WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**5284/19**
Applicant:	**Dale Slade**
Respondent:	**Peter James Rogers t/as The Little Green Truck Mid North Coast**
Date of Determination:	**12 December 2019**
Citation:	**[2019] NSWWCC 404**

The Commission determines:

1. There is an Award for the respondent with respect to the applicant's claim for a consequential or secondary condition in his right shoulder as a result of injury to the left shoulder and/or cervical spine on 24 October 2016.

2. 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 24 October 2016.
    (b) Body System: Cervical Spine and Left Upper Extremity (shoulder) - both frank injuries.
    (c) Documents to be provided to Approved Medical Specialist (with attachments unless excluded):

        (i) The Application to Resolve a Dispute.

        (ii) The Reply and Application to Admit Late Documents dated 4 November 2019.

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.

A Reynolds

Antony Reynolds
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Dale Slade (the applicant) claims lump sum compensation for impairments arising from injuries allegedly sustained in an incident on the 24 October 2016 whilst employed by Peter Rogers t/as Little Green Truck Mid North Coast (the Respondent).

2. There is no dispute that an incident occurred, and the Respondent accepts that a left shoulder injury was sustained as a result. However, the applicant also claims impairments arising from injury to the cervical spine in the incident. He also claims impairment arising from a consequential condition in his right shoulder. This is said to arise as a result of, firstly the increased use of his right arm as a result of symptoms in the left shoulder and/or the cervical spine; and secondly, as a result of muscle wasting around his right shoulder (agreed to be due to the pathological condition in the applicant's cervical spine) and alleged injury in his cervical spine.

3. The applicant's claim is based on a medico-legal assessment by Dr James Bodel, Orthopaedic Surgeon, in a report dated 28 November 2018. Dr Bodel assesses 27% whole person impairment (WPI) arising from the cervical spine (25% WPI from the spine itself and 2% WPI for interference with activities and daily living (ADLs)), 6% WPI from the left upper extremity (shoulder), and 6% WPI from the right upper extremity (shoulder). The total impairment claim is 35% WPI.

ISSUES FOR DETERMINATION

4. The issues to determine are:

    (a) Whether the applicant suffered injury by way of a frank aggravation of an underlying degenerative condition in his cervical spine pursuant to s 4(a) or s 4(b)(ii) of the *Workers Compensation Act 1987* (1987 Act) on 24 October 2016; and/or

    (b) Whether, as a result of the accepted left shoulder injury and/or the cervical spine injury (if proven) the applicant developed a consequential condition in his right shoulder.

5. The parties agree that if injury to the cervical spine, or a consequential condition in the right upper extremity is determined in favour of the applicant, the matter must be referred to an Approved Medical Specialist (AMS) for assessment of overall impairment as a result of the injury.

PROCEDURE BEFORE THE COMMISSION

6. The parties attended arbitration in Port Macquarie on 26 November 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.

7. Mr Hunt of counsel appeared for the applicant who was also present. Mr Doak of counsel appeared for the respondent.

EVIDENCE

Documentary evidence

8. 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;
    (b) Reply; and
    (c) Application to Admit Late Documents dated 4 November 2019.

9. There was no oral evidence or cross examination.

FURTHER BACKGROUND AND THE EVIDENCE

Applicant's Statement dated 4 October 2019

10. The applicant describes pursuing an apprenticeship as a diesel mechanic, and subsequently working as a truck driver from the age of about 24 years. He says he commenced work with the Respondent in 2013, although this may be inaccurate, as clinical notes refer to losing a job in August 2014 and first mention being employed by the Respondent on 22 September 2015. Nevertheless, as this is a frank injury only, this is of little moment.

11. The first evidence from the applicant is a statement dated 4 October 2019. There are no statement more contemporaneous to the injury and the development of symptoms. In this statement the applicant describes delivering a wooden wall unit on 24 October 2016, with him carrying the large unit upstairs. It seems from other evidence that he was assisted by another worker. He says,

    > "While navigating the stairs I lost my footing, fell down three stairs, I felt a sudden sharp pain in my left shoulder and left hip [sic]."

12. He says he has seen his General Practitioner (GP), Dr Adrian Smith, and Orthopaedic Surgeons Dr Liaw and Dr Ralph Stanford (a spine surgeon).

13. His statement thereafter largely chronicles attendances on various doctors and what the applicant says was said, noted or reported. However, I rely upon the direct evidence in medical reports and clinical notes in that regard. In any event, after treatment for the left shoulder and investigations by Dr Liaw, it was considered that his arm symptoms were largely deriving from cervical pathology. He was referred to and came to surgery by Dr Stanford on 24 Jan 2018 by way of anterior cervical discectomy and fusion at C4/5 and C5/6. This surgery was approved and paid for by the Respondent's insurer.

14. Although it oddly expressed in the statement by referring to Dr Stanford's reports, I accept that the statement endorses the fact that the surgery contributed to increased coordination in his fingers and the range of motion in his neck. Due to the muscle wasting in the right shoulder, physiotherapy was pursued.

15. In relation to the development of his claimed consequential or secondary condition in his right shoulder he says:

    > "As a result of my workplace injuries I have begun over-compensating with my right arm for everyday tasks. Due to this over-reliance of my right arm

> and the muscle wasting that I have in my right shoulder I suffer from constant pain. I have a restricted range of motion in both my left and right shoulder and I can no longer either arm [sic] above shoulder height without aggravating the pain. I have a constant tingling sensation in my neck which becomes painful whenever I use my left or right shoulder. . .”

