WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number: **4908/19**
Applicant: **Corinne Toynton**
Respondent: **Kmart Australia Limited**
Date of Determination: **20 December 2019**
Citation: **[2019] NSWWCC 421**

The Commission determines:

1. The applicant sustained injury to her right shoulder on 23 December 2018 pursuant to ss 4(a) and 9A of the *Workers Compensation Act 1987*.

2. The applicant has had no current work capacity from 28 June 2019 to date as a result of the injury on 23 December 2018.

3. The corticosteroid injection proposed by Dr Abraham on 21 May 2019 is reasonably necessary as a result of the injury on 23 December 2018.

The Commission orders:

1. The respondent to pay the applicant weekly benefits from 28 June 2019 to date and continuing pursuant to s 37(1)(a) of the *Workers Compensation Act 1987* based on a Pre-injury Average Weekly Earnings rate of $413.60, as periodically adjusted.

2. The respondent to pay the applicant's reasonably necessary medical expenses pursuant to s 60 of the *Workers Compensation Act 1987*, upon production of accounts, receipts and/or valid Medicare charge, including the costs of and incidental to the right corticosteroid injection proposed by Dr Abraham in his letter dated 21 May 2019.

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

Rachel Homan
Arbitrator

I CERTIFY THAT THIS PAGE AND THE FOLLOWING PAGES IS A TRUE AND ACCURATE RECORD OF THE CERTIFICATE OF DETERMINATION AND REASONS FOR DECISION OF RACHEL HOMAN, ARBITRATOR, WORKERS COMPENSATION COMMISSION.

A MacLeod

Ann MacLeod
Acting Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Ms Corinne Toynton (the applicant) commenced employment with Kmart Australia Limited (the respondent) on a casual basis in August 2016. The applicant's duties included tidying up fitting rooms, placing clothing back into the store and ensuring that displays were neat and tidy. The applicant claims that she sustained an injury to her right shoulder in the nature of scapular dyskinesis due to the repetitive nature of her work duties on 23 December 2018.

2. The applicant made a claim for compensation on or about 8 January 2019. On 6 June 2019, the respondent's insurer declined liability, issuing a dispute notice pursuant to s 78 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act).

3. The present proceedings were commenced by an Application to Resolve a Dispute (ARD) filed in the Commission on 19 September 2019. The applicant seeks compensation in the form of weekly benefits from 25 June 2019 to date and continuing and medical expenses pursuant to s 60 of the *Workers Compensation Act 1987* (the 1987 Act) including the costs of and incidental to a subacromial corticosteroid injection proposed by her treating specialist.

ISSUES FOR DETERMINATION

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

    (a) Whether the applicant sustained injury to her right shoulder on 23 December 2018;

    (b) Quantification of any entitlement to weekly benefits; and

    (c) Entitlement to medical expenses including the proposed corticosteroid injection.

PROCEDURE BEFORE THE COMMISSION

5. The parties appeared for conciliation conference and arbitration hearing on 20 November 2019. The applicant was represented by Mr Ross Hanrahan of counsel, instructed by Mr Wayne Keen. The respondent was represented by Mr David Saul of counsel.

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

EVIDENCE

Documentary Evidence

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

    (a) ARD and attached documents;

    (b) Reply and attached documents; and

    (c) Documents attached to an Application to Admit Late Documents filed by the applicant on 7 November 2019.

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

Applicant's evidence

9. The applicant's evidence is set out in a statutory declaration made by her on 5 September 2019.

10. The applicant said she usually worked for the respondent in its Blacktown store, between 15 and 20 hours per week. On occasions, the applicant would work more hours, depending on the time of year. The applicant said her duties involved a lot of repetitive lifting, carrying and working at and above shoulder height. The applicant was required to move and carry large amounts of clothing.

11. In the second half of 2018, there were a couple of episodes where the applicant felt slight pain in the right shoulder region, when working extended hours. Pain would subside shortly afterwards and the applicant had no pain in the right shoulder or scapular region when she commenced work on 23 December 2018.

12. On that date, the applicant was about one hour into her normal shift and in the process of placing clothing onto a movable clothes rack used to transport clothing throughout the store. As the applicant placed clothing onto the upper rail of the rack, she felt immediate pain from the top of her right shoulder extending down to below the shoulder blade and across into her neck. The applicant described it as a throbbing, burning type pain.

13. The applicant reported the injury to a co-worker and manager. The applicant used an icepack on her shoulder and sat on the ground for the remainder of the shift.

14. The next day, the applicant consulted her general petitioner, Dr Al Faruque. Dr Al Faruque referred the applicant for an ultrasound and prescribed Mobic and Panadeine Forte. The ultrasound was performed on 27 December 2018.

15. The applicant had been due to return to work on 24 December 2018 but was unable to work shift. The applicant went to work a few days after Christmas and completed an incident report. The applicant then continued to work her rostered shifts but experienced pain in her right shoulder. The applicant initially told her employer that she did not want to lodge a worker's compensation claim as she hoped the condition would improve.

16. The applicant was referred for an MRI scan of her right shoulder which was carried out on 22 January 2019. The applicant also received a cortisone injection but it did not help relieve her pain. The applicant was referred for physiotherapy also attended two chiropractic treatments.

