IN THE DISTRICT COURT
AT WELLINGTON

I TE KŌTI-Ā-ROHE
KI TE WHANGANUI-A-TARA

[2022] NZACC 107 ACR 312/19

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPEAL UNDER SECTION 149 OF THE ACT
BETWEEN	RONALD CARMICHAEL Appellant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Hearing:	30 May 2022
Held at:	Auckland/Tāmaki Makaurau By AVL
Appearances:	H Peart for the appellant I Hunt for the Accident Compensation Corporation
Judgment:	7 June 2022

RESERVED JUDGMENT OF JUDGE P R SPILLER
[Claims for personal injury – ss 25-26 and weekly compensation – s 103, Accident Compensation Act 2001]

Introduction

[1] This is an appeal from the decision of a Reviewer dated 7 November 2019. The Reviewer dismissed an application for review of the Corporation's decisions:

(1) dated 17 December 2018, declining to grant cover for a right shoulder rotator cuff tear; and

(2) dated 5 January 2019, declining to grant weekly compensation.

Background

[2] Mr Carmichael was born in 1960, and he worked as a builder and carpenter. His evidence is that, prior to his accident, he never experienced any problems with his shoulders.

[3] On 28 August 2017, Mr Carmichael suffered an accident while lifting heavy roof trusses during his work. He wrenched his shoulder when the wind caught hold of the trusses he was trying to control and he felt a "popping noise" in his right shoulder. From that afternoon, he found that he was unable to raise his right arm above shoulder height, and his arms and shoulders, especially on the right side, were painful and the right arm had limited power.

[4] On 31 August 2017, Mr Carmichael visited Dr Simon Davies, GP, and reported that he had injured both his shoulders, with right shoulder impingement. However, Dr Davies did not lodge a claim with the Corporation.

[5] On 21 September 2017, Mr Carmichael visited Dr Tonya Cruikshank, GP, and reported, amongst other matters, aching shoulders and upper limbs, having lifted heavy trusses.

[6] On 27 October 2017, Dr Cruikshank lodged a claim for sprain of Mr Carmichael's shoulders and upper arms arising out of the August 2017 accident. On 1 November 2017, the Corporation accepted cover for bilateral shoulder sprains suffered on 28 August 2017.

[7] Between 16 and 27 November 2017, Mr Carmichael underwent physiotherapy. He reported dull ache with both shoulders and occasional sharp pain when lifting his arm. The aggravating factor listed was lifting his arm above 45 degrees.

[8] On 21 November 2017, Dr Cruikshank noted that Mr Carmichael's right shoulder remained sore, he had been unable to work since 28 August and had to hire others to fulfil his contracts. Dr Cruikshank submitted a medical certificate, to this effect, to the Corporation.

[9] On 20 December 2017, Mr Carmichael underwent x-ray and ultrasound tests. According to the x-ray of the right shoulder, there was no osteoarthritic change demonstrated and there was no obvious calcification of the soft tissues. The ultrasound report concluded that the supraspinatus/rotator cuff was intact.

[10] In March 2018, Mr Carmichael visited Finland and realised that he qualified for Finnish healthcare. On his return to New Zealand, Mr Carmichael tried to get further specialist assistance for his shoulder injuries. He faced a waiting list