WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: 4876/20
Applicant: Shane Jonathon Hare
Respondent: Boral Construction Materials Group Ltd
Date of Determination: 19 January 2021
Citation No: [2021] NSWWCC 20

The Commission determines:

1. Award for the respondent in respect of the claim pursuant to section 66 of the Workers Compensation Act 1987 (the 1987 Act) in respect of impairment alleged to arise from injury to the cervical spine and the onset of a pathological condition in the lumbar spine as a result of injury to the cervical spine by way of incomplete cervical lesion.

2. The remaining claim pursuant to section 66 of the 1987 Act is remitted to the Registrar for referral to an Approved Medical Specialist to assess whole person impairment arising from injury to the left upper extremity (shoulder) on 29 September 2005.

3. The documents to be supplied to the Approved Medical Specialist should include:

    (a) The Application to Resolve a Dispute and attached documents;

    (b) Reply and attached documents;

    (c) Documents attached to Application to Admit Late Documents by the applicant dated 9 September 2020;

    (d) Documents attached to Application to Admit Late Documents by the respondent dated 10 November 2020, and

    (e) Documents attached to Application to Admit Late Documents by the applicant dated 16 November 2020

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

W Dalley
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 OFWILLIAM DALLEY, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

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

STATEMENT OF REASONS

BACKGROUND

1. Shane Jonathon Hare, (Mr Hare/the applicant) has filed an Application to Resolve a Dispute (the Application) seeking further lump sum compensation pursuant to section 66 of the *Workers Compensation Act 1987* (the 1987 Act) in respect of injuries alleged to have been suffered in the course of his employment with Boral Construction Materials Group Limited (the respondent) on 29 September 2005.

2. Mr Hare had previously been paid lump-sum compensation in 2007 in respect of 7% whole person impairment resulting from impairment in the left upper extremity (shoulder) and had received a further payment in 2011 in respect of 1% whole person impairment (WPI) resulting from impairment in the right upper extremity (elbow).

3. In the Application filed in the Commission Mr Hare alleged injury "to the cervical spine, central incomplete cervical cord lesion, left shoulder, left bicep tear, lumbar spine, weakness in his legs and left hemi sensory deficit" as well as a "consequential injury to the right elbow from overuse and compensating for left shoulder as well as consequential injury to the left carpal tunnel."

4. The claim pursuant to section 66 of the 1987 Act was made in respect of impairment to the left upper extremity, cervical spine and lumbar spine.

5. The respondent did not dispute injury to the left upper extremity but disputed injury to the cervical spine and lumbar spine.

ISSUES FOR DETERMINATION

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

    (a) Did the applicant suffer injury to his cervical spine in the course of his employment with the respondent on 29 September 2005?

    (b) Did the applicant, as result of injury to the cervical spine, suffer the onset of a consequential condition giving rise to impairment in the lumbar spine?

    (c) If it is found that the applicant suffered injury to his cervical spine and onset of a consequential condition in the lumbar spine what is the extent of impairment flowing from the cervical spine injury and lumbar spine condition respectively?

Matters not previously notified

7. At hearing, the applicant amended the application to delete the claim of injury to the lumbar spine and to substitute a claim of onset of a consequential condition in the lumbar spine as a result of injury to the cervical spine by way of incomplete cervical lesion.

PROCEDURE BEFORE THE COMMISSION

8. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

9. The matter proceeded to hearing on 17 November 2020. Mr Wilson of counsel appeared for the applicant and Ms Goodman of counsel appeared for the respondent. Leave was granted to the respondent to admit late medical reports. The applicant sought to have admitted, at the hearing, two further medical reports in reply. The admission of the applicant's late reports was opposed by the respondent.

10. For the reasons given at the hearing, leave was granted to the respondent to admit the late medical reports in its case and the applicant was directed to file and serve the medical reports in reply which the applicant sought to rely on. A direction was made for the matter then to proceed by way of written submissions.

EVIDENCE

Documentary evidence

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

    (a) Application and attached documents;

    (b) Reply and attached documents;

    (c) Documents attached to the Application to Admit Late Documents by the applicant dated 9 September 2020;

    (d) Documents attached to the Application to Admit Late Documents by the respondent dated 10 November 2020; and

    (e) Documents attached to the Application to Admit Late Documents by the applicant dated 16 November 2020.

12. A claim for lump-sum compensation based on the same or similar allegations of injury had proceeded to hearing before me on 25 November 2019 before being discontinued to permit consideration to be given to adding a further body part. The oral submissions of the parties in those proceedings were recorded, a transcript was made available to the parties and leave was granted to refer to and incorporate appropriate excerpts from those submissions in the present proceedings. (No further body part was in fact added.)

Oral evidence

13. No application was made for the giving of oral evidence or for the cross examination of any witness.

FINDINGS AND REASONS

Issue 1 – injury to the cervical spine

14. The applicant submitted that the evidence established cervical spine injury by way of incomplete cervical lesion and a consequential injury[1] to the lumbar spine. The applicant sought orders referring the cervical spine injury and consequential condition in the lumbar spine with the diagnosis of "incomplete central cervical cord lesion" together with "injuries to the left arm and left shoulder" with the diagnosis of "brachial plexus lesion" for assessment by an Approved Medical Specialist. In the alternative, the applicant sought orders for the referral of those body parts without the suggested diagnoses.

[1] Strictly speaking the appropriate allegation was of a "condition" rather than an "injury".

15. The applicant's claim is based on assessment of the left upper extremity by an orthopaedic surgeon, Dr Roger Pillemer, who had assessed 7% WPI as result of injury to the left upper extremity and an assessment by a neurologist, Dr Paul Teychenné, who assessed the cervical spine at 15% WPI, lumbar spine and 10% WPI with an additional 2% WPI in respect of restriction of activities of daily living.

16. The respondent did not dispute that injury to the left upper extremity was established. The respondent disputed that the applicant had suffered injury to the cervical spine whether by way of incomplete cervical lesion or otherwise and accordingly disputed that the applicant had suffered a consequential condition in the lumbar spine.

17. The applicant that Mr Hare had suffered prior problems with his neck and back but submitted that "the complaints were minor in nature and never prevented the applicant from performing his preinjury duties with his employer." The applicant submitted that Mr Hare in the course of his employment with the respondent had been required to perform hard manual labour without restrictions.

Pre-existing injury history

18. Mr Hare, in his statement dated 17 September 2019 noted a number of previous accidents. He said that he had suffered a fall from a motorbike and 1985 when he had suffered injury to right elbow, fracture of the left arm and broken ribs.

19. On 12 October 1987, he suffered injury when his right arm was caught in a moving conveyor belt. Treatment involved revision of the surgery which had previously been carried out with respect to the right elbow.

20. Mr Hare said that he had commenced proceedings against his previous employer in the Compensation Court seeking lump sum compensation in respect of injuries to both arms, his back and neck as result of the conveyor belt injury in 1987. His recollection was that this was in 1997 at the proceedings number that he provides, 7399/95, clearly indicates that it was somewhat earlier.

21. The Application for Determination in those proceedings was in evidence and confirms that a claim was made in respect of permanent impairment of the neck and permanent impairment of the back in addition to the right arm at that time. That Application for Determination asserts that Mr Hare had no capacity for work following the 1987 accident and made a claim for the maximum statutory rate throughout that period at least to the date of filing in 1995.

22. Mr Hare noted that the proceedings had been discontinued in February 1997 for want of evidence by way of medical records. Mr Hare stated that, prior to the subject injury on 29 September 2005, he had been in good health and had rarely seen his doctor for treatment.

23. In correspondence which was in evidence, the respondent drew Mr Hare's attention to SIRA records which showed nine prior claims for injuries sustained from 12 October 1987 up to the date of the subject injury on 29 September 2005. The applicant's solicitors provided details of those previous accidents and their reply can be summarised as follows:

    12/10/87 – conveyor belt injury referred to above;

    24/11/88 - contraction of disease condition in the stomach;

    17/01/89 - laceration to the right knee;

    06/11/89 - not recalled;

    29/08/90 - not recalled;

06/03/90- not recalled;

15/10/03 - “may have been for a stiff neck”;

11/05/05 - not recalled – possibly a reference to injury on 1 June 2005, and

01/06/05 - “strain to his neck and upper back when some timbers fell from a bundle onto his neck and upper back.”

24. A letter from the relevant insurer confirmed that payment had been made in respect of a visit to a medical practitioner in respect of the accident on 1 June 2005 but there did not appear to be any loss of wages.

25. Based on that evidence I am satisfied that Mr Hare suffered previous injuries to his neck on 12 October 1987 and on 1 June 2005. He suffered an injury to his back in the earlier of these accidents. I am satisfied that Mr Hare continued to suffer symptoms in his neck and back as a result of the earlier accident up until at least 1995. I make that finding based on an inference that, prior to commencing proceedings, Mr Hare would have been assessed by an independent medical expert and would have been complaining of symptoms arising from the neck and back as otherwise the claim could not have been made.

Cervical spine injury

26. The respondent submitted that the absence of any complaint of neck pain prior to 2008 cast doubt on injury to the neck having occurred as a result of the subject accident in September 2005. In answer to that submission the applicant reviewed the medical evidence, noting that the treating notes of the original treating general practitioner, Dr Antoun, were not available as they had been destroyed.

27. The applicant noted that the first report of neck symptoms in the available evidence was to be found in progress notes of the general practitioner, Dr Sor. The applicant submitted that, when read in the light of the evidence of Mr Hare, the delay was explained by the concentration on the pathology in the left shoulder and the issue of whether there was brachial plexus involvement.

28. It is not disputed that Mr Hare’s two previous claims for lump-sum compensation made respectively in 2007 and 2011 had not included a claim in respect of the cervical spine.

29. The first issue to be determined upon arbitration hearing in the present proceedings is whether Mr Hare suffered injury to his cervical spine in the course of his employment on 29 September 2005. The probative value of reports by treating practitioners and independent medical experts in later years is partly governed by the issue of whether it is accepted that Mr Hare has complained of symptoms that are found to relate to the cervical spine either continuously since the date of the accident or within a relatively short time thereafter.

Shane Hare, the applicant

30. A number of statements by Mr Hare were in evidence. The first of these is dated 6 December 2005 and appears to have been made to an insurance company investigator. Mr Hare confirmed that he was born in 1969 and is left-handed. He said that he had always worked in his present position with the respondent for the last three years. He noted that his duties included filling orders for scaffolding to be placed onto pallets. He also drove a forklift.

31. Mr Hare described work he was allocated on 29 September 2005 lifting scaffolding components weighing between 10 and 20 kg. He said:

> "I remember walking past one of the pallets and seeing that one of the standards wasn't sitting correctly. As I walked back past it I grabbed it with my left hand to straighten it up. I kept walking holding it but the standard had become wedged. I didn't realise it at the time. It jarred my shoulder because I had kept walking. I told Paul that I had hurt my shoulder but didn't think much of it that first time. I kept working with Paul."

32. Mr Hare said that on a subsequent lift on that day his side of the load had not moved and he had felt more pain in the shoulder. He reported to the first aid station and was told to go and see a doctor. He said that he put ice on the shoulder, but by the end of the day his shoulder was very painful. He said he found it difficult to drive home.

33. Mr Hare said he saw Dr Antoun the next day and was placed on light duties. He said an MRI scan had shown ligament and joint damage. A cortisone injection had not helped. He described his current condition as "uncomfortable" and said that he was "still concerned about my shoulder". He said he had never previously had any workers compensation claims.

34. Mr Hare described the accident as continuing to impact on his social life, restricting him from assisting in housework and noting that driving was "a bit difficult" and was also the case with parking.

35. In a further statement dated 11 January 2008, Mr Hare again described how the injury occurred:

> "I sustained an injury to my left shoulder and arm during the course of my employment on 29 September 2005 while sorting out pallets of 3 m long standard scaffolding. I gripped the scaffolding with my left hand and tried to lift it. Unfortunately the scaffolding did not move when I pulled it and I immediately noticed pain in my left shoulder radiating down my arm. I reported the incident then drove myself home. I found it extremely difficult to drive home due to the high levels of pain and limited range of movement."

