WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **2218/20**
Applicant: **James Marsland**
Respondent: **Bing Lee Electronics Pty Ltd**
Date of Determination: **16 July 2020**
Citation: **[2020] NSWWCC 244**

The Commission determines:

1. The applicant sustained an injury to the left elbow on 2 October 2017 pursuant to s 4(a) of the *Workers Compensation Act 1987* (the 1987 Act).

2. The applicant's employment with the respondent was a substantial contributing factor to the injury pursuant to s 9A of the 1987 Act.

The Commission orders:

1. The respondent to pay the costs of and incidental to the ulnar nerve release surgery at the left elbow proposed by Dr Cherukuri pursuant to s 60 of the 1987 Act.

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

Rachel Homan
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 RACHEL HOMAN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

L Golic

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

STATEMENT OF REASONS

BACKGROUND

1. Mr James Marsland (the applicant) sustained an injury when he stumbled whilst carrying a microwave whilst in the course of his employment with Bing Lee Electrics Pty Ltd (the respondent) on 2 October 2017. An injury to the applicant's lumbar spine in this event was accepted by the respondent's insurer and on 12 April 2018, the applicant underwent surgery to his lumbar spine.

2. On 29 August 2019, the applicant's treating surgeon, Dr Ravi Kumar Cherukuri sought approval from the insurer for the applicant to undergo an ulnar nerve release surgery at the left elbow.

3. Liability for an injury or consequential condition at the applicant's left elbow and the surgery proposed by Dr Cherukuri was declined by the insurer in dispute notices issued pursuant to ss 78 and 287A of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) dated 27 November 2019, 17 December 2019 and 21 April 2020.

4. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) lodged in the Commission on 23 April 2020, seeking compensation under s 60 of the *Workers Compensation Act 1987* (the 1987 Act) for the costs of and incidental to the left ulnar release surgery proposed by Dr Cherukuri.

ISSUES FOR DETERMINATION

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

    (a) whether the applicant sustained an injury or consequential condition at his left elbow as claimed, and

    (b) whether the need for surgery results from the injury on 2 October 2017.

PROCEDURE BEFORE THE COMMISSION

6. The parties appeared for conciliation conference and arbitration hearing by telephone on 23 June 2020. The applicant was represented by Mr Mark Boulton of counsel, instructed by Mr Imran Khan, legal practitioner. The respondent was represented by Ms Lyn Goodman of counsel, instructed by Ms Amber Chandler.

7. 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

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

    (a) ARD and attached documents, and
    (b) Reply and attached documents.

9. Neither party applied to adduce oral evidence or cross-examine any witness.

Applicant's evidence

10. There are two written statements from the applicant in evidence but only one, dated 8 February 2020, relates to the issues presently in dispute.

11. On or around 2 October 2017, the applicant was carrying a microwave oven when his foot got caught in the packing strap for a fridge. The applicant tripped and fell forward but managed to save himself from falling to the ground. The applicant said he jarred himself quite badly in his attempts to not drop the microwave when he tripped. The applicant felt immediate pain in his back and heard a large crack in his neck.

12. The most serious injury at the time was the applicant's lower back. The applicant experienced pain from the lower back referred into his legs. The applicant focused on his back problems and discussed these issues with his general practitioner. The applicant was referred for various scans and physiotherapy. Eventually, the applicant was referred to a neurosurgeon, Dr Cherukuri, who recommended surgery.

13. The applicant underwent an L4/5 discectomy on 12 April 2018 performed by Dr Cherukuri. The surgery alleviated the pain and numbness the applicant was experiencing his right leg but the applicant continued to experience pain across his hips, legs and back.

14. After the back surgery, the pain in the applicant's neck and left elbow became more prominent. The applicant said:

> "I believe that my left elbow problems may have been related to the way I was getting out of bed after my back surgery. Because of the severe pain I was in from my back both before and after the surgery I would normally place all of my weight on my left elbow when rolling out of bed to avoid exacerbating my back pain. This technique was taught to me by physios in hospital. After doing this for an extended period of time on a daily basis I began to experience increasing pain and problems in my left elbow. The pain I experience in the inner side of my elbow extends from the elbow down my left forearm and into my hand and left little and ring fingers."

15. The applicant also described left-sided neck pain extending down the left arm into his wrist. The applicant said he experienced weakness of grip in his left hand and numbness in his left arm and hand.

16. The applicant was referred back to Dr Cherukuri when his neck and left elbow problems became more severe. Dr Cherukuri diagnosed left ulnar neuropathy at the elbow and left C6/7 radiculopathy. With respect to the left elbow problem, Dr Cherukuri recommended surgery in the form of left ulnar nerve release.

17. The applicant said he believed the surgery was the only option for him. All other conservative measures had failed to provide significant relief. The applicant said he understood the risks involved with the surgery and wished to pursue it. The applicant hoped that the surgery would provide some relief.

18. The applicant denied any previous injuries or problems at the left elbow. Prior to the incident at work, the applicant was pain-free and able to complete his normal work duties, which were quite physical and heavy in nature.

