WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **6004/20**
Applicant: **Deborah Everingham**
Respondent: **Woolworths Group Limited**
Date of Determination: **8 January 2021**
Citation No: **[2021] NSWWCC 11**

The Commission finds:

1. The accepted injury to the right shoulder has materially contributed to the applicant's left shoulder condition.

The Commission orders:

2. I remit this matter to the Registrar for referral to an AMS for an assessment of Whole Person Impairment on the following bases:

(a)	Date of injury:	12 March 2009.
(b)	Matters for assessment:	Right upper extremity (shoulder). Left upper extremity (shoulder).
(c)	Evidence:	ARD and attached documents. Reply and attached documents. Complete report of Dr Conrad dated 20 January 2020.

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

John Wynyard
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 JOHN WYNYARD, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

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Lucy Golic
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Deborah Everingham, the applicant, brings an action against Woolworths Group Limited, the respondent, for lump sum benefits in respect of injuries to her right and left upper extremities.

2. Dispute notices were lodged which accepted liability in relation to the injury to the right upper extremity but denied liability with regard to the left upper extremity.

ISSUES FOR DETERMINATION

3. The parties agree that the following issue remains in dispute:

    (a) Is the respondent liable for lump sum compensation in relation to the claim regarding the left upper extremity?

PROCEDURE BEFORE THE COMMISSION

4. The matter was heard by way of telephone conciliation and arbitration on 24 November 2020. The applicant was represented by Ms Deborah Calabretta and Mr Ian Roache from Shaddicks Lawyers, instructing Ms Lyn Goodman. Mr Josh Beran appeared for the respondent briefed by Mr David Hughes from BBW Lawyers. 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

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

    (a) Application to Resolve a Dispute (ARD) and attached documents;
    (b) Reply and attached documents, and
    (c) copy of page 2 of the report of Dr Conrad dated 28 January 2020 by consent.

Oral evidence

6. No application was made in relation to oral evidence.

FINDINGS AND REASONS

7. This is a case of some vintage, beginning when Ms Everingham injured her right shoulder on 12 March 2009. The medical evidence covers different periods. Dr Deveridge wrote six medico-legal opinions between 27 September 2012 and 22 December 2016. Thereafter Dr Deveridge retired from practice, and Dr Peter Conrad supplied three reports, 4 December 2019, 28 January 2020 and 16 June 2020. Mr Beran objected to any reliance by the applicant on the opinions of both practitioners, as he claimed the provisions of regulation 44 of the Workers Compensation Regulation 2016 were contravened. The transcript will show that I rejected that submission as due to the retirement of Dr Deveridge, the provisions of regulation 45 (3) applied.

8. Dr Michael Walsh was the treating surgeon whose reports of 22 September 2011 and 7 November 2012 were also before me. Dr Walsh referred Ms Everingham to Dr Warren Kuo for treatment and management of her left shoulder in August 2013. Dr Patel, Ms Everingham's GP, referred her to in November 2014 Dr Desmond Bokor.

9. Also relied on by the applicant was General Medical Assessment Certificate issued by Dr John M Harrison dated 17 October 2014. The respondent relied on the medico-legal opinion of Dr Raymond Wallace, Orthopaedic Surgeon dated 14 October 2013.

10. Ms Everingham made two statements dated 14 July 2014 and 26 August 2017

11. In her statement of 26 August 2017, Ms Everingham said that she began her employment with Woolworths on 4 November 1998. She began as a casual night filler and by July 2009 was working in the shoe department, working 20 (or 26 as other evidence indicated) hours per week. She described the work as "heavy" as it was necessary to often get heavy boxes of shoes and boots off high shelving or to get to them to find shoes and boots for the customers. She said the boxes were heavy, weighing maybe 15 kg or so. There was considerable working with her arms above her head level handling the boxes, which is work she said she had been doing "for years."

12. It is relevant to note that Ms Everingham had a deprived childhood as a result of which she had "no education. I can write a little bit but not very well and have great trouble reading."

13. She said that about six weeks before she went to see her GP she had an accident when she was serving a customer looking for work boots. She said the boots were at the back dock on a pallet and whilst reaching up above head height the box fell down on her when she was trying to extricate it. She said that the box fell and hit her causing pain in her "chest and both shoulders, more on the right than the left."

14. She saw her GP, Dr Smehal Patel, on 25 May 2009, and investigations were carried out of her right shoulder on 23 June 2009. On 8 July 2009, in company with the Return to Work Coordinator from "Big W" she again attended Dr Patel concerning a "right supraspinatus tendon tear – total." On the same day Ms Everingham signed a Claim Form stating that she had injured her "right shoulder" when she "felt pain whilst lifting boxes and moving stock cages". The task she was performing was "filling stock in footwear department".

15. The Claim Form nominated the date of injury as being "March" 2009, and a witness to the injury was named as Joanne Palfreyman, "Store Manager in training." Ms Everingham was reported in the form as saying that she did not report the injury because she "thought the pain was arthritis"[1]. In her statement she denied that she had ever thought her injury was arthritis.