16. The applicant says he is restricted in tasks involving lifting, carrying, pushing and pulling and he continues to experience pain. This has curtailed his pre-injury activities and self-care. His pre-injury hobbies included fishing, surfing, boating, tennis, swimming and camping.

GP Notes: Port Macquarie Medical and Dental

17. Clinical notes before me date back to the year 2000. I have reviewed these notes carefully and the following entries are of some significance, some more relevant than others.

18. On 13 Jan 2002 a record indicates “S&S” (which I interpreted to mean symptoms and signs) of rotator cuff tendonitis, without identifying which shoulder. An ultrasound was ordered. I have not been able to locate the report of that investigation in evidence. The following day, a note records that the right shoulder was still painful but better. There was reduced range of motion and the record says there was no history of injury. I conclude that the notes relate to the right shoulder.

19. I then see no further relevant entries until 26 December 2012 when a note records right shoulder pain for four months with the notation “? Rotator cuff injury/tear”. An examination revealed no tenderness, swelling or deformity but range of movement in abduction was restricted to 90% and impingement was negative. An ultrasound was ordered but I have not been taken to the results of that study, either. The applicant had attended for left-sided rib cage pain after a fall two days prior, and X-rays of the rib were ordered as well.

20. The following day, 27 December 2012 a note reports that the rib X-rays reported no obvious fracture but make no mention of any ultrasound report.

21. I did not discern any further relevant entries until the 9 October 2015. A note reports a right rib fracture following a four metre fall at work. From further clinical notes, this fall seems to have created some friction in the workplace, however it seems that on 8 November 2015 the applicant was certified “medically fit” to return to work on 23 November 2015.

22. There are no further relevant entries until after the subject injury which is said to have occurred on about 24 October 2016. The applicant’s description of that injury is set out above. The first recorded attendance on any practitioner after the injury by the applicant is not until 21 November 2016 where the record says:

> “Left shoulder pain for three weeks.
>
> Fall fracturing ribs three months ago [sic] – otherwise no recent injury but does a lot of heavy lifting with work.
>
> **Examination:** Left shoulder-pain in superior aspect shoulder extending into trapezius.
>
> **Actions:** Diagnostic imaging requested: X-ray left shoulder: ultrasound left shoulder.”

23. A medical certificate was said to have been provided but I have not been taken to that certificate.

24. There are then a number of attendances on the GP citing only the left shoulder with no reference to the neck, or right shoulder. On 24 November 2016 an ultrasound of the left shoulder occurred. This was reported to show sub-scapular tendinopathy and sub-acromial bursitis. A shoulder injection was organised and subsequently occurred.

25. On 2 December 2016 a certificate of capacity was completed by the GP. The applicant has recorded this:

> "Started with a fall, no injury register, got worse with time."

26. In the certificate, the applicant referred to the previous fall in 2015 fracturing his ribs, disclosing that there were no workers compensation records but there were records at the Port Macquarie Base Hospital.

27. On 10 Jan 2017 the GP noted pain and tenderness at the proximal part of the shoulder and around the base of the neck laterally and referred the applicant to a physiotherapist, Mr Murray, who practices in the same clinic. The referral by the GP still referred only to the left shoulder. The applicant saw Mr Murray that same day and his clinical notes appear in the same record. He recorded the history of a "slip down steps while carrying furniture". He noted the applicant had been off work with left shoulder pain and restriction. He also noted a decrease in sensation in the upper arm and referred to an "old neck injury" which has not been elaborated upon. The applicant had displayed increased anxiety and Mr Murray said the applicant was "more troubled by lack of strength and mobility than pain". A restricted range of movement and power in external rotation in the shoulder was said to be weak. C4/5 was "stiff and sore".

28. On 13 January 2017 Mr Murray again treated the applicant repeating the same clinical notes as in the first attendance, however this time Mr Murray added "Cx traction". Mr Murray continued to treat the applicant over a number of months, recording substantially the same information.

29. On 10 February 2017 the GP noted continuing improvement in the left shoulder but there had been intermittent numbness in the right hand which he attributed to a potential carpal tunnel syndrome on the right. He said the cervical spine was not tender and there was good range of motion.

30. The GP seemed to remain unaware of any implication of the cervical spine or of Mr Murray's observation of C4/5, stiffness and soreness, as over the subsequent several consultations all attentions were to the left shoulder and there were no recorded complaints of neck symptoms.

31. In May 2017 Mr Murray suggested to the GP that a referral to an orthopaedic specialist would be of benefit due to the length of time from injury.

32. In the context of subsequent consultations with specialists, however, it seems that neurological issues are more pertinent than neck pain. Eventually, the applicant was referred to Dr Liaw, Orthopaedic Surgeon, again referring to the left shoulder only. During this period of time the applicant was receiving cervical traction as arranged by Mr Murray.

33. On 29 May 2017 Dr Liaw examined the applicant. The history recorded by Dr Liaw is set out as Mr Doak makes submissions in relation to the precise mechanism of injury assumed by experts. Dr Liaw recorded:

> "He stated to have injured his left shoulder in October last year at work when he fell down some stairs onto his left shoulder while carrying a large wall cabinet with another worker."

34. Dr Liaw then refers only to shoulder pain and physiotherapy with steroid injections without much relief. He also said that currently the applicant was complaining of numbness in the whole of his left shoulder and decreased shoulder range of motion. Examination revealed a reduced range of motion in the shoulder and slightly reduced supraspinatus power. Signs of decreased sensation in the left arm and forearm over C5 and C6 distributions were noted by Dr Liaw. He noted the ultrasound's findings in the left shoulder of bursitis and tendinosis and thought there may be a rotator cuff tear. MRI of the shoulder was arranged. On 14 June 2017 an MRI scan reported a labral tear and supraspinatus tendinopathy.