Treating medical evidence etc

19. A notification of injury/illness form completed by the applicant's employer described an injury on 2 October 2017 to the lower back. The injury was described as "hurt back while carrying a microwave oven". An accident and injury report form dated 2 October 2017 also describes the injury as affecting only the lower back.

20. The applicant was referred by his general practitioner, Dr Syed Bassam, to physiotherapist, Mr Rod Napier on 5 October 2017 for work-related lumbar injury and pain. An MRI of the lumbar spine performed on 1 November 2017 was reported to show L4/5 moderate postero-central disc protrusion touching the descending nerve roots. A CT guided steroid injection to the exiting left L4 nerve root was performed successfully on 28 November 2017. A further CT guided steroid injection was performed on the right on 30 November 2017.

21. Dr Bassam referred the applicant to neurosurgeon and spinal surgeon Dr Ravi Cherukuri on 7 December 2017 for ongoing lumbar and referred leg pain after work injury. Guided injections were said to have not helped much.

22. Further MRIs and x-rays of the lumbar spine were performed in early 2018. On 27 February 2018, Dr Cherukuri wrote to Dr Bassam reporting a history of acute onset of back pain radiating to both legs when the applicant hurt his back at work. Dr Cherukuri described the injury as occurring when the applicant was carrying about 10 to 15 kg, when he tripped and suddenly developed back pain. Dr Cherukuri advised that further investigations were required. On 16 March 2018, Dr Cherukuri requested approval for a right L4/5 laminotomy, foraminotomy, microlumbar discectomy and rhizolysis.

23. An operation report indicates that on 12 April 2018, the applicant underwent the surgery proposed by Dr Cherukuri at Wollongong Private Hospital. Dr Cherukuri reported to Dr Bassam that the applicant was doing quite well following surgery on 29 April 2018 and had stopped Endone and Palexia. The applicant was still on Norspan patch and Panadol Osteo.

24. In June 2018, Dr Bassam referred the applicant for psychological treatment.

25. On 7 December 2018, the applicant complained of paraesthesia in the left fourth and fifth fingers to Dr Bassam.

26. On 11 December 2018, an ultrasound of the left wrist was performed at Dr Bassam's request. A clinical history of paraesthesia in the left fourth and fifth fingers was noted in the report. The ultrasound was reported as revealing ulnar neuritis at the cubital tunnel at the left elbow and normal ulnar nerve appearance at the wrist.

27. On 30 January 2019, the applicant was referred by Dr Bassam to undergo an ultrasound guided left cubital tunnel injection of steroid.

28. On 1 May 2019, Dr Bassam referred the applicant back to Dr Cherukuri with regard to neurotic pain and symptoms of the fourth and fifth fingers which was initially confirmed to be ulnar neuritis at the elbow. This did not respond to cubital guided injections. An MRI of the cervical spine showed some discopathies.

29. Dr Cherukuri reported to Dr Bassam on 23 July 2019. Dr Cherukuri noted the history of injury to the lumbar spine and stated:

> "In addition he noticed neck pain, numbness in the left hand particularly the medial to fingers for the past year or more."

30. Dr Cherukuri said his examination showed left ulnar nerve distribution weakness and numbness in addition to left elbow flexion and extension weakness. Tinel's sign was positive over the ulnar nerve at the elbow. Dr Cherukuri noted that the applicant had undergone a cortisone injection for ulnar neuropathy and possibly an ultrasound although he did not have those reports. Dr Cherukuri referred the applicant for an MRI scan of the left elbow and nerve conduction studies.

31. An MRI of the left elbow was performed on 24 July 2019 and was reported to show mildly enlarged ulnar nerve with increased T2 signal, concerning for ulnar nerve neuropathy. There was overlying subcutaneous tissue oedema involving the region of the ulnar nerve extending to the medial aspect of the elbow.

32. A neurophysiologist, Dr Robert McGrath, performed nerve conduction studies on 12 August 2019, which were reported to show conduction velocity slowing of the left ulnar motor nerve across the elbow. Dr McGrath diagnosed left ulnar neuropathy at the level of the elbow.

33. On 29 August 2019, Dr Cherukuri reported to Dr Bassam that nerve conduction studies had confirmed left ulnar neuropathy at the elbow in addition to left C6/7 radiculopathy. MRI scan of the left elbow had confirmed the left ulnar neuropathy. Dr Cherukuri reported that the applicant's main symptoms were from the left ulnar neuropathy at the elbow with soft tissue injury around it which had been ongoing for a while. Dr Cherukuri advised the applicant of his options for management. As the applicant wished to consider surgery, Dr Cherukuri sought approval to proceed with a left ulnar nerve release at the elbow.

34. Dr Cherukuri reported again to Dr Bassam on 2 October 2019, stating:

> "We had a few questions to answer with regards to the onset of his symptoms from his neck and the elbow. He remembers hearing a big 'crack' in the neck when he originally injured his back. Of course the back and the leg pain have been quite intense and overshadowed the rest of his symptoms. He certainly became more aware of his neck and arm symptoms once he recovered from the back surgery and pre-pain has improved. He reckons some of the elbow symptoms might have aggravated when he was getting in and out of bed following the back surgery, although the symptoms might have been more prominent once he recovered from the back surgery with the distracting pain resolved following surgery."