16. On 23 June 2009, a right shoulder ultrasound and x-ray revealed a full thickness tear in the anterior third of the supraspinatus tendon measuring 1.4×1.2 cm.

17. On 26 July 2009, Dr Patel wrote to the respondent's Claims Officer, reporting Ms Everingham's presentation on 27 May 2009 complaining of right shoulder symptoms over the past three months[2]. Dr Patel said that there was no recollected history of any injury or repetitive shoulder use aside from her work.

[1] ARD page 30.
[2] Reply page 1.

18. On 25 September 2009, Dr Patel's clinical notes recorded:[3]

> "Pain for one hour at night when lying on the shoulder also getting L shoulder pain at night when lying on it."

19. In her statement, Ms Everingham said that she returned to work "as usual" after the box fell on her, and that over time her pain became worse. She said that she did not complain because she was afraid of losing her job. She said that her left shoulder bothered her as well and "I suppose I was using that side more because of the problems with my right." She said that Dr Patel prescribed medication which helped her and she also stated that Dr Patel asked her about her left shoulder over this time.

20. The time to which she referred covered a period of about two and a half years, until her pain "flared up" whilst she was doing her usual duties, at which time she was referred to Dr Michael Walsh, Orthopaedic Surgeon by Dr Patel. Dr Walsh reported on 22 September 2011 that he had seen Ms Everingham on 13 September 2011. Ms Everingham said that over that period one of the main problems with her shoulders was sleeping at night. She said that she could not lie on either of them and had to sleep on her back, which resulted in her being sleep deprived.

21. Ms Everingham came to surgery with Dr Walsh on or about 20 October 2011. This treatment was unsuccessful and a revision was done by Dr Walsh on 17 January 2013.

22. In her statement of 26 August 2017, Ms Everingham said that she returned to work on light duties on 20 January 2012. The evidence did not describe in any detail the nature of that light work, although there were entries in Dr Patel's clinical notes that showed there were lifting restrictions which were reviewed from time to time.

23. Dr Patel's clinical notes of 21 May 2012 showed:[4]

> "Shoulder pains starting up again at night – R and L."

24. On 7 June 2012, Dr Patel noted that Ms Everingham had suffered pain in her right elbow three days earlier and favoured the left arm because she was still sore following day.

25. Dr Walsh reported to Dr Patel on 7 November 2012, and after commenting on the right shoulder problem said:[5]

> "As well is she has been noticing pain in the left shoulder, but that is an incidental problem compared to the left [sic] and is due to advanced gleno-humeral degeneration."

26. I assume Dr Walsh intended to compare the left shoulder to the right shoulder. Dr Walsh referred Ms Everingham to Dr Kuo with regard to her left shoulder condition. In his referral of 16 July 2013, Dr Walsh noted that the "real problem" was now "the left shoulder."

27. On 30 August 2013, Dr Kuo took a history that Ms Everingham had been experiencing pain in her left shoulder over the past year without a recent precipitant. He noted Dr Walsh's advice that there was dual pathology of a significant cuff tear as well as advanced glenohumeral joint osteoarthritis. Dr Kuo advised against a reverse total shoulder replacement, saying that Ms Everingham was too young for such treatment and he expressed some reservations as to whether the left shoulder weakness was "truly due to the cuff damage or actually due to pain (or a combination of both)."

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[3] Reply page 6.
[4] Reply page 15.
[5] ARD page 132.

28. Dr Kuo expressed some doubt as to whether Ms Everingham's osteoarthritis was related to her work and indicated that it was unlikely unless there was a specific injury indicated in the records. He stated that the left shoulder would "definitely" have been "taking a greater degree of the load and work required for ADLs and work" for periods of time as Ms Everingham had been through two right shoulder operations**.**

29. As at the date of her first statement, 14 July 2014, Ms Everingham had been working 26 hours per week working with customers, and a further one half hours after closing, recovering stock.

30. In her second statement of 26 August 2017, Ms Everingham said that she was in constant pain notwithstanding that she was working short hours on "very light duties." She said that she was run off her feet and was in constant pain. She ceased work on 24 December 2015 and took accrued leave thereafter.

31. In Dr Deveridge's first report of 27 September 2012, he took a consistent history of the injury of 12 March 2009, including that she experienced pain in both shoulders on that occasion, but more so on the right initially. He recorded Ms Everingham's complaint that she had suffered the left shoulder pain from the outset, but that it had worsened since the right shoulder operation:[6]

> "As she has relied much more on the left arm for all activities. She can't lift any significant weight nor can she reach above about chest height. She has lost strength in both arms."

32. With regard to Ms Everingham's activities of daily living, Dr Deveridge noted:

> "She has been quite limited in activities of daily living. Most of the domestic chores and all of the gardening are now performed by her husband or son. She can't peg out laundry or bring it in. She can only use a vacuum cleaner for five or 10 minutes at a time. She can't make or change bedding. She has difficulty with personal care-showering, hair care, dressing and even with her shoes. Her son does most of the shopping. Recreational restrictions include gardening, knitting and lifting her grandchildren."