17. On 26 February 2019 the applicant underwent an MRI scan of the cervical spine. As the applicant's condition was not improving, her doctor referred her to a sport and exercise physician, Dr David Abraham. Dr Abraham saw the applicant in late March 2019 and referred her for an MRI scan of the right scapula, which was performed on 12 April 2019. After reviewing the results, Dr Abraham recommended a further ultrasound-guided cortisone injection.

18. The applicant went off work from 8 January 2019 and remained off work for approximately two months, returning on light duties 11 March 2019. The applicant worked two shifts but found it very difficult to perform her duties due to intense pain. The applicant had not returned to work since that time. The applicant said she was paid weekly benefits and medical expenses by the insurer until liability was declined on 6 June 2019.

19. The applicant denied any previous injuries to her right shoulder or neck.

20. The applicant's current disabilities included pain, tenderness and restriction of movement of her right shoulder and neck, difficulty raising her right arm above shoulder level, restricted ability to push, pull or lift weights, difficulty performing domestic tasks and difficulty sleeping. The applicant was taking medication in the form of Palexia SR, Mobic, Panadol and Nurofen.

Evidence from the applicant's treating practitioners

21. The clinical notes of the applicant's general practitioner, Dr Mohammad Al Faruque are in evidence and on 24 December 2018 include an entry as follows:

> **"Surgery consultation Recorded by: Dr Mohammad Al Faruque Visit date: 24/12/2018**
> **Recorded on: 24/12/2018**
> rt shoulder injury at work
> ? ligamental injury
> advised USG and pain relief and rest
> depending on USG findings if needs arise for physio we will consider work cover certificate
>
> Diagnosis:
> Shoulder pain
>
> Reason for visit:
> Shoulder pain
>
> Actions:
> Imaging request printed: Rt shoulder USG.(? spinatus ligamneta injury? bursities)
> Prescription printed: Panadeine Forte 500mg;30mg Tablet 2 tablet Three times a day"

22. The report of an ultrasound of the applicant's right shoulder performed on 27 December 2018 indicated subacromial bursitis without right shoulder impingement. The remainder of the study was within normal limits and the rotator cuff was intact.

23. On 16 January 2019, Dr Al Faruque responded to a series of questions put to him by the insurer. Dr Al Faruque diagnosed subacromial bursitis without shoulder impingement due to repetitive movements of the right shoulder at work. Dr Al Faruque considered the diagnosis was related to the applicant's employment and said there was no relevant past history. The applicant was not fit for pre-injury duties. The applicant already had a cortisone injection and needed to start seeing a chiropractor or physiotherapist.

24. The report of an MRI of the applicant's right shoulder performed on 22 January 2019 indicated there was no rotator cuff tear. Mild supraspinatus tendinosis was identified and there were some changes suggestive of a mild subacromial bursitis.

25. A letter of referral to Dr David Abraham by Dr Al Faruque dated 29 January 2019, stated:

> "Patient injured while at work on her shoulder, we did an MRI, bursities [sic] and tendinosis noticed, Cortisone injection and chiropractor is ongoing at present, but she complains more pain at the shoulder and scapular area on rt side and radiated to her neck area. It's getting worse…"

26. A letter from the applicant's physiotherapist, Jude Holroyd, to Dr Al Faruque dated 8 February 2019 indicated the applicant was still complaining of constant pain and discomfort in her right shoulder. Both thoracic and cervical ROM assessments were able to reproduce the shoulder pain. The applicant reported having pain at rest and on examination showed some strength deficits.

27. On 25 February 2019, Mr Holroyd reported to Dr Al Faruque the applicant's pain was "localised to the medial border of the right scapula with thoracic and cervical movements increasing her symptoms."

28. The report of an MRI of the applicant's cervical spine performed on 26 February 2019 found:

> "Disc/osteophyte complex at the C5/6 level causing slight distortion of the anterior theca. No significant foraminal stenosis appreciated laterally at this level.
>
> No significant disc protrusion elsewhere in the cervical region. The central bony spinal canal is capacious. Mild osteophytic narrowing of the left C3/4 neural exit foramen is noted. No significant foraminal stenosis laterally elsewhere. Incidental note is made of a perineural nerve root sleeve cyst on the left at the C7/TI level measuring 3mm."

29. A report from a different physiotherapist, Mr Justin Graham, dated 29 March 2019, stated,

> "Ms Toynton has been reporting a continuous pain that runs from the R side of her neck, to her AC joint and follows the medial border of her scapular. The pain began around 3 months ago while at work at Kmart while hanging clothes onto a rack. She reported feeling a pain at the time, which then progressed over the shift, to the point that the next day she was unable to use her arm. She currently reports her P being constant, with is aggravated by standing for longer than 40min. She reports her arm gets shooting P and P&N the longer she stands. Ms Toynton reports that when she lies down the discomfort reduces. An initial scan of her shoulder showed some RC irritation, however a cortisone injection had no impact."

30. Mr Graham noted that the applicant was extremely sensitive around all the structures that supported right scapula along her lower cervical and upper thoracic spine. Mr Graham said he had discussed the possibility of undertaking further investigation of her cervical spine but said that would "likely return with numerous variations, and will probably not be relevant to her injury".

