WORKERS COMPENSATION COMMISSION

CERTIFICATE OF DETERMINATION

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

Matter Number:	**3000/20**
Applicant:	**Sandra Joan Lehman**
Respondent:	**Specialist Diagnostic Services Pty Ltd t/as Laverty Pathology**
Date of Determination:	**20 August 2020**
Citation:	**[2020] NSWWCC 283**

The Commission finds:

1. The applicant suffered a consequential injury to her left shoulder as a result of overuse following injury to her right shoulder on 29 March 2018.

2. The injury to the applicant's right shoulder on 29 March 2018 materially contributed to the need for surgery to her left shoulder.

The Commission orders:

3. The respondent will pay the cost of, incidental to and associated with the surgery recommended by Dr Wade Harper of a left shoulder arthroscopic acromioplasty, rotator cuff repair, AC joint excision and open sub pectoral LHB tenodesis.

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

John Wynyard
Arbitrator

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

S Naiker

Sarojini Naiker
Senior Dispute Services Officer
As delegate of the Registrar

STATEMENT OF REASONS

BACKGROUND

1. Sandra Joan Lehman, the applicant, brings an action against Specialist Diagnostic Services Pty Ltd t/as Laverty Pathology, the respondent, seeking a declaration that surgery proposed by her treating surgeon, Dr Wade Harper, is reasonably necessary.

2. The insurer issued a s 78 notice on 19 September 2019 and a s 287A notice on 19 December 2019, following which the Application to Resolve a Dispute (ARD) and Reply were duly lodged.

ISSUES FOR DETERMINATION

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

    (a) Has the applicant suffered a consequential condition to her left shoulder as a result of overuse following the accepted injury to her right shoulder on 29 March 2018,
    (b) If so, has the necessity for surgery resulted from the consequential condition caused to the left shoulder.

PROCEDURE BEFORE THE COMMISSION

4. This matter was heard on 14 July 2020. The applicant was represented by Mr Ross Stanton of counsel instructed by Ms Marie Bollins. The respondent was represented by Mr David Saul of counsel instructed by Mr Thomas Murray. I am satisfied that the parties to the dispute understand the nature of the application and the legal implications of any assertion made in the information supplied. I have used my best endeavours in attempting to bring the parties to the dispute to a settlement acceptable to all of them. I am satisfied that the parties have had sufficient opportunity to explore settlement and that they have been unable to reach an agreed resolution of the dispute.

EVIDENCE

Documentary Evidence

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

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

Oral Evidence

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

FINDINGS AND REASONS

7. On 29 March 2018 Ms Lehman suffered an injury to her right shoulder whilst lifting boxes in performance of duties as a Phlebotomist with the respondent, for whom she had been working since 5 March 2007. She attended her GP, Dr Tony Webber the same day, and investigations in form of ultrasound and MRI were carried out over the following weeks. Dr Webber's clinical notes were tendered.

8. Ms Lehman was treated by ultrasound guided steroid injection in early April 2018 without significant improvement. However she returned to work on restricted duties around 20 April 2018. Her condition worsened and she went off work again on 26 April 2018.

9. In early May, Ms Lehman was referred to Dr Laurent Wallace at the South West Pain Clinic, and she was also referred for physiotherapy. Conservative treatment failed to improve her symptoms and on 20 June 2018 Ms Lehman underwent a suprascapular nerve and steroid block and pulsed radiofrequency procedure to her right shoulder with Dr Wallace.

10. This treatment also was unsuccessful in alleviating her condition. Dr Webber had also referred Ms Lehman to Dr Wade Harper, Shoulder and Elbow Surgeon in early May 2018 and with the failure of the procedure by Dr Wallace, it was decided that surgery should be performed.

11. On 2 August 2018, Ms Lehman had a subacromial decompression with excision of the distal clavicle of her right shoulder with Dr Harper at the Prince of Wales Private Hospital.

12. On 21 January 2019, again with Dr Wallace, Ms Lehman underwent a further procedure, as the surgery had failed to resolve her symptoms in the right shoulder. This consisted of a further subscapular nerve block. On 13 February Dr Wallace recorded that Ms Lehman's pain was "only very slightly improved."