35. When reviewing the MRI study in June 2017 Dr Liaw noted the continuing complaint of numbness over the whole shoulder and restricted range of movement, with some decrease in power. There was also decreased sensation in the index and middle fingers but clinical signs for carpal tunnel syndrome were negative. At this stage Dr Liaw raised the question of whether or not a C5 nerve route impingement or brachial plexus injury could be involved and arranged for the appropriate MRI scan.

36. That scan occurred on 5 June 2017 with the history to the radiologist, in addition to the left shoulder weakness and movement "? left C5 nerve route impingement". The findings reported in the cervical spine were extensive and will not be set out. It is significant to say that there was marked foraminal stenosis at multiple levels with signs of nerve route impingement at C5 and C6. There was also marked disc degeneration and other levels and moderate facet joint osteoarthritis. There was no other abnormality in the brachial plexus.

37. On reviewing that MRI scan Dr Liaw reported on 11 July 2017 as follows:

> "Clinically Dale's left arm problem is secondary to his cervical canal stenosis causing nerve route compression which has been exacerbated by his fall at work. I have discussed with his regarding his neck problem and referred him onto a spinal neck surgeon, Dr Ralph Stanford. . . "

38. Dr Liaw said because there was no left shoulder pain in the context of a labral tear, inoperative management was warranted.

39. On 4 September 2017 Dr Stanford recorded a history that the applicant was carrying a cabinet during a house removals job:

> "when he stumbled down three steps. *At the time he did not have much in the way of symptoms but in the following four weeks he developed weakness and numbness of the left shoulder and arm.* He notes numbness in both hands. There has been no pain in his shoulder or upper limbs. . ." (my emphasis)

40. On examination Dr Stanford noted gross wasting of the right deltoid and periscapular muscles, which was not replicated on the left. There was neck stiffness in all directions without reproduction of neurological symptoms. Motor testing of the right upper limb demonstrated power deficits affecting C5, C6 and C7. Biceps jerk was absent bilaterally. Diffuse sensory change in the left upper limb was also noted and there was reduced sensory change to C8 dermatome on both sides. The MRI scan was noted to show "severe multilevel foraminal stenosis bilaterally and changes within the spinal cord at C4/5 and C5/6.

41. Dr Stanford concluded that the presentation was “chronic right cervical radiculopathy as represented by the advanced muscle wasting on that side”, with little clinical deficit on the left despite complaints. There are clinical features of cervical myelopathy due to the degenerative canal stenosis of the cervical spine. He said:

> “These clinical features are long-standing, as are the appearances on the MRI scan. It is my opinion that Dale requires surgical intervention to treat the cervical myelopathy and secondarily the right cervical radiculopathy. However, it is difficult to relate the chronic and degenerative nature of his pathology to the injury of October 2016. I will propose the required surgical treatment to his Workcover insurer to seek their approval or otherwise of this.”

42. Dr Stanford did not consider the absence (“not much in the way of symptoms”) and the development of increased symptoms after the injury when expressing this view of the cause of the pathology, or the “clinical features”.

43. On 12 September 2017 Dr Liaw noted Dr Stanford’s views and the applicant’s keenness to proceed to surgery. He said the left shoulder labral tear could be managed non-operatively and therefore transferred management of the applicant.

44. The Respondent’s insurer approved funding for the proposed surgery on a “without prejudice” basis and it occurred on 24 January 2018. In essence, there was a cervical fusion at the two levels of C4/5 and C5/6 with insertion of a plate.

45. There appears to be a reasonable response to the surgery as reported by the applicant himself and on 31 July 2018, to Dr Stanford. He said symptoms were now minor right sided neck pain and both shoulder movements were not restricted in elevation.

Forensic Reports

Dr Bodel, Orthopaedic Surgeon dated 20 November 2018

46. The applicant was examined by Dr James Bodel at the request of his solicitor on 20 November 2018. Dr Bodel noted the previous fall involving the ribcage in 2015 and said that there was an injury to the left shoulder in that fall as well, although nothing is made of that history by either the applicant or the Respondent. For the subject injury he noted the applicant delivering, with assistance, wall units up a set of stairs. He recorded:

> “He states that there was a lot of bending, twisting and lifting and he was straining to hold on and as he did this activity, he felt sudden severe pain in the neck and shoulders, and he fell down onto the stairs.”

47. Dr Bodel said he went to see his doctors with increasing pain in the left shoulder “a few days later”. This is clearly not correct as it is approaching a month before medical treatment was sought.

48. Dr Bodel noted the subsequent treatment including the relatively unsuccessful injections of cortisone in the left shoulder, physiotherapy and referral to Dr Liaw including the discovery of the labral tear. He noted Dr Liaw’s suspicion that there may also have been a cervical spine injury resulting in the referral to Dr Stanford. He recorded Dr Stanford’s clinical signs as set out above, as well as his conclusion that there was chronic right cervical radiculopathy with advanced muscle wasting, and cervical myelopathy from the degenerative central canal stenosis of long-standing nature. He noted the relative success of the surgery performed by Dr Stanford.

