WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **4909-19**
Applicant: **Edwin Smith**
Respondent: **Scott Boxsell Transport Pty Ltd**
Date of Determination: **28 November 2019**
Citation: **[2019] NSWWCC 380**

The Commission determines:

1. Award for the respondent in respect of the claim for injury to the cervical spine.

2. Award for the respondent in respect of the claim for a consequential injury to the right upper extremity (shoulder).

3. The permanent impairment dispute in respect of the left upper extremity (shoulder) resulting from an injury on 28 February 2018 is remitted to the Registrar for referral to an Approved Medical Specialist for assessment of whole person impairment.

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

Deborah Moore
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 DEBORAH MOORE, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. The applicant, Edwin Smith, was employed by the respondent, Scott Boxsell Transport Pty Ltd as a truck driver.

2. On 28 February 20I8, as he was strapping a load on his truck using a ratchet, the ratchet gave way causing him to forcefully strike his left elbow.

3. He said that he experienced immediate discomfort involving his neck, left shoulder and left elbow.

4. He also said that subsequently, as a consequence of favouring his left shoulder, he developed pain in his right shoulder.

5. Liability for the left shoulder injury was accepted by the respondent's insurer, Employers Mutual Ltd, but declined in respect of the neck and the consequential right shoulder condition.

6. By an Application to Resolve a Dispute (the Application) registered in the Commission on 20 September 2019, the applicant claimed lump sum compensation for 25% whole person impairment (WPI) in respect of the cervical spine and both upper extremities.

ISSUES FOR DETERMINATION

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

    (a) Whether the applicant sustained an injury to his cervical spine and a consequential injury to his right upper extremity (shoulder) as a result of the incident on 28 February 2018.

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.

EVIDENCE

Documentary evidence

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

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

Oral evidence

10. Although the respondent had flagged at the teleconference that it may wish to cross-examine the applicant, at the hearing Counsel for the respondent did not press that issue. I formed the view that I had sufficient evidence before me to enable me to determine the matter without the need for oral evidence.

THE EVIDENCE DISCUSSED

11. In his statement dated 19 June 2019, the applicant said that at the time of the incident "I experienced immediate discomfort involving my neck, left shoulder and left elbow."

12. He added:

> "On 18 April 2018, Dr Leonello performed arthroscopic surgery to my left shoulder. Post operation, I underwent physiotherapy treatment and my condition slightly improved but still suffered from residual left shoulder pain and stiffness. I was also suffering from neck discomfort and stiffness.
>
> I did not report the neck injury at the time as I did not believe I had suffered a neck injury. Whenever I attended doctor and specialist appointments, I would primarily complain about my left shoulder pain as it was the part of the body that was causing me most discomfort.
>
> I started to not use my left shoulder as much since the date of injury and started to entirely rely upon my right shoulder and arm.
>
> Despite being at home and on worker's compensation, I still attempted to do what I could to help out my wife around the house…
>
> Washing up dishes with one hand is a very hard process. It would require significant force to be exerted by the right hand to scrub off anything…I would experience pain within the right shoulder. This repetitive motion of washing dishes and also placing plates and pans above shoulder height using only one limb…resulted in pain within the right shoulder at the end of the day.
>
> Hanging out washing with one arm… I found that reaching above shoulder height (right shoulder only) on these occasions would cause pain within the right shoulder which I had not experienced previously.
>
> I would also try and assist with general cleaning around the house including wiping up table tops and this would require repetitive movement of the right shoulder. I also generally relied upon the right shoulder to do even the most basic tasks around the house including picking up stuff off the floor and other such tasks which would cause pain within my right shoulder…
>
> Ever since the injury, I've had extreme pain within the left shoulder and this pain did not improve following surgery.
>
> I continue to rely upon the right shoulder to date to perform all activities at home…
> In respect of the neck injury that I have suffered, I wish to explain the lack of complaints that is reflected in the clinical notes that I have viewed. I am a lay individual. I am not medically trained. No investigations were conducted since I was referred to Dr Mohammed Assem for an independent medical examination on 20 February 2019. Investigations in respect of my neck injury did not occur until this time.