31. Also, on 29 March 2019, sport and exercise physician, Dr David Abraham reported to Dr Al Faruque noting that the applicant had injured her arm/shoulder on 23 December 2018 when loading clothes onto a rail. Dr Abraham noted the MRI of the right shoulder and said that on examination her right shoulder had full range with no pain or abduction. The applicant did have a scapular ache with shoulder flexion. The right scapula had a tender medial border and the applicant was tender over the right T5 to 7 costovertebral and facet joints.
Dr Abraham formed the impression the applicant had "right periscapular pain with muscular spasm and possible thoracic facet sprains". Dr Abraham referred the applicant for an MRI of her right scapula.

32. The report of an MRI scan of the right scapula performed on 12 April 2019 indicated that despite the applicant's ongoing symptoms, periscapular and scapular MRI was normal. The report stated:

> "Abnormal excursion of the scapula on the posterior chest wall (dyskinesia) may still be present despite normal MRI appearances. Please therefore assess for any scapulothoracic dyskinesia."

33. Dr Abraham reviewed the MRI results and on 10 May 2019 reported to Dr Al Faruque:

> "MRI of her scapula was normal. There was a suggestion of scapula dyskinesis.
> …
> Today, Corrine had a painful abduction arc with scapula dyskinesis on repeated abduction motions. She had hitching of her shoulder at 90 degrees abduction and a positive Hawkin's impingement sign.
> …

> Given the findings, her scapula and shoulder pain is likely from impingement and rotator cuff dysfunction. I will request approval for an ultrasound guided cortisone injection of her subacromial space and an appropriate rotator cuff and scapula program."

34. On 21 May 2019, Dr Abraham prepared a quote for the insurer for a subacromial corticosteroid injection which he said would likely benefit the applicant.

35. On 11 June 2019, Dr Al Faruque issued a certificate stating:

> "Mrs Corinne Toynton, is suffering from Scapula Dyskinesis, she was seen by physiotherapy and also Sports Physician, Her symptoms looks like contributed from her shoulder, where impingement and rotator cuff dysfunction is possible cause.
>
> It was possibly due to repeated abduction movement of her shoulder joint of the right side.
>
> I don't believe that this pain is from her neck or cervical vertebrae related pathology, And in my opinion, it is due to her work related injury."

36. In a report to the applicant's legal representatives dated 16 July 2019, Dr Abraham recited the history previously reported by him. Dr Abraham noted that the MRI of the applicant's scapula was normal but examination suggested she had a right shoulder impingement syndrome for which she requested a subacromial space corticosteroid injection, which was not approved. The applicant had pain with shoulder motion and some thoracic spine related discomfort. This limited the applicant's ability to lift and perform manual work. With regard to causation, Dr Abraham said,

> "The mechanism of injury as described by the patient at work is the likely cause of her pain and dysfunction. I believe her duties on the day were the cause of her pain due to the repetitive nature of the work of loading clothes."

37. From 1 June 2019 to 29 December 2019, the applicant was certified by Dr Al Faruque as having no current work capacity for any employment.

Dr Woo

38. The applicant relies on a medicolegal report prepared by orthopaedic surgeon, Dr Alexander Woo, dated 8 August 2019. Dr Woo took a history of the injury consistent with the applicant's evidence. Dr Woo said the applicant complained of right shoulder pain starting anteriorly and radiating to the scapula down the right arm with pins and needles in the right fourth and fifth fingers. The applicant did not complain of neck pain.

39. On examination, Dr Woo noted no tenderness or spasm in the cervical spine and normal cervical movement. There was diffuse tenderness over the right trapezius muscle as well as decreased sensation in tenderness around the scapular region. There was anterior tenderness over the acromioclavicular joint right. Active elevation of the right shoulder was accompanied by movement of the whole scapula and the right shoulder was raised above the left shoulder. Dr Woo said this was "consistent with some form of shoulder and scapular dysfunction (scapula dyskinesis)." Active range of movement was markedly restricted in all directions and internal rotation was completely absent. Dr Woo also performed a neurological examination.

40. Dr Woo considered the investigations referred to above and concluded,

> "I agree with the opinion of her treating GP and Specialist that she suffers from some form of Scapular Dyskinesis. She has also developed symptoms and signs of frozen shoulder."

41. Dr Woo disagreed with the opinion expressed by the independent medical examiner qualified by the respondent, Dr Anthony Smith, that the applicant's condition was entirely related to an aggravation of a degeneration of the cervical spine. Dr Woo said his clinical findings showed that the applicant suffered scapular dyskinesis and frozen shoulder about three months after she was assessed by Dr Smith. Dr Woo noted that although the applicant had symptoms and signs of non-verifiable radiculopathy she had no pain, spasm or guarding in the cervical spine and movement was normal. The neurological symptoms and signs were not consistent with findings of radiculopathy.

42. Dr Woo said,

> "Her current medical conditions, scapular dyskinesis and frozen shoulder are related to her employment.
>
> She is currently unfit to return to her employment because of ongoing right shoulder pain and restricted movement."

43. Dr Woo recommended treatment along the line of frozen shoulder unless any further investigations identified more specific pathology including radiculopathy related to cervical disc injury and nerve root impingement and/or ulnar nerve injury.

Dr Smith

44. The respondent relies on a medicolegal report prepared by orthopaedic surgeon, Dr Anthony Smith, dated 29 May 2019. Dr Smith took a history broadly consistent with the other evidence.