13. The effect of treatment was described by Ms Lehman in her statement. She said:[1]

> "25) For 6 weeks after my right shoulder surgery I was strapped in a sling.
>
> 26) For 6 weeks after my right shoulder surgery I showered with a shower sling to my right shoulder.
>
> 27) For 6 weeks I was not allowed to move my right shoulder.
>
> 28) For a further 6 weeks, I was only allowed to move my right arm from the elbow down, I was still strapped into the sling. I used my left arm for everyday living.
>
> 29) I was in a sling for my right shoulder for a total of 12 weeks. I was unable to bear any weight on my right shoulder.
>
> 30) After 12 weeks, I used the sling if my right shoulder was painful and for bedtime. I still had further restrictions to my right shoulder with no weight bearing and unable to lift my right arm.
>
> 31) After 12 weeks, I tried to carry a cup of tea on my right hand and I found it quite difficult. So I had my left hand support carrying the cup of tea.
>
> 32) I am right hand dominant and during this time it was very difficult using predominantly my left arm use for everyday activities as I normally use my right hand.
>
> 33) During this time, my right arm was incapacitated and I only used my left arm for everyday living and activities to include but not limited to:
>
> i) Going to the bathroom and using my left arm to turn the taps to wash my hands;
> ii) Using my left arm to assist me going to the toilet;

[1] ARD pages 2-3

iii) Showering and using my left arm to turn the water taps and washing my hair and body;
iv) Using my left arm to dry myself after having a shower;
v) At meal times I was unable to use a knife and fork and I used my left arm to use a fork or spoon to eat my food."

14. Ms Lehman said that these restrictions affected her left shoulder. She said[2]:

> "34) I was off work for about 8 mths after my right shoulder surgery and as I was favouring my right arm, I developed similar symptoms in my left shoulder.
>
> 35) I felt an increased pain to my left shoulder due to overuse and overcompensating during the recovery period of my right shoulder surgery."

15. I note in passing that the words "8 mth" was written in handwriting over the typed words of "twelve weeks", and had Ms Lehman's signature next to the alteration.

16. Ms Lehman referred to the rehabilitation she was referred to by the insurer for her right shoulder.

17. She said that her rehabilitation had required her to use difficult types of exercise machines to strengthen her right shoulder. She stated that one of them was "a water resistant machine" and she had to use both her arms to "go against the water" which caused problems to the left shoulder and further aggravated her right shoulder[3].

18. On advising the treating surgeon Dr Harper of her difficulties, she was advised to stop using that machine and was given a pulling system which hang on the roof of a door frame above her head.

19. Ms Lehman said she would use her left arm to pull the right arm up in the air and vice versa which assisted in the range of movement but she felt an increased pressure in her left shoulder as a result.

20. She said that she noticed increasing left shoulder pain over nine months during the recovery period following the surgery to her right shoulder.

21. Ms Lehman remained on restricted duties. The evidence was unclear as to how long, but the clinical notes of Dr Webber on 7 March 2019 indicated that she was working three days a week (and that she was told to stop exercise physio).[4] Ms Lehman said that whilst on suitable duties she had observed to her area coordinator, Ms Marnie Stenhouse, that her left shoulder was very sore and she was advised to see her GP in that regard, and she was advised to report it to her GP.

22. Ms Lehman said that such duties as reaching out across her desk to pick up a pen, or when attaching a needle to its barrel when taking blood from a patient, irritated her left shoulder.

23. On 28 May 2019, Dr Webber's notes recorded:[5]

> "Now has pain in the left shoulder for several weeks, pain worse from pulling doona up in bed."

[2] ARD page 3
[3] ARD page 3 [38]
[4] ARD page 326
[5] ARD page 329

24. The latter comment to a large degree was the basis of the respondent's denial, as will be seen.

25. Ms Lehman referred to that episode in her statement. She said that on 27 May 2019 whilst she was in bed she felt a sharp pain in her left shoulder when she used both hands to pull the doona up. She saw her GP, Dr Webber, the next day and an ultrasound on 4 June 2019 showed a supraspinatus tendinosis with subacromial bursitis.