33. Dr Deveridge's opinion was that Ms Everingham had developed bilateral shoulder pain following the work injury of 12 March 2009. He noted the investigations for the right shoulder which showed a complete rupture of the rotator cuff and a bursitis which Dr Deveridge thought to be consistent with a mechanism of the injury described and the clinical presentation. He thought that there was similar rotator cuff damage in the left shoulder. He thought that the residual disability and both upper limbs was attributable to the event of 12 March 2009.

34. In his next report of 28 November 2012, Dr Deveridge had available investigations of the left shoulder dated 17 October 2012. He noted degenerative changes with partial bone-on-bone contact. An ultrasound of the same date showed a partial-thickness articular sided tear of the supraspinatus measuring 9 mm. Moderate grade bursitis was also found with decreased range of movement and personal bunching causing impingement.

35. Dr Deveridge commented that the studies confirmed his clinical impression as to the pathology involved, which he said was consistent with the effect of the subject work injury in March 2009. The left shoulder was shown to have a partial-thickness rotator cuff tear, bursitis and impingement. Dr Deveridge disagreed with the opinion of Dr Walsh that the left shoulder condition was not related to the work injury, as it was contrary to the history took and there was no evidence of any prior problems with the left shoulder.

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[6] ARD page 93.

36. On 15 August 2013, Dr Deveridge supplied a further report regarding the left shoulder condition. He noted that Ms Everingham had since undergone her second operation on her right shoulder on 17 January 2013, and that she had been referred to Dr Kuo, although he had no report from him at that stage.

37. Dr Deveridge took a history that Ms Everingham was back at work full-time following the first operation, but receiving help lifting a heavy boxes.

38. Dr Deveridge repeated that there was no relevant past history of injury to the left shoulder that would have resulted in the degree of arthritic change seen on the investigations. Dr Deveridge's opinion was that the imaging had demonstrated pathology in the rotator cuff on a background of moderately advanced degenerative osteoarthritis. The arthritic condition was constitutional but Dr Deveridge considered that it had been subject to acceleration over the years by the nature and conditions of Ms Everingham's employment. He thought the partial-thickness rotator cuff tear probably was resulted from the subject injury and that there was thereafter further material aggravation exacerbation of the arthritic process. He thought that the effects of the aggravation were likely to be long-standing. He said:[7]

> "On the balance of probabilities, the greater part of the disability and it left upper limb is attributable to the fall on 12.3.2009.in addition, following two surgical procedures on the right shoulder, she was obliged to place more stress on the left shoulder both at her workplace and in other activities of daily living."

39. Dr Deveridge reported again on 24 March 2014. He confirmed the history originally taken from Ms Everingham and he commented on other medical material that had been supplied to him. He recorded at that time Ms Everingham was working her full 26 hour week mainly serving customers and doing other light duties. Dr Deveridge noted complaints of bilateral shoulder pain which was then worse on the left side. His opinion was that the mechanism of injury could well have resulted in a rotator cuff rupture at the right shoulder with aggravation of underlying constitutional osteoarthritis and that the nature and conditions of her employment over the years contributed by way of aggravation exacerbation and acceleration of those changes.

40. He thought the degree of osteoarthritis in both shoulders was excessive for a woman of her age, and he commented that whilst it was not surprising that she had arthritis in the weight-bearing joints of her lower limbs as she was overweight, that did not explain the degree of arthritic change in both shoulder joints. As to the left shoulder, Dr Deveridge noted the subsequent development of similar complaints and said:[8]

> ".. I believe that this is reasonably attributable to placing excessive and repetitive biomechanical forces on that joint, as a consequence of favouring the painful right shoulder. On the balance of probabilities, residual disability and the right upper limb and the greater part of the disability in the left upper limb is attributable to a combination of the specific injury on 12.3.2009 and the nature and conditions of her employment with Woolworths Ltd. Although the arthritis would have developed over a number of years, it was not causing any prior symptomatic impairment."

41. Dr Deveridge accepted Dr Kuo's opinion, but considered there was on the balance of probabilities a reasonable nexus between the left shoulder disability and Ms Everingham's employment. Dr Deveridge had to hand a report by Dr Wallace dated 14 October 2013 which did not cause him to alter his opinion.

[7] ARD page 103.
[8] ARD page 109.

42. Dr Wallace took a history that Ms Everingham was struck in her chest in the subject injury, but that she noted no pain and continued her normal duties. It was not until about two weeks later that she noted the onset of right shoulder pain. He further recorded that Ms Everingham resumed her pre-injury duties in September 2009 but noted a recurrence of pain in the right shoulder in March 2011. With regard to the left shoulder condition, Dr Wallace noted that Ms Everingham claimed that she injured it at the time of the subject injury, but that some three years later in mid-2012 she noted the onset of pain in that shoulder.