35. Dr Cherukuri prepared a report for the applicant's solicitors on 19 February 2020. Dr Cherukuri noted that the applicant presented in July 2019 reporting numbness in the left hand particularly the medial to fingers for the past year or more. Dr Cherukuri diagnosed left ulnar neuropathy. Dr Cherukuri said the proposed left ulnar nerve release surgery was reasonably necessary in view of "clinical, radiological and electrophysical evidence of severe involvement of nerve". Dr Cherukuri said this was an accepted medical procedure and the chances of recovery were fair if done in a reasonable timeframe.

36. Dr Cherukuri was asked whether the applicant's injury on 2 October 2017 was a "substantial contributing factor to the injuries and disabilities at the lower back, neck and left elbow". Dr Cherukuri responded:

> "Yes, to lower back and neck; left elbow symptoms were not prominent initially and I haven't scan him at that time. They have certainly worsened over time and are preventing return to work."

Dr Guirgis

37. The applicant relies on a series of medicolegal reports prepared by consultant orthopaedic surgeon, Dr Medhat Guirgis, dated 26 November 2019, 20 January 2020 and 4 March 2020.

38. In his first report, Dr Guirgis took a history of the applicant carrying a microwave oven when his foot got caught in the packing strap for a fridge. The applicant tripped and fell forward and jarred himself badly as he remained upright holding the microwave, feeling immediate pain in his back. The applicant continued to complain of lumbosciatic symptoms that steadily worsened and failed to respond to usual conservative measures. Surgical treatment was performed by Dr Cherukuri on 12 April 2018. The post-operative period past uneventfully.

39. With regard to the left elbow symptoms, Dr Guirgis took a history as follows:

> "Following the surgery and as the ultra-acute painful lumbo-sciatic syndrome settled down after the surgery, he started noticing gradual onset and progressive course of left sided neck pain and stiffness with persistent radiation down the left arm with pain and dysthaesiae of C6/7 distribution stopping at the wrist level. He also described persistent pain in the inner side of his left elbow with radiation of pain and dysthaesiae form the medial border of his left elbow down the medial border of his left forearm & hand and to the left little & ring fingers. The electrophysiological tests confirmed the presence of signs of active left C6/7 radiculopathy and of active left ulnar neuropathy in the ulnar cubital tunnel. Dr Cherukuri had requested approval from the insurer to perform left ulnar release surgery in the ulnar cubital tunnel…"

40. Dr Guirgis's examination revealed localised tenderness over the internal epicondyle an extension of that tenderness to involve the medial intramuscular septum in the lower arm. The ulnar nerve was clinically irritable with a positive Tinel's sign and grade four weakness in the ulnar nerve supplied muscles on the left-hand.

41. Dr Guirgis provided an opinion on diagnosis and causation in the lower back and neck with regard to the left elbow Dr Guirgis said:

> "The left elbow involvement proved to be thought provoking. The incident would have caused straining in the ulnar nerve in its course through the fibro-osseous cubital tunnel while under loading of the weight of the microwave. A combination of shoulder abduction, elbow flexion, and wrist extension, while being exposed to the force of gravity pulling down the microwave load against the contraction of the involved muscles of the left upper limb to secure the load as what happened to his left arm in this case, would result in the greatest increase in cubital tunnel pressure, with ulnar intraneural pressure increasing to about 6 times normal.
> …
> Within the cubital tunnel, this significantly increased mean intraneural pressure would be greater than the mean extraneural pressure and this would block the transport of nutrients across the nerve interstitial fluid barrier. The nerve, axon, and myelin can be affected by this lack of normal axonal transport and this effect may be selective affecting some fascicles of the nerve than others. The following diagram shows the disposition of the various components of the ulnar nerve which would explain the current clinical presentation of Mr Marsland.
>
> In addition to the above discussed altered homeostasis in the ulnar cubital tunnel, it is documented that proximal compression of a nerve trunk in the neck, as a result of cervical radiculopathy, may lead to increased vulnerability to nerve compression in a distal segment. This 'double crush' condition in this case had affected the ulnar nerve through its course in the ulnar cubital tunnel.
>
> As such one should conclude that the current Mr Marsland's onset of symptoms and signs of ulnar cubital tunnel syndrome, was the result of the 2-10-2017 accident. On the balance of probabilities should the above accident did not happen, he would not be complaining of the symptoms and signs of ulnar cubital tunnel syndrome. The surgical treatment suggested by Dr Cherukuri is reasonable and necessary and should be accepted by the insurer as being liable for the injuries sustained as a result of the 2-10-2017 including the back, the neck, and the left elbow."