> I attribute entirely the neck pain that I am suffering and right shoulder pain to my injuries that I suffered in the course of employment with Scott Boxsell Transport Pty Limited.
>
> I believe that my focus was entirely upon the left shoulder as this was causing me the most pain. It continues to cause me the most discomfort to date. However, once consulting with Dr Mohammed Assem and now receiving appropriate treatment and control of the pain symptoms I was experiencing, I was able to identify that I am also suffering severe neck pain and that I had begun to rely upon the right shoulder constantly which has caused a deterioration and injury to same."

13. In his claim form completed on 7 March 2018, Mr Smith described the incident as "tightening up racket [sic] it gave way causing my left elbow to slam into trailer of truck."

14. His injuries he noted as "my left upper arm above elbow and left shoulder, cannot lift left arm. Very painful."

15. Dr Assem saw the applicant at the request of his solicitors on 20 February 2019, approximately one year after the injury. He obtained a history of the circumstances of the incident adding: "He experienced immediate discomfort involving his neck, left shoulder and left elbow."

16. Dr Assem continued:

> "Mr Smith stated that his neck symptoms have subsided. He experienced pins and needles involving the second, third and fourth digits of his left hand approximately one month ago and was admitted to hospital with a suspected cerebrovascular accident. His left elbow symptoms had subsided. There is still intermittent discomfort on the anterolateral aspect of his left shoulder associated with a restriction in movement."

17. On examination, Dr Assem said:

> "He reported tenderness over the left upper trapezius. There was no muscle guarding present. Cervical movements were within normal limits inflexion, extension, lateral flexion and rotation…
>
> There was sensory loss involving the left second, third and fourth digits that he attributed to his CVA but the distribution would suggest C6-7 radiculopathy. Further imaging would be necessary to accurately delineate the cause of his symptoms…I would therefore recommend an MRI scan of the cervical spine to exclude cervical radiculopathy."

18. Dr Assem diagnosed "Acute left rotator cuff tear requiring arthroscopic surgical decompression and repair [and] soft tissue injury [to the cervical spine] with possible radicular symptoms involving his left hand."

19. In a supplementary report dated 15 May 2019, Dr Assem merely stated:

> "Thank you for requesting a supplementary report on Mr Edwin Smith. The mechanism of injury described caused a severe jarring injury to his neck accompanied by an immediate onset of discomfort. His employment is therefore the main contributing factor to his cervical spine injury."

20. The terms of the request are not identified.

21. In a further report dated 24 June 2019, when asked the question “Is employment the substantial contributing factor to the development of our client's cervical spine injury sustained on 28 February 2018?” Dr Assem said:

> “Mr Smith reported immediate discomfort involving his neck, left shoulder and left elbow following the work-related injury on 28 February 2018. Dr Mitchell examined him on 5 March 2018 (one week after the injury) and noted mild tenderness over the left trapezius. However, there were no pins and needles/ numbness in his left arm. The above clinical records would suggest a jarring tissue injury to the cervical spine that gradually worsened due to postural abnormalities associated with his left shoulder injury. On the balance of probabilities, his employment is a substantial contributing factor to his cervical spine injury.

22. The next question asked was “Did our client's employment and the subject incident aggravate, accelerate or exacerbate underlying asymptomatic pathology within our client's cervical spine on 28 February 2018?” to which Dr Assem replied: “He has probably aggravated pre-existing long-standing degenerative pathology in the cervical spine rendering it symptomatic.”

23. Next, he was asked:

> “Has our client sustained a consequential injury to his right shoulder as a result of over reliance following his left shoulder injury? If so, please outline as to the activities in which you believe and the manner in which our client has sustained a consequential injury to his right shoulder as a result of the events which occurred in employ on 28 February 2018.”