49. Dr Bodel did not take any history of injury to the right shoulder, nor did he note an assumption that the applicant had overused his right shoulder as a result of either the left shoulder injury or any injury to his cervical spine (or wasting around the right shoulder). He did not note overuse at all. Dr Bodel did note continuing neck pain and difficulty using the arms overhead which aggravated that pain. The pain was said to radiate into both arms which was worse than the actual pain of the neck. He noted continuing pins and needles extending to both hands with the left worse than the right.

50. Examination of the cervical spine indicated tenderness and reduced range of movement.

51. Similarly, in the shoulders there was a reduction of movement in both sides of equal severity. He found impingement in both shoulders, but made no mention of tenderness or other signs.

52. Dr Bodel reviewed various relevant radiology and made summary comments on various reports of Dr Liaw and Dr Stanford.

53. Dr Bodel's diagnosis relating to the cervical spine was:

> ". . . cervical disc injury which at the very least is an aggravation and acceleration, exacerbation and deterioration of a disease process, being cervical degenerative disc disease at C4/5 and C5/6 and this occurred in the incident when lifting the cabinets and walking up a set of stairs while working with his boss on 24th October 2016."

54. He confirmed that the "work injury that occurred on 24th October 2016" was the "main substantial contributing factor" to his ongoing complaints.

55. In relation to the left shoulder Dr Bodel said that "he had aggravated previous pathology and now had rotator cuff pathology." He did not offer a diagnosis for the right shoulder, but as that is not claimed as a statutory injury, that does not mean the applicant cannot succeed (although Dr Bodel does not consider the secondary nature of the condition relied upon by the applicant).

56. From the basis of this report and findings, he assessed impairments in the cervical spine and both shoulders. He seemed to assume that the right shoulder was directly injured in the incident in doing so.

Dr Panjratan, Orthopaedic Surgeon dated 19 November 2019

57. Dr Panjratan's examination occurred at the request of the Respondent. He was provided with a raft of materials including the clinical records of the GP and physiotherapist, Dr Bodel's report and the reports of treating specialists Dr Liaw and Dr Stanford amongst other documents.

58. It is apparent from Dr Liaw's report that the applicant was clearly confused regarding which injury he was being examined for – the April/May 2015 injury involving the ribs, or the subject injury on 24 October 2016. Nevertheless, Dr Panjratan himself sorted out the scattered facts to put together the history of the subject injury. He recorded the incident as follows:

> "He was carrying an item upstairs and going backwards at the top end, the other person stumbled, and he stumbled as well and ended up going down the left hand side. He fell. He felt uncomfortable, dusted himself off and got on with it."

59. Dr Panjratan did not say what felt uncomfortable. He then recorded that the applicant did not go to the doctor but only went when “things became worse and he could not work”. Dr Panjratan noted the 2002 clinical record concerning a right shoulder injury and the applicant’s long battle with depression. He recorded present symptoms of constant neckache without noting any neurological or sensory deficits in either limb. The doctor recorded that the right shoulder had not changed and there was wasting in it, but the applicant had “no idea why there was wasting”. He reported feeling a numbness in the left shoulder with a numbing sensation of pins and needles. There was numbness in the left thumb and index finger on both sides as well.

60. On examination cervical spine movements were less than normal, there was no tenderness and no spasm. He detected normal reflexes and confirmed the absence of sensation in the left shoulder, and wasting in the right shoulder.

61. Dr Panjratan specifically noted that the Respondent had disputed the injury to the neck and right shoulder. The doctor was specifically asked to find out why there was delay in attending a doctor after the injury but said he couldn’t get a straight answer and the applicant was “mixed up”, although the applicant did refer to the fact that the employer did not have insurance (which is assumed to be a misapprehension on the part of the applicant). Dr Panjratan, when addressing “diagnosis and causation” noted Dr Stanford’s report saying it was difficult to relate the chronic and degenerative nature of his pathology to the injury of October 2016. Dr Panjratan diagnosed “age-related cervical spine marked degenerative changes” noting the particularly affected areas.

62. He diagnosed in the right shoulder “idiopathic age-related degenerative changes”.

63. Dr Panjratan’s assessment of gross impairments of the cervical spine and both upper limbs was more or less the same as Dr Bodel.

SUBMISSIONS

The applicant’s Submissions

64. Mr Hunt, for the applicant, submitted that the occurrence of an incident on the 24 October 2016 is not in dispute. He submits that the applicant’s evidence regarding no mention of cervical spine at the time was consistent with the medical evidence and is consistent with the fact that the complaints of pain or other symptoms were initially in the shoulder and upper limbs rather than in the applicant’s neck. Accordingly, attention was devoted to the left shoulder, the side of the primary symptoms at the time. Nevertheless, ultrasound evidence of pathology in the subacromial bursa and tendinopathy was uncovered.

65. He says this delay in report, by chronicling the various reports before him, was noted by Dr Bodel and I would be satisfied that Dr Bodel took that into account.

66. Mr Hunt says that on the first examination by a specialist (Dr Liaw), the neurological symptoms were identified at the C5/C6 area in addition to the then probable left shoulder pathology. It was only then that the MRI scan reported the marked multilevel degenerative changes and the spinal cord pathology, resulting in the referral to Dr Stanford and ultimately the surgery.

67. The submission is basically that the incident involving the applicant’s lifting and stumbling (with or without a fall) produced the symptoms emanating from the cervical spine as well as causing the labral tear in the left shoulder.

68. Unprompted, in a clinical report, Dr Liaw opined on the 11 July 2017 that the fall aggravated the degenerative changes in the applicant's neck resulting in the upper limb neurological symptoms.