45. Dr Smith noted that the applicant had an injection into the shoulder which made no difference and the applicant continued to experience symptoms. Physiotherapy also did not help as the physiotherapist was working on the applicant's shoulder. An MRI of the shoulder demonstrated minor degenerative changes in the supraspinatus. An MRI of the scapula demonstrated no real abnormality. Dr Smith noted that Dr Abrahams had suggested injection under ultrasound guidance in the area of the right shoulder blade.

46. Dr Smith noted that extension of the neck produced pain in the back of the neck and into the top of the shoulder blade on the right as did lateral rotation of the neck to the left and lateral flexion of the neck to the left. Neck movements were otherwise normal and pain free. The shoulders moved normally in range and rhythm.

47. Dr Smith expressed the opinion:

> "In my opinion, this woman has symptomatic cervical degenerative disease which became symptomatic during her employment when doing overhead activities on 23 December 2018. There is in my opinion no likelihood that the symptoms she described could have originated from any shoulder injury. The ultrasound and MRI of the right shoulder are both normal. In my opinion, the bursitis is within normal limits. See excerpt of Girish et al at the end of this report.
>
> If one sees a thousand patients with pain about the shoulder blades or between the shoulder blades, at least 950 of them will have those symptoms as referred pain from the cervical spine.

> We all get cervical degenerative disease. It is part of the normal ageing process. If one consults with a large number of patients who have symptomatic cervical degenerative disease that is a problem and enquires of them their age at the time of onset of the symptoms, the most common answer is around the age of 40. See excerpts of Matsumoto et al and Eubanks et al at the end of this report."

48. Dr Smith concluded that employment was not a substantial contributing factor to the applicant's underlying cervical degenerative disease. The underlying pathology was normal and part of the ageing process and within normal limits as it had been asymptomatic until the first exacerbation.

49. Dr Smith accepted that employment activities were a substantial contributing factor to an exacerbation on 23 December 2018 but said it was improbable that any symptoms present now were consequent to that activity. The symptoms sustained on 23 December 2018 would have resolved on their own accord after a number of hours, days or a week or two.

50. Dr Smith expected that the applicant would get better if treatment were directed at her neck.

Respondent's submissions

51. Mr Saul submitted that it was the respondent's case that the applicant did not suffer a right shoulder injury. The respondent relied on the opinion of Dr Smith which was expressed some six months after the date of injury. Mr Saul said Dr Smith's qualified opinion was that the applicant had symptomatic cervical degenerative disease. Dr Smith expressed the opinion that there was "no likelihood" that the applicant's symptoms could have originated from a shoulder injury.

52. Mr Saul noted that there was a medical contest between the applicant's practitioners and Dr Smith. Dr Smith understood the diagnosis made by the applicant's treating practitioners, had seen the various radiological reports, examined the applicant and had expressed his opinion in strong language. Mr Saul noted that I had to be satisfied on the balance of probabilities as to the nature of the injury.

53. Mr Saul observed that Dr Smith further expressed the view that the applicant would have recovered from any exacerbation of the degenerative condition caused by the applicant's work.

54. With regard to capacity, Mr Saul noted that the applicant had been certified by Dr Al Faruque as having no current work capacity. Mr Saul submitted that no explanation had been given by Dr Al Faruque as to why he had certified the applicant as having different levels of capacity at different times. Mr Saul noted that in January 2019 the applicant was certified fit for 15 hours per week, which was essentially her pre-injury hours. The next certificate reduced the applicant's capacity to "no current capacity" without explanation. Without any explanation or foundation underpinning the change in certification, Mr Saul submitted that I would not give the certificates any weight.

55. The only opinion on capacity expressed by Dr Woo was made by reference to pre-injury duties. That report, was dated in August 2019, and did not suggest the applicant had no current work capacity. Mr Saul said the opinion expressed by Dr Woo left open the possibility that the applicant was fit for suitable employment.

56. Mr Saul submitted that Dr Abraham did not give a clear opinion on capacity.

57. In contrast, Dr Smith expressed the view that the applicant was fit to work but should avoid repetitive or continuous overhead activity. Mr Saul submitted that those restrictions would allow the applicant to be fit for a wide variety of jobs including reception work, call centre work or any other work that did not involve overhead repetitive or continuous activity. Mr Saul submitted that I would be guided by the definition of "suitable employment" in s 32A.

58. Mr Saul submitted that the applicant's PIAWE figure after the deduction in s 37 applied was approximately $330 per week. That was a very low figure against which capacity needed to be measured. If the applicant were able to earn at least $330 per week, the applicant would have no entitlement to weekly compensation. Mr Saul noted that there was no discretion in this regard. Mr Saul submitted that having regard to the restrictions noted by Dr Smith and Dr Woo I would be comfortably satisfied that the applicant was able to earn more than $330 per week.

59. Mr Saul submitted that there was nothing remarkable in the clinical records, although the initial record indicated that the doctor queried whether there was a ligament injury. Mr Saul noted that the cortisone injection given to the applicant had no effect. Referring to the authorities in *Diab v NRMA Ltd*[1] (*Diab*), *Rose v Health Commission (NSW)*[2] *Bartolo v Western Sydney Area Health Service*[3], Mr Saul submitted that given the earlier injection offered no benefit a further injection should not be ordered. Mr Saul submitted that a general order for medical expenses should suffice and if anything in particular was disputed the applicant could proceed to have a dispute determined in the Commission.

60. Mr Saul noted that the applicant had four children and said this circumstance was relevant to capacity. The applicant's children were aged between 15 and six years, and Mr Saul submitted that the effort required to run her household would be a relevant consideration in determining the applicant's capacity for work.