24. Dr Assem replied:

> “Mr Smith reported the later development of pain in his right shoulder due to compensatory overuse. At the time of my previous assessment, he had mild right shoulder symptoms and a mild restriction in shoulder motion. However, I was not aware of a previous injury to his right shoulder following a truck accident ten years earlier that was documented by Dr Powell. He required surgical repair of the rotator cuff followed by a period of rehabilitation. I have therefore applied a one-tenth deduction for his right shoulder complaints.”

25. Asked to comment upon “the reliability and accuracy of Dr Powell's report enclosed”, Dr Assem said:

> “I would agree that the report of Dr Powell is accurate and correct with regards to the left elbow and left shoulder injury. However, there is evidence that there was a significant injury to the left shoulder causing immediate pain rather than the development of left shoulder pain due to postural abnormalities... I have expressed a different opinion about the injury to the cervical spine based on the information provided by Mr Smith and a review of the contemporaneous medical evidence showing that he had symptoms involving the left upper trapezius that most likely originating [sic] from the cervical spine.”

26. Dr Leonello was the applicant’s treating specialist. In a report to Dr Mitchell dated 20 March 2018, approximately one month after the injury, he said:

> “He was working when using a heavy ratchet strap that suddenly gave way causing him to land heavily onto his left elbow causing immediate pain in his shoulder with weakness and pain since. This occurred on the 28th of February. His symptoms have not settled with persistent weakness and pain since…

He has an acute work-related rotator cuff injury and this is full thickness and sizable enough to justify repair."

27. In a report dated 18 June 2018, Dr Leonello said:

> "Examination shows moderate stiffness of the shoulder but his pain and stiffness I have reassured him is still quite in keeping with the early recovery phase. His cuff mechanism is intact."

28. On 16 October 2018, Dr Leonello wrote:

> "Eddy is about six months after his rotator cuff repair on the left. His Oxford shoulder score is 38 and is a considerable improvement to his preoperative score and has noticed improvements…He is however still very deconditioned in his supraspinatus function but maintains good infraspinatus and subscapularis . Elevation mobility is also reduced but I have reassured him that it is still relatively early stages in his recovery and at this stage he can continue a graduated strength program."

29. On 15 January 2019, Dr Leonello wrote: "I think he has signs of post-operative frozen shoulder which is not uncommon…"

30. On 25 February 2019, following an MRI of the left shoulder, Dr Leonello said: "Eddie's shoulder continues to be moderately stiff but still better than pre-operatively. His MRI reassuringly shows his rotator cuff as intact."

31. He added:

> "Additionally, he has some neuropathic symptoms in his hands and I wonder if these are cervicogenic in nature. He will have his MRI soon. It also may be carpal tunnel syndrome and some nerve conduction studies would be of use which I have ordered."

32. An MRI of the cervical spine performed on 26 February 2019 reported:

> "Cervical ribs, larger on the right than the left. Degenerate change including posterior disc protrusion at C6-7 mild to moderately effacing the thecal sac. Areas of mild to moderate foraminal effacement including on the left at C3-4."

33. The applicant was then seen by Dr Lee, Associate Professor of Neurology, on 12 March 2019. He performed nerve conduction studies and said:

> "He presents with the issue of sensory disturbances of digits 1-3 bilaterally. The electrophysiology does show evidence of bilateral carpal tunnel syndrome. I have explained to him the anatomy and physiology behind carpal tunnel syndrome and the rationale for seeking a surgical opinion for a carpal tunnel release."

34. Clinical notes produced by the general practitioners at Mount Gambier disclose that the applicant first attended there on 5 March 2018 and saw Dr Mitchell. The entry reads:

> "Injury at work last week on 28.02.2018. Was pulling down ratchet strap with both hands, strap gave way and he landed on the truck with full body weight going through left elbow and jarred left shoulder. Pain and reduced movement since. Has been resting, using deep heat and pm ibuprofen. No pins and needles/numbness left arm. Right hand dominant. No previous injury to left shoulder. Tender over AC joint. Tender over biceps. C-spine - full range of motion, some mild tenderness over left trap. rotator cuff injury? Bursitis?"