43. Dr Wallace was of the opinion that the right shoulder injury was not related to the subject accident of 12 March 2009, an opinion which was not shared by any other medical practitioner, nor the respondent, as it has accepted liability that injury.

44. With regard to the left shoulder, Dr Wallace thought that it was due to Ms Everingham's pre-existing degenerative osteoarthritis, which he said was constitutional in origin and not work-related. That opinion was also based on an assumption that the left shoulder pain did not commence until mid-2012.

45. A General Medical Assessment Certificate (MAC) was issued on 17 October 2014 by Dr John Harrison. The MAC was issued in answer to a request for an opinion as to whether the left shoulder problems were consequentially related to the right shoulder injury and as to whether certain treatment was reasonably necessary.

46. Dr Harrison took a history that was consistent with other accounts in that the carton of boots dropped as she was trying to pull it down and that it struck her across the front of her chest. However Dr Harrison also took a history that it was not until two weeks later that she began to notice pain in the front of the right shoulder and some "lesser discomfort" on the left, which was starting to trouble her when she tried to sleep. He also took a history that in March 2011 she noted escalating patterns of pain which began to affect her shoulder "again."

47. Dr Harrison's summary was that with the breakdown of the right shoulder rotator cuff following surgery Ms Everingham "not surprisingly" began to experience features of osteoarthritic change associated with the lack of support for the rotator cuff. The associated impingement and restriction of motion generated by the painful response of both upper limbs at the shoulders that she had suffered since stemmed from that right shoulder breakdown.

48. Dr Harrison thought Mr Everingham to be cooperative and not exaggerating her real and on-going complaints. He thought it was "theoretically possible" to have had a "notional jarring or jerking force to both arms at the shoulders." However he doubted that the forces involved could have created a massive rotator cuff tear in the right shoulder. He said that a similar argument would pertain regarding the left shoulder, bearing in mind the even greater delay in the onset of symptoms to that of the right shoulder.

49. In his opinion, Dr Harrison agreed that primary osteoarthritis in the shoulders was unusual, but accepted that it did happen. Dr Harrison said:[9]

> "I believe there is a clear causative link to the problems in relation to her left shoulder as related to the apparent injury to her right shoulder that followed the incident that I have described."

50. Mr Beran submitted that this opinion contained a typographical error and that Dr Harrison intended to say that there was "no" clear causative link, as later in the following paragraph he said:

> "…In my opinion the lack of clear causative link between the injury in 2009 and her current symptoms and incapacities affecting the left arm at the shoulder.. would impact in a negative way in accepting the decision as to liability..."

[9] ARD page 27.

51. Although Ms Goodman relied on Dr Harrison's positive opinion, I agree with Mr Beran that in view of his further comment Dr Harrison intended to say that there was "no clear causative link." However, Dr Harrison then said:

> "… The breakdown of the initial repair happened and the second effort at surgical repair of thickened tissue structures has also failed …."

52. On 10 November 2014, Ms Everingham was seen by Dr Desmond Bokor, having been referred by Dr Patel. Dr Bokor took a history of bilateral shoulder pain which developed following the subject accident. He noted the surgical history and that the left shoulder had continued to be bothersome. Bilateral shoulder pain he noted was causing "night pain" on both shoulders. Dr Bokor noted the investigations which showed significant osteoarthritis in the left shoulder, and a small full thickness tear. He agreed with Dr Kuo's opinion that there was dual pathology, and thought it "highly improbable" that the subject injury would "in any way" contribute to the arthritis.

53. The final report of Dr Deveridge before his retirement was dated 22 December 2016. At that time, he had to hand the report of Dr Bokor dated 10 November 2014, and the MAC by Dr John Harris in dated 14 August 2014, together with updated medical imaging.

54. Dr Deveridge commented that there had been no significant interval change since his last examination and he confirmed that the residual disability in the right upper limb and the greater part of the disability in the left upper limb was attributable to the work injury of 12 March 2009 as well as the nature and conditions of her employment. He said that although Ms Everingham had moderately advanced osteoarthritic changes in both shoulder joints, which would have developed over several years, he believed those changes would have been aggravated and accelerated by her work tasks. He also was of the opinion that the subject injury could well have resulted in a rotator cuff rupture. Dr Deveridge did not agree with Dr Harrison's view that the injury was not of sufficient magnitude to have created the massive rotator cuff tear on the right shoulder, nor to the left shoulder where there was a greater delay in the onset of clinical symptoms.

55. As indicated, Dr Peter Conrad supplied three medico-legal reports, following Dr Deveridge's retirement. In his first report of 4 December 2019 he took a consistent history that Ms Everingham felt pain in both shoulders, the right more affected than the left in the subject injury. Dr Conrad noted the reports from Dr Deveridge and was unsure of the surgical history regarding the right shoulder. Dr Conrad said that additionally the heavy conditions at work since 1998 had caused Ms Everingham to develop arthritis in both shoulders, and particularly in the left shoulder.