26. Ms Lehman then detailed the subsequent treatment she underwent prior being recommended the surgery proposed by Dr Harper. This included imaging studies which showed pathology in the left shoulder, and injection into the shoulder on 11 June 2019, which caused only short term relief.

27. No issue has been raised by the insurer as to whether that surgery was reasonably necessary. It was described on 8 July 2019 as "left shoulder arthroscopic acromioplasty, rotator cuff repair, AC joint excision and open subpectoral LHB tenodesis".[6]

28. Dr Peter Giblin, Orthopaedic Surgeon, was retained as Ms Lehman's medico-legal referee. On 20 November 2019, Dr Giblin reported regarding the injury to the right arm and recorded:[7]

> "[Ms Lehman] sought specialist advice and on 2 August 2018 had a subacromial decompression with excision of the distal clavicle. This caused her to be off work for about twelve weeks and as she was favouring the right arm, she started to develop similar symptoms in the left shoulder."

29. At that time, Ms Lehman was back at work doing five hours a day, three days a week on suitable duties and she was taking Endone tablets on a regular basis.

30. Dr Giblin noted an MRI scan investigation of the left shoulder taken on 19 June 2019, which showed sub deltoid bursitis with high grade full thickness tear of the rotator cuff.

31. Dr Giblin diagnosed an acute soft tissue injury to the right shoulder and a secondary or compensatory injury to the left shoulder consequent upon the index accident[8].

32. On 3 July 2019, Dr Harper reported to Dr Webber. He noted that Ms Lehman was 11 months following the right shoulder surgery and he said:[9]

> "She had developed increasing left shoulder pain over the last 6 weeks. She attributed the onset of her symptoms to increase load [sic] during the recovery from her right shoulder surgery…..
>
> "MRI scan of the left shoulder showed an appearance very similar to her right shoulder preoperative scan. There was a high-grade supraspinatus tendon tear with extension posteriorly to the supraspinatus infraspinatus interval. There was acromioclavicular joint arthritis with synovitis."

33. The respondent relied on the report of Dr Richard Powell, Orthopaedic Surgeon, dated 23 July 2019[10]. He took a consistent history of the injury to the right shoulder on 29 March 2018 and subsequent treatment therefor. He said:[11]

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[6] ARD page 53
[7] ARD page 10
[8] ARD page 12
[9] ARD page 53
[10] ARD page 39
[11] ARD page 40

> "Approximately 2 to 3 months ago Ms Lehman became aware of the development of symptoms in the left shoulder. There was no specific precipitating incident. Symptoms were attributed to the increased use of the left upper limb.
>
> She suffered a further aggravation one night at home in bed when she pulled the doona up and experienced a significant increase in her pain.
>
> She returned to her local doctor, Dr Webber, and was investigated with ultrasound and referred for a corticosteroid injection. This was of little benefit. An MRI scan was performed in June 2019, identifying significant rotator cuff pathology."

34. Dr Powell noted that the right shoulder injury consisted of an aggravation of pre-existing degenerative disease involving the right shoulder, and that the aggravation led to surgery and would be considered permanent. He said with regard to the left shoulder that there was no specific precipitating incident, no history of injury in the course of employment and that Ms Lehman had been on light duties since the right shoulder surgery. He said[12]:

> "….her left shoulder symptoms developed in an insidious fashion, though were aggravated by a non-work related incident at home"

35. Dr Powell noted that Ms Lehman had significant degenerative pathology in the left shoulder. He said[13]:

> "….This is not the result of her employment. It is does not represent a consequential injury."

36. Dr Powell was then asked whether he thought the left shoulder injury was as a result of the right shoulder injury. He said[14]:

> "Ms Lehman's left shoulder symptoms developed whilst she was on light duties and performing normal activities of daily living. There is no history of any specific incident. Although there would have been increased use of the left shoulder whilst rehabilitating from her right shoulder injury and surgery, the duties she was performing with her left shoulder were restricted at work and represented normal activities of daily living at home. These duties would be well within the physiological capabilities of a normal shoulder.
>
> The presence of significant pre-existing degenerative pathology in both shoulders suggests it is most likely part of an underlying pre-existing pathological process. I would not consider her employment to represent the main contributing factor in either the development or aggravation of the underlying degenerative disease process involving the left shoulder."