35. The notes continue up to 25 January 2019.

36. There is no reference to any neck pain or right shoulder pain.

37. A number of medical certificates included in the Application also only make reference to a left shoulder injury.

38. Dr Powell saw the applicant at the request of the insurer on 29 April 2019. In a report of the same date he said:

> "He was pulling down on the straps using the ratchet. He was standing on the ground next to the tray pulling down on the ratchet which was in the final stages of securing, requiring two hands and full body weight to keep the best tightness. As he did this, the ratchet broke and his left arm came down heavily on the edge of the tray striking the posterior aspect of the left elbow with the elbow flexed.
>
> There were no other injuries at the time.
>
> He had immediate pain from the elbow up to the shoulder through the arm indicating over the deltoid area, lateral and posterior elbow region.
>
> On 18 April 2018, he had arthroscopic rotator cuff repair performed, a subacromial decompression and biceps tenodesis.
>
> There has been improvement in his shoulder but he has continued difficulties.
>
> He has, since the operation, developed headaches which have persisted.
>
> Recent investigations have identified difficulties in the cervical spine.
>
> Since the incident, he has been aware of pins and needles and tingling in the left hand on the dorsal aspect of the index, long, and ring fingers that have persisted. This is present most of the time. It has not been altered by the surgery (he has been advised he has some carpal tunnel difficulties).
>
> Prior to the incident of February 2018, he had no previous injuries nor symptoms involving the left shoulder region nor arm.
>
> He is right handed.
>
> Some 10 years ago, he did his right rotator cuff in a truck accident and had rotator cuff repair…and after a period of rehabilitation, he regained good function about the shoulder which has continued to the present."

39. On examination, Dr Powell said:

> "Cervical Spine: He is not particularly tender at the neck apart from slight tenderness at the base to deep palpation. Range of motion is markedly restricted globally with elevation just above visual horizon. Lateral flexion and rotation are reduced to both left and right, symmetrically without guarding or obvious irritation…
>
> Power showed slight reduction of sustained grip in the left hand. Power in other muscle groups appeared symmetric and normal about the elbow down to the wrist and hand. Intrinsic function was intact and sound. (It was difficult to test power about the left shoulder due to irritability).
>
> Left Shoulder: At the left shoulder, there is slight wasting of the supraspinatus deltoid region compared to the opposite side… There is prominence of the acromioclavicular joints on both sides though tender on the left. There was tenderness in the supraclavicular fossa and supraspinatus fossa extending out to the acromion and over

the lateral aspect of the humeral head.

At the right shoulder, there was no tenderness to right palpation. Range of motion showed flexion to 180°, extension to 40°, abduction to 160° with adduction to 20°. External rotation was to 60° and internal rotation was to 60° with the rotator cuff being clinically intact."

40. Although Mr Smith did not bring any investigations with him, Dr Powell then said:

> "Dr Leonello, in his letter to Mr Smith's GP, of 20 March 2018 indicates that a plain X-ray of the shoulder showed some subacromial spurring and enthesopathy change at the greater tuberosity. An ultrasound was consistent with a full thickness retracted tear of the "supraspinatus". MRI of the cervical spine from 26 February 2019 reported the patient showed cervical ribs larger on the right than the left with degenerate change including posterior disc protrusion and C6/7 mild to moderate effacement of the thecal sac, with areas of mild to moderate foraminal effacement including on the left at C3/4."

41. In summarising his opinion, Dr Powell said:

> "Mr Smith developed left elbow to shoulder region pain with sudden impact to the left elbow when the ratchet that he was pulling down heavily on gave way while loading his truck in February 2018. He did not fall and there were no other injuries at the time.
>
> He was found to have rotator cuff pathology and came to arthroscopic repair, subacromial decompression and biceps tenodesis. He has some residual stiffness and irritability at the shoulder. He has been found to have some cervical ribs and cervical spondylitic change on imaging."