42. Dr Guirgis prepared a supplementary report dated 20 January 2020 in which he was asked to address a report prepared by the orthopaedic surgeon qualified by the respondent, Dr Raymond Wallace, dated 23 October 2019. Dr Guirgis responded:

> "I read with interest Dr Wallace's report and the answers to the cleverly put leading questions aiming at achieving the insurer's goal of denying liability to the neck and left upper limb symptoms. I beg to disagree with Dr Wallace's conclusions in my comments in this regard are as follows:
>
> 1….As a result of the resultant complex forces applied to his spine including sudden unguarded contraction of the paraspinal muscles in his neck and lower back, abnormal tracking in the facet joints, abnormal stretching of the spinal ligaments and shear stress loading of the intervertebral discs. It was clear from the natural history of his injury complex that he was in a state of ultra-acute lumbosciatic syndrome that would be expected to overshadow any other symptoms, for which he was prescribed strong analgesic medication which would mask the pain in his neck and his arm. The complaints in his neck and left arm started to became clear after he underwent the surgery on his lower back and the minimisation of pain killing medication.
>
> 2. The delay in the clinical presentation of the ulnar neuropathy around the left elbow could be explained by the kinematics of the ulnar nerve in the ulnar cubital tunnel. On the balance of probabilities, the 2-10-2017 incident resulted in micro-disruption in the fibrous covering of the fibro-osseous ulnar cubital tunnel leading to entrapment of the ulnar nerve. The excursion of the ulnar nerve up and down the narrowed segment of the tunnel with the movements of the elbow during the usual DLAs would cause changes in the intraneural microcirculation and nerve fibre structure, impairment of axonal transport, and alterations in vascular permeability, with oedema formation (responsible for the thickening noted in the MRI studies) and deterioration of nerve function as noted in the results of the electrodiagnostic studies. With this probable traumatic background, one would refrain from using the description of the condition to be 'idiopathic'."

43. Dr Guirgis said the most common cause of ulnar cubital tunnel syndrome was post-traumatic with a mostly delayed onset. Dr Guirgis agreed that the incident on 2 October 2017 was a substantial contributing factor to the injury to the left elbow.

44. In a report dated 4 March 2020, Dr Guirgis said he had considered a supplementary report of Dr Wallace dated 12 March 2020 and the applicant's statement. Dr Guirgis said:

> "In light of the above history, his symptoms in the left elbow appear to have become noticeable after his back surgery when he was placing his weight on his left elbow to get out of bed. As such, one could advised that performing this activity repeatedly after the surgery could have exacerbated the elbow problems leading to the need for left ulnar nerve release surgery."

Dr Wallace

45. The respondent relies on medicolegal reports prepared by orthopaedic surgeon, Dr Raymond Wallace, dated 4 November 2019 and 12 March 2020.

46. Dr Wallace took a history of the injury on 2 October 2017 as follows:

> "He was involved in an incident at work on 2 October 2017. At that time, he was carrying a microwave when his foot became caught in a packing strap causing him to stumble forwards. He states that he was able to 'drag himself back' to stop himself falling to the ground but felt a crack at his neck and noted the onset of pain at his back and legs."

47. Dr Wallace took a history of the treatment to the applicant's lumbar spine which was consistent with the evidence set out above. In mid-2018, the applicant noted the onset of numbness involving the ring and left little fingers of his left hand without a history of further injury. Dr Wallace noted that the applicant underwent corticosteroid injection at the left elbow on 30 January 2019. On 23 July 2019, he was reviewed by Dr Cherukuri who ordered further investigations in the form of MRI investigation and nerve conduction studies. On review on 29 August 2019, Dr Cherukuri diagnosed ulnar neuropathy at the left elbow and recommended surgical intervention in the form of left ulnar nerve release. The applicant noted no previous history of injury at his left elbow.

48. The applicant described paraesthesia and numbness globally about the ring and little fingers of the left hand and weakness of grip at the left hand.

49. With regard to causation, Dr Wallace stated:

> "There is no objective medical evidence that Mr Marsland suffered any injury at his left elbow at the time of his work incident on 2 October 2017.
>
> I note in the Accident & Injury Report form completed on 2 October 2017 that Mr Marsland notes the nature of his injury as, 'lower back injury.'
>
> At the time of initial review with Dr Cherukuri on 27 February 2018, some 5 months postinjury, he made no complaint of any cervical spinal or upper limb symptoms.
>
> Further, he did not undergo investigation in regard to his left hand symptoms until December 2018, at which time he underwent ultrasound examination of the left wrist for investigation of paraesthesia involving the ring and little fingers of his left hand. This investigation was carried out some 15 months post-injury in October 2017.
>
> Mr Marsland's ulnar neuropathy at the left elbow is idiopathic in origin and unrelated to his work incident of October 2017.
>
> The mechanism of injury he describes at work on 2 October 2017 of stumbling whilst carrying a microwave is not consistent with being the cause of any significant left elbow pathology."

50. Dr Wallace agreed that the applicant had evidence of ulnar neuropathy at the left elbow and would benefit from ulnar nerve release at the left elbow for treatment of the idiopathic ulnar neuropathy. Dr Wallace found that there was no causal link to the accepted lumbar injury.

51. In the supplementary report of 12 March 2020, Dr Wallace said he had reviewed the reports of Dr Guirgis dated 26 November 2019 and 20 January 2020. Dr Wallace maintained his opinion that the applicant had not suffered any injury at his left elbow as a result of the work incident on 2 October 2017 for the reasons detailed in his previous report.