69. Subsequently, Dr Stanford medically attributed the applicant's symptoms to the cervical spine. Although Dr Stanford said that the pre-existing degenerative changes were not caused by the incident, that is unremarkable as all medical examiners conclude the same including Dr Liaw, Dr Bodel and Dr Panjratan.

70. Mr Hunt's submission is that it is not the cause of the degenerative pathology that is relevant tin the circumstances, but whether it was aggravated in the incident. In this regard, Mr Hunt relied upon s 4(a) and s 4(b)(ii) the 1987 Act in the alternative.

71. Both Dr Bodel and Dr Liaw confirmed that such degenerative changes were aggravated.

72. Mr Hunt submits that Dr Panjratan's report would be of little assistance because his conclusion, like Dr Stanford, that the degenerative changes were not caused by the accident, is not a disputed issue.

73. Regarding the right shoulder in particular, Dr Stanford noted the issue was bifocal. Firstly, there is the impact of the applicant's wasting around the right shoulder which seems to be accepted as being caused from the cervical spine and its radiculopathy. Further, that is it is the long-standing nature of the pathology that has caused the wasting, not the aggravation.

74. However, that leaves the contribution to the right shoulder condition from the left shoulder labral tear, and possibly the symptoms from the claimed cervical aggravation. Mr Hunt pointed to the applicant's evidence that he would use his right shoulder to protect his cervical spine and left shoulder. He was not able to point me to any evidence regarding the onset of right shoulder symptoms in relation to that overuse, or the timing of the onset of such symptoms.

Respondent's Submissions

75. Mr Doak submitted as follows.

76. Regarding the cervical spine, I would not conclude that Dr Stanford was simply saying that the pathology was of long-standing, because he referred to the "clinical features" as being long-standing as well as the appearances on the MRI scan.

77. Mr Doak noted Dr Liaw's understanding of the incident was that the applicant "fell down some stairs onto his left shoulder while carrying a large wall cabinet". He points to discrepancies in the evidence as to whether or not the applicant actually fell onto his left shoulder, or whether he merely stumbled and didn't fall at all. He says the applicant does not provide any significant assistance with this in his own statement, saying simply that he "lost my footing, fell down three stairs" when he identified only a sudden sharp pain in his left shoulder and left hip (not his neck). The submission is that Dr Liaw's conclusion depends on the finding that a fall occurred, and that it involved falling onto his left shoulder, and that has not been made out.

78. Further, Mr Doak says that Dr Liaw does not explain how the "fall at work" exacerbate the cervical canal stenosis and nerve route compression. This resulted in significant exchange between Mr Doak and myself as to whether or not the applicant needed to establish that there was an exacerbation to the actual pathology in order to satisfy the definition of injury under s 4(a) or a 4(b) of the 1987 Act. Mr Doak confirmed that such evidence was not necessary. However, Mr Doak argued that an explanation of how the

exacerbation to that pathology was occasioned is necessary to understand Dr Liaw's reasoning and to give Dr Liaw's opinion any weight. He referred to the Federal Court decision of *Ocean Marine Mutual Insurance Association (Europe) OV v Jetopay Pty Ltd (2000*) 120 FCR 146: [2000] FCA 1463 (*Ocean Marine*), and *Rolleston v Insurance Australia Limited* [2017] NSWCA 168 (*Rolleston*). I will refer to these decisions below.

79. In the absence of sufficient evidence to establish whether the applicant fell onto his left shoulder - that is, fell at all or merely stumbled - the precise mechanism of injury, Mr Doak says, can only be speculated upon. In particular, Mr Doak submitted that I could not infer that if one were to fall onto the left shoulder that forces relevant to the cervical spine would be implicated.

80. Similarly, Mr Doak submits that Dr Bodel simply assumed that there was a fall down some stairs, whereas in the history he records says that the applicant felt pain in his shoulder and neck prior to the fall and not the result of it. At this point, I suggested to Mr Doak that to glean such nuances from a history taken by a doctor and suggest that they are inconsistent with the applicant's own statement probably should have been the subject of such evidence giving the applicant the opportunity to deal with the issue. Whether that would have resulted in any clarification of the issue, however, may be unlikely given the applicant's difficulties as an historian to all of the different doctors and in particular separating the effects of the fall injuring his ribs over a year prior to this incident from the subject incident.

81. Further, Mr Doak submits, Dr Bodel records the symptoms as being "continuing" neck pain which suggests that he assumes there was neck pain since the injury itself which is not supported by the historical documents.

82. Additionally, Dr Bodel's diagnosis is an aggravation of a "disc injury" when there is no direct evidence of a disc injury, or aggravation of it. The cause of that was said to be "when lifting cabinets" further underlying the previous submission as to the timing of the onset of the symptoms between the actual lifting of the cabinet and the fall.

83. Mr Doak also says I would not accept Dr Bodel's opinion as carrying any weight because he (like Dr Liaw) also does not explain why or how the "disc disease" or "associated myelopathy" has been aggravated, relying upon the same authorities referred to above. Mr Doak says the only way to read the opinion of Dr Stanford's is overwhelming that the pathology must have been aggravated in these circumstances (even though there is an acceptance that the applicant need not prove such an aggravation if the applicant's condition has been otherwise aggravated). I understand this to mean that an absence of "simple" aggravation of the applicant's condition is not enough, whereas Dr Bodel relies upon there being an aggravation of the actual pathology.