42. "Current complaints" were noted as follows:

> "principally stiffness at the left shoulder noted in reduced ability to elevate the arm above shoulder height and to rotate the arm particularly behind his back. He gets discomfort about the shoulder area following a period of activity of the left upper limb and utilises analgesics taken daily. Since the incident, he has suffered headaches frequently. He has also noticed a feeling of pins and needles involving the left index, long and ring fingers that persist."

43. As regards his diagnosis, Dr Powell said:

> "It is difficult to provide a precise diagnosis, there being minimal imaging and other information available. Upon the information available as outlined above of the mechanism of the incident, it is most likely that Mr Smith suffered a direct contusion to the posterior aspect of the left elbow against a truck tray which has resolved with no ongoing difficulties. (The expected natural history).
>
> The imaging identified by Dr Leonello indicates that Mr Smith had longstanding changes involving the rotator cuff at the left shoulder region with enthesopathy noted on plain X-ray in the greater tuberosity. Rotator cuff tendinopathy, with or without structural failure, is common through the community with varying degrees of functional and symptomatic presentation.
>
> The changes, including tendon failure, become more frequent with advancing age to the point where they are largely endemic in the older population. Imaging changes take some time to develop and indicate that he had some degree of rotator cuff tendinopathy without any apparent symptoms developing for some time prior to the incident. (This is also on a background of having had rotator cuff failure requiring repair some years previously on the opposite side).

He is also an insulin dependent diabetic of some 10 years standing, which may also have contributed to soft tissue and connective tissue failure along with age and other constitutional factors.

At the time, there was sudden impact to the left upper limb while applying complex load through the upper limbs and given the symptoms that he described, and reduced ability to elevate the left arm at the shoulder, it is most likely that a component of the acute presentation was extension of structural failure of components at the rotator cuff (most likely supraspinatus and possibly involving long head of biceps acutely or acute on chronic).
Currently, he is post-surgical repair of left rotator cuff including supraspinatus repair, biceps tenodesis with subacromial decompression. (His imaging indicates that he had early changes of impingement which is also constitutional and age related in nature and may or may not have been symptomatic…

He indicated that he was found to have carpal tunnel changes and this would suggest that he has had nerve conduction studies. The distribution of symptoms in the hand does suggest a local median nerve compression neuropathy as a possible explanation for these symptoms. The ENG changes however are common with advancing age and also with diabetes and may, or may not, be associated with clinical carpal tunnel syndrome.

Imaging at the cervical spine has identified multilevel cervical spondylosis from the mid to the lower cervical spine, a condition which is common in his age group and is principally constitutional and age-related in nature. He has also been identified as having bilateral cervical ribs more developed on the left and incomplete on the right (this is likely to be completed by a fibrous band which may not be evident on imaging).

He shows signs of having cervical spondylosis with neck stiffness. Despite the cervical rib there were no signs nor symptoms to suggest a lower brachial plexus root irritation and the sensory alteration is very confined and does not suggest a radicular origin and certainly not the lower brachial plexus rib component. These right ribs were an incidental finding that currently do not appear to be causing any clinical signs or symptoms.

As far as I can determine, with respect to the work incident on 24 February 2018, Mr Smith suffered extension of the left rotator cuff structural failure for which he has had operative repair and currently has post-injury and post-surgical left shoulder stiffness."

44. Dr Powell was then asked this question:

> *"Do you agree/disagree with Dr Assam's opinion that the claimant sustained injury to his cervical spine as a result of a 'severe jarring injury'? Why/why not?"*

45. He replied:

> "There is no indication from Mr Smith's description of the mechanism of injury nor a description of subsequent history, that he suffered any injury to the cervical region, direct or indirect.