52. Dr Wallace said Dr Guirgis's explanation did not cause him to alter his opinion as to causation. The description of the work incident on 2 October 2017 was not consistent with being the cause of any significant left upper limb pathology. Asked to comment on Dr Guirgis's inclusion of the history of trauma in the development of the worker's left elbow condition, Dr Wallace said he had "no idea what Dr Guirgis is talking about".

Applicant's submissions

53. Mr Boulton said the applicant's second statement set out how he came to be injured. Mr Boulton noted the treatment to the applicant's back including the surgery performed by Dr Cherukuri and said that after the surgery the pain in the applicant's elbow became more prominent. The applicant expressed the belief that the symptoms in his left elbow may have been related to the way he was getting out of bed following the back surgery. This opinion was supported by Dr Guirgis.

54. Mr Boulton noted that there was no dispute as to the pathology in the applicant's left elbow. It was also agreed that surgery was the applicant's only option. Mr Boulton described the relevant issue as the relationship between the surgery and the injury on 2 October 2017.

55. Mr Boulton said the applicant's case received support from Dr Cherukuri. Although Dr Cherukuri's reports provided no clear path of reasoning, he was the applicant's treating surgeon since February 2018. Dr Cherukuri had formed an opinion based upon a lengthy period of treatment that there was some connection between the left elbow condition and the work injury.

56. Mr Boulton said support also came from the reports of Dr Guirgis. Dr Guirgis thought the issue of causation was "thought-provoking" indicating some challenge in working out what was causing the left elbow problem. Dr Guirgis had quoted from a number of articles and research in trying to resolve the thought-provoking problem. Dr Guirgis concluded that these symptoms and signs of ulnar cubital tunnel syndrome were the result of the incident on 2 October 2017. Dr Guirgis concluded that on the balance of probabilities the applicant would not be complaining of the symptoms and signs of ulnar cubital tunnel syndrome had it not been for the injury.

57. Mr Boulton noted that there did not seem to be any dispute that the applicant had no previous history of symptoms attributable to the left ulnar nerve. The only traumatic event revealed by the evidence was that which occurred on 2 October 2017. Dr Guirgis related the pathology to that incident.

58. Mr Boulton noted that Dr Guirgis, in his first report, considered the mechanism of injury supported the involvement of the left elbow in the initial event. The symptoms became more prominent after the surgery in April 2018. Until that point, the applicant had been prescribed strong analgesic medication, which would have masked the pain in his neck and arm. Those complaints became clearer after the painkilling medication was minimised following the surgery. Mr Boulton said this explained the delayed onset of symptoms. Dr Guirgis had also expressed the opinion that the most common cause of the syndrome was post-traumatic with delayed onset.

59. Mr Boulton noted that in his second supplementary report Dr Guirgis had additionally expressed the opinion that getting out of bed could have exacerbated the condition leading to the need for surgery.

60. Mr Boulton noted that Dr Wallace's report emphasised the delayed onset of symptoms. Dr Wallace expressed the view that the condition was idiopathic. Dr Wallace had not dealt with Dr Guirgis's view that the most common cause of the applicant's condition was trauma with delayed onset of symptoms.

61. Mr Boulton said I would accept the opinion of Dr Guirgis as he had provided a full explanation of the causal relationship between the condition at the left elbow and the injurious event. Dr Wallace simply disagreed and did not refer to any literature.

62. Mr Boulton noted that Dr Wallace did not deal at all with the alternative reasoning path suggested by Dr Guirgis in his supplementary report.

63. Mr Boulton submitted that the Commission would prefer the views of Dr Guirgis, as supported by Dr Cherukuri.

Respondent's submissions

64. Ms Goodman submitted that I would not be satisfied that there was an injury to the applicant's left elbow. It was not until 7 December 2018 that any practitioners were given a history of paraesthesia in the left fourth and fifth fingers. Ms Goodman noted that it was Dr Bassam that obtained that history in a consultation of that date. The notes of that consultation indicated there had been a case conference in relation to the applicant's accepted lumbar injury. The paraesthesia of the left fourth and fifth fingers and ulnar nerve sheath tightness were identified as the second matter dealt with at the consultation.

65. Ms Goodman noted that the applicant first saw Dr Bassam on 5 October 2017. On that occasion, the applicant made no complaint of injury to any body part other than the lumbar spine. No complaints were recorded in the clinical notes in relation to the left elbow until the consultation on 7 December 2018 despite multiple attendances in the intervening period. Ms Goodman said it was more than a year after the original incident that the complaints were first made.

66. Ms Goodman noted that the applicant had suggested that his elbow symptoms became more prominent following the surgery. Ms Goodman noted, however, that the surgery was performed in April 2018. No complaints were made for a further eight months until December 2018. The applicant continued to see Dr Cherukuri in the period following the surgery but there was no mention of any symptoms in the left elbow until 23 July 2019 when the nerve conduction studies were performed. On that occasion, it was reported by Dr Cherukuri that the applicant had experienced numbness for a year or more. Despite this, there were no reported complaints.