84. In addition, Mr Doak says Dr Bodel's opinion is based on an acceptance of the existence of neck symptoms from the time of injury, when that is not the case. Further, the existence of symptoms associated with the neck were not even recorded contemporaneously on the first complaint to his doctor on the 21 November 2015 or thereafter until 10 January 2017, when Mr Murray identified decreased sensation in the upper arm (old neck injury) and the stiff C4/C5 and implicates the cervical spine as a source of his symptoms.

85. Presumably to undermine the mechanism of injury (because, there can be no doubt about an injurious event occurring as far as the left shoulder in concerned) relied upon by various experts, Mr Doak also points out that even in the first attendance on 21 November 2016 the record does not describe a specific incident involving the stairs or a fall, merely that the applicant "does a lot of heavy lifting with work".

86. All of these matters, submits Mr Doak, mean the applicant, in reliance upon any of his experts, has not discharged his onus to establish an injury to the cervical spine under either s 4(a) or s 4(b)(ii).

87. In relation to the consequential right shoulder condition claimed, Mr Doak points out the evidence that the wasting in the right shoulder is the result of the long-standing degenerative changes in the cervical spine identified by Dr Stanford. As those changes were long-standing, and they are not implicated directly into any injury claim by the applicant, any secondary condition resulting from those changes would not be compensable. That is, the wasting is not said to be due to the aggravation of any such changes, but as a result of the changes themselves.

88. In relation to the overuse of the right limb argument due to cervical pain or left arm pain, this is not borne out by the evidence either. Whilst the applicant says he overused his arm, he does not indicate that it was associated with the onset of any symptoms in the right arm. In any event, the applicant's principal witness on causation regarding the secondary condition is Dr Bodel and he does not address any over-reliance or secondary nature of the injury, or any injury at all for that matter. He relies upon some findings on examination to assess impairment and then simply includes it as a result of the injury.

FINDINGS AND REASONS

89. In the case of the cervical spine, an injury pursuant to s 4 of the 1987 Act is claimed. "Injury" refers to both the injurious event and the pathology arising from it: *Lyons v Master Builders Association of NSW Pty Ltd* (2003) 25 NSWCCR 422 (*Lyons*) per Neilson CCJ at [429]. However, in the case of an aggravation of a disease, *Federal Broom Co Pty Ltd v Semlitch* [1964] HCA 34; 110 CLR 626 (*Semlitch*), Kitto J said:

> "There is an exacerbation of a disease where the experience of the disease by the patient is increased or intensified by an increase or intensifying of symptoms. The word is directed to the individual and the effect of the disease upon him rather than being concerned with the underlying mechanism".

3. In *Semlitch* Windeyer J also said:

> "[t]he question that each [aggravation; acceleration; exacerbation; deterioration] poses is, it seems to me, whether the disease has been made worse in the sense of more grave, more grievous or more serious in its effects upon the patient" (at 639).

90. In *Murray v Shillingsworth* [2006] NSWCA 367; 4 DDCR 313 (*Murray*), Einstein J (Hodgson and Santow JJA agreeing) rejected as "misconceived" (at [62]) the employer's submissions that the substantial contributing factor test in s 9A was only satisfied if employment was a substantial contributing factor to a "fully blown injury". His Honour pointed out that the submissions failed to recognise that in s 4(b)(ii) the only compensation is for the effect of the aggravation and not for the effect of the original non-aggravated disease.

91. In the context of this lump sum claim, I am only required to find that an injury to the cervical spine occurred. For the right shoulder, a consequential condition is all that is claimed. The consequences will be a matter for the AMS: *Jaffarie v Quality Castings* [2014] NSWWCCPD 79 (*Jaffarie*).

92. In the case of the consequential right shoulder condition, it is not necessary to establish that there was "significant pathology" in his shoulder: *Kumar v Royal Comfort Bedding Pty Ltd* [2012] NSWWCCPD 8. In *Catholic Healthcare Limited v Rhyder* [2016] NSWWCCPD 60, Snell DP said at [125]:

> "125. The Arbitrator, in his reasons at [59], quoted a passage from Kumar (see [13] above) which clearly identified the distinction between proof of a consequential condition, as opposed to an 'injury' under s 4 of the 1987 Act. At [58] of his reasons he correctly identified the question requiring his determination.
> 126. The dichotomy which the appellant seeks to draw between a condition (on the basis of symptoms) and 'injury' within the meaning of s 4 of the 1987 Act is not helpful. Whilst the occurrence of 'injury' by way of the aggravation, acceleration, exacerbation or deterioration of a disease may involve pathological change, it also may simply involve the worsening of symptoms (see Federal Broom Co Pty Ltd v Semlitch [1964] HCA 34; 110 CLR 626 at [7] per Kitto J). On the other hand, if a worker's injured leg gives way, and he falls fracturing his arm, this is consequential to the original leg injury, but clearly involves the occurrence of additional pathology."