He was performing a complex activity, pulling down on straps, the load being transmitted principally through the upper limbs to the torso to the ground but not directly involving the head and neck region with the sudden loss of control on impact on the left upper limb but without sufficient force to knock him over and while he may have had some jarring of various muscles in the limb girdle, with the sudden release and subsequent impact in the "jarring" injury would be confined to muscular structures and would be temporary.

These injuries proceeded through their natural history of inflammation and repair over several weeks. Tendon component was isolated to those of the left rotator cuff supraspinatus bicep and as these do not spontaneously repair were managed surgically."

46. He added:

"Cervical spondylosis will proceed along with its natural history.

He has been found to have a cervical rib as in incidental finding and this is a congenital abnormality which has been present all his life, without any apparent ill-effect in the various occupations and activities he has undertaken over many years. However, a cervical rib, particularly in the place of incomplete and with a possible fibrous band, may cause some local deformity of neural structures exiting from the cervical spine and contributing to the brachial plexus can increase susceptibility to neurologic disorder over time…

Neurologic symptoms in the upper limbs can frequently be associated with postural change, particularly drooping of the upper limb through lack of exercise, weakness through reduced use and so on. Mr Smith, with the anatomic abnormality of the cervical region, has an increased susceptibility to the effects of such postural change (even now, he tends to carry his left upper limb around with him with reduced spontaneous use)."

47. Dr Powell assessed 11% WPI in respect of the left upper extremity (shoulder). He added: "There is no assessable impairment in the cervical region, there being no injury to the cervical spine and no impact to cervical pathology by the left shoulder injury, neither directly nor indirectly."

48. Subsequently, Dr Powell was asked: "*Whether…there is any right shoulder involvement in the patient? Particularly if there is any 'over-compensation' in the right shoulder due to the left shoulder being injured?*

49. In a report dated 25 September 2019, he said:

"At the right shoulder he has a pre-existing condition.

He had had a rotator cuff repair some 10 years previously. Although the details of this injury and the state of his rotator cuff at the time are not clear, given his presentation and other co-morbidities it is likely that there is some combination of some form of focal injury on a background of degenerate disease.

Mr Smith has been diabetic for more than 10 years and is now on insulin and there has been some difficulty with control.

Diabetes is a condition that has effects through the body, potentially on all the body's systems given its nature and difficulties of control. It can be associated with weakening of the connective tissues and contribute to structural failure of connective tissues such as rotator cuff tendons and is also associated with inflammatory difficulties and responses in connective and other tissues.

Mr Smith is also exposed through general constitutional age-related factors that affect his body generally and in particular soft tissue components such as rotator cuff tendons notwithstanding the other co-morbidities.

He therefore has a number of factors that influence deterioration of the right shoulder. He is right handed…

In view of coping with the difficulties with his left shoulder and post-operative care, it is likely that he did have a slight dependence upon the right upper limb. This might increase the number of times he moves his shoulder per day to do his day to day activities. This slight alteration in demand is well within the parameters of a normal shoulder that can adequately handle such demand and would not be expected to result in injury.

However, where the tissues have deteriorated to a point where they have little in reserve, a slight change in demand in such circumstances can result in development of pain symptoms. These pain symptoms are nociceptive and draw the patient's attention to the compromised right shoulder region fairly quickly so that the patient can take appropriate action and diminish exposure of the region to load and thus reducing the potential for aggravation of the failing shoulder certainly well before causing actual injury. (It is very difficult for an individual to self-harm voluntarily.)

When biologic tissues are exposed to repetitive non-lethal demand the response is for hypertrophy and to get stronger. This further reduces the potential for actual harm to occur to anatomic structures. (This forms the basis of the benefit of exercise and enhancing performance with exercise and perseverance.)

He does have a disease process and age-related processes that are reducing the efficiency of the right shoulder and its associated tissues and thus reducing capacity. These are natural processes and pre-existing and are unrelated to the effect of injury and surgery on the left upper limb."