67. Ms Goodman submitted that Dr Cherukuri did not in any way deal with causation of the left ulnar neuropathy. Ms Goodman noted that there was nothing in the reports of the applicant's psychologist to indicate the applicant was experiencing symptoms at the left elbow. The applicant was also undergoing physiotherapy and the reports from the physiotherapist revealed nothing in relation to the left elbow.

68. Ms Goodman noted that the applicant's first written statement recorded the incident on 2 October 2017 but said nothing about the left elbow. Although that statement was dated in 2018 it referred to events in 2019 suggesting the date was wrong. Ms Goodman noted that the applicant's second statement was prepared after Dr Guirgis's first report of 26 November 2019. It was only after Dr Guirgis's report that the applicant suggested injury to other body parts as a result of the event on 2 October 2017. Ms Goodman suggested that the evidence set out in the second statement consisted of a recent construction based upon Dr Guirgis's report.

69. Ms Goodman noted that the notification of injury reports referred only to the back.

70. Ms Goodman submitted that at the end of the day the Commission would not be satisfied that the applicant suffered a primary injury to his left elbow ulnar nerve on 2 October 2017, owing to a lack of contemporaneous material and the length of time before complaints were articulated.

71. Ms Goodman submitted that the Commission would also not accept that there was a consequential condition given the lack of complaint until five or six months after the surgery, during which time the applicant was seen by his general practitioner and surgeon without reference to symptoms.

72. Ms Goodman submitted that the evidence set out in the applicant's second statement should not be accepted given the passage of time between the injury and the date the statement was prepared. The statement was prepared more than two and half years after the actual incident.

73. Ms Goodman submitted that Dr Guirgis's opinion should not be accepted because the history provided to him could not be accepted. Dr Guirgis did not explain the length of the delayed onset of symptoms. Ms Goodman described the delay as considerable, consisting of more than one year.

74. Ms Goodman noted that Dr Wallace's first report was prepared before the applicant's second statement. Dr Wallace was not aware of any allegation of a consequential condition. Dr Wallace was given a history that in mid-2018, the applicant noted the onset of numbness without a history of further injury. It was not until six months later that the applicant actually complained of his symptoms to Dr Bassam. Although Dr Wallace agreed there was ulnar nerve neuropathy, he said it was idiopathic in origin and unrelated to the injury given the delay. Dr Wallace further considered the mechanism of injury was not consistent with any significant elbow pathology.

75. Ms Goodman conceded that Dr Wallace did not address the applicant's claim of aggravation due to getting out of bed. Although this allegation was unanswered, Ms Goodman submitted that it would not be accepted because of the very long period before any symptoms emerged. Ms Goodman submitted that the Commission would not be satisfied that the condition at the applicant's left elbow related either to the frank incident or any consequential condition.

Applicant's submissions in reply

76. Mr Boulton submitted that the event on 2 October 2017 constituted a serious injury to the back. That explained the reference to the lumbar spine in the injury notification forms. Mr Boulton submitted that thereafter the applicant was treated only for his lumbar spine because that was his major concern. Although the applicant was referred to Dr Cherukuri in December 2017, he did not see Dr Cherukuri until February 2018. By that time, the applicant had sciatica down both legs. Mr Boulton submitted that the failure of the doctors to record the applicant's complaints was insignificant given the quite significant back symptoms and the nature of the procedure performed.

77. Mr Boulton noted that Dr Cherukuri recorded a history of significant elbow symptoms for the past year or more in July 2019. Mr Boulton submitted that the applicant was not cross-examined and the Commission should believe that what he said was true. The symptoms may not have been recorded in the general practitioner's notes but that was not of great significance. Mr Boulton submitted that there was no reason why the applicant's physiotherapist or psychologist would record anything about the elbow. Mr Boulton submitted that the Commission should accept what the applicant had told his doctors about the onset of problems that is, things became more prominent following the surgery. Up until that point, the treatment had focused on the lumbar spine.

FINDINGS AND REASONS

Injury

78. Section 9 of the 1987 Act provides that a worker who has received an 'injury' shall receive compensation from the worker's employer in accordance with the Act. The term "injury" is defined in s 4 of the 1987 Act as follows:

> **"4 Definition of 'injury'**
>
> In this Act:
> **injury:**
>
> (a) means personal injury arising out of or in the course of employment,
>
> (b) includes a disease injury, which means:
>
> (i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and
> (ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, and
>
> (c) does not include (except in the case of a worker employed in or about a mine) a dust disease, as defined by the *Workers' Compensation (Dust Diseases) Act 1942*, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined."

79. The applicant in this case claims that he sustained both an "injury" pursuant to s 4(a) to his left elbow on 2 October 2017 and a consequential condition at his left elbow resulting from the lumbar injury on that date, as result of repeatedly leaning on the left elbow to get out of bed following the lumbar surgery.

80. Although there is no dispute as to the nature of the pathology at the applicant's left elbow or that the surgery proposed by Dr Cherukuri is reasonably necessary treatment for that pathology, there is a dispute as to the causal connection between the pathology at the left elbow and the work incident on 2 October 2017.