61. Mr Saul conceded that Dr Smith did not refer to having considered the MRI scan of the cervical spine but took me to the report and said it did reveal pathology. Mr Saul noted that Dr Woo had considered that pathology in the cervical spine could at least be responsible for tingling in the applicant's fingers. Mr Saul said there was enough pathology shown in the report of the MRI of the cervical spine to justify Dr Smith's opinion.

Applicant's submissions

62. With regard to the proposed injection, Mr Hanrahan noted that approval for the procedure had specifically been sought and declined and was now in dispute before the Commission. Approval for the procedure had been declined on the basis of the opinion of Dr Smith which Mr Hanrahan submitted was erroneous.

63. Mr Hanrahan noted that the applicant was right-handed and 38 years old. The applicant commenced employment with the respondent when she was 35 years old. Mr Hanrahan submitted that given the time of year it was reasonable to infer that the store in which the applicant was working was very busy on 23 December 2018. The applicant's duties involved a lot of repetitive lifting, carrying and work above shoulder height.

64. Mr Hanrahan submitted that the task the applicant was performing when she was injured involved some static postural loading. The applicant described immediate pain. Mr Hanrahan took me to the evidence given by Dr Al Faruque to the insurer and Dr Abraham's reports. Mr Hanrahan submitted that Dr Abraham possessed relevant expertise to express a qualified opinion on the applicant's injury.

[1] [2014] NSWWCCPD 72.
[2] [1986] NSWCC 2; (1986) 2 NSWCCR 32.
[3] (1997) 14 NSWCCR 233; [1997] NSWCC 1.

65. Mr Hanrahan conceded that Dr Smith's opinion had been expressed in strong language but submitted that Dr Smith had not engaged in any anatomical analysis of the applicant's condition or provided an explanation to justify his opinion. Mr Hanrahan submitted that Dr Smith relied on research about other people and did not engage in any consideration of whether the applicant might fall within the 5% minority of patients presenting with the same symptoms who did not have a cervical condition. The basis for Dr Smith's conclusion had not been made clear. Mr Hanrahan said there was better evidence to explain the applicant's symptoms.

66. Mr Hanrahan noted that the initial attendance upon Dr Al Faruque was indicative of a right shoulder injury and had triggered a referral for ultrasound of the shoulder. That investigation showed pathology affecting the tendons as well as the bursa. Mr Hanrahan noted that investigation of the applicant's cervical spine and scapula had taken place and referred me to the relevant reports. Mr Hanrahan noted that Dr Al Faruque had given the opinion that the applicant's neck was not involved in the applicant's presentation.

67. Mr Hanrahan referred to Dr Abraham's evidence and submitted that Dr Abraham had provided a justification for his opinion that a further injection was warranted. Dr Abraham had expressed the opinion that the applicant had an inability to perform any form of manual work.

68. Mr Hanrahan took me through Dr Woo's report and noted in particular his opinion that the applicant did not have signs consistent with radiculopathy. Dr Woo confirmed the opinions expressed by Dr Abraham in his final report.

69. Mr Hanrahan submitted that the variation in the WorkCover certificates was explained by the applicant's evidence. The applicant had said she had returned to work but was unable to continue because of her complaints of pain. Mr Hanrahan submitted that no practitioner had identified work the applicant could do. Mr Hanrahan noted that the applicant left school in Year Nine and brought up for children. She had only ever worked at Kmart doing physical work. The applicant was right hand dominant and had disability at her right shoulder. Mr Hanrahan submitted that there had to be a real job that the applicant could do. Call centre work, for example, would involve use of her right arm to enter data.

70. With regard to the claim for a further corticosteroid injection in circumstances where the previous injection had offered the applicant no benefit, Mr Hanrahan noted the complexity of the shoulder structure and submitted that the location of the injection would determine its effectiveness. The pathology was dynamic and changing. It was reasonable that a repeat effort be made.

FINDINGS AND REASONS

Injury

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

> **"4 Definition of 'injury'**
>
> In this Act:
> **injury:**
>
> (a) means personal injury arising out of or in the course of employment,
>
> (b) includes a disease injury, which means:

(i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and

(ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, and

(c) does not include (except in the case of a worker employed in or about a mine) a dust disease, as defined by the *Workers' Compensation (Dust Diseases) Act 1942*, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined."

72. The Court of Appeal in *Nguyen v Cosmopolitan Homes*[4] has found that a tribunal of fact must be actually persuaded of the occurrence or existence of the fact before it can be found, summarising the position as follows:

(1) A finding that a fact exists (or existed) requires that the evidence induce, in the mind of the fact-finder, an actual persuasion that the fact does (or at the relevant time did) exist;

(2) Where on the whole of the evidence such a feeling of actual persuasion is induced, so that the fact-finder finds that the probabilities of the fact's existence are greater than the possibilities of its non-existence, the burden of proof on the balance of probabilities may be satisfied;

(3) Where circumstantial evidence is relied upon, it is not in general necessary that all reasonable hypotheses consistent with the non-existence of a fact, or inconsistent with its existence, be excluded before the fact can be found, and

(4) A rational choice between competing hypotheses, informed by a sense of actual persuasion in favour of the choice made, will support a finding, on the balance of probabilities, as to the existence of the fact in issue.