50. A number of rehabilitation reports included in the Reply made reference only to the injury to the left shoulder.

FINDINGS AND REASONS

51. The applicant bears the onus of proving that his alleged injuries are work-related. In determining the cause of an injury, the Commission must apply a common-sense test of causation. In the workers compensation context, the appropriate test for causation was set out by Kirby P (as he then was) in *Kooragang Cement Pty Ltd v Bates* (1994) 10 NSWCCR 796 where his Honour said:

"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… What is required is a common-sense evaluation of the causal chain…"

52. There is a useful review of the authorities concerning the issue of injury in *Castro v State Transit Authority (NSW)* [2000] NSWCC 12; (2000) 19 NSWCCR 496. That case makes clear that what is required to constitute "injury" is a "sudden or identifiable pathological change". In *Castro* a temporary physiological change in the body's functioning without pathological change, did not constitute injury.

53. Liability for an employer to pay compensation pursuant to s 9 is limited by the requirement under s 9A that employment is a substantial contributing factor to the injury. Section 9A was introduced shortly after the High Court's decision in *Zickar v MGH Plastic Industries Pty Ltd* [1996] HCA 31; 187 CLR 310, and relevantly provides:

> "No compensation is payable under this Act in respect of an injury (other than a disease injury) unless the employment concerned was a substantial contributing factor to the injury.
>
> Note: In the case of a disease injury, the worker's employment must be the main contributing factor. See section 4."

54. Subsection (2) of section 9A provides examples of matters to be taken into account in determining whether employment was a substantial contributing factor. The list, which is not exhaustive, has six examples:

    (a) the time and place of the injury,

    (b) the nature of the work performed and the particular tasks of that work,

    (c) the duration of the employment,

    (d) the probability that the injury or a similar injury would have happened anyway, at about the same time or at the same stage of the worker's life, if he or she had not been at work or had not worked in that employment,

    (e) the worker's state of health before the injury and the existence of any hereditary risks,

    (f) the worker's lifestyle and his or her activities outside the workplace.

55. Dealing firstly with the claimed injury to the cervical spine, Counsel for the applicant submitted that the failure to report complaints of symptoms in the neck is explained both by the applicant in his statement and Dr Assem. It was following treatment and further investigations that pathology in the cervical spine was identified.

56. It was further submitted that the force of the impact injury to the left elbow, as documented by all the doctors, was consistent with the conclusion by Dr Assem that such an injury would affect the cervical spine.

57. In short, it was submitted that despite the lack of complaints of neck pain, based on the report of Dr Assem, the applicant's history and statement, and "persistent neurological type complaints," I would be satisfied that the applicant sustained an aggravation injury to his cervical spine.

58. Further, it was submitted that Dr Powell did not deal discreetly with the cervical spine. His reference to a "temporary aggravation" I should infer includes the cervical spine.

59. I do not doubt the applicant's description of his injury: it has been relatively consistent throughout.

60. What I do have difficulty in accepting is that he did not once mention any symptoms in his neck to any of his treating doctors. His assertion in his statement that "I am a lay individua - I am not medically trained…" does not seem to me to be a credible explanation for the lack of complaints. I cannot accept that even a "lay" individual would not mention pain if it were present.

61. When the applicant presented to Dr Mitchell on 5 March 2018, examination reported: "C-spine - full range of motion, some mild tenderness over left trap." Symptoms then were confined to the shoulder and left trapezius, not the neck.

62. This is very similar to his presentation to Dr Assem who noted: "He reported tenderness over the left upper trapezius. There was no muscle guarding present. Cervical movements were within normal limits…"

63. Ultimately, as is often the case in the Commission, I am faced with two competing medical opinions: those of Dr Assem and Dr Powell. Dr Leonello of course did not address this issue directly, because the history he obtained was of an injury to the left shoulder only.

64. I find Dr Powell's opinion persuasive. He has explained in considerable detail how the mechanism of the injury would not cause an injury to the cervical spine. He has also provided a clear explanation for the "persistent neurological type complaints" referred to by Counsel for the applicant.