56. In his second report of 28 January 2020, Dr Conrad noted that his retaining solicitors had asked him to reconsider the question of causation, and his attention had been drawn to the reports of Dr Deveridge which he had already noted. Dr Conrad was further asked for clarification and supplied his third report on 16 June 2020. He repeated his opinion that the work performed by Ms Everingham since 1998, noting "that her main job was packing shelves," would have put a strain on both shoulders. In addition, Dr Conrad said, the subject injury caused pain in both shoulders, the right more than the left. He said:[10]

> "It would be my view as expressed in my report that due to the heavy conditions at work since 1998 as well as the effects of her accident, she has developed arthritis in both shoulders, which appears to be more affecting the left shoulder than the right.…
>
> It is my view that more probable than not the work performed by Ms Everingham aggravated her arthritis."

[10] ARD page 129.

SUBMISSIONS

57. Mr Beran, in a helpful analysis of the issues raised in the case, submitted that the applicant was alleging a number of causes for the left shoulder condition which were contradictory, and which were not supported by the evidence.

58. Mr Beran referred to the various opinions as to causation regarding the left shoulder and submitted that many of the assumptions upon which the opinions of Dr Deveridge and Dr Conrad were based had not been proven.

59. He submitted that he had to meet three separate cases, and that the pleadings accepted the fact that there was no clear identification of how the injury to the left shoulder occurred. It was alleged that firstly that there had been a frank injury, secondly that the nature and conditions had aggravated a pre-existing condition, or alternatively that the nature and conditions caused some underlying disease process, and thirdly that the left shoulder condition was consequential to the right shoulder injury.

60. Mr Beran referred to the clinical notes of Dr Patel, noting that there was no reference to the left shoulder until 25 September 2009, and that then it was only a reference to problems Ms Everingham had whilst sleeping. Mr Beran submitted that Dr Walsh, who was the Orthopaedic Surgeon treating the right shoulder problem noted a complaint of left shoulder pain in his report of 7 November 2012 but that it was an incidental problem, by which I understood Mr Beran to submit that there was therefore no work-related connection. Mr Beran relied on the opinions of Dr Bokor and Dr Kuo that it was highly improbable that the subject injury would have contributed to the osteoarthritis in the left shoulder.

61. Mr Beran submitted that the Claim Form of 8 July 2009 referred only to the right shoulder. Mr Beran submitted that the contemporaneous evidence did not support the allegations made by Ms Everingham in her two statements.

62. Mr Beran submitted that Ms Everingham did not give sufficient detail of the nature and conditions of her work in the shoe department that would justify an inference that she suffered an overuse syndrome. Ms Everingham's evidence consistently alleged that she had injured both her left and right shoulders in the subject accident. I would view with some circumspection her assertion that she did not report the injury immediately for fear of losing her job, as such a fear would not have prevented her consulting her general practitioner Dr Patel.

63. Mr Beran submitted that in fact the left shoulder problem was not reported for years, leaving aside the entry in the notes of it being symptomatic at night. It was unlikely, Mr Beran submitted, that a reasonably competent medical practitioner would have ignored Ms Everingham's complaint about her left shoulder, even if the right shoulder was the focus of her treatment. It could not therefore be argued, I understood Mr Beran to submit, that the left shoulder condition was the result of the frank injury of 12 September 2009.

64. As to claim that the left shoulder condition was consequential, Mr Beran submitted that Ms Everingham also failed to satisfy her onus of proof. If the allegation was that her right shoulder was so badly affected that she had to rely heavily on her left shoulder, the evidence was lacking as to the particularity of the work she was required to do that would have resulted in such overuse. Mr Beran acknowledged that Ms Everingham had described her work as heavy and repetitive, but all the evidence disclosed was that she worked in a shoe department stacking boxes. Ms Everingham's statement that after her two bouts of surgery for the right shoulder she had to use her left arm more, suffered from the same lack of detail as to what activities she had to use her left arm for. An inference could be drawn from her description of the light duties she was given following that surgery that there was no requirement for her to rely on her left shoulder to any extent.

65. The same criticism was made by Mr Beran regarding any claim that the nature and conditions of Ms Everingham's employment had aggravated or exacerbated the underlying constitutional condition. Ms Everingham's statement was "almost silent" and did not give the evidence that was required to support any assumption of fact upon which such a diagnosis had been made.

66. Dr Deveridge's reports were criticised by Mr Beran, as Dr Deveridge had accepted that the subject injury affected both the left and right shoulders, for which there was no contemporaneous support. Moreover Mr Beran argued, although Dr Deveridge accepted Ms Everingham's history that she needed to rely more on her left arm, that assumption had not been supported by sufficient particulars from Ms Everingham in her statement.

67. Mr Beran referred to the opinion of Dr Walsh, which Mr Beran submitted discounted any relationship between the left shoulder condition and Ms Everingham's employment.