81. As noted by Ms Goodman, no symptoms were reported at the applicant's left elbow following the injurious event until a consultation with the applicant's general practitioner, Dr Bassam on 7 December 2018. That is, some 14 months after the injurious event and despite multiple medical consultations, claim forms and a written statement having been completed in the intervening period. Dr Bassam's clinical notes of the consultation on 7 December 2018 do not suggest that the symptoms complained of in the applicant's fingers at that time were related to the work injury. The clinical history set out in the report of the ultrasound performed on 11 December 2018 also made no reference to a work injury.

82. An injection to the left cubital tunnel was performed in January 2019 and on 1 May 2019, Dr Bassam considered it appropriate to refer the applicant back to Dr Cherukuri. The letter of referral to Dr Cherukuri of that date refers to a work-related lumbar spine injury and surgery "AND" symptoms of ulnar neuritis at the elbow. The manner in which the referral is expressed suggests that the symptoms of ulnar neuritis were regarded as separate to the work-related injury. At the very least, the referral from Dr Bassam does not explicitly suggest a connection between the ulnar neuritis and the work-related lumbar spine injury. There is no opinion from Dr Bassam in the evidence before me dealing with causation in respect of the left elbow symptoms.

83. Dr Cherukuri's first report dealing with the left elbow symptoms on 23 July 2019 also does not explicitly suggest a connection between the elbow symptoms and the work injury. The history recorded by Dr Cherukuri was of symptoms for the past year or more, suggesting an onset in mid-2018.

84. The first suggestion of a possible connection between the symptoms at the left elbow and work injury arises from Dr Cherukuri's request for approval from the respondent's insurer to proceed with the left ulnar nerve release in the letter on 29 August 2019.

85. Dr Cherukuri dealt expressly with the issue of causation in his letter of 2 October 2019. Dr Cherukuri, on this occasion, referred to the history given by the applicant of a crack in his neck at the time when he originally injured his back. Dr Cherukuri's report suggests the back and leg pain were intense and overshadowed the other symptoms. The applicant became more aware of arm symptoms once he recovered from the back surgery and the preoperative pain had improved. Dr Cherukuri also recorded the applicant's opinion that some of the elbow symptoms might have been aggravated by getting in and out of bed following the back surgery.

86. I do not accept that this letter from Dr Cherukuri, contains an opinion from Dr Cherukuri himself with regard to the cause of the applicant's symptoms. Rather it constitutes a record of the applicant's opinion as to causation.

87. Similarly, Dr Cherukuri seems to have avoided giving his own opinion on causation despite direct questioning from the applicant's solicitors in his report of 19 February 2020. Although Dr Cherukuri expressly agreed that the lower back and neck symptoms were related to the injury on 2 October 2017, he merely stated that the left elbow symptoms were not prominent initially and he had not scanned the applicant at the time. The symptoms were said to have worsened over time and were preventing a return to work.

88. I am not satisfied, therefore, that there is any actual opinion from Dr Cherukuri in support of a causal connection between the applicant's left elbow symptoms and the work injury on 2 October 2017. There is in fact, no direct evidence on this issue from any of the applicant's treating practitioners.

89. The only opinion in favour of a causal connection between the left elbow symptoms and the work injury appears in the reports of Dr Guirgis. Dr Guirgis's first report suggests that he found it somewhat challenging to discern a relevant causal connection. This is reflected in his comment that the matter proved to be "thought provoking".

90. Dr Guirgis found, however, that the mechanism of injury would have, through a combination of shoulder abduction, elbow flexion and wrist extension while being exposed to the force of gravity pulling down on the microwave load, caused an increase in cubital tunnel pressure. Dr Guirgis said this pressure would have blocked the transport of nutrients across the nerve interstitial fluid barrier, affecting the nerve. In addition, Dr Guirgis suggested there may be a "double crush condition" whereby the compression of a nerve trunk in the neck as a result of cervical radiculopathy may lead to increased vulnerability to nerve compression at a distal segment, in this case the ulnar cubital tunnel.

91. Dr Guirgis's explanation of the causal connection is complex and difficult for a layperson to follow. The elaboration provided in Dr Guirgis's supplementary report is equally difficult to follow. In that report, Dr Guirgis said the incident on 2 October 2017 had caused "micro-disruption in the fibrous covering of the fibro-osseous ulnar cubital tunnel leading to entrapment of the ulnar nerve". This was said to have caused "changes in the intraneural microcirculation and nerve fibre structure, impairment of axonal transport, and alterations in vascular permeability, with oedema formation … and deterioration of nerve function".

92. Although Dr Guirgis has expressed the view that the most common cause of ulnar cubital tunnel syndrome is post-traumatic with a "mostly delayed onset", I accept Ms Goodman's submission that Dr Guirgis has not expressly considered whether a significant delay, in this case of around nine months after the traumatic event, based on the history provided to Dr Cherukuri, is common. Dr Guirgis does, however, accept that the pain and analgesic medication relating to the applicant's lumbar spine injury up until the time of surgery may have masked the early symptoms. In this regard, I am satisfied that Dr Guirgis was aware there was a significant delay in reported symptoms in this case.