65. These complaints have subsequently been identified as resulting from a bilateral carpal tunnel condition.

66. The applicant said: "However, once consulting with Dr Mohammed Assem and now receiving appropriate treatment and control of the pain symptoms I was experiencing, I was able to identify that I am also suffering severe neck pain and that I had begun to rely upon the right shoulder constantly which has caused a deterioration and injury to same."

67. Yet Dr Assem obtained a history that the applicant experienced "immediate discomfort involving his neck, left shoulder and left elbow…" This in my view is inconsistent with the applicant's statement which suggests that he only "identified" symptoms in his neck after consulting with Dr Assem.

68. Curiously, Dr Assem stated "his neck symptoms have subsided" which seems inconsistent with the applicant's statement as to the severity of his neck symptoms.

69. I should add that Dr Assem diagnosed "possible radicular symptoms involving his left hand" which as I said, having been investigated by Dr Leonello and Dr Lee now relate to carpal tunnel syndrome.

70. Indeed, Dr Leonello eventually noted "some neuropathic symptoms in his hands" which he wondered "if these are cervicogenic in nature… It also may be carpal tunnel syndrome…" thus he ordered and some nerve conduction studies which confirmed his diagnosis.

71. For these reasons, I am not persuaded that the applicant has demonstrated that he suffered an injury to his cervical spine in accordance with the legislation to which I have referred above.

72. Turning to the issue of the consequential injury to the right shoulder, I note at the start that Dr Assem made no reference to any right shoulder condition until he was specifically asked "Has our client sustained a consequential injury to his right shoulder as a result of over reliance following his left shoulder injury?"

73. A leading question without doubt, especially in the context of his initial examination and report where no mention of symptoms in the right shoulder was made.

74. Indeed, in his statement the applicant focussed more on the sorts of activities he was preforming with his right arm (noting he is right hand dominant) rather than any specific symptoms other than a mention of "pain."

75. Again, it is Dr Powell who has carefully explained the reasons why he believes that this is not so, not only in terms of the beneficial aspects of normal use of a limb but also the consequences of other medical conditions the applicant suffers.

76. In *Trustees of the Roman Catholic Church for the Diocese of Parramatta v Brennan* [2016] NSWWCCPD 23 (*Brennan*) Deputy President Snell dealt with the question of a consequential injury. He summarised a number of Presidential decisions concerning consequential injury, including *Kumar v Royal Comfort Bedding* [2012] NSWWCCPD 8 (*Kumar*), as follows:

> "100. There have been a number of Presidential decisions dealing with the nature of claims in respect of consequential conditions. The principles are described in a number of these decisions, for example *Moon v Conmah Pty Limited* [2009] NSWWCCPD 134 (*Moon*) and (*Kumar*). It is unnecessary for a worker alleging such a condition to establish that it is an 'injury' (including 'injury' based on the 'disease' provisions) within the meaning of s 4 of the 1987 Act."

77. The test of causation in a claim for lump sum compensation is the same as it is in a claim for weekly compensation, namely, has the loss 'resulted from' the relevant work injury. It is not a question merely of symptoms – there must be evidence of a loss arising from the primary injury which provoked the consequential injury.

78. I have been unable to identify any radiological evidence in respect of the right shoulder.

79. Given the lack of complaints of symptoms in the right shoulder, the assumptions made by Dr Assem and the detailed explanations provided by Dr Powell as to other causes for any such symptoms, I am not satisfied that the applicant has discharged his onus of proof in establishing that he sustained a consequential condition in his right shoulder resulting from the injury to his left shoulder.

SUMMARY

80. For these reasons, there will be an award in favour of the respondent in respect of the claim for injury to the cervical spine and a consequential injury to the right upper extremity (shoulder).

81. The claim for whole person impairment in respect of the left upper extremity (shoulder) will be remitted for assessment by an Approved Medical Specialist.