36. Mr Hare noted that he had consulted a general practitioner, Dr Anton [sic] but had subsequently consulted Dr Sor. He noted that he been referred to an orthopaedic surgeon, Dr Goldberg, who carried out surgery on the left shoulder on 16 February 2006. Mr Hare noted that, following the injury, he had been performing light duties until the surgery was performed.

37. Mr Hare said that until the subject accident he had been performing additional work as a forklift driver for another company and had also been a drummer in a band for many years.

38. Mr Hare described his symptoms:

> "I still experience pain in my left shoulder on a daily basis and this is further aggravated if I lift objects. Not only do I experience pain in my left shoulder but I feel that to overcompensate for my injury my right elbow is becoming extremely painful. I am able to ease some of the symptoms by stretching however I am never totally pain-free."

Mr Hare did not refer to symptoms in his neck in that statement.

39. In a further statement dated 30 January 2017, Mr Hare again described the subject accident saying, “I wrenched my left shoulder and I had intense pain in my left shoulder.” Although Mr Hare said in his earliest statement that he had continued to work on light duties for his “full hours”[2] his subsequent recall was that Dr Antoun had placed him on light duties four days per week with a lifting restriction of 15 kg. He noted that he had had physiotherapy.

40. Mr Hare noted the referral to Dr Goldberg and subsequent surgery with a return to work on light duties after some weeks. He said his left arm was in a sling. He continued to suffer pain and developed symptoms in the right elbow. Dr Antoun referred him to a physician, Dr John Best who treated his right elbow.

41. Mr Hare’s employment with the respondent was terminated in 2007 and he set out the work that he had performed since then. He said that his left shoulder was always painful and symptoms in the right elbow were getting worse. He was receiving treatment for depression and severe anxiety.

42. Mr Hare reported: “I have constant pain in the left shoulder. There is numbness and there is hypersensitivity in the left hand. There is a damaged nerve in the left side of my neck. The neck was also injured in the accident. I do not have a full range of movement in the left shoulder.”

43. Mr Hare noted earlier injuries including the motorbike accident in 1986, the onset of the disease resulting from falling into a grease trap and the injury suffered cleaning a conveyor belt in 1987.

44. In a further statement dated 17 September 2019, Mr Hare noted that he was left hand dominant. He said that as a result of the accident in September 2005, he had suffered injury to his “left shoulder, partial cervical cord lesion, neck, symptoms in the lumbar spine of weakness in the legs and left hemi sensory deficit, and consequential injury to the right elbow from overuse.”

45. Mr Hare again noted the motorcycle accident which he then thought was in 1985, the incident with the grease trap in 1987 and the injury while cleaning the conveyor belt in October 1987. He noted that he had subsequently performed heavy labouring duties. Mr Hare said that he had commenced proceedings against his then employer in respect of the conveyor belt injury claiming injuries to “both arms, lower back and neck”. He noted that the proceedings had been discontinued for lack of evidence.

46. Mr Hare again described the subject injury. He said: “From when I injured my shoulder, I have had a cracking in my neck. Whenever I turn my neck, I feel that it cracks, I also lose vision for a split second. I refer to this as ‘blacking out’.” He said that he had consulted Dr Antoun and was certified as fit for full hours with restrictions. He said he had no time off work.

47. In November 2005, Mr Hare said that he had commenced a physiotherapy program for the left shoulder. He noted that the Management Plan recorded complaints of “burning” in the biceps. He said “I had a stiff neck and I could not drive my car because reversing was too difficult.” He did not receive treatment for the neck. Mr Hare noted his second Physiotherapy Management Plan had also recorded complaints of “burning” in the biceps.

48. Mr Hare said that following the injury, upon the left shoulder surgery he had been suffering from a stiff neck and had struggled while driving a car as he turned his whole body. He said that he had complained to Dr Antoun of the burning pain in the left shoulder and “stiffness in the neck, crack/click noise when turning my neck, burning pain down the left arm and tingling in the fingers of the left hand”.

[2] Reply p 6.

49. Mr Hare noted the report of the MRI scan of the left shoulder carried out in October 2005 and the referral to Dr Goldberg who recommended surgery. He said that he consulted Dr Antoun on 16 December 2005 who had noted his complaint of "burning" discomfort over the anterior shoulder area as reported by Dr Antoun as recorded by Dr Antoun in a report which followed his last consultation with Mr Hare on 10 April 2006.[3]

50. Mr Hare said that he had also been experiencing "burning" in the left arm and fingers and was complaining of numbness, sensitivity and burning pain in the fingers of the left hand. He said that the complaints of "burning" which he had made to Dr Antoun were the same complaints of burning that he made to Dr Teychenné in 2018.

51. Following the surgery by Dr Goldberg, Mr Hare said that he had started to attend a general practitioner locally although he continued to consult Dr Antoun until early 2006. Mr Hare noted the diagnosis of Dr Sor. He said that he returned to work after approximately two weeks following the left shoulder surgery on restricted duties. He said that he continued to have "discomfort and pain in the left shoulder and pain radiating down the left arm to the fingers." He described the work that he was given which, he said, had led to epicondylitis in the right arm.

52. Mr Hare said that he believed he had suffered a consequential injury to his right elbow and carpal tunnel syndrome on the left-hand because of the subject injury. He said that he lodged a workers compensation claim "with respect to the left biceps insertion tear/supraspinatus tendinopathy" in April 2006. He said that he had commenced a third physiotherapy Management Plan. He said the symptoms in the left shoulder have been aggravated by incidents that occurred while he was travelling to work by public transport. He continued to see Dr Goldberg and continued to have physiotherapy for the left shoulder.

53. Mr Hare said that he had consulted Dr Sor on 5 October 2006 complaining of "clicking" in the neck and with unchanged pain. He noted that Dr Sor had recorded "clicking" on that date[4]. He had a further MRI scan of the left shoulder in January 2007 which he said was ordered "because I continued to suffer from symptoms of pain in the left shoulder pain and numbness extending down the left arm to the fingers." He noted the contents of the report.

54. Mr Hare said that he had continued to consult Dr Goldberg who had recommended permanent restrictions on his lifting. He had commenced a further physiotherapy Management Plan, noting that the physiotherapy records recorded "burning" pain in the biceps. Mr Hare said that physiotherapy was not assisting and was painful to the point where he would break down in tears. He had not complained of symptoms in the neck. He said that he had mentioned "cracking of the neck and momentary blackouts, lasting a second".

55. Mr Hare summarised his continuing treatment by Dr Goldberg. He said that Dr Goldberg had provided a report to his then solicitors for medicolegal purposes. He had then been assessed by Dr Ian Collins at the request of the insurer. Dr Collins had assessed 7% whole person impairment in respect of the left shoulder.

56. In June 2007, Mr Hare's employment was terminated as light duties were no longer available. He said that, at that time, "I had not mentioned my neck symptoms of pain, cracking, stiffness, blacking out and tingling to Dr Sor because I thought the neck symptoms were from the shoulder condition. This is what doctors were telling me. I had no idea that I had suffered injury to my neck".

57. Mr Hare noted the course of treatment throughout 2007. He said that he had started to withdraw from strong medication at which point he said "I then became more aware of neck pain and tingling in the neck." He said Dr Sor had been prescribing Endone, Tramadol, and Codalgin Forte. With the cessation of that medication he said that he had started noticing

[3] In evidence at page 37 of the reply.
[4] Reply page 108.

symptoms in the left side of his neck which had then reported to Dr Sor in a consultation on 6 March 2008.

58. Mr Hare said that he believed that it was in about 2007 he "became more aware of intermittent pain in my lower back". He said this coincided with him ceasing stronger pain medication. He said he had not sought medical advice with regard to this because the pain subsided within two days. The left shoulder pain was "much stronger".

59. In mid-2008, Dr Goldberg discharged Mr Hare from his care, referring him to Dr Best for management of the right elbow condition. He noted that he had suffered an aggravation of left shoulder pain when holding his young daughter's hand and she had fallen.

60. Mr Hare described his treatment with respect to the right elbow provided by Dr Best. He said that Dr Sor had also referred him to a neurologist, Dr Rail, following Mr Hare reporting numbness in the fingers and the left-hand. Mr Hare said that these were the same symptoms that he reported to Dr Teychenné in 2018.

61. Mr Hare said that he had seen Dr Rail in November 2008. He had told the neurologist of symptoms in the neck, left shoulder, left arm and hand and that he was dropping things. Mr Hare noted the report from Dr Rail to Dr Sor. He said his complaints to Dr Rail were the same complaints of paraesthesia in the left hand that he had made subsequently to Dr Teychenné in 2018.

62. Mr Hare said that he suffered aggravation of his right elbow condition while working at a wildlife park and in March 2010 was referred to an orthopaedic surgeon, Dr Mark Perco, for further treatment of the right elbow. He noted the course of treatment by Dr Perco in respect of the right arm. He said that he suffered an aggravation of his left arm symptoms following examination by Dr Perco and was forced to attend the Accident and Emergency Department of his local hospital.

63. Mr Hare reported the increased level of symptoms in his left arm to Dr Perco and said that the symptoms "were the same complaints of constant pain in the left arm and hand which I made many years later Dr Teychenné in 2018". MRI scans of the right elbow and left shoulder confirmed pathology. He noted Dr Perco's report which included reference to restriction of cervical spine movement.

64. Mr Hare next referred to further consultation in June 2010 with Dr Best who had noted complaints of neck and shoulder pain. The treatment provided by Dr Best respect to the right elbow was noted. Mr Hare noted that it complained of "left-hand numbness and paraesthesia" when he next saw Dr Perco. Dr Perco had recommended nerve conduction studies.

65. Mr Hare said that he next saw Dr Rail in July 2010. Dr Rail noted recent exacerbation of symptoms in the left arm. Those symptoms were described by Dr Rail as "radicular symptoms".

66. Mr Hare said that he had next seen Dr Breit in August 2010 at the request of the insurer. Dr Breit noted complaints of pain in the neck on the left side and the contents of Dr Breit's report to the insurer. Mr Hare said that his complaint to Dr Breit of "burning, pins and needles in the hand and fingers, numbness and tenderness in the left side of the neck and left shoulder and hand" which he said were the same symptoms of which he had complained to Dr Teychenné in 2018. He noted that Dr Breit's diagnosis had included neck pain. It also included abnormal illness behaviour.

67. In February 2011, Mr Hare said that he had entered into a Complying Agreement for lump-sum compensation in respect of the right elbow, consequential upon injury to the left shoulder.

68. Mr Hare and attempted to return to work without success. He said that in September 2011, he had lodged a Worker's Injury Claim Form to add injury to the left wrist and hand on the basis of the diagnosis of carpal tunnel syndrome. He said that he had not then been aware and did not know "that the symptoms in my left hand and fingers of numbness, burning and paraesthesia, coming from my neck condition which was later diagnosed by Dr Teychenné in 2018 is incomplete cervical cord lesion."

69. In 2012, Mr Hare was examined by specialists with respect to a Total and Permanent Disability claim. He said that in January of the following year he had reported symptoms of numbness in the left foot and back pain which he had experienced over the last two years. He had continued to complain of numbness in the left hand. A scan of the neck had been performed.

70. Mr Hare said that he had suffered a transient aggravation of neck and left shoulder pain when his vehicle was struck in the rear by another vehicle. He had reported that to his general practitioner. He noted the complaints that he had made to the general practitioner on the following consultations.

71. Mr Hare noted that Dr Sor's notes include a reference to an incident at work on 1 June 2005 when he had been struck on the head and neck by timber boards. He had reported the incident and made a claim. He then went on holidays and the pain "mainly resolved" although he continued to have pain for approximately a week after returning to work after which he said he was "pretty much symptom-free".

72. Mr Hare said that he continued to complain to Dr Sor of neck pain and tingling in the left hand with crepitus in the neck and mild headache. An MRI scan of the cervical spine was performed on 9 January 2014 the results were reported as "normal".

73. Mr Hare said that he obtained work as a meter reader for gas and electricity meters but this had aggravated his complaints. He suffered episodes of "blacking out" for intervals of about a second. He continued to complain of symptoms in 2015 and in April 2016 was referred again to Dr Best with respect to his right elbow. He continued to receive treatment for the right elbow throughout 2016 and again in March 2017. In May 2017, he was examined again by Dr Perco who treated the right elbow over the following months.