73. There is in this case a clear medical dispute as to whether the applicant sustained a shoulder injury. The applicant's treating practitioners and expert, Dr Woo, have given an opinion that the applicant did sustain an injury to her shoulder. Dr Smith, on the other hand, for the respondent has given the opinion that the applicant's symptoms were due to a degenerative condition in her cervical spine which was rendered symptomatic on 23 December 2018. Dr Smith further opined that the aggravation or exacerbation which occurred on 23 December 2018 would have resolved of its own accord within a short period of time and was no longer responsible for the applicant symptoms.

74. The history of injury presented by the applicant has been consistent over time. The applicant has described the onset of immediate pain from the top of her right shoulder extending below the shoulder blade and across into her neck. The applicant said she had iced her shoulder immediately after the injury.

75. That the applicant considered she had sustained an injury to her shoulder is corroborated by contemporaneous medical evidence. Dr Al Faruque recorded in his clinical notes the day after the injury that the applicant had reported a right shoulder injury at work. Whilst Dr Faruque appears to have been uncertain as to the pathology, insofar as he queried whether there was a ligamental injury, I am satisfied that it was his initial impression that there may be a shoulder injury of some kind, given that he ordered an investigation of the applicant's right shoulder by ultrasound.

[4] [2008] NSWCA 246.

76. On 16 January 2019, Dr Al Faruque expressed an opinion to the insurer that the applicant had sustained a right shoulder injury at work in the nature of subacromial bursitis. The applicant had by this stage already received a cortisone injection and had been referred to a chiropractor and physiotherapist. When this treatment did not improve the applicant's symptoms, the applicant was referred to Dr Abraham.

77. Dr Abraham did not see the applicant until late March 2019. In the interim, the applicant's physiotherapist had noted that cervical and thoracic movements reproduced the applicant's pain and investigation was undertaken by way of MRI of the applicant's cervical spine. Whilst I accept Mr Saul's submission that the report of an MRI reveals some pathology at the cervical spine, it does not appear to have been the opinion of the applicant's treating practitioners, including Dr Al Faruque, Dr Abraham or her second physiotherapist, Mr Graham, that pathology in the cervical spine was the cause of all the applicant symptoms.

78. The evidence from the applicant's treating practitioners indicates that the applicant consistently reported pain and tenderness around her right scapula. This prompted Dr Abraham to refer the applicant for an MRI of her right scapula. Although the MRI was normal, the report stated that abnormal excursion of the scapula on the posterior chest wall or dyskinesia may still be present. It was recommended that the applicant be assessed for scapulothoracic dyskinesia.

79. When Dr Abraham reviewed the applicant with these results on 10 May 2019, he observed that the applicant had a painful abduction arc with scapula dyskinesis on repeated abduction movements and hitching of her shoulder at 90° abduction as well as a positive impingement sign. It was in this context that Dr Abraham requested approval for a subacromial corticosteroid injection of the subacromial space.

80. A review of the evidence from the applicant's treating practitioners therefore reveals a consistent reporting of shoulder symptoms over a period of time by the applicant. Investigations into the applicant's shoulder, right scapula and cervical spine were undertaken and a range of treatment measures adopted including injection and physiotherapy, before a conclusion was reached by the applicant's specialist that she was suffering from scapula dyskinesis or pathology at her right shoulder. This is an opinion with which the applicant's general practitioner has expressed agreement. Importantly, this opinion was reached after specific investigation of the possibility that the applicant's symptoms stemmed from her cervical spine. Dr Al Faruque has given an express opinion that he did not believe that the applicant's pain was from her neck or cervical vertebrae.

81. The opinions expressed by the applicant's treating practitioners are supported by the applicant's independent expert, Dr Woo. By the time of Dr Woo's examination of the applicant in August 2019, symptoms had progressed and she was now showing signs and symptoms of frozen shoulder. This confirmed Dr Woo's view, consistently with the applicant's treating practitioners, that the applicant had sustained an injury to her right shoulder.

82. Weighing against this evidence is the report of Dr Smith upon which the respondent relies. I accept that Dr Smith has given a firm and unequivocal opinion that there is no likelihood of the applicant's symptoms being caused by a shoulder injury. Dr Smith appears to rely on the fact that treatment directed at the applicant's shoulder including corticosteroid injection had failed to alleviate her symptoms. Dr Smith also reviewed the MRIs of the applicant's shoulder and scapula. Dr Smith's examination produced pain in the back of the applicant's neck into the top of her shoulder blade, upon extension, lateral rotation and lateral flexion of the neck. Dr Smith concluded that the source of the applicant's pain was symptomatic cervical degenerative disease. Dr Smith appears to have reached this conclusion with particular reliance on research cited by him suggesting that 95% of patients with pain about the shoulder blades or between the shoulder blades have referred pain from the cervical spine.

83. Mr Hanrahan has submitted, and I agree that Dr Smith does not appear to have turned his mind to whether the applicant fell within the 5% minority of patients whose pain was not referred from the cervical spine. It is significant also that Dr Smith did not have the results of the MRI of the applicant's cervical spine before him. Mr Saul has submitted that the report of the MRI of the cervical spine showed pathology capable of supporting Dr Smith's opinion. Whilst that may be so, the fact remains that Dr Smith's opinion was given without the benefit of that investigation. That investigation was available to the applicant's treating practitioners and was expressly considered by Dr Woo. Dr Woo and the treating practitioners reached the view that the applicant's symptoms were in fact coming from her shoulder. Dr Smith's failure to meaningfully engage with the applicant's particular circumstances and have regard to the cervical spine imaging are factors weighing against acceptance of Dr Smith's opinion over the applicant's medical evidence.