93. In *JR & DI Dunn Transport Pty Ltd v Wilkinson* [2015] NSWWCCPD 38, Keating J said at [135]:

> "135. The submission against a finding of a consequential back condition is that such a finding is not supported by reasoned opinion or change in pathology. I reject that submission. I am satisfied that the history recorded by Dr Endrey-Walder provided a fair climate for the acceptance of his opinion. That opinion was that Mr Wilkinson suffered a consequential back condition by reason of the accepted injuries to his neck and shoulder: Paric v John Holland (Constructions) Pty Ltd [1985] HCA 58; 62 ALR 85; 59 ALJR 844.
>
> 136. Mr Wilkinson did not allege that he suffered a s 4 injury to his back in the altercation. His case was that, as a result of the injuries received in the altercation, he suffered an increase in the back symptoms caused by an earlier back injury. In other words, his case (as argued at the arbitration) was that his back symptoms have, in part, resulted from the injuries received in the altercation (Kooragang). Dr Endrey-Walder's evidence supports such a connection and the appellant called no contrary evidence. *Therefore, Mr Wilkinson did not have to show that the altercation caused a pathological change in his back, such as to support a s 4 injury.*" (my emphasis)

94. When an injury or condition is claimed, the cause of it 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.

95. 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])

96. When reading the expert reports I acknowledge the passage by Spigelman CJ (Giles and Ipp JJA agreeing) in *Australian Security and Investments Commission v Rich* [2005] NSWCA 152 at [170] (*Rich*), where he said: "[a]n expert frequently draws on an entire body of experience which is not articulated and, is indeed so fundamental to his or her professionalism, that it is not able to be articulated".

97. However, inferences may only be drawn from acceptable evidence. Inferences cannot be used to create evidence: H*evi Lift (PNG) Ltd v Etherington* [2005] NSWCA 42; *Conargo Shire Council v Quor* [2007] NSWWCCPD 245; *Rodger W Harrison and Peter L Siepen t/as Harrison and Siepen v Craig* [2014] NSWWCCPD 48 (*Craig*). Findings must be based on the evidence, or reasonable inferences open to be drawn from the evidence, not on the judge's knowledge (*Strinic v Singh* [2009] NSWCA 15 at [60]).

98. In *Luxton v Vines* [1952] HCA 19; (1952) 85 CLR 352 (*Luxton*), at 359, it was held in that:

> "[The element of causation would not be established] where it is 'quite impossible to reconstruct from any materials' the manner in which the accident occurred and where that 'can be done only by conjecture' but where 'a number of conjectures is open, equally plausible'".

99. In *Flounders v Millar* [2007] NSWCA 238 (*Flounders*), Ipp JA said at [35]:

> "…it remains for the plaintiff, relying on circumstantial evidence, to prove that the circumstances raise the more probable inference in favour of what is alleged. The circumstances must do more than give rise to conflicting inferences of the equal degree of probability for plausibility. The choice between conflicting inferences must be more than a matter of conjecture. If the court is left to speculate about possibilities as to the cause of the injury, the plaintiff must fail".

Cervical Spine: The incident and description of symptoms

100. I accept that in the incident on 24 October 2016, the applicant, in a very short instant, experienced pain and stumbled (not necessarily in that order). In his statement over two years later, the applicant says he "lost his footing" and fell down the stairs experiencing pain in the left shoulder (reference to hip pain is not relevant to me).

101. Various difficulties eliciting a cogent history from the applicant have been experienced by the doctors over the years. In my view, it is unnecessary to identify with the

exactness urged by Mr Doak as to when the initial symptoms in the left shoulder were experienced. An injury occurred, and there is no dispute about it.

102. The applicant makes no claim of experiencing sudden neck pain, or even for that matter, any sudden neck associated symptoms such as numbness or radiculopthy.

103. Accordingly, I do not accept Mr Doak's detailed submissions concerning the language used by Dr Bodel in recording the history of the fall, or in expressing his diagnosis as to the cause. Whilst it is clearly open for Mr Doak to make those submissions, I do not consider that Dr Bodel meant to intend that, with precision, the sudden severe pain in the neck and shoulders occurred in sequence prior to the fall or stumble. Rather, I interpret Dr Bodel's statement to convey that the work he was doing involved a lot of bending, twisting, lifting and straining to hold on to the furniture and as a result of these two things happened – he felt severe pain in his neck and shoulders and he fell down the stairs. I do not believe Dr Bodel was intending to describe it instant by instant, but rather the overall activity and its consequences. I will deal with the assumption that there was "severe pain in his neck" at the time of the incident, later.

104. I do conclude that the applicant stumbled and fell. His claim on 2 December 2016 recorded that it "(s)tarted with a fall, no injury register, got worse with time." Thereafter the clinical notes record a fall. Whether he fell "onto his left shoulder is, I believe not important in the context of the cervical injury. Clearly the various doctors have assumed that either the lifting of a heavy cabinet, the fall itself, or a fall onto the shoulder are each capable of establishing the onset of the cervical symptoms (which I am satisfied commenced at the time or over the following weeks as a consequence of the trauma).

105. As for the question of whether there was a disc injury, the MRI scan of 5 July 2017 clearly notes degenerative discs throughout the cervical spine. There are explicit references to broad based disc bulges, on the background of the pre-existing changes, with osteophytes causing canal stenosis. The criticism is not accepted.

106. Provided the applicant's condition has been made worse (in this case by the advent of numbness around the shoulder and in the upper limbs), it is not necessary to identify the advancement of that disc pathology in order to establish an aggravation of the overall underlying degenerative spinal condition, which not only included disc pathology, but other causes for stenosis as well: *Semlitch.* I am satisfied that effects of the applicant's cervical disease was made worse or more grave.

107. It is true that the GP did not record any neck related symptoms until 10 January 2017, not even on the first complaint to his doctor on the 21 November 2015 or thereafter. However, I consider it relevant that as soon as Mr Murray examined him, decreased sensation in the upper arm and the stiff C4/C5 implicating the cervical spine as a source of his symptoms was identified. He implemented "Cx traction" a few days later.