37. Dr Powell also said[15]:

> "In the case of the left shoulder, there is no history of any specific precipitating incident and her left shoulder symptoms developed in an insidious fashion, though were aggravated by a non-work related incident at home."

[12] ARD page 44
[13] ARD page 44
[14] ARD page 45
[15] ARD page 45

38. Dr Webber responded to Dr Powell's report on 1 August 2019. He said:[16]

> "…. While I understand Ms Lehman did have long standing wear and tear damage to her left supraspinatus tendon, this would be the case in many people of her age. Before her injury she was totally asymptomatic. The extra stress placed on her left shoulder as a direct resulted in the injury and subsequent surgery required her to compensate by using her left upper limb. This resulted in the recent rupture of the tendon."

39. On 18 February 2020, Dr Giblin wrote a further report in response to the report of Dr Richard Powell of 23 July 2019. He said:[17]

> "It would be my opinion, that the left shoulder injury, is a consequent injury to the right shoulder on the basis that there is always a subconscious favouring of the injured part.
>
> Although she would make an effort to look after both her arms, it is, in my experience, a normal reaction for a patient to unconsciously look after their injured extremity such that the uninjured extremity becomes the dominant source of physical independence and therefore are prone to aggravation of any underlying asymptomatic degenerative changes as Dr Powell's letter correctly implies.
>
> On that basis, it is my opinion that Mrs Lehman's left shoulder injury is work-related although it is in a secondary or compensatory fashion."

40. Dr Giblin then referred to what counsel for the respondent described as "the doona incident." Dr Giblin said:

> "This history refers to an incident one night at home when she was in bed and pulled up the doona cover….
>
> The significant increase in pain is not anatomically located [by Dr Powell] but I am going to assume that it refers to the left shoulder…
>
> It would be my opinion, that Mrs Lehman was using her left arm in a subconscious fashion when she was in bed knowing that to use the right arm would produce pain at the site of her index injury."

41. In a second report dated 9 March 2020 Dr Webber said:[18]

> "3. Ms Lehman's right shoulder has improved following surgery, however she does not have a full range of movement and is unlikely to do so. In addition she has pain in the right shoulder when used excessively or repetitively. Her left shoulder gives her constant pain and her range of movement is decreasing. This is of concern due to the possibility of long term disability due to frozen shoulder.
>
> 4. The treatment Ms Lehman received for her right shoulder injury has been adequate and appropriate. The fact that treatment has been delayed for her left shoulder could worsen her long term prognosis and is regrettable.

[16] ARD page 52
[17] ARD page 75
[18] ARD page 78

5. The right shoulder injury was a direct result of her work place injury. Due to the long recovery before and after definitive surgery she was forced to use the left upper limb for all her activities of daily living. Being her non dominant limb her muscle strength in the left arm was not the same as her right. These two factors have caused her left shoulder injury. The left shoulder injury is a direct consequence of her work related injury to her right shoulder."

SUBMISSIONS

42. Mr Saul submitted that I would attach great importance to "doona incident" of 27 May 2019. This occurred some nine months following the surgery of 2 August 2018, and was accorded some significance by Dr Powell. The first contemporaneous complaint about the left shoulder occurred the following day, 28 May 2019.

43. Mr Saul submitted that I would not accept the opinions of Dr Giblin as they offended against the rules regarding expert evidence. His diagnosis of secondary or compensatory injury was no more than an ipse dixit as it contained no reasoning or discussion of the facts and circumstances that led him to that conclusion.

44. Dr Powell's opinion however supported his submission that it was the "doona incident" that caused the left shoulder injury and, as it occurred outside the work place, could be seen as a novus actus interveniens. Moreover Mr Saul submitted it was severe enough to cause a rotator cuff tear as was discovered on the MRI scan noted by Dr Harper on 3 July 2019, namely a high grade full thickness tear of the supraspinatus.