68. Although Dr Deveridge repeated in his report that the left shoulder had been injured in the subject accident, he did not describe the nature and conditions. Mr Beran referred to the history taken by Dr Deveridge on 15 August 2013 that Ms Everingham had been working for the respondent for 15 years with the first two being as a night-filler and thereafter in the shoe department doing repetitive lifting and reaching whilst handling items of up to 15 kg. I would not accept that evidence Mr Beran submitted, as it was not supported within Ms Everingham's statement, and did not appear elsewhere in Dr Deveridge's reports. Mr Beran submitted that working in the shoe department did not equate to the work of a picker and packer.

69. Consequently, argued Mr Beran, the applicant's evidence did not support the finding by Dr Deveridge that the nature and conditions of employment had accelerated her underlying osteoarthritic condition. Mr Beran submitted that if an exacerbation or acceleration of an underlying degenerative condition occurred as a result of a frank injury then the provisions of ss 15 and 16 of the *Workers Compensation Act 1987* (the 1987 Act) would have no work to do. Mr Beran argued that Dr Deveridge's opinions had changed over time. Dr Deveridge began by saying that the subject accident injured Ms Everingham's left shoulder -that is to say, a frank injury - but now said the injury was in the nature of the aggravation of her underlying degenerative condition. Mr Beran submitted that I would discount Dr Deveridge's reports because he failed to explain how or why his opinion had changed.

70. Mr Beran then considered the reports of Dr Conrad and submitted that his opinion too could not be accepted because he failed to adequately describe the nature and conditions of Ms Everingham's work, and overlooked the fact that when Ms Everingham return to work she was only doing light duties.

71. Mr Beran adopted the opinion of the Approved Medical Specialist (AMS) Dr Harrison in his MAC of 17 October 2014, which when making allowance for the typographical error, did not find any clear causative link between the left shoulder condition and the accepted injury to the right shoulder.

72. Mr Beran also submitted that Dr Wallace provided a further opinion that the left shoulder condition was not related to the right shoulder injury, although Mr Beran conceded that Dr Wallace did not find there had been a right shoulder injury either.

73. Mr Beran submitted that, applying the "Kooragang test" I could not accept that the nature and conditions of Ms Everingham's employment either caused the rotator cuff tear or any other problems with her shoulders. I would dismiss Dr Conrad's opinion "out of hand" as his opinion stood on its own, contrary to all of the doctors, that the nature and conditions of Ms Everingham's employment since 1998 had aggravated her arthritic condition. Mr Beran conceded that Ms Everingham has a significant underlying arthritic problem in both

shoulders, especially the left shoulder. It had to be remembered, I understood Mr Beran to submit, that there had been a "massive rotator cuff tear" in the right shoulder which was a different pathology to the aggravation of the underlying osteoarthritic condition of the left shoulder, and therefore the matter could not be referred to an AMS on the basis that both shoulder conditions could be aggregated.

Ms Goodman

74. Ms Goodman filed written submissions. She advanced reasons why I could accept the alternative bases on which Ms Everingham's claim had been made. She made submissions as to why I could find that the left shoulder was a frank injury, or a consequential injury, or the aggravation of a disease injury caused by the nature and conditions of her employment. I have accepted her submissions as to one of her alternatives, and her arguments as to the other causes are dealt with in my reasons below.

DISCUSSION

75. Both Counsel submitted that there were alternative causes for Ms Everingham's left shoulder condition. It was submitted by Mr Beran that the objective contemporaneous evidence did not support Ms Everingham's assertions within her statements, or the assumptions made by the expert witnesses.

76. In her statement of 14 July 2014, Ms Everingham claimed that when she first saw Dr Patel about six weeks after the injury, she complained of pain to both shoulders, but that because she said the right shoulder was worse, Dr Patel only treated the right shoulder. In his letter to the Claims Officer dated 26 July 2009, Dr Patel advised that Ms Everingham first presented on 27 May 2009 so that her evidence as to when she first sought medical help was consistent ("maybe six weeks").

77. The respondent lodged Dr Patel's clinical notes, but unfortunately they did not include the entry for 27 May 2009. They commenced on 8 July 2009. The pathology revealed by the investigations on 23 June 2009 revealed a full thickness tear of the right shoulder rotator cuff measuring 1.4 x 1.2 cm. The clinical history noted by the Radiologist was of right shoulder pain. Over two years later Dr Walsh described it as a "very significant rotator cuff tear."

78. I note that when she consulted Dr Patel on 8 July 2009 Ms Everingham was accompanied by the Return to Work Coordinator from the employer, and her claim form was dated the same day. Only the right shoulder was claimed as being injured.

79. Dr Patel noted in his letter to the employer of 26 July 2009 that if the right shoulder problem did not recover with physiotherapy, surgery might be needed. It is relevant to note that Ms Everingham continued on her normal duties until she was referred to Dr Walsh in September 2011. Ms Everingham said that during that time she was getting worse but that she did not complain because she was afraid of losing her job. I accept Ms Everingham's statement in that regard as her virtual illiteracy would have put her at a disadvantage in finding another job. There was, however, no support for her contention that her left shoulder was also getting worse.