84. The other circumstance weighing against an acceptance of Dr Smith's opinion over that of the treating practitioners and Dr Woo is the fact that Dr Woo's examination of the applicant took place some three months after that performed by Dr Smith. By this time there had been a progression of the applicant's symptoms and she was showing signs of frozen shoulder. Dr Woo considered this was consistent with a diagnosis of injury at the shoulder.

85. In all the circumstances I prefer the consensus of opinion expresses by the treating practitioners and Dr Woo. A careful weighing of the evidence leaves me with an actual persuasion that the probabilities of the applicant having sustained an injury to her shoulder are greater than the possibilities that she did not. I am satisfied on the balance of probabilities that the applicant injured her right shoulder on 23 December 2018 pursuant to s 4(a) of the 1987 Act. I am also satisfied on the evidence before me, including the opinions given by Dr Abraham, Dr Al Faruque and Dr Woo, that employment was a substantial contributing factor to the injury for the purposes of s 9A of the 1987 Act.

Quantification of entitlement to weekly benefits

86. Section 33 of the 1987 Act provides that if total or partial incapacity for work results from an injury, the compensation payable by the employer under this Act to the injured worker shall include weekly payments during the period of incapacity.

87. In the ARD, the applicant sought weekly benefits from 25 June 2019 to date and continuing. The dispute notice issued under s 78 of the 1998 Act on 6 June 2019 indicated that the decision to dispute liability would take effect, and weekly payments would cease, on 27 June 2019. The relevant period in which weekly benefits can be claimed in these proceedings therefore commences on 28 June 2019.

88. The parties have agreed that the applicable Pre-Injury Average Weekly Earnings (PIAWE) figure is $413.60. It is also common ground between the parties that the applicant has received in excess of 13 weeks of weekly payments and so her claim falls within the second entitlement period pursuant to s 37 of the 1987 Act as it applies to this claim.

89. In order to determine the applicant's entitlement to weekly compensation in these periods, I must determine whether, the applicant had, at the relevant times, "no current work capacity" or "current work capacity" as defined in s 32A of the 1987 Act.

90. Section 32A of the 1987 Act defines the relevant terms as follows:

> "**current work capacity**, in relation to a worker, means a present inability arising from an injury such that the worker is not able to return to his or her pre-injury employment but is able to return to work in suitable employment.

no current work capacity, in relation to a worker, means a present inability arising from an injury such that the worker is not able to return to work, either in the worker's pre-injury employment or in suitable employment.

suitable employment, in relation to a worker, means employment in work for which the worker is currently suited:

(a) having regard to:

(i) the nature of the worker's incapacity and the details provided in medical information including, but not limited to, any certificate of capacity supplied by the worker (under section 44B), and
(ii) the worker's age, education, skills and work experience, and
(iii) any plan or document prepared as part of the return to work planning process, including an injury management plan under Chapter 3 of the 1998 Act, and
(iv) any occupational rehabilitation services that are being, or have been, provided to or for the worker, and
(v) such other matters as the WorkCover Guidelines may specify, and

(b) regardless of:

(i) whether the work or the employment is available, and
(ii) whether the work or the employment is of a type or nature that is generally available in the employment market, and
(iii) the nature of the worker's pre-injury employment, and
(iv) the worker's place of residence."

91. The applicant relies on WorkCover certificates covering the period from 1 June 2019 to date which certify her as having no current work capacity. Mr Saul has submitted that those certificates are unreliable owing to an unexplained reduction in capacity from January 2019.

92. Mr Hanrahan has submitted and I accept that the reduction in capacity is explained by the applicant's lay evidence. The applicant's evidence was that she attempted to continue work in January 2019 but found herself unable to do so due to her pain. After two months off work, the applicant attempted a return to work on light duties in March 2019 but worked only two shifts as she experienced intense pain.

93. The medical evidence from the treating practitioners also indicates a steady deterioration in the applicant's symptoms and experience of pain from the date of injury. The clinical notes show increases and changes in the medications prescribed by Dr Al Faruque. By the time of Dr Woo's report there had been a particular deterioration in the range of movement of the applicant's right shoulder.

94. In the circumstances, I am not satisfied that the certifications given by Dr Al Faruque are unreliable. I accept they are evidence that the applicant had no current work capacity during the period of weekly benefits claimed.

95. Mr Saul submitted that Dr Woo's opinion on capacity was directed only at the applicant's capacity to perform her pre-injury duties. I accept that Dr Woo's opinion leaves open the possibility that the applicant was fit for suitable employment. Although Mr Saul submitted that Dr Abraham did not give an opinion on capacity that was of assistance, Dr Abraham does indicate that the applicant was unfit for manual work in his report to the applicant's legal representatives dated 16 July 2019. In view of my findings above, I am not satisfied that Dr Smith's opinion on incapacity is reliable as he was not of the view that there was any shoulder injury at all.