45. Mr Saul submitted that the onus was on the applicant to show that there had been a material contribution by the index injury to the condition of the left shoulder. He said however that there is also an onus on the applicant to show that not only was there a material contribution from the index injury to the left shoulder condition but that the need for surgery resulted from that condition.

46. With regard to Dr Giblin's report of 18 February 2020, Mr Saul submitted that Dr Giblin's opinion that there was "always a subconscious favouring of the injured part" made no sense.

47. Mr Saul submitted that I would not accept that it was a normal reaction for patients to unconsciously look after their injured extremity such that the uninjured extremity becomes the dominant source of physical independence. It did not follow that this made them prone to aggravation of any underlying asymptomatic degenerative changes. Although Dr Giblin agreed with Dr Powell's opinion was that there was degenerative pathology in Ms Lehman's left shoulder, it did not follow that it had been aggravated by overuse, it was submitted.

48. With regard to the Doona incident, Dr Giblin thought that Ms Lehman would have used her left arm "in an unconscious fashion" when she was in bed knowing that to use her right arm would cause pain in the right shoulder. Mr Saul submitted that this mechanism had not been described by the applicant and was something of a surprise. He submitted that there were no other histories that suggested the involvement of the subconscious and that such an explanation was fanciful and should be rejected.

49. Mr Saul then referred to Dr Harper's report of 3 July 2019 and particularly the complaint of increasing left shoulder pain "over the last six weeks". Six weeks before 3 July would place the onset of the increasing left shoulder pain at about the time of the doona incident, he submitted.

50. Mr Saul submitted that that report had no opinion as to causation. This was correct, however only the first page of Dr Harper's report had been lodged, and it was obviously incomplete.

51. Mr Saul concluded by submitting that in terms of justice Kirby's well known dicta in *Kooragang Cement Pty Ltd v Bates*[19] that the onus was on the applicant to prove that the necessity for surgery was connected to the index injury in an unbroken chain.

Decision

52. Mr Saul's submissions were most thorough and useful. However, they failed, with respect, to establish that the assumptions they relied on were supported by the material facts.

53. Mr Saul's argument was that Ms Lehman's left shoulder condition (which he conceded showed significant pathology) was caused by a novus actus interveniens, namely, pulling up her doona as she prepared to go to sleep. It was that action, as I understood the submission, that aggravated the degenerative condition in her left shoulder.

54. His argument was that therefore there was no material contribution made by the subject injury.

55. There are a number of evidentiary obstacles to be overcome in order for Mr Saul's submission to be accepted.

56. Firstly, there is the evidence of the applicant. I have not understood that Ms Lehman's credit is in issue. Indeed Mr Saul said in his submissions in reply that he was not impugning Ms Lehman's credit, but rather her reliability, which I found to be a nice distinction. Nonetheless, Ms Lehman gave cogent and detailed evidence. Although her statement was dated 25 February 2020, her evidence as to the onset of her left shoulder condition was corroborated by contemporaneous material.

57. Secondly, Mr Saul's submission did not engage with the entire entry of Dr Webber's note of 28 May 2018. Mr Saul's case was structured on the entry that Ms Leeman's shoulder pain was "worse from pulling doona up in bed." It was this fact that was also relied on by Dr Powell, who identified the action as aggravating the underlying degenerative disease process.

58. However, Mr Saul did not engage with the first sentence in the entry, which recorded a complaint of pain in the left shoulder for several weeks. This was consistent with Ms Leeman's statement, which explained in some detail the onset of her left shoulder problems following the surgery on her right shoulder. The detail concerned the fact that she was doing light duties and having to favour her right shoulder, the difficulties she encountered during rehabilitation, and as her symptoms intensified, her domestic situation.

59. Thirdly, although Mr Leeman's statement was not obtained until February 2020, I accept that she has taken some care to ensure that its contents are true and correct to the best of her knowledge. The fact that she altered her estimate of the time she was off work following surgery from 12 weeks to 8 months and went to the trouble of signing the alteration indicates that she took some care to ensure that the contents of her statement were accurate.