80. Moreover, the reference in her statement that she "supposed" her left shoulder was also bothering her because she was using it more, did not persuade me that her right shoulder injury was then causing a consequential overuse of her left shoulder. The only possible support for her contention was an entry in Dr Patel's clinical notes of 25 September 2009 that Ms Everingham was getting left shoulder pain at night when she was lying on it. I do not regard that evidence as indicating a work-related condition.

81. It needs to be borne in mind that, apart from seeing Dr Patel and undergoing investigations in 2009, Ms Everingham managed to keep doing her normal duties until she was referred to Dr Walsh. Dr Walsh did not note any complaint about the left shoulder in his initial report of 22 September 2011, but in his post-surgery report of 7 November 2012 took a history of the onset of left shoulder pain. Dr Walsh's comment that the left shoulder pain was incidental and due to advanced gleno-humeral degeneration was relied on by Mr Beran as evidence that it was not connected to employment. Whilst the degenerative condition may not have been caused by Ms Everingham's employment, I do not agree that the onset of symptoms was unconnected to her right shoulder injury, as will be seen later in these reasons.

82. The surgery occurred on 20 October 2011 and the first reference to the onset of left shoulder symptoms appeared in Dr Patel's notes of 21 May 2012, which showed that shoulder pains were starting up "again" at night in relation to both shoulders. Further confirmation of difficulties with the operation of the right arm appeared on 7 June 2012 in Dr Patel's notes, which noted that Ms Everingham was favouring the left arm.

83. Ms Everingham's statement of 26 August 2017 related that she returned to work following the surgery of October 2011 on 20 January 2012. Regrettably, she did not describe the nature of the work she had to do.

84. The best evidence came from Dr Deveridge's report of 27 September 2012. As indicated, he took a history that the left shoulder pain had worsened since the operation. His description of Ms Everingham's limitation of her daily activities was consistent with the complaint he recorded that Ms Everingham was experiencing significant difficulties because of her right shoulder surgery, and having to use the left arm more. The confirmation of similar radiological findings in the left shoulder to that of the right in Dr Deveridge's report of 28 November 2012 was further support that there was a pathological basis for Ms Everingham's left shoulder complaints, but it did not support Dr Deveridge's opinion that the left shoulder had been symptomatic since 2009.

85. I agree with Mr Beran that the evidence regarding the actual duties Ms Everingham had to perform at this time was scant, but it stands to reason, using common sense, that it would have been necessary to rely much more on the left arm for all activities, as Dr Deveridge noted, following the right shoulder surgery. The probability of the limitations of activity caused by the right shoulder on Ms Everingham's return to work on 20 January 2012 is further supported by the fact the first surgery was unsuccessful.

86. Dr Deveridge's report following the second surgery confirmed that Ms Everingham was obliged to place more stress on her left shoulder at work and at home as a result of the weakened state of the right shoulder.

87. This opinion was also expressed in August 2013 by Dr Kuo, to whom Ms Everingham was referred for treatment and management. Whilst Dr Kuo, like Dr Walsh, thought that the presence of arthritis in the left shoulder was unlikely to be related to work, he accepted that following two right shoulder operations, the left shoulder would be taking a greater degree of the load in both work and daily living activities.

88. The opinion of Dr Harrison in the MAC of October 2014 I found to be problematic. Although he was asked whether the left shoulder condition was consequentially related to the right shoulder injury, he did not answer that question. He doubted that the "massive" right shoulder rotator cuff tear had been caused by the subject accident in 2009, although he thought it "theoretically possible" that such an accident might have been related to the pathology in both shoulders. He thought however that the long delay in the onset of symptoms in the left shoulder made that a doubtful proposition.

89. Dr Harrison also noted that the presence of primary osteoarthritis in the shoulders was unusual, but did not think that there was a clear causative link between the left shoulder condition and the 2009 subject accident.

90. What Dr Harrison did not address was whether the injury to the right shoulder had created a necessity for Ms Everingham to take a greater degree of her workload and daily activities in her left shoulder as a result of the weakness caused to the right shoulder by the two surgeries. Dr Harrison referred to the breakdown of the initial surgical repair to the right shoulder and the failure of the second attempt, but did not consider, as did Dr Kuo and Dr Deveridge, the consequential load such failed treatment would put on the contralateral shoulder.

91. The history taken by Dr Conrad was consistent with that of Dr Deveridge, in that Dr Conrad recorded that Ms Everingham experienced pain in both shoulders at the time of the subject accident. However Dr Conrad did advance the theory that the nature and conditions of Ms Everingham's work since 1998 would have aggravated the arthritic condition of her shoulders. Dr Conrad assumed incorrectly that work had been that of packing shelves. I do not think that Ms Everingham's duties could be thus described of her work in the shoe department.

92. It can be seen however that the question of Ms Everingham's osteoarthritic condition was considered as a cause for the left shoulder condition. Dr Walsh described it as "incidental" and Dr Kuo discounted it in the absence of any record of there being an injury to the left shoulder. Dr Wallace rejected the condition as being causative, as it was pre-existing and constitutional.