96. The evidence must be considered as a whole. In considering the applicant's capacity to work I have noted that she is right hand dominant and is suffering a right shoulder injury. There is no evidence before me that the applicant has experience performing anything other than manual work. I have considered Mr Saul's submission that the applicant's ability to run a household including for children should be taken into account. There is, however, no evidence before me as to the manner in which the applicant is able to run her household or perform domestic tasks. The applicant's own statement indicates she has difficulty performing domestic tasks. I do not find this circumstance to be of particular assistance.

97. Reading Dr Al Faruque's certificates together with the opinions given by Dr Abraham and Dr Woo and the applicant's lay evidence, I am satisfied that in the relevant period, the applicant has had no current work capacity. The applicant is entitled weekly benefits from 28 June 2019 to date and continuing in accordance with the calculation set out in s 37(1)(a) as it applies to this case.

98. The PIAWE figure of $413.60 will be subject to periodic adjustment including indexation pursuant to s 82A of the 1987 Act.

Entitlement to medical expenses

99. Section 60 of the 1987 Act relevantly provides:

> "(1) If, as a result of an injury received by a worker, it is reasonably necessary that:
>
> (a) any medical or related treatment (other than domestic assistance) be given, or
> (b) any hospital treatment be given, or
> (c) any ambulance service be provided, or
> (d) any workplace rehabilitation service be provided,
>
> the worker's employer is liable to pay, in addition to any other compensation under this Act, the cost of that treatment or service and the related travel expenses specified in subsection (2)."

100. In *Diab*, Roche DP, referring to the decision in *Rose*, a non-exhaustive list of considerations when determining if medical treatment is "reasonably necessary" as a result of a work injury:

> "In the context of s 60, the relevant matters, according to the criteria of reasonableness, include, but are not necessarily limited to, the matters noted by Burke CCJ at point (5) in *Rose* (see [76] above), namely:
> (a) the appropriateness of the particular treatment;
> (b) the availability of alternative treatment, and its potential effectiveness;
> (c) the cost of the treatment;
> (d) the actual or potential effectiveness of the treatment, and
> (e) the acceptance by medical experts of the treatment as being appropriate and likely to be effective.
>
> With respect to point (d), it should be noted that while the effectiveness of the treatment is relevant to whether the treatment was reasonably necessary, it is certainly not determinative. The evidence may show that the same outcome could be achieved by a different treatment, but at a much lower cost. Similarly, bearing in mind that all treatment, especially surgery, carries a risk of a less than ideal result, a poor outcome does not necessarily mean that the treatment was not reasonably necessary. As always, each case will depend on its facts."[5]

[5] At [88]-[89].

101. These proceedings include a claim specifically for the costs of a corticosteroid injection into the subacromial space as recommended by Dr Abraham on 21 May 2019. Submissions were made at hearing as to whether that procedure was reasonably necessary as a result of injury. The respondent made submissions to the effect that such a procedure would not be reasonably necessary in view of the dispute as to whether there was an injury to the applicant's shoulder. That dispute has been resolved above.

102. It still remains to be determined whether the procedure is reasonably necessary to treat the injury I have found. The evidence indicates that the applicant received little to no benefit from a corticosteroid injection administered in January 2019. Mr Hanrahan submitted that this circumstance would not render the injection now proposed by Dr Abraham unreasonable given the complex structures of the shoulder, the further investigation of the applicant's condition and given that the location at which the injection is administered is likely to determine its effectiveness.

103. I accept that Dr Abraham has had the benefit of MRI investigations of the applicant's shoulder, scapula and cervical spine which were not available at the time of the previous injection. He has examined the applicant on number of occasions. Dr Abraham expressed the view that the injection proposed by him would provide the applicant with relief.

104. There has now been considerably more investigation of the applicant's condition than there had at the time of the initial injection. Although Dr Woo has not expressly given an opinion as to whether the injection is reasonably necessary, I am satisfied that there is a sound basis for accepting Dr Abraham's opinion that such treatment would be of benefit to the applicant. I note that Dr Al Faruque has not expressed a contrary opinion.

105. The cost of the treatment is relatively low. Whilst other conservative treatments are currently being administered, I accept the injection proposed by Dr Abraham has potential to be effective as part of the applicant's treatment regime.

106. I am satisfied, therefore, that the injection proposed by Dr Abraham on 21 May 2019 is reasonably necessary as a result of the applicant's injury on 23 December 2018. There will be an order for the respondent to pay the applicant's medical expenses pursuant to s 60 of the 1987 Act upon production of accounts receipts and/or valid Medicare charge, including the costs of and incidental to the proposed injection.

SUMMARY

107. The Commission determines:

    (a) The applicant sustained injury to her right shoulder on 23 December 2018 pursuant to ss 4(a) and 9A of the 1987 Act.

    (b) The applicant has had no current work capacity from 28 June 2019 to date as a result of the injury on 23 December 2018.

    (c) The corticosteroid injection proposed by Dr Abraham on 21 May 2019 is reasonably necessary as a result of the injury on 23 December 2018.

108. The Commission orders:

    (a) The respondent to pay the applicant weekly benefits from 28 June 2019 to date and continuing pursuant to s 37(1)(a) of the 1987 Act based on a PIAWE rate of $413.60 as periodically adjusted.

(b) The respondent to pay the applicant's reasonably necessary medical expenses pursuant to s 60 of the 1987 Act, upon production of accounts, receipts and/or valid Medicare charge, including the costs of and incidental to the right corticosteroid injection proposed by Dr Abraham in his letter dated 21 May 2019.