108. Even after that clinical observation, the GP remained silent about any neurological type symptoms from the neck. Even though the practice's clinical records clearly note that there was pain at the base of the neck but the applicant was "more troubled by lack of strength and mobility than pain". Nevertheless, these symptoms and signs were picked up by both Dr Liaw and Dr Stanford in due course, the latter recording that the initial lack of (cervical) symptoms developed over the following four weeks.

109. As the neck pain appears to be of secondary importance to the experts involved in the case, I am not convinced that any assumption by Dr Bodel that there was immediate neck pain and that it continued undermines the essential conclusion. That is, that the fall aggravated the neurological effects of the cervical disease.

110. Contrary to Mr Doaks' submissions, I do not conclude that Dr Stanford was simply saying that "clinical features" were long-standing, as well as the appearances of cervical pathology on the MRI scan. Dr Stanford identified clinical features of cervical myelopathy and radiculopathy. He took no history of the time of onset of any such clinical symptoms or signs to make it open to him to conclude they were of long-standing. Rather, I conclude that Dr Stanford was simply saying that the pathology (that is, the features on MRI) were of long-standing. I conclude that he used somewhat imprecise language (not, I emphasise in a medico-legal sense) to refer to the pathological picture with which the applicant presented to him at the time, confirmed by his examination and elicitation of the symptoms and signs at the time of presentation. I note again that Dr Stanford did not consider the absence of symptoms ("not much in the way of symptoms") and the development of increased symptoms after the injury when expressing this view of the cause of the pathology.

111. As for Mr Doak submissions that the doctors do not explain how the incident exacerbated the cervical canal stenosis and nerve route compression, I again note *Semlitch*. As noted in *Rich*, *"*an expert frequently draws on an entire body of experience which is not articulated and, is indeed so fundamental to his or her professionalism, that it is not able to be articulated". The symptoms were mad worse, and that is sufficient.

112. With reference to the Full Federal Court in *Ocean Marine* and NSW Court of Appeal *Rolleston*, I do not accept Mr Doak's submissions. In *Ocean Marine*, the Full Federal Court held the trial Judge had erred in admitting expert (mechanical) reports due the reports not containing how the experts' opinions were based on any specialised knowledge possessed by them, or demonstrate that any such knowledge was based on any training, study or experience. This was based on the opinion rule" in s 79 of the *Evidence Act* 1995 (Cth). The rules of evidence do not apply in this Commission: s 354(2) of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act).

113. Nevertheless, this proposition is not completely dismissed, but the more appropriate authorities are *Hancock v East Coast Timbers Products Pty Ltd* [2011] NSWCA 11 (*Hancock*); and *Paric v John Holland (Constructions) Pty Ltd* [1985] HCA 58 (*Paric*).

114. The principles I take from these authorities are assumptions underpinning an expert opinion must provide a "fair climate" to ground the opinion. The assumed facts need not be set out an exhaustively. It is sufficient that the overall context be put as the facts upon which the ultimate opinion is based. The facts, provided they are the basis upon which the ultimate opinion is based, may be set out in more than one report, as Dr Liaw has done.

115. Ultimately, I accept the views of Dr Liaw that the incident aggravated the existing cervical pathology. This is supported by Dr Bodel. The other experts are silent on the crucial issue of aggravation.

116. Therefore, I am satisfactorily persuaded that on the balance of probabilities the applicant aggravated the effects of significant pre-existing pathology in his cervical spine in the incident on 24 October 2016. Given the sudden nature of the event, I consider the injury is more appropriately identified as a person injury under s 4(a) of the 1987 Act, although it would also be acceptable to consider it a s 4(b)(ii) injury as well. In either case, I conclude that the applicant's employment was a substantial, indeed the main, contributing factor to the aggravation.

Right Shoulder consequential condition

117. The applicant says he began “over-compensating” and attributes his pain in the shoulder to “over-reliance of my right arm and the muscle wasting that I have in my right shoulder”. He says using either shoulder causes tingling in his neck.

118. I am also faced with prior, apparently spontaneous, symptoms in the right shoulder (albeit, some time ago). In Jan 2002 There was reduced range of motion and the record says there was no history of injury. In December 2012 a rotator cuff injury or tear was suspected.

119. I am satisfied that, as Dr Stanford observes, the wasting in the right shoulder is the result of the long-standing degenerative changes in the cervical spine. I accept Mr Doak’s submission that their long-standing nature, and the absence of expert evidence that any aggravation of them is implicated as a cause of any secondary condition resulting in the shoulder, leaves the applicant having failed to discharge his onus.

120. In relation to the overuse of the right limb due to left arm pain, this is not borne out by the evidence either. Whilst the applicant says he overused his arm, he does not indicate when. The applicant’s principal witness on causation regarding the secondary condition is Dr Bodel and he does not address any over-reliance or secondary nature of the injury, or any injury at all for that matter (noting that identified pathology is not required for the consequential condition). He relies upon some findings on examination to assess impairment and then simply includes it as a result of the injury.

121. Although, I may be entitled to draw inferences of causation in the absence of medical evidence in some circumstances, I do not do so in this case. The issue, given the multi factorial alleged contributors to the alleged condition, is medically complex and it would be inappropriate for me to do so: *Craig.*

122. As there appears to be a significant issue regarding the potential deduction for any impairment due to pre-existing injury or abnormality pursuant to s 323 of the 1998 Act, I would decline to assess the impairment as a result of the injury.

SUMMARY

123. The applicant has established that he suffered injury to his cervical spine but has not discharged his onus to establish a consequential condition in his right shoulder. Impairments from the left shoulder and cervical spine should be assessed by an AMS.