93. As is not unusual when medical practitioners are considering causation concerning pre-existing degenerative conditions, attention was not paid to the question as to whether the pre-existing arthritic state of Ms Everingham's left shoulder had been aggravated, exacerbated, accelerated or deteriorated by the nature and conditions of employment.

94. Section 4 of the 1987 Act provides relevantly:

> "'injury' –
>
> (a) means personal injury arising out of or in the course of employment,
> (b) includes a
>
> 'disease injury' , which means-
>
> (i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and
>
> (ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease"

95. That Ms Everingham suffers from a disease condition in her left shoulder (and for that matter, her right shoulder) in the form of osteoarthritis is not in dispute. The evidence shows that Ms Everingham has dual pathology in her left shoulder, being the rotator cuff tear (and bursitis) and the osteoarthritis, which may or may not have been pre-existing.

96. The first allegation in the Injury Details within the ARD form was that both shoulder injuries had been caused by the nature and condition of employment since 1998. The relevant injury is the left shoulder injury, and the only expert who embraced that claim was Dr Conrad, whose opinion was based on an incorrect history, as I have indicated. The right shoulder injury has been accepted it would seem on the basis that it was a frank, or s 4(a) injury – although the assessment is a matter for the AMS. I reject the claim that the nature and conditions of Ms Everingham's employment caused an injury as described in s 4(b)(i) or (ii) – or that they caused multiple micro-traumata to her shoulder. As indicated, there was no adequate description of the nature of her duties upon which to base such a finding.

97. In that regard I accept the submissions of Mr Beran that the evidence falls well short of establishing that the type of work Ms Everingham was required to perform was as assumed. Whilst the Commission is able to draw inferences from established facts, I agree with Mr Beran's submission that the evidence, particularly the statements made by Ms Everingham, did not provide a sufficient factual basis for the assumptions made by Dr Deveridge and Dr Conrad, as I have indicated.

98. I am also not persuaded that the applicant has satisfied her onus to show that she did in fact injure her left shoulder on the 2009 subject accident. I note that Ms Everingham makes that claim in her statements, but whilst I do not suggest that she intentionally sought to mislead the Commission, some caution must be applied to statements that were taken many years after the events described. That the deponent has a vested interest in the outcome of the proceedings, and the fallibility of memory means there is always a danger that such statements have inadvertently reconstructed events. Whilst Ms Everingham also gave that history to Dr Deveridge in September 2012, it was not supported in the contemporaneous notes of Dr Patel, nor in the reports of Dr Walsh or Dr Kuo. Dr Walsh noted in November 2012, in passing, that Ms Everingham had been noticing pain in the left shoulder, but there was no suggestion that it dated back to, or was connected with, the 2009 incident. Dr Kuo noted that the symptoms have begun a year before he saw her in August 2013.

99. These accounts created some doubt as to the accuracy of the suggestions that the left shoulder had been injured at the time of the 2009 accident. Moreover the claim form of 8 July 2009 only nominated the right shoulder.

100. However, the claim that the left shoulder condition is the result of Ms Everingham's right shoulder injury I find to be made out. I have referred to the opinions of Dr Kuo and Dr Deveridge that the surgical procedures on the right shoulder must have added to the load on the left shoulder. It is significant that there was no record of any complaint by Ms Everingham regarding her left shoulder symptoms until after the first right shoulder surgery in October 2011.

101. Thereafter, particularly after the failure of the second right shoulder surgery in January 2013, the condition of Ms Everingham's left shoulder has deteriorated as was illustrated by the referral to Dr Kuo in August 2013 for treatment and management of the left shoulder only. It is probable that such failed surgery has caused the contralateral shoulder to take on additional load, regardless of the actual nature of the work Ms Everingham was performing on light duties. Her activities in all the aspects of her daily life have been compromised by the resultant weakness in the right shoulder, and the treatment Ms Everingham has undergone since that failed surgery specifically for the left shoulder condition with Dr Kuo and later with Dr Bokor is evidence of that cause.

102. The standard of proof on an injured worker to establish that he/she has suffered a consequential condition is not onerous. All that has to be established is that the subject injury materially contributed to the onset of the condition.[11]

[11] *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49 per Roche DP at [58].

103. I am satisfied that the injury to Ms Everingham's right shoulder on 12 March 2009 materially contributed to the condition of her left shoulder. There was considerable debate at the outset of the proceedings as to the appropriate date of injury, but it follows from my finding that the applicable date of injury is 12 March 2009, as pleaded.

SUMMARY

104. The Commission finds:

    (a) The accepted injury to the right shoulder has materially contributed to the applicant's left shoulder condition.

105. The Commission orders:

    (a) I remit this matter to the Registrar for referral to an AMS for an assessment of whole person impairment on the following bases:

(i)	Date of injury:	12 March 2009
(ii)	Matters for assessment:	Right upper extremity (shoulder) Left upper extremity (shoulder)
(iii)	Evidence:	ARD and attached documents, Reply and attached documents, complete report of Dr Conrad dated 20 January 2020.