60. Fourthly, Ms Leeman also identified the respondent's agent, Ms Marnie Stenhouse, to whom she complained of the onset of her left shoulder problems, and from whom she received the advice to report the matter to her GP.

61. No evidence has been obtained from Ms Stenhouse, neither has any explanation been made as to its absence. I accordingly infer that Ms Stenhouse's evidence did not assist the respondent. I also infer that it was in response to the advice from Ms Stenhouse that Ms Leeman attended Dr Webber on 28 May 2018 and complained that she had been suffering left shoulder problems for seven weeks.

[19] (1994) 35 NSWLR 452 (*Kooragang*)

62. Fifthly, Dr Powell acknowledged that history when he gave his opinion that the left shoulder condition was unrelated to employment. It was common ground that no specific precipitating incident had occurred, and it was common ground that the left shoulder symptoms developed in an insidious fashion, which Dr Powell accepted. However in attributing the left shoulder problems to an aggravation of degenerative changes through Ms Leeman's pulling up her doona, Dr Powell made no attempt to explain the reasons for the insidious development of her left shoulder symptoms whilst she was doing light duties and recovering from her right shoulder surgery.

63. It may be that Dr Powell was not aware of the legal requirements governing the causation of consequential conditions. His reference to whether employment was the main contributing factor to the onset of the left shoulder problems rather indicates that he was not, as such considerations are not relevant. The legal requirement for an applicant claiming a consequential condition simply requires that a material contribution from the subject injury be shown to have caused it.[20] Accordingly I reject Dr Powell's opinion.

64. Sixthly, Mr Saul criticised the reports of Dr Giblin and his opinion that the favouring of an uninjured contralateral extremity in the presence of an injury to the opposite extremity involved a subconscious or unconscious element. However, Dr Giblin in his first report of 20 November 2019 took a correct history that symptoms developed in the left shoulder because Ms Lehman was favouring the right shoulder, and his second report of 18 February 2020 was concerned with Dr Powell's opinion regarding the doona incident. Whilst being somewhat simplistic, I do not find anything within Dr Giblin's reports that is inconsistent with this finding that the condition of the left shoulder resulted from the injury to the right shoulder.

65. Finally, I found the report of Dr Webber to contain a useful summary of the circumstances by which Ms Lehman's left shoulder condition occurred. Although not being a medico-legal referee, Dr Webber has had the care and management of Ms Lehman over a number of years and was most familiar with the evolving left (and right) shoulder condition.

66. I found Dr Webber's opinion of 1 August 2019 to accord with common sense. He stated that whilst many people in Ms Lehman's age group would have long-standing wear and tear damage to her left supraspinatus tendon, nonetheless Ms Lehman was asymptomatic at the time of her right shoulder injury. I accept that the extra stress placed on the non-dominant left shoulder particularly over the long recovery process both before and after the right shoulder surgery, required a level of activity that caused the aggravation of her underlying left shoulder condition, and indeed the rotator cuff tear found on MRI scanning.

67. It follows therefore that the injury to Ms Lehman's right shoulder on 29 March 2018 materially contributed to the need for surgery to her left shoulder.

68. As it was common ground that the recommended surgery is reasonably necessary, I accordingly find in favour of the applicant.

SUMMARY

69. The Commission finds:

    (a) The applicant suffered a consequential injury to her left shoulder as a result of overuse following injury to her right shoulder on 29 March 2018.

    (b) The injury to the applicant's right shoulder on 29 March 2018 materially contributed to the need for surgery to her left shoulder.

[20] See *Murphy v Allity Management Services Pty Ltd* [2015] NSWWCCPD 49 per DP Roche at [57-58]; *Secretary, New South Wales Department of Education v Johnson* [2019] NSWCA 321

70. The Commission orders:

(a) The respondent will pay the cost of, incidental to and associated with the surgery recommended by Dr Wade Harper of a left shoulder arthroscopic acromioplasty, rotator cuff repair, AC joint excision and open sub pectoral LHB tenodesis.