93. Dr Guirgis has also accepted, based on the applicant's history, that the symptoms in the left elbow became more noticeable following the surgery due to the applicant placing weight on his left elbow to get in and out of bed. Dr Guirgis expressed the view that performing this activity repeatedly after the surgery could have exacerbated the elbow problems, leading to the need for left ulnar nerve release surgery.

94. Weighing against Dr Guirgis's opinions are the opinions expressed by Dr Wallace. Dr Wallace's view that the ulnar neuropathy at the left elbow was unrelated to employment appears to have been based primarily on the absence of contemporaneous reporting of injury to the left elbow. Dr Wallace has not addressed Dr Guirgis's view that it is common for there to be a delayed onset of symptoms following trauma at the cubital tunnel. Dr Wallace has also not explicitly addressed the possibility that the applicant's back pain and analgesic treatment may have masked or overshadowed the early symptoms at the left elbow.

95. Dr Wallace did express the view that the mechanism of injury was inconsistent with being the cause of any significant left elbow pathology. Dr Wallace did not, however, explain why this was the case. Given that carrying the microwave would, as a matter of common sense or logic, have entailed some load to the elbow, which may have increased suddenly when the applicant tripped and fell forward, I consider that some explanation or reasoning in support of Dr Wallace's opinion was warranted.

96. Dr Wallace also failed to address at all Dr Guirgis's view that the symptoms in the left elbow would have been aggravated by the applicant placing weight on the left elbow to get in and out of bed following the surgery to his lumbar spine.

97. Although Dr Wallace has said that the reports of Dr Guirgis did not cause him to alter his opinions, he has not explicitly engaged with Dr Guirgis's reasoning or provided any explanation for why he did not consider that reasoning persuasive.

98. The Court of Appeal in *Nguyen v Cosmopolitan Homes*[1] has found that a tribunal of fact must be actually persuaded of the occurrence or existence of the fact before it can be found, summarising the position 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

[1] [2008] NSWCA 246.

(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."

99. It is the applicant who bears the onus of establishing on the balance of probabilities that he sustained an injury or consequential condition at the left elbow.

100. The applicant has provided a lay opinion as to the cause of his elbow symptoms which has been accepted by his medicolegal expert. Ms Goodman submitted that the applicant's evidence should not be accepted due to the passage of time between its preparation and the incident. The failure to mention the elbow symptoms in the first statement and the late preparation of the second statement, can, however, be explained by the delayed onset of symptoms. The applicant's complaints of symptoms, once articulated, have been consistent.

101. The applicant's expert, Dr Guirgis, has provided a reasoned, albeit somewhat convoluted, explanation of the causal connection between the incident on 2 October 2017 and the left elbow symptoms, which pays regard to the particular mechanism of injury.

102. I am also satisfied that Dr Guirgis was aware of the delay in reporting symptoms and addressed this by reference to a delayed onset of symptoms being common as well as the presence of an "ultra-acute lumbosciatic syndrome" treated by strong analgesic medication which would be expected to overshadow or mask the symptoms in the elbow.

103. Dr Guirgis's view that there is a causal connection between the incident on 2 October 2017 and the symptoms which the surgery is proposed to treat receives implicit although not explicit support from Dr Cherukuri by virtue of his request for approval from the respondent's insurer.

104. Dr Wallace's reports, on the other hand, lack sufficient reasoning or explanation to cause me to doubt that Dr Guirgis's expert opinion should not be accepted. I am satisfied that there is a fair climate for the acceptance of Dr Guirgis's opinion and do so.

105. Ultimately, while I do not find the applicant's evidence on causation especially compelling, on the balance of probabilities, I am satisfied that the applicant did sustain an injury to the left elbow on 2 October 2017 for the purposes of s 4(a) of the 1987 Act. I am further satisfied on the basis of Dr Guirgis's reports that employment was a substantial contributing factor to the injury the purposes of s 9A of the 1987 Act.

106. Having made these findings, I accept that the applicant has a compensable injury at the left elbow. Section 60 of the 1987 Act relevantly provides:

"(1) If, as a result of an injury received by a worker, it is reasonably necessary that:

(a) any medical or related treatment (other than domestic assistance) be given, or
(b) any hospital treatment be given, or
(c) any ambulance service be provided, or
(d) any workplace rehabilitation service be provided,

the worker's employer is liable to pay, in addition to any other compensation under this Act, the cost of that treatment or service and the related travel expenses specified in subsection (2)."

107. There is no medical dispute that the surgery proposed by Dr Cherukuri is reasonably necessary treatment for the pathology at the applicant's left elbow. There will be an order for the respondent to pay the costs of and incidental to the surgery.

SUMMARY

108. The applicant sustained an injury to the left elbow on 2 October 2017 pursuant to s 4(a) of the 1987 Act.

109. The applicant's employment with the respondent was a substantial contributing factor to the injury pursuant to s 9A of the 1987 Act.

110. The respondent to pay the costs of and incidental to the ulnar nerve release surgery at the left elbow proposed by Dr Cherukuri pursuant to s 60 of the 1987 Act.