further, I do not consider Dr Giblin's assumption that applicant's recollection of a frozen right shoulder and her left shoulder became sore very soon after the first operation undermines his conclusion. While the assumption does not accord with contemporaneous evidence, the fundamental proposition, that the applicant overused her left arm because of significant difficulties she was having with her right arm (including a clinical diagnosis of CRPS by Dr Dowd) is made out.

108. Similarly, I do not accept Mr Baker's submission left arm pain was "radiating" from the neck into the left arm and leading to the MRI scan in April 2018 disclosing generalised degenerative changes undermines the applicant's case, or Dr Giblin's assumptions.

109. While Mr Baker noted the absence of any evidence from Dr Yee, concerning a possible diagnosis of carpal tunnel, that condition is not raised in the evidence otherwise, nor would it explain the left shoulder complaints and the radiological findings.

The neck

110. The first note of cervical problems seems to be on 15 March 2018, when Ms Whitson noted severe limited left shoulder movement and pain in her right shoulder, cervical spine, and thoracic area. Thereafter MRI scanning showed widespread uncodiscarthrosis from C3/4 to C6/7, disc bulges and foraminal narrowing and canal stenosis. Dr Mahmood considered these changes as "nothing serious".

111. Dr Giblin records the onset of neck soreness shortly after the first operation which occurred on 5 October 2016. The contemporaneous evidence is clearly inconsistent with this record.

112. Most telling, as properly conceded by Mr Petrie, is the absence of any expert analysis of the factual issue as to how a right wrist, or even arm injury is likely to lead to over-reliance on the cervical spine or otherwise place strain or pressure on the neck, so as to cause a cervical condition, even pain. The absence of lay evidence as to how the neck was or would be affected by the right arm injury, or even by the consequential left shoulder condition, is problematic. The common sense observation by Roche DP regarding the left/right shoulder effect in *Moon* is not so straight forward when one considers the cervical spine.

113. Accordingly, although I have found Dr Giblin's succinct conclusion as to a "secondary" condition involving the left shoulder persuasive, I am not similarly persuaded that the applicant has presented the evidence, factual or expert, to establish a secondary cervical condition. That is not to say the MRI findings are not likely to cause symptoms. I am not persuaded that there is a connection "so obvious that it requires no further explanation by the medical experts" between any neck symptoms and the injury to the right wrist or shoulder. I am also not persuaded that there is such a connection to the left shoulder condition.

114. There will be an Award for the respondent for the claim for the cervical spine.

SUMMARY

115. As the claim is for lump sums only, the matter must be remitted to the Registrar for referral to an AMS for assessment of impairment from the right wrist and left shoulder.