74. Mr Hare was also been seen by Dr Pillemer for medicolegal assessment at the request of his solicitors. He noted the contents of Dr Pillemer's report. Dr Pillemer suggested referral to a neurologist and was referred to Dr Teychenné by his general practitioner, Dr Nelmes, who was undertaking his care following Mr Hare's move to the St George's Basin area.

75. Mr Hare detailed the history provided to Dr Teychenné and subsequent treatment which included EMG muscle sampling. An MRI scan of the spine was reported as normal. Dr Teychenné had carried out "numerous extensive investigations between July to November 2018". He said:

> "Dr Teychenné advised me that even though the radiological investigations of MRI scans did not show nerve damage, based on his findings when he conducted his examinations, there was evidence that the nerve in my neck was not working properly. Dr Teychenné told me that the back symptoms of intermittent, short lived episodes of weakness in the legs and numbness in the left leg and foot was from damaged nerve in the neck."

76. Mr Hare detailed his current symptoms including occasional pain in the back aggravated by activities around the home and pain and discomfort from the left side of the neck into the fingers the left hand. He had intermittent neck stiffness and said that he had developed "chronic pain syndrome". In all he listed 48 symptoms.

77. A claim form dated 10 April 2006 in respect of the subject injury was in evidence. The form notes the report of injury on 29 September 2005. Mr Hare appears to have recorded the injury as a torn bicep. The treating doctor has diagnosed “L biceps insertion tear/supraspinatus tendinopathy”.

78. A further claim form dated 18 November 2010 notes the same history of injury but adds a complaint of left-hand carpal tunnel. A third claim form dated 26 September 2011 alleges injury to the left hand/wrist due to nature and conditions of employment.

MEDICAL EVIDENCE

79. A number of records and reports relating to Mr Hare’s psychological state were in evidence. Those reports were not referred to in submissions and do not assist in determination of the issue of injury to the cervical spine.

80. The numerous reports relating to treatment of the right elbow have been considered but do not appear to assist resolution of the current issues except where the history provided touches upon the probability of injury to the cervical spine. Those observations are noted below.

Dr Antoun, General Practitioner

81. The earliest relevant medical report in evidence appears to be that of Dr Antoun who provided an undated report to the claims manager, written after his last consultation with Mr Hare on 10 April 2006. Dr Antoun reported that he first saw Mr Hare on 30 September 2005, the day following the subject injury. He reported the circumstances of injury: “while lifting a pallet the side was jammed and as he pulled with a sudden jolt to his left side, he felt a sudden onset of pain over the top of the shoulder in the front area”.

82. On examination, Dr Antoun noted that Mr Hare was tender along the origin of the biceps tendon, along the front of the shoulder and over the subacromial bursal space. He noted mild limitation of shoulder movement. Mr Hare had been prescribed physiotherapy and placed on light duties.

83. At consultation on 16 December 2005, Mr Hare had reported feeling much better. The doctor noted: “Mr Hare reported feeling much better, and had minimal signs of impingement with some mild discomfort still over the anterior shoulder area, which he described as ‘burning’”. Dr Antoun noted continuing symptoms and referral to Dr Goldberg who performed surgery. He noted that Mr Hare’s care had been taken over by his local general practitioner. The report contains no reference to the neck, cervical spine or neurological symptoms.

84. Dr David Sor, General Practitioner

85. The clinical records of Dr Sor, Mr Hare’s general practitioner, in respect of consultations in the period 23 February 2006 to 24 May 2018 were in evidence. No history is recorded in respect of consultation on 23 February 2006. The next occasion on which Mr Hare consulted Dr Sor is 5 October 2006 when the doctor recorded “pain unchanged, clicking – insurance co stopped physio – under financial stress – surgeon wants physio to continue – abduction 100 – normal internal rotation.”

86. The records of subsequent consultations up to 5 April 2007 simply record medication was prescribed. On 5 April 2007 the general practitioner noted that the pain had improved with cortisone but Mr Hare was “still getting exacerbation”. Mr Hare continued to see Dr Sor regularly in 2007 and 2008 but the clinical notes record only the creation of letters and medication prescribed.

87. At consultation on 6 March 2008, Dr Sor recorded “still seeing physio – has been getting left neck pain – shoulder no better – limited sleep.” Following that consultation Mr Hare continued to see Dr Sor regularly but the notes again record only medication and the creation of letters up to 14 August 2008 when the pain is noted to be “generally unchanged, may be worse”. At the following consultation on 13 September 2008 Dr Sor noted that Mr Hare was “hurting more since an injury – was holding daughter’s hand and she fell down – seen sports physician, had cortisone, six weeks physio, review in six weeks – more left shoulder pain.”

88. The general practitioner recorded consultation on 27 October 2008, when he noted “numbness in D3-5 left side – six months – physio twice a week for elbow – elbow non-tender but still getting pain when using – nerve impingement – dropping things”.

89. Subsequent consultations record the course of treatment with continuing pain through 2009. On 1 July 2010, the general practitioner has recorded symptoms of numbness in the fingers and palm of the left arm following examination by a specialist. Mr Hare was referred to Dr Rail.

90. Following consultation on 12 June 2012, the next consultation recorded is on 31 January 2013 when Dr Sor noted complaints of “two years of numbness plantar surface left foot – caused three falls – caused after walking for a period of time – had history of back injury many years ago – no weakness.”

91. On 29 February 2013, Dr Sor recorded complaints of numbness in the left hand affecting the little finger. He noted that Mr Hare “had a scan done of his neck”. Exacerbation of neck and shoulder pain following the motor vehicle accident is noted on 18 July 2013. Complaints of “getting neck pain – some clicking on neck movements – pain right side of neck – sometimes gets electric shock sensation when picking up a bucket with right hand – can get ulnar nerve symptoms” are recorded in on 8 August 2013.

92. On 29 August 2013, Dr Sor has recorded “in 2005 he lodged a complaint about neck pain – date of injury 1/6/5, claim number 222/101284911 – bundles of timber fill onto back of neck – did not see doctor, he then went on holiday – symptoms got better.”

93. Subsequent attendances record complaints of paraesthesia in the right-hand, tingling and discomfort in the hands “C/W carpal tunnel syndrome”. An MRI scan of the neck showed no abnormalities. There are numerous reports of emotional problems. An entry in November 2014 records “some neck pain”. At consultation on 30 July 2015 Dr Sor has recorded “shoulder a bit better – coping well at work – neck still cracking”.

94. In a report to the insurer dated 17 March 2007, Dr Sor noted his treatment of Mr Hare since 22 February 2006. The report makes reference only to the left shoulder, which is said to be considerably improved.

95. In a fax dated 24 September 2010 the insurer asked Dr Sor whether he agreed with the diagnosis of Dr Breit which is noted below. Dr Sor replied “I agree with the diagnosis. Abnormal illness behaviour was not observed while I was treating. It is a subjective diagnosis.” Dr Sor confirmed that while he had been treating Mr Hare, he had complained of significant symptoms attributable to medial epicondylitis as well as mild carpal tunnel symptoms.

96. At consultation on 19 April 2018, Dr Sor has recorded that Mr Hare had commenced seeing Dr Nelmes. He noted complaints of problems with the right elbow and left arm. The general practitioner recorded that Mr Hare had nerve conduction tests and “thought it could be related to cervical spine neuropathy”.

Dr Douglas Jameson and others, North Nowra Medical Practice.

97. Mr Hare consulted general practitioners at the North Nowra Medical Practice. The clinical records of that practice record consultations from 3 November 2009 to 10 January 2013.

98. On 3 November 2009, Mr Hare consulted Dr Paw who recorded that Mr Hare had moved to Nowra from Picton. He recorded the history:

> "long-term L shoulder rotator cuff issue and golfer's elbow on the R and secondary depression, previous suicidal thought – shoulder – looked after by Dr Goldberg – elbow – by Dr Best – previous treatment of operation, rehab, analgesia, physio – poor shoulder function and pain, cannot work."

99. Subsequent visits recorded complaints of pain and psychological difficulties. On 29 March 2010, Dr Jamieson recorded "nerve irritation pain for two days, decreased neck movements". Dr Jamieson noted that Mr Hare was seeing Dr Perco throughout the right elbow and suggested that he should also treat the left shoulder. Dr Jamieson subsequently noted paraesthesia in the left hand and reduced power, left-hand numbness and hyperaesthesia.

100. Complaints of pain and psychological distress continued through 2011 and 2012. An increase in left arm/shoulder/neck pain was recorded in January 2013 after performing work in the yard. No further attendances are recorded at that practice.

101. A letter referring Mr Hare for physiotherapy dated 27 October 2011 from Dr Jamieson was in evidence. The referral letter seeks assistance "regarding consideration for physio, perhaps associated with Rehwork for cervical nerve compression LHS." Other referral letters by Dr Jamieson record a diagnosis of depression and chronic pain syndrome.

Dr Nelmes, Dr Zenifa, St Georges Basin Medical Centre.

102. Records from the practice of Dr David Nelmes and Dr Zenifa, general practitioners who were consulted by Mr Hare after he moved to St George's Basin, were in evidence.

103. Clinical notes record consultations from 31 March 2016 22 February 2019. The initial consultation on 31 March 2016 records the workplace injury. Mr Hare is noted to be unable to "move his arm much". The general practitioner noted depression.

104. On 17 May 2016, the general practitioner recorded a history of shoulder injury in 2005 and treatment by way of cortisone injections and surgery. Right elbow pain and left shoulder pain were noted. Subsequent consultations note complaints of pain in the shoulder and elbow as well as anxiety. A mental health plan is discussed and continuing depression noted.

105. On 18 January 2017, the general practitioner noted continuing emotional problems as well as an accident with a pushbike where Mr Hare had attended the hospital, having hurt his shoulder. On 9 May 2017, the general practitioner noted continuing depression with pain around the elbow and "loss of sensation in his left arm and hand due to shoulder and neck pain".

106. Consultations with Dr Nelmes from 29 August 2017 on refer to "left biceps tendon rupture, left biceps tenodesis, chronic pain, hypersensitive to touch, left golfer's elbow and elbow fracture." The general practitioner in subsequent consultations note the difficulty in obtaining a referral to a neurologist.

107. By August 2018, the general practitioner is awaiting approval for an MRI scan of the neck with a diagnosis from Dr Teychenné of spinal cord injury. Dr Nelmes noted diagnosis from Dr Teychenné of "moderate left cervical cord lesion" but subsequently records a diagnosis of "moderate left brachial plexus injury".

108. A Health check on 19 February 2019 noted neurological signs: “numbness of hands (to wrists and feet to lower calves but travels to below knees when walking). Split second memory loss. Headache. Faints (if turns head to right quickly or stands up quickly). Disoriented at times.”

109. The records include a number of referral letters to neurologists, Dr David Serisier (4 December 2017), Dr Peter Puhl (24 January 2018), Dr Alessandro Zagami (9 February 2018), Professor James Colebatch (9 March 2018) and Dr Teychenné (15 May 2018).

110. The referral letters are in similar terms referring Mr Hare for “opinion and management”. Dr Nelmes’ notes typically:

> “He is a sincere genuine patient experienced [sic] what has been described as a left shoulder and brachial plexus traction injury some 12 years ago, this has resulted in a multitude of life changes and is still subject to legal proceedings. The accompanying orthopaedic report [medicolegal] is I believe comprehensive and clearly recommending he undergo neurological assessment to clarify his injury status and possibly offer neurosurgical treatment if indicated, he has significant and reproducible median nerve paraesthesia. His Workers Comp orthopod review [dr pilmer] [sic – Dr Pillemer] has suggested C6 and brachial plexus testing. Shane will bring this in with him.”

111. There is also a referral letter to Dr David Rail dated 23 January 2018. Dr Rail was advised:

> “He has recently had a very thorough and comprehensive review for legal reporting purposes on his very genuine background of injury to brachial plexus/shoulder. He has significant ongoing issues with pain and burning paraesthesia involving the left trapezius shoulder complex. The accompanying report covers this well. Clearly it has been suggested we investigate to get to the bottom of this symptom complex. I believe he has seen you previously in relation to this injury situation though things have reportedly worsened considerably.”

112. The records include a report of an MRI scan of the cervical, thoracic and lumbar spines dated 17 September 2018 on referral from Dr Teychenné. The conclusion is “no chord abnormality identified. No high-grade canal or foraminal narrowing”.

Dr Phillip Sharp, Consultant Surgeon.

113. Mr Hare was examined by a surgeon, Dr Phillip Sharp, at the request of the insurer on 4 January 2006. Dr Sharp recorded the history: “On September 29, 2005 Mr Hare told me that he attempted to straighten a crooked pipe by holding it his left hand and walking forward. The pipe jammed and did not move and he jarred his left shoulder causing immediate pain to the front and back of his shoulder.”

114. Dr Sharp noted that Mr Hare had seen the company doctor, Dr Sor, the following day who had prescribed Voltaren tablets as well as physiotherapy. A cortisone injection had only given temporary relief. Dr Sharp noted that Mr Hare had not had any time off work to that point.

115. Mr Hare complained of “constant pain in the front and back of his left shoulder and over the upper part of his left biceps muscles.” This was described as a “burning sensation”. The symptoms were said to have plateaued. Dr Sharp noted the report of the MRI scan of the left shoulder taken in October 2005. He noted that Mr Hare was left hand dominant and had normal grip and pinch strength in either hand. He recorded “Movements of his cervical spine were full and normal. Muscle power, tone, sensation reflexes were equal and normal in both upper limbs.” He noted reduction of movement in the left shoulder.

116. Dr Sharp recommended referral to an orthopaedic surgeon to treat the left shoulder.

Dr Jerome Goldberg, Orthopaedic Surgeon.

117. An extensive series of reports from Dr Goldberg, the treating orthopaedic surgeon who performed an arthroscopic repair of Mr Hare's left shoulder on 16 February 2006 were in evidence. Arthroscopy revealed extensive haemorrhaging in the biceps tendon with a normal labour and normal articular cartilage. Dr Goldberg performed a left glenohumeral arthroscopy. The procedures are noted in the operation report dated 16 February 2006 which was in evidence.

118. At subsequent consultations Dr Goldberg certified Mr Hare as fit for a clerical or administrative role with physiotherapy. By 24 July 2006, Dr Goldberg was noting slow but good progress. He noted "clinically he has near full movement and good power." On 21 November 2006, Dr Goldberg reported that Mr Hare had commenced a gym program. He noted that Mr Hare had "occasional clicking on the shoulder but little pain." Movements of the shoulder were again noted to be full and power to be normal.

119. Dr Goldberg reviewed Mr Hare in January 2007 at the request of the rehabilitation provider. He noted that Mr Hare was suffering discomfort about the shoulder when lifting more than 10 kg and was doing overhead lifting. He arranged a further MRI of the shoulder and reported that "this confirmed a flat acromion. There is some mild residual tendinitis". He carried out a cortisone injection. Dr Goldberg was concerned that if Mr Hare returned to repetitive heavy work his shoulder may deteriorate and he recommended permanent light duties.

120. On 19 February 2007, Dr Goldberg reported to the insurer diagnosing "a traumatic impingement lesion" of the left shoulder and bicipital tendinitis. He felt this was consistent with the account of injury. He again recommended permanent light duties.

121. On review in April 2007, Dr Goldberg noted that rotator cuff tenderness and slightly restricted movement. He reported "the patient exhibited poor scapulothoracic control. The impingement sign was positive." He again carried out a cortisone injection.

122. A medicolegal report from Dr Goldberg dated 28 May 2007 was in evidence. In that report Dr Goldberg described the findings on examination and the results of the MRI scan of the left shoulder with a diagnosis of "chronic impingement of the left shoulder combined with bicipital tendinitis". He confirmed that he had performed an arthroscopic biceps tenodesis combined with an arthroscopic acromioplasty. Dr Goldberg reported that eight months after surgery Mr Hare had mild residual pain.

123. Physiotherapy reports in evidence understandably refer only to the left shoulder in 2006, presumably following referral from Dr Goldberg.

Dr Ian Collins, Physician.

124. Mr Hare was examined by a physician, Dr Collins, at the request of the insurer on 19 June 2007. Dr Collins noted the history of accident on 19 June 2007 in similar terms to that recorded by Dr Sharp. He noted the surgery performed by Dr Goldberg on 16 February 2006 and the findings of changes in the supraspinatus and significant bicipital haemorrhage. A further MRI in January 2007 had shown a rotator cuff injury and tendinitis affecting the biceps. Mr Hare is noted to be having pain and difficulty in using the left shoulder.

125. Dr Collins recorded reduced movement in the left shoulder and pain. He noted that Mr Hare was also starting to experience discomfort in the right shoulder and right elbow while doing light duties

126. Dr Collins noted the radiological investigations of the left shoulder and the cortisone injections which had provided some relief. On examination he found reduced range of motion in the left shoulder and diagnosed injury to the left shoulder involving the rotator cuff in the tendon of the biceps. He noted that Mr Hare had continuing problems with tendinitis.

Dr Henry Lam, Pain Management Specialist.

127. Mr Hare was examined by Dr Lam, a pain management specialist on 10 August 2007. He reported to the insurer noting the "traction type injury to the left shoulder". Dr Lam noted the results of the MRI scan and the treatment by Dr Goldberg. Mr Hare reported continuing complaints of pain which had been treated with cortisone injections with transitory results. Mr Hare reported to Dr Lam that "even massages would make him 'pass out from pain'."

128. Dr Lam reported that Mr Hare had developed a "chronic persistent pain condition". He reported:

> "The pain is described as a constant pain with paroxysmal attacks as well as increasing intensity associated with activity. The characteristics of the pain are described as dull, aching, sharp, stabbing, hot, burning, shooting, throbbing, pruritus and paraesthesia. He describes a history of motor dysfunction, discolouration and clamminess in the hand. Pain radiates from the shoulder into the top of the forearm region."

Pain was said to be improved with medication, ice and rest.

129. On examination, Dr Lam noted a reduced range of shoulder movements with tenderness. He said "Trigger points demonstrated primary and secondary hyperalgesia. Neuro tension sign in the arm was positive. The left hand was clammy and discoloured." Dr Lam diagnosed "mixed nociceptive/neuropathic pain with a component of musculoskeletal pain." He prescribed analgesic medication and recommended a course of pain management education.

Dr Robert Breit, Orthopaedic Surgeon

130. Dr Breit examined Mr Hare in August 2006 at the request of the insurer. There seems to be no report that specifically deals with that examination in evidence but a report in evidence dated 12 January 2007 notes a request from the insurer for a "supplementary report". Dr Breit noted a slower than expected recovery from the left shoulder surgery performed by Dr Goldberg. Dr Breit had noted "full movements and power" and that Mr Hare was tackling his exercise program with enthusiasm. Dr Breit also noted depression "because he was a very active person and was restricted by his shoulder disability." Dr Breit was concerned that Mr Hare was exercising excessively "in attempting to get back to his preinjury duties."

131. Dr Breit again examined Mr Hare on 31 March 2008 at the request of the insurer. At that time Dr Breit obtained a history of injury consistent with that noted in the applicant's statements. Dr Breit noted the course of treatment to that time including the surgery performed by Dr Goldberg and the failed attempt at a gym program. He noted that Mr Hare was receiving physiotherapy.

132. Dr Breit recorded present complaints as follows:

> "There is pain over the shoulder cowl, which is said to be constant at 4-5/10 and when it becomes more severe it is 7-9/10, there is a deep itching sensation in the back of the shoulder and sometimes over the upper aspect of the inner arm.
>
> He complains of pins and needles occurring four-five times a day involving the whole palm and fingers of the left hand but not the dorsum. He is unable to lie on the side or use the arm overhead. He has difficulty washing and brushing his long hair."

133. Dr Breit reported: “I am told the neck has had a lot of treatment, indicating there is pain at the base of the occiput, which he was told is due to his neck problems.” He noted complaint of right medial elbow pain over the past year related to activity. On examination Dr Breit noted reduced range of movement with positive test results for biceps irritation. Dr Breit noted the radiological reports. He diagnosed “left rotator cuff impingement and biceps tenodesis with “a chronic pain syndrome, but not CRPS” [chronic regional pain syndrome] as well as right medial epicondylitis, neck pain and drug habituation.

134. Dr Breit commented:

> “Mr Hare’s left shoulder pain and disability is really quite extraordinary, given the pathology and treatment. That aside, it is common for people to have some secondary neck pain when there is shoulder movement, but it is most unusual for them to complain of medial epicondylar symptoms. There is no impairment in the left forearm and epicondylitis is associated with forceful repetitive use and Mr Hare is not working.”

135. With respect to the cervical spine, Dr Breit assessed Mr Hare as falling within DRE Category I by reason of complaint of neck pain but with “normal movement, no spasm and no symptoms that could be considered radicular in nature.”

136. Dr Breit again examined Mr Hare on 11 August 2008. In his report to the insurer, Dr Breit again noted the circumstances of injury and the history of treatment to that point. Dr Breit noted on examination:

> “There is pain in the neck on the left side posterior early and laterally and when the shoulder is sore the head tends to be pulled over to the left, demonstrating marked lateral flexion. There is anterior shoulder pain, sometimes anterior and lateral distal radiation. It clicks; he cannot lie on the side and claims that since the accident he had not had a decent night’s sleep. The arm can be used overhead but it is painful and he avoids the posture.”

137. Dr Breit noted range of movement in the left arm and noted complaints of pain “all over the left hand and a burning sensation in the fingernails as well as electric shock like pain in the top of the hand.” Mr Hare complained of pins and needles in the palm and fingers of the hand and numbness in the fingertips as well as tenderness. He also noted complaints of right elbow pain.

138. Dr Breit noted a full range of movements in the left hand and elbow but diminished sensation in the distribution of the median nerve “with the exception that it tended to extend down into the palm of the hand but not the dorsum.” Dr Breit diagnosed right medial epicondylitis, left carpal tunnel syndrome, left rotator cuff impingement and biceps tendinosis, neck pain and abnormal illness behaviour.

139. Dr Breit believed that there was evidence of left carpal tunnel syndrome confirmed on EMG studies as well as mild medial epicondylitis. He felt the symptoms were “unreasonably severe”.

140. Dr Breit reported that Mr Hare’s employment with the respondent was a substantial contributing factor to the neck and shoulder. He confirmed “The neck and shoulder problems relate to the injury of 29 September 2005.”

141. Dr Breit’s report notes that Mr Hare had said that the sensation of pins and needles in the left hand had occurred following the shoulder surgery but otherwise did not report a history as to the onset of symptoms in the neck/cervical spine. Previous medical history was noted only as the motorcycle accident involving the right elbow. Dr Breit noted that Mr Hare denied any previous compensation claims.

Dr David Rail, Neurologist

142. Dr Rail examined Mr Hare on referral from Dr Sor in November 2008. He noted a history of left shoulder injury in September 2005 which had led to surgery in February 2006. He reported "over the last six months he has been developing paraesthesia in D3 to 5 in the left hand. This is associated with difficulty with grip. He has some neck stiffness intermittently." He felt "the clinical picture is consistent with a C7/8 radicular one and I have given him a little Epilim to try and reverse matters." He noted symmetrical reflexes in both arms with slightly altered sensation over left fingers, D3 to 5.

143. Dr Rail again examined Mr Hare in December 2008 and changed his medication. He did not comment on the symptoms that time.

144. On 13 July 2010, Dr Rail again reported to Dr Sor noting that Mr Hare was complaining of increased pain in the left shoulder over the past two to three months. He said the pain was widespread extending into the hands and with associated paraesthesia through the left hand. He said "I note that he has had this ongoing problem for a number of years." Dr Rail reported: "I saw him last back in 2008 and at that stage had him on Epilim for radiculopathy. There has been considerable improvement in those symptoms but as mentioned it recently exacerbated."

145. Dr Rail subsequently reported a further change of medication. On 24 September 2010, he was asked by the insurer to advise the body parts which he was currently treating. He reported "I am treating neck pain with nerve involvement in the arm".

Dr John Best, Sports Physician

146. A series of reports from Dr Best, sports physician, were in evidence. Mr Hare was referred by Dr Goldberg to Dr Best with respect to Mr Hare's problems with the right elbow. The series of reports from 4 September 2008 to 12 November 2009 deal with treatment of the right medial epicondyle and establish that during 2010 Mr Hare was receiving treatment not only for the left shoulder but also for a condition in the right elbow that was clearly of concern to him.

147. The report of 18 June 2010 refers to worsening of the medial epicondylosis which Dr Best felt was due in part to "the fact that his left upper limb is not working well with neck and shoulder pain and also numbness in the left hand, which I believe is being investigated".

148. Dr Best again saw Mr Hare in 2016 with regard to the right elbow. He underwent an MRI scan of the right elbow as well as x-ray. His reports detail treatment of the right elbow condition on 14 March 2017 Dr Best reported that a heavy fall and hard work in removing a fallen tree at home had aggravated Mr Hare's left shoulder.

Dr Mark Perco, Orthopaedic Surgeon

149. Mr Hare was referred by his then general practitioner, Dr Jamieson, to orthopaedic surgeon, Dr Perco. After consideration of the MRI scans Dr Perco reported "his MRI results of elbow and shoulder have demonstrated a medial epicondyle flex or tendinopathy of the elbow and partial thickness supraspinatus tendon changes of the left shoulder."

150. Dr Perco reported that Mr Hare had recently developed "considerable hand problems with numbness and paraesthesia in the hand" which were reported by Mr Hare as constant and associated with a feeling of swelling and altered sensation in the fingertip.

151. On examination, Dr Perco noted hand swelling. He also noted "he has some restriction of cervical spine movement but cervical spine motion does not aggravate his hand symptoms." Dr Perco diagnosed "acute carpal tunnel compressive neuropathy." He recommended physiotherapy and a hand splint.

152. On 9 July 2010, Dr Perco reported to the insurer that Mr Hare had been referred initially for treatment of right medial epicondylitis but he had also complained of ongoing left shoulder pain present for a number of years. He said that at the second visit Mr Hare had complained of left-hand numbness and paraesthesia which he considered was due to a carpal tunnel compressive neuropathy.

153. Dr Perco said that Mr Hare had complained that the symptoms had been present from the time of the left shoulder injury but had not been able to confirm that. He recommended nerve conduction studies.

154. Mr Hare again consulted Dr Perco in May 2017 with complaints of right elbow pain. Dr Perco noted that he had seen Mr Hare some 10 years earlier and that Mr Hare had been employed as a gas meter reader more recently which had aggravated his right elbow symptoms. He noted that Mr Hare was unable to use the left hand "due to a long-standing left sided shoulder complaint".

155. Dr Perco noted that imaging in 2010 had demonstrated a flexor origin tendinopathy. He requested updated radiology. A subsequent report in July 2017 deals only with the right elbow.

Dr James Bodel, Orthopaedic Surgeon

156. Dr Bodel examined Mr Hare on 15 November 2010 at the request of Mr Hare's then solicitors. Dr Bodel recorded a history of injury to the left shoulder, subsequent development of numbness and tingling in the left hand and right elbow pain. He noted the history of the subject injury, investigation of the left shoulder and subsequent surgery with a disappointing outcome.

157. He noted that Mr Hare had undergone extensive physiotherapy and hydrotherapy and had anaesthetic and hydrocortisone injections. He noted the onset of symptoms in the right arm while using that non-dominant arm to perform light duties. Dr Bodel recorded "He has also begun to develop numbness and tingling in the left hand and has been diagnosed with carpal tunnel syndrome but has not had surgery for this at this stage." He also noted the onset of a depressive illness.

158. In addition to left shoulder and right elbow pain, Dr Bodel noted complaints of "continuing numbness and tingling in the left hand and this involves mainly the middle, ring and little finger but occasionally the thumb and index finger" as well as continuing neck pain.

159. On examination, Dr Bodel noted tenderness in the trapezius muscles at the base of the neck on the left-hand side and reduced range of neck flexion, extension and rotation in all directions most restricted on rotation to the right. He noted tenderness over the lateral epicondyle in the right elbow. He noted no evidence of radiculopathy in the left upper limb.

160. Dr Bodel assessed impairment of the left upper extremity. He commented that the relatively new symptoms of numbness and tingling in the hands needed further investigation.

161. In a report dated 11 March 2011, Dr Bodel reported that the carpal tunnel condition in the left hand had arisen as a consequence of the nature and conditions of work as a result of performing the duties on return to work following shoulder surgery. That condition or injury did not attract rateable impairment.

Dr Thomas Rosenthal, Specialist Occupational Physician

162. Mr Hare was examined by Dr Rosenthal on 22 January 2013. Dr Rosenthal noted the history of injury to the left shoulder and subsequent treatment. He noted that Dr Goldberg had diagnosed "an intrinsic degenerative tendinopathy of the rotator cuff of the left shoulder associated with muscular dysfunction".

163. Dr Rosenthal noted that the neurologist, Dr Rail, had "thought he had a radiculopathy in the left arm" in July 2010 and that Dr Perco had diagnosed acute carpal tunnel syndrome in June 2010.

164. Mr Hare complained to Dr Rosenthal of "ongoing right elbow pain and left shoulder pain." He told Dr Rosenthal that Dr Rail had advised him that he had a "pinched nerve" in his neck. Dr Rosenthal noted that Mr Hare was complaining of left-hand numbness. Current symptoms are recorded:

> "He reports that his left hand goes numb on occasions. His left shoulder is painful with restricted movement. His right elbow is painful on and off. He can drive and he does have a vegetable garden which he tends at home and does some household chores. Can't play his musical instruments."

165. On examination, Dr Rosenthal noted normal gait and posture. There was reduced range of motion in the left shoulder. Dr Rosenthal noted "a full range of movement of his neck" as well as a full range of movement the right elbow. He noted no deficits in the upper limbs.

166. Dr Rosenthal diagnosed chronic tendinopathy in the left shoulder and intermittent medial right epicondylitis. He reported "He has developed chronic pain particularly in the left shoulder. The symptoms in his left hand were not confirmed today and there is no evidence of radiculopathy emanating from his neck."

Dr Sham Deshpande, Orthopaedic Surgeon

167. Mr Hare was examined by Dr Deshpande, orthopaedic surgeon, at the request of the insurer on 29 July 2014. Dr Deshpande noted the history of injury and consequential surgery. He noted the onset of medial epicondylitis in the right elbow following the shoulder surgery and the return to work on light duties. Dr Deshpande noted complaint of symptoms:

> "He complains of left shoulder pain anteriorly and posterior early. This pain is constant. He has difficulty getting dressed and brushing his hand. He is left-handed. He has a stiff left shoulder.
>
> Right elbow: he complains of pain over the common flex or origin of the right arm.
>
> He experiences tingling and numbness in the left hand. He feels this in all his fingers.
>
> He feels depressed."

168. On examination, Dr Deshpande noted a reduced range of motion in the left shoulder. Neck movements and neurological examination were reported as normal. He also noted tenderness in the lateral epicondyle on the right. He diagnosed left shoulder postsurgical adhesive capsulitis and right elbow medial epicondylitis.

169. In a subsequent report Dr Deshpande commented on various employment prospects for Mr Hare.

MRI cervical spine

170. A report of an MRI scan of the cervical spine dated 9 January 2014 was in evidence. The report notes a "history of neck pain and tingling left hand". The radiologist reported:

> "There is normal cervical alignment. The intervertebral disc space heights are maintained. The facet joints are intact. No disc protrusion is demonstrated at any cervical level. The spinal canal and exit foramina remain adequate and there is no suggestion on [sic] nerve root impingement."

The report concludes that this is a "normal study".

Dr Yiu-Key Ho, Orthopaedic Surgeon

171. Mr Hare was examined by Dr Yiu-Key Ho, orthopaedic surgeon, at the request of the insurer on 18 May 2017. Dr Ho noted the history of injury to the left shoulder and the subsequent operative treatment by Dr Goldberg. Dr Ho noted ongoing symptoms following the surgery and the development of right elbow symptoms subsequently.

172. Dr Ho's report deals only with the left shoulder pathology and the right elbow. He did not accept that Mr Hare was fully cooperating on examination. He assessed impairment in respect of the left shoulder and the right elbow and expressed doubts as to whether his assessment was based upon the full range of movement of which Mr Hare was capable.

173. Dr Ho examined Mr Hare again on 21 January 2019. In his report to the insurer he noted the contents of his previous report. He noted that Mr Hare had been examined by Dr Pillemer and also by Dr Colebatch, a neurologist, as well as by a further neurologist, Dr Teychenné. Dr Ho noted that nerve conduction studies and scans had been made following which Dr Teychenné had diagnosed a cervical cord lesion.

174. Dr Ho noted complaints of numbness in the left hand and arm which he said Mr Hare felt had commenced approximately a year after shoulder injury. Dr Ho said this was the first time that Mr Hare had mentioned neurological symptoms; "because last time we mainly concentrated on the shoulder without any complaint of this type of neurological symptoms."

175. On examination, Dr Ho assessed the left shoulder and right elbow again. He said:

> "Neurological examination was very difficult to test because he complained of numbness basically in the whole left upper limb from the elbow downwards. I could not see any obvious features of peripheral nerve problems in terms of the carpal tunnels, ulnar nerve and median nerve."

176. Dr Ho noted the report of the MRI scan as normal. He said:

> "The history of injury is detailed again in this report. It was a lifting injury causing some problems in the shoulder and at my last examination he only complained of shoulder problems with pain and stiffness but this time due to the report and review of Dr Teychenné, he started to complain of all sorts of symptoms which sound like some neurological problems but it is very bizarre.
>
> I must admit that I never noticed that he complained of those sort of symptoms when I asked him about the onset, he said right from the time of the injury but if we go back to his statement in 2005 and in 2008, there is no mention of any neurological symptoms. I realise it in the past he had seen other neurologists like Dr Rao [sic – Dr Rail?] Who only suspected that he may have some cervical radiculopathy or some carpal tunnel syndrome but he never did any neurological tests or neurological study to exclude the pathology that was described by Dr Teychenné."

177. Dr Ho said that he did not accept Dr Teychenné's diagnosis of "incomplete cervical cord lesion" as Mr Hare had "never complained of those sort of neurological symptoms before to any treating specialist or doctors responsible to do a medicolegal report according to his medical file". Dr Ho noted that all the tests which Dr Teychenné had ordered had been reported as normal.

178. Dr Ho was of the opinion that it would be appropriate to have a neurologist look at the issues raised by Dr Teychenné's reports. He noted that Mr Hare had also seen Dr Colebatch who "did not think that all the neurological symptoms complained of were related to neurology and it is related to the shoulder except there may be mild left carpal tunnel syndrome."

179. In a further report dated 28 September 2020, Dr Ho noted Mr Hare's more recent statements and reports of Dr O'Sullivan, Dr Pillemer and Dr Teychenné as well as clinical records of the treating general practitioners. Dr Ho noted that it was only a couple of years after the shoulder surgery that Mr Hare began to complain of neurological symptoms. He noted that Dr Goldberg had not commented on any neurological symptoms and that the report of Dr Perco seem to be the first time there was talk of numbness in the left hand which may have been carpal tunnel syndrome.

180. Dr Ho felt that Dr Pillemer had believed there was C6/7 radiculopathy on the left side which Dr Ho did not accept as it was not confirmed by MRI examination. Dr Ho disagreed with the diagnosis of incomplete cervical lesion by Dr Teychenné, commenting that this would be expected to show on an MRI scan.

Professor James Colebatch, Neurologist.

181. Professor Colebatch examined Mr Hare on 3 April 2018 upon referral from Dr Nelmes. Professor Colebatch noted the history of injury with the onset of immediate severe pain in the left shoulder. He noted that "this has been a persisting problem" despite the surgery performed by Dr Goldberg.

182. Professor Colebatch was shown the reports from Dr Rail who "in November 2008 found weak left shoulder abduction with normal elbow and hand strength, with symmetrical reflexes and a slight alterations sensation over digits 3 to 5." He noted that Dr Rail had referred to an EMG study "showing possible left carpal tunnel syndrome, but seems to have favoured a C7/8 radicular lesion."

183. Professor Colebatch noted the MRI scan of the cervical spine performed in January 2014 which was normal. He noted the complaints of ongoing pain. On examination Professor Colebatch found that cranial nerve examination was normal. Examination of the upper limbs showed normal muscle bulk with surgical scarring of the left shoulder. There was reduced abduction of the left shoulder with pain. He reported:

> "There was a slight reduction of left triceps jerk versus the right but it was present. Pinprick sensation showed a possible reduction over digits 2 on the left with more sensation over the palm, with a general increase in sensation on the left below the med arm. He had a tender right medial epicondyle. Examination of the lower limbs showed normal power, symmetrical reflexes in down going plantar responses, and a normal pinprick sensation."

184. Professor Colebatch commented; "Physical examination suggests the problem lies with the shoulder but we will proceed to do an EMG/nerve conduction study to see whether there is any evidence of additional nerve involvement."

185. The results of the testing were in evidence[5]. Professor Colebatch reported:

> "Left median SNAP[6] was small. Radial and medial antebrachial sensory SNAPs were normal. Motor responses were within normal limits. Needle EMG of triceps and biceps showed no definite abnormality. There is neurophysiological evidence for left-sided mild carpal tunnel syndrome without evidence of additional abnormalities."

Dr Roger Pillemer, Orthopaedic Surgeon

186. Mr Hare was examined by an orthopaedic surgeon, Dr Pillemer, at the request of his current solicitors on 26 October 2017. In his report Dr Pillemer noted the history of injury with the onset of severe pain in the shoulder extending down the left arm and fingers of the left hand.

[5] ARD page 256.
[6] Sensory Nerve Action Potentials.

187. Dr Pillemer noted the history of treatment and the attempts to return to employment. He recorded complaints:

> "Mr Hare has significant ongoing symptoms indicating discomfort extending from the left side of his neck into his left shoulder and down his arm and into the fingers of his left hand. He has difficulty distinguishing which fingers are involved but it seems to be mainly the lateral digits rather than his little finger. These symptoms have been present ever since the onset and he feels that with time they are becoming worse. He does say that if he is simply resting and being careful he can go for up to 4 hours without any particular discomfort but symptoms are aggravated by 'life'."

188. Mr Hare complained of discomfort in the neck particularly on turning the neck rapidly noting that he can "blackout" for a split second. Mr Hare told Dr Pillemer that he felt that his neck symptoms had come on one to two years after his shoulder operation.

189. On examination, Dr Pillemer noted "a very satisfactory range of cervical movement when carried out slowly and carefully suggesting that symptoms are not arising from his cervical spine." Triceps jerk was absent and biceps and brachioradialis reflexes were diminished. There was hypoaesthesia down the radial border of the left distal forearm and into the hand. There was hypoaesthesia to pinprick in the palm of the left hand.

190. Dr Pillemer noted sensitivity to percussion of the median nerve producing paraesthesia in the fingers. Percussion of the ulnar nerve also caused paraesthesia into the ring and little finger.

191. Dr Pillemer diagnosed a traction lesion to the left shoulder on 29 September 2005 as well as a traction injury of the brachial plexus which appeared to involve particularly the middle trunk with C6 and C7 nerve involvement. He said this was evidenced by the sensory loss in the C6/7 distribution as well as the absent left triceps jerk and the diminished biceps and radialis reflexes.

192. Dr Pillemer felt that Mr Hare needed to consult a neurologist with regard to the neurological signs and symptoms. Dr Pillemer assessed 11% whole person impairment in respect of the left shoulder.

193. In a further report dated 12 November 2020, Dr Pillemer commented on the report of Dr Ho (noted above). Dr Pillemer pointed out that he had not made a finding of C6 and C7 radiculopathy but had rather diagnosed a traction injury of the brachial plexus. (Radiculopathy involves a nerve root lesion). Dr Pillemer confirmed that the brachial plexus lesion would not be picked up by an MRI scan of the cervical spine. He noted that Dr Ho had not found depressed triceps jerk on the left side nor sensory loss in the C6 and C7 distribution but maintained his opinion on the basis of his examination.

Dr Paul Teychenné, Neurologist

194. A series of reports by a neurologist, Dr Teychenné, were in evidence. Dr Teychenné saw Mr Hare on referral from the current treating general practitioner, Dr Nelmes in July 2018. Dr Teychenné recorded the history of injury on 29 September 2005 in similar terms to that contained in Mr Hare's statements. Dr Teychenné recorded the onset of symptoms:

> "At that time, he stated he had a dead pain around the left shoulder and the whole of the left upper arm, within one hour his left arm was weak. The pain was severe for six weeks at intensity 10/10. The pain was particularly intense around the left shoulder but extended over the anterior aspect of the left upper chest and over the posterior left supra scapular region. He stated that he could not drive home. He had a manual car. He could not change gear with the arm. He had marked pain in the left shoulder and over the lateral aspect of the left forearm. Within two minutes the pain was travelling down the left lower arm into the left hand."

195. Dr Teychenné noted the left shoulder surgery and the continuing complaints of pain in the left shoulder and down the left arm. Mr Hare had informed Dr Teychenné that he had noted pain over the left side of his neck approximately one year after the injury. This pain had "joined into the pain over the left suprascapular region and also the pain over the left anterior chest within the C3/C4 dermatome and the pain extending down the left arm into the left hand associated with numbness in the left hand."

196. Dr Teychenné recorded that Mr Hare experienced a "crack over the left side of the neck" which caused intense pain if there was a quick sharp movement of the neck. He said this pain was localised over the left side of the neck. This problem had also been first noted approximately 12 months after the accident.

197. Mr Hare had recalled that he had first noticed pain in the neck across the left suprascapular region across the anterior left C3/4 dermatome six months after the injury. Dr Teychenné also recorded complaints of electric shock sensations in the left side of the neck with darkened vision in both eyes. About a month after the injury Mr Hare had begun to notice symptoms in the legs. Two years after the injury he noted the pain in the left knee and left hip.

198. Dr Teychenné detailed his findings on examination which included "normal movement of the neck but flexion of his neck induced a stiff pain which was an electric current tingling sensation from the lower left paracervical region down the left parathoracic region to T6." Dr Teychenné noted that gait, Rhomberg and heel-to-toe gait was normal. Tone and coordination were normal. He noticed decrease in pain sensation over certain areas.

199. Dr Teychenné carried out EMG nerve conduction studies of the bilateral median and ulnar nerves which appeared normal. He also carried out Brainstem Evoked Response testing which was again normal. Visual Evoked Response testing was also normal.

200. Dr Teychenné made a finding of "incomplete cervical cord lesion." He planned to do further neurophysiologic assessment to assess spinal cord and peripheral nerve function. He said "His clinical picture is consistent with incomplete cervical cord lesion which I do not infrequently see with the type of accident that he described where he appears to have a severe traction injury." The normal MRI scan, he said, was not inconsistent with this diagnosis.

201. Dr Teychenné again reported to Dr Nelmes on 11 July 2018. He noted complaints of pins and needles in the soles of the feet after walking a kilometre. He said this had been present for eight years but worse over the past 12 months. Mr Hare complained of memory loss with symptoms of itching and blacking out. There were also complaints of loss of hearing and loss of feeling in the left hand. On turning the head to the right Mr Hare noted a "massive crack" and his vision was affected.

202. He said:

> "Over the past eight years if he stands up quickly the room spins for about three seconds. He may also lose vision peripherally if he stands up quickly similar to the sensation if he quickly rotates his head to the right. He is concerned if he quickly rotates his head to the right that he may blackout."

203. Dr Teychenné recorded findings on examination which were similar to those in his earlier report. He carried out an EMG nerve conduction study within the lower limbs the results of which were normal. Upper Extremity Short Latency Somatosensory Evoked Potentials were noted to be normal and "Conduction through the posterior cervical spinal cord, brainstem thoracic outlet in cervical nerve roots was within the normal range." Dr Teychenné planned to do further neurophysiologic assessments "to assess spinal cord and peripheral nerve function".

204. On 18 July 2018, Dr Teychenné reported to the general practitioner that Mr Hare had complained the previous week that he developed pins and needles in the soles of his feet after walking one hundred metres. He had headaches which persisted for three hours. He said “the headache appeared to be more an aching neck pain.”

205. Dr Teychenné also recorded history of onset of nocturia within the first two years following the subject injury. He had also developed faecal incontinence in that time, the first episode being eight months after the injury. He continued to suffer from bowel urgency.

206. Mr Hare further complained that in 2008 he had noticed “a slow pain extending from the whole of the left hand or fingers as a stiff tingling creeping up the left arm.” He could not actually move the arms with the intense pain. The left arm was weak and paralysed. Mr Hare also noticed problems with ejaculation approximately 12 months after the injury. He reported recent “blank episodes” and amnesic episodes for about half a minute. He had noticed these episodes since the accident.

207. Dr Teychenné detailed findings on examination in similar terms to those in his two previous reports. Lumbar nerve testing, right posterior tibial nerve testing and right and left median nerve studies were all normal. Dr Teychenné said that the clinical picture was consistent with incomplete cervical cord lesion and felt that a further MRI scan will be necessary.

208. Dr Teychenné next reported to Dr Nelmes on 1 August 2018. On that occasion Mr Hare complained of urinary urgency. Mr Hare had complained of bowel incontinence over the first three months after the injury. He continued to have bowel urgency. Dr Teychenné noted continuing episodes of amnesia. These episodes could last 15 to 20 seconds. He again noted symptoms of amnesia, pins and needles in the right hand down the medial aspect of the left upper arm. There were continuing complaints of loss of feeling and loss of power in the left arm and continuing pain with occasional nausea.

209. EMG muscle sampling was said to indicate decrease in recruitment pattern. Dr Teychenné prepared to do further EMG muscle sampling “to assess spinal cord and peripheral nerve function”. He again felt that the clinical picture was consistent and incomplete cervical cord lesion.

210. In his report dated 8 August 2018, Dr Teychenné reported similar complaints and noted similar signs and symptoms to those recorded in his earlier reports. He felt there was a marked decrease in recruitment pattern on muscle sampling. Dr Teychenné reported:

> “The clinical findings were consistent with involvement of the right L5 and bilateral S1 spinal segment but the findings are more likely due to an incomplete cervical cord lesion. I will do further neurophysiologic assessment to assess spinal cord and peripheral nerve function.”

211. In his report dated 22 August 2018 to the general practitioner, Dr Teychenné noted that Mr Hare had told him:

> “If he pushes himself then he begins to get to the point where he has quite severe pain which is localised over the left supra scapular region, supraclavicular region into the left shoulder and down the whole of the left arm into the dorsal and ventral aspect of the left hand. At that stage he cannot move the left arm because of the pain. He has difficulty changing his clothes, having a shower or washing. He has difficulty cutting food and this can persist for up to three days. He basically has to rest and not move the left arm.”

212. Dr Teychenné noted further extensive symptoms including “excruciating pain in the right loin.” Sitting for two hours was said to induce numbness within the hands and feet. Mr Hare complained that if he was walking he “couldn’t feel his feet”. He noted the left ankle giving way. Mr Hare said that he had noted episodes of flushing with nausea over the past 10 years with feelings of faintness or that he could black out. This was said to have started three years after the injury.

213. Findings on examination was similar to those reported in the earlier reports. On muscle sampling, Dr Teychenné noted decreased sensation in the left arm. He said “the findings were consistent with involvement of the left and right C7 to T1 spinal segments in the absence of marked evidence of ulnar nerve compression.” Dr Teychenné proposed to do further muscle sampling to assess spinal cord and peripheral nerve function.

214. In his report dated 29 August 2018, Dr Teychenné noted further complaints by Mr Hare. He was unable to lie on his left side and there were continuing complaints of pain and headaches. He again noted episodes of blacking out.

215. Further muscle sampling indicated normal recruitment pattern with a marked decrease within the FHB bilaterally. Dr Teychenné reported “while these findings could be consistent with involvement of the S1 spinal segments, straight leg raising was normal in both sides. The decrease in recruitment pattern is most likely due to an upper motor neuron lesion at the level of the cervical spine.”

216. Dr Teychenné requested an MRI scan of the cervical, thoracic and lumbar spine which was performed on 17 September 2018. The findings were reported as normal in respect of the cervical, thoracic and lumbar spine.

217. In his next report to the general practitioner on 17 October 2018, Dr Teychenné noted complaints of increased urgency in the bowel and sensation of numbness around the anal region. There was urinary and bowel urgency. Mr Hare was noted to be uncomfortable with soreness in every position. There were similar findings on examination. Dr Teychenné noted that the MRI scan of the cervical spine: “did not show any macroscopic T2 hyper intensity within the cord. He did have a shallow left paracentral disc protrusion at T5/6 without significant canal narrowing, in the absence of a significant disc osteophyte compressing the cord I would treat him conservatively.” Dr Teychenné again diagnosed incomplete cord syndrome which he said was generally microscopic and not apparent on macroscopic MRI scan of the spinal cord.

218. Dr Teychenné provided a medicolegal report on 30 November 2018 which was in evidence. Dr Teychenné noted that Mr Hare had been assessed by Dr Rail on 10 November 2008 with findings of paraesthesia in the third to fifth fingers of the left hand associated with difficulty in gripping. There was intermittent neck stiffness as well as weakness of the left shoulder abduction. He commented that EMG showed a marginal left carpal tunnel syndrome without any evidence of an ulnar nerve lesion. Dr Teychenné felt that “the clinical picture is consistent with a C7/8 radicular syndrome.”

219. Dr Teychenné noted the treatment by Dr Rail as well as the treatment in respect of the left shoulder and the surgery. He noted that an MRI scan of the cervical spine in January 2014 was normal with no evidence of nerve root impingement. Reviewing the past clinical notes, Dr Teychenné felt that Mr Hare had sustained a left cervical radiculopathy in addition to the shoulder injury.

220. Dr Teychenné said that he had first seen Mr Hare on 15 May 2018 with a history of left shoulder and brachial plexus traction injury “some 12 years ago”. Dr Teychenné noted previous neurological findings and the nerve conduction studies carried out at the Prince of Wales Hospital on 3 April 2018 which were essentially normal.

221. Dr Teychenné noted Dr Pillemer's report. He said that his findings on examination were consistent with those of Dr Pillemer. Those findings were "quite consistent with the sensory hyperalgesia and allodynia produced by an incomplete cervical cord lesion." He explained that "that is a central incomplete cervical cord lesion involving predominantly the spine earth alarming tracts."

222. Dr Teychenné noted that Dr Pillemer had considered that Mr Hare had sustained a traction injury to the brachial plexus particularly involving the C6 and C7 nerve. That finding he said was based on findings of sensory loss in the C6/7 distribution and the absent reflexes in the left arm. Dr Teychenné said at the time of his examination the sensory deficit was more consistent with an incomplete cervical cord lesion and he had not found reflex asymmetry in the upper limbs. He said "in my experience patients presenting with incomplete cervical cord lesions may appear to have a clinical picture based on the symptoms of a brachial plexus injury. This is well described in the literature."

223. Dr Teychenné summarised the history he had been provided with by Mr Hare as noted in his earlier reports. He noted the essentially normal nerve conduction studies in the left arm. He noted the complaints of loss of vision and hearing as well as the feelings of faintness. He said "This description of symptoms including the blurring of vision and the loss of hearing is not an unusual constellation of symptoms in patients who sustain incomplete central cervical cord lesion."

224. Dr Teychenné reported: "On repeat examination he had evidence of the left hemi sensory deficit pain, temperature and touch sensation as well as the bilateral stocking deficit pain, temperature and touch sensation consistent with a central incomplete cervical cord lesion." He noted that "Mr Hare did not have any obvious prior injury to the same body parts."

225. In assessing impairment in respect of the cervical spine and lumbar spine, Dr Teychenné said "the AMA Guidelines do not adequately assess impairment due to incomplete cervical cord lesion." He said that he had therefore applied the DRE [Diagnostic Related Estimates] method of assessment noting:

> "He had a left hemi cape distribution, hyperalgesia and at times decreased sensation within the left hemi cape distribution. This was quite consistent with a spinothalamic lesion where there may be hyperalgesia to deeper stimulation but numbness to superficial stimulation."

226. Dr Teychenné made a similar comment with regard to assessment of the lumbar spine noting "myelopathic weakness in the legs and left hemi sensory deficit."

227. In a report to the solicitors dated 15 November 2020, Dr Teychenné commented on the report of Dr O'Sullivan dated 14 October 2020 which is noted below. He noted that Dr O'Sullivan had concluded that Mr Hare's current condition was related to the left shoulder pathology and there was no spinal cord injury. Dr O'Sullivan had also not accepted Dr Pillemer's assessment of a brachial plexus injury.

228. Dr Teychenné noted an article which appeared in the Journal of Neurology, Neurosurgery and Psychiatry in 1973 detailing a number of cases with severe pain in the shoulders and arms after relatively minor injuries. Dr Teychenné discussed the symptoms in the cases detailed. He noted a post-mortem study from 1958 where spinal cord damage was shown upon post-mortem examination although it had appeared macroscopically normal. He said it was more likely than not that the patient would not have had evidence which would have shown on an MRI scan.

229. Dr Teychenné reviewed other journal articles which he said supported the view that a person could suffer incomplete cervical cord lesion which would not be apparent through MRI scans. He explained why he thought that Dr O'Sullivan's view was incorrect. In summary Dr Teychenné said that, considering his findings on examination and the symptoms reported by Mr Hare, he was satisfied that Mr Hare had suffered an incomplete cervical cord lesion. Dr Teychenné disagreed with Dr O'Sullivan over the significance of signs that he had observed on examination.

230. Dr Teychenné accepted that Dr Pillemer's assessment of brachial plexus injury was "feasible" but felt that better diagnosis was "incomplete cervical lesion". He concluded:

> "As I indicated, it has been my experience when reviewing assessments of patients with incomplete central cord lesion is that assessing physicians are not fully aware of the history and examination findings consistent with a central incomplete cord lesion and are often not aware of the type of injury which may result in incomplete central cord lesion. These lesions are often equated with more severe transection injuries to the spinal cord. The difference between a central incomplete cord lesion and a transection lesion of the spinal cord is often not appreciated."

Dr Dudley O'Sullivan, Neurologist

231. Mr Hare was examined by Dr Dudley O'Sullivan, neurologist, at the request of the insurer on 22 February 2019. Dr O'Sullivan was provided with reports of the medical practitioners set out above. He recorded the history of injury in more or less the same terms as the other medical practitioners who had seen Mr Hare.

232. He noted the immediate onset of left arm pain. He was informed that Mr Hare had be unable to drive home because of pain in the left arm and had to use public transport. Dr O'Sullivan noted the course of treatment that followed with respect to the left shoulder. He said:

> "Approximately 12 months post incident, he noticed some numbness in the left hand which extended up to the left elbow as well as to both feet, left greater than right. Because of this he was referred to see Dr Rail, Neurologist, who felt that he may have a left C6/7 radiculopathy as well as a mild left carpal tunnel syndrome. He mentioned that ever since his shoulder surgery if he turns his head to the right, he notices a clicking sensation in his neck which produces a headache."

233. Dr O'Sullivan noted present complaints related to the left shoulder and the left hand associated with pins and needles both on the palmar and dorsal surfaces as well as pain around the shoulder blade together sensation of a deep itch around the left shoulder. He reported:

> "His neck symptoms have been persistent, as described. He said that after the injury he would have some difficulty controlling his bowel and bladder and which have been persistent. He feels that he has lost the sensation in the anal region. However, sexual function is normal."

234. Dr O'Sullivan noted that Dr Teychenné had diagnosed "an incomplete cervical cord lesion". Dr O'Sullivan said that he could not substantiate that diagnosis. He noted that the testing done by Dr Teychenné had been essentially normal. Dr O'Sullivan noted that an earlier treating neurologist, Professor Colebatch had arranged nerve conduction studies which showed "evidence of mild left carpal tunnel syndrome, but no additional abnormalities."

235. On examination Dr O'Sullivan found no abnormality of the cranial nerves. There were normal visual fields and normal eye movements. There was no facial weakness nor any sensory impairment with regards to the cranial nerves.

236. There was no muscle wasting in the upper limbs but there was a restricted power in the left shoulder. Examination of the lower limbs revealed no muscle wasting with normal tone, power and coordination. All deep tendon reflexes in the upper and lower limbs were observed to be symmetrical and equal. The plantar responses were flexor and he had preserved abdominal reflexes. Anal reflexes were preserved and anal sensation was intact. Dr O'Sullivan continued:

> "On more detailed sensory examination, he had preserved joint position sense, vibration sense and two-point discrimination. There was a subjective alteration to temperature and pinprick over the entire left half of his body up to the face, but this changed to the midline. His gait was normal and he was able to walk heel to toe, and he had negative Rhombergism."

237. Dr O'Sullivan commented that the MRI scan of the cervical spine was normal. In his opinion the only abnormality was to the left shoulder. His opinion was that the injury in September 2005 would not have resulted in injury to the spinal cord. He said "he has no neurological abnormality apart from having a very mild left carpal tunnel syndrome."

238. In a supplementary report dated 14 October 2020, Dr O'Sullivan responded to a request to explain the reason that he had come to the opinion that there was no injury to the spinal cord. Dr O'Sullivan explained that 12 months post-accident Mr Hare had noted numbness in the left hand and nerve conduction studies performed by Dr Rail had found evidence for mild left carpal tunnel syndrome with a possibility of a left C7 radiculopathy.

239. Dr O'Sullivan explained that his examination and testing of Mr Hare had revealed no signs of pathology. Professor Colebatch's nerve conduction studies had again shown evidence of mild left carpal tunnel syndrome. Otherwise there was no abnormality. There was no evidence to support a diagnosis of incomplete cervical cord lesion. He felt that, if there had been injury to the cervical spine, this would have been immediately apparent.

240. Dr O'Sullivan provided a further report dated 14 October 2020 commenting on the reports of Dr Ho, Dr Pillemer and Dr Teychenné. Dr O'Sullivan agreed with Dr Ho's assessment that there was no evidence of incomplete cervical cord lesion. Dr O'Sullivan further reported that his observation of the normal reflexes in both the upper and lower limbs ruled out the existence of a brachial plexus lesion as postulated by Dr Pillemer.

241. Dr O'Sullivan set out in detail his reasons for disagreeing with Dr Teychenné about the existence of any incomplete cervical lesion. Basically his reasoning was that he had found no evidence to support a finding of spinal cord lesion. He points to the fact that incomplete cervical lesion had been described more than 60 years earlier in an era when MRI scans were not available. He suggested that, if the cases referred to by Dr Teychenné were examined today, MRI scans would reveal pathology.

242. Dr O'Sullivan mentioned that the Guidelines for whole person impairment do not permit the use of neurophysiological studies or electromyographic studies for the purposes of assessing whole person impairment. Whilst I accept this as correct, it is not the issue of the extent or nature of impairment that is in question in the present proceedings, but whether Mr Hare suffered injury to the cervical spine on 29 September 2005. If the neurophysiological and electromyographic studies provided relevant evidence in support of this, then they would need to be taken into consideration. However, in the current case there is no suggestion that the EMG testing disclosed any significant abnormality.

243. Dr O'Sullivan confirmed that he did not consider that Mr Hare had suffered a work-related injury to cervical spine or lumbar spine as result of the incident on 29 September 2005.

Discussion

244. Counsel for the applicant submitted that Mr Hare's evidence was that he had made complaints of neck pain at earlier times than was indicated by the medical records which showed the earliest complaint of neck pain as having been made to Dr Sor in March 2008. Mr Wilson noted that the records of Dr Antoun were not available to the applicant as they had been destroyed.

245. It does appear that the first reference to neck pain in the medical records is to be found on the occasion of the consultation on 6 March 2008 when Dr Sor noted "has been getting left neck pain".

246. In his fourth statement of 17 September 2019, Mr Hare said that he complained to Dr Sor of "clicking in the neck" on 5 October 2006. The note by Dr Sor on that date is "pain unchanged, clicking". There is no indication that the clicking referred to was in the neck and I note that Dr Goldberg, reporting to Dr Antoun on 21 November 2006, places the "clicking" in the shoulder; "He gets occasional clicking in the shoulder but little pain." I do not accept that Mr Hare complained to Dr Sor of clicking in the neck on 5 October 2006.

247. Although the applicant was unable to obtain Dr Antoun's clinical notes, there was a report to the insurer in evidence from that general practitioner. Dr Antoun detailed his findings on examination of Mr Hare on 30 September 2006. As noted above, he recorded; "on examination, Mr Hare was tender along the origin of the biceps tendon. He was tender along the front of the shoulder as well as over the subacromial bursal space. There was mild limitation of shoulder movement with positive impingement and tenderness in subacromial pressure."

248. Under the heading "The findings of your initial examination" Dr Antoun recorded "the findings were consistent with reduction in the left shoulder movement, which were mild on initial presentation and tenderness along the origin of the biceps tendon, as well as the subacromial space."

249. On 2 December 2006, Dr Antoun noted that Mr Hare had presented stating "he felt extremely well with much improvement in the left shoulder and was feeling better". He noted that the range of movements in the left shoulder had improved "dramatically". On 16 December 2005, Dr Antoun said that Mr Hare was feeling much better and had minimal signs of impingement "with some mild discomfort still over the anterior shoulder area which he describes as 'burning'." At the last consultation on 10 April 2006 Dr Antoun noted that Mr Hare had a better range of movement and was able to abduct his shoulder to 90° with good elevation but with some mild discomfort. He was noted to be improving "quite well".

250. The report by Dr Antoun in evidence covers the whole period during which that practitioner was treating Mr Hare. In the report Dr Antoun detailed the specific areas in which painful symptoms were noted. Those areas did not include the neck.

251. The statements of Mr Hare in December 2005 and January 2008 make no reference to any symptoms in the neck. In his statement made in January 2008 Mr Hare said "I still experience pain in my left shoulder on a daily basis and this is further aggravated if I lift objects not only to experience pain in my left shoulder but I feel that to overcompensate for my injury my right elbow is becoming extremely painful." No mention is made of the neck.

252. The applicant noted that Dr Breit referred to pain at the "base of the occipit" which Mr Hare told him was "due to his neck problems". The applicant submitted that Dr Breit was well-placed to comment on the symptomatology given that he had examined Mr Hare in March 2008. The applicant noted that Dr Breit had identified chronic pain syndrome and psychological issues which gave support to the applicant's statement that his neck symptoms have been masked by medication and by concentration on the shoulder problems.

253. It is difficult to give weight to the reports of Dr Breit in support of the applicant's case. Dr Breit was not told of the earlier injuries to the neck. The earlier of these in 1987 apparently continued to trouble Mr Hare until at least 1995 when he made a claim against the employer which included a claim of permanent impairment of the neck.

254. Again in June 2005, Mr Hare suffered an injury to the neck when timber fell onto his neck and upper back. Both those injuries appear to have become asymptomatic but they nevertheless do not support the history given to Dr Breit that there had been no previous compensation claims. Dr Breit recorded that "I am told the neck has had a lot of treatment, indicating there is pain at the base of the occiput, which he was told is due to his neck problems."

255. The contemporary medical records contain no evidence whatsoever of any treatment of the neck up to that point. There is no evidence to establish who it was that told Mr Hare that the pain at the base of the occiput was due to neck problems. I do not accept that there had been treatment of the neck at that point.

256. The applicant submitted that it was "curious" that the respondent had not referred Mr Hare to Dr Breit on subsequent occasions. I do not think that this is a matter of any weight. There are numerous reasons why further referral to Dr Breit may not have been available or appropriate. While Dr Breit's reports clearly establish complaints of neck symptoms at examination in March 2008, I do not think that, when read with the evidence of Dr Rail, the prior history of Mr Hare and the clinical notes, that I could give weight to Dr Breit's opinion as to the neck symptoms being causally related to the subject injury in September 2005.

257. In November 2008, Dr Rail noted the onset of neurological symptoms in the left hand (D3 to 5) as having come on "over the last six months".

258. I am satisfied that the first reference to neck problems in the treatment records is that referred to in the records of Dr Sor in March 2008. I interpret Dr Sor's note "has been getting left neck pain" as recording a relatively recent event and not a complaint of symptoms going back to the date of injury or shortly thereafter.

259. I accept the applicant's submission that an overwhelming majority of examination treatment was given to the left shoulder giving rise to the surgery in February 2006 by Dr Goldberg. However I cannot accept that this, together with the analgesic medication, caused Mr Hare and his treating practitioners to not mention the neck.

260. The symptoms recorded by Mr Hare in his fourth statement are not symptoms which were likely to go unreported or, if reported, unrecorded by his medical advisors. Mr Hare reported withdrawing from his "strong medication" in 2007. He said it was at this point that he "became more aware of neck pain and tingling in the neck".

261. Mr Hare said that he had complained to Dr Antoun of "stiffness in the neck, crack/click noise when turning my neck, burning pain down the left arm and tingling in the fingers of the left hand." Those complaints are not supported by the report of Dr Antoun.

262. Dr Pillemer recorded a history of discomfort extending from the left side of the neck into the left shoulder and down the arm into the fingers of the hand from the date of the accident. As noted in Mr Hare's fourth statement he was said to have momentary periods of blackout when turning his head sharply. Dr Teychenné recorded the history of loss of bowel control in the year following the subject injury as well as symptoms extending up into the face. Mr Hare noted difficulty with driving and particularly reversing.

263. It is difficult to accept that this level of symptoms would have been overlooked in the first year following the accident. It would be understandable if Mr Hare's symptoms were simply of pain in the left side of the neck. However, that is not the history recorded by various doctors and is not the history given in Mr Hare's most recent statement.

264. I accept that Dr Rail in 2008 noted symptoms (which he said had developed in the last six months) which he felt were consistent with a C7/8 radicular condition. Following the complaint of exacerbation in 2010 Dr Rail ordered further testing which was apparently suggestive of carpal tunnel syndrome. Dr Rail's reports do not address the issue of causation.

265. The applicant addressed the disagreement between Dr O'Sullivan and Dr Teychenné as to the existence of an incomplete cervical lesion caused by the subject accident. Counsel for the applicant noted that Dr Teychenné had addressed the criticisms levelled by Dr O'Sullivan by reference to the clinical signs and symptoms that he had noted which were consistent with an incomplete cervical lesion.

266. While I accept that Dr Teychenné points to particular signs and symptoms as forming the basis of his opinion that there is "incomplete central cervical cord lesion", it is by no means clear what signs and symptoms are accepted by the medical profession as demonstrating the existence of an incomplete cervical lesion.

267. Dr Teychenné explained that the condition of incomplete cervical lesion was not detectable by testing. He cited an example from 1958 where post-mortem examination had demonstrated an incomplete cervical lesion which was not able to be detected by macroscopic examination.

268. To that extent, Dr Teychenné's opinion is a bare *ipse dixit* as to the signs and symptoms accepted by the medical profession as constituting an "incomplete cervical lesion". Dr Teychenné points to signs and symptoms and identifies these as being consistent with a cervical cord lesion. How the connection is made is not explained. There does not appear to be any reference in the literature cited by Dr Teychenné to any study which establishes a connection between particular signs and symptoms and post-mortem investigation which identifies incomplete cervical lesion not detectable by MRI scan.

269. In addition, Dr Teychenné's opinion is based upon an acceptance of a history of bowel problems, vision problems, facial paraesthesia and blackouts which are simply not established on the evidence, on the balance of probabilities. Dr Teychenné has also not been able to give consideration to the effects of the two earlier neck injuries as it appears he was not told about these.

270. I accept that all investigations of the cervical spine have been reported as showing no abnormality. Wider nerve testing has detected results that may be consistent with carpal tunnel syndrome or, in the opinion of Dr Pillemer, brachial plexus injury.

271. While Dr Pillemer felt that there may have been a brachial plexus injury[7], Dr O'Sullivan did not agree with that proposition. There are therefore three opposing theories, Dr Teychenné who felt that the signs and symptoms established an incomplete cervical lesion, Dr Pillemer who felt that the signs and symptoms established brachial plexus injury and Dr O'Sullivan who was of the opinion that neither of those views was correct.

272. Counsel for the applicant submitted:

> "The applicant acknowledges that the finding of a brachial plexus injury is connected to the neurological problems including that which relates to the cervical spine. Dr Teychenné at page 7 of his report of 15 November 2020 acknowledges Dr Pillemer's finding of neuropathic pain but is of the opinion that it is more likely due to a central incomplete cervical cord lesion. The difference of opinion from the two different specialties is noteworthy, and the applicant considers it reasonable to refer the matter to an AMS as a brachial plexus injury."

[7] report 9 January 2020, page 4.

273. Upon review of the medical evidence, it is difficult to arrive at a definite conclusion as to the existence of signs and symptoms in the cervical spine. Mr Hare's more recent statements contrast with his earlier statements. Mr Hare told Dr Teychenné and Dr O'Sullivan that, on the day of his injury in September 2005, he had been unable to drive home. That was not correct as his earlier statements confirmed that he did in fact drive home. Mr Hare is not altogether consistent in reporting the date of onset of symptoms to the medical practitioners who have examined him.

274. I prefer the earlier statements made in December 2005 and 11 January 2008, where there is conflict with his later statements because Mr Hare's recollection of events is more likely to have been correct those earlier times. Where his later statements conflict with reports made to medical practitioners, I prefer the latter as more likely to be correct as they are closer in time to the subject injury than the more recent statements.

275. The medical experts make different findings on examination. Dr Breit found signs that he felt may be radicular. Dr Sharp in 2006 found neck movements that were "full and normal" with normal muscle power, tone and sensation reflexes. Dr Rosenthal in 2013 reported "a full range of movement of his neck" and Dr Deshpande in 2014 reported neck movements and neurological examination as normal.

276. Neither Dr Lam, Dr Best nor Dr Collins referred to neck movements but Dr Perco and Dr Bodel noted restriction of neck movements. I am not persuaded that the finding of restriction of neck movement on examination in 2010 and later is evidence sufficient to support a finding of injury to the neck in September 2005, in the absence of complaints to medical practitioners of neck pain before March 2008.

277. Four neurologists have examined Mr Hare. Dr Rail felt that there were radicular symptoms but this opinion was not borne out by later nerve conduction studies. Professor Colebatch reported "There is neurophysiological evidence for left-sided mild carpal tunnel syndrome without evidence of additional abnormalities". Dr Teychenné diagnosed an "incomplete cervical lesion" and Dr O'Sullivan accepted Professor Colebatch's suggestion of mild left carpal tunnel syndrome but otherwise felt there was no abnormality.

278. NoIn my view there is no basis upon which I could conclude that I should prefer the opinion of Dr Teychenné over that of Professor Colebatch and Dr O'Sullivan. Dr Teychenné states in his supplementary report dated 30 November 2018 that he has assessed Mr Hare as falling within DRE Cervical Category III. In the absence of a fracture or fractures to one or more cervical vertebrae, that assessment requires the presence of radiculopathy[8], that is a pathological condition of the nerve roots[9].

279. Dr Teychenné disagrees with Dr Pillemer in placing the pathology within the spinal cord and presumably involving the relevant nerve roots (as well as the hypothalamic tract). Dr Pillemer, on the other hand, diagnoses a brachial plexus injury which would represent a different body part to the cervical spine which is the body part referred to in the current claim. An injury to the brachial plexus could not be classified as an injury to the cervical spine. That distinction is drawn by Dr Pillemer in his report dated 12 November 2020 where he says "an MRI of the cervical spine would not pick up a brachial plexus lesion."

280. I therefore do not accept the submission of the applicant that the disagreement between Dr Teychenné and Dr Pillemer is capable of supporting a referral to an Approved Medical Specialist in respect of the brachial plexus instead of the cervical spine.

[8] *American Medical Association Guides to the Evaluation of Permanent Impairment, fifth edition*, page 392, Table 15-5.
[9] Op cit, page 602.

281. Having regard to the absence of any complaint of neck problems in Mr Hare's statements made in December 2005 and January 2008 and in particular the absence up to March 2008 of complaints of the symptoms reported by Dr Teychenné in his assessment, the absence of any pathology demonstrated on investigation, the incomplete history provided to all the medical practitioners and the inability of experts to agree on the presence of any pathology, I could not be satisfied on the balance of probabilities that Mr Hare had suffered an injury to his cervical spine on 29 September 2005, whether by way of incomplete cervical lesion or otherwise.

282. The applicant's case for there being a consequential condition in the lumbar spine is dependent upon a finding of injury to the cervical spine by way of incomplete cervical lesion. As I am not satisfied that Mr Hare had suffered an incomplete cervical lesion, the claim in respect of the lumbar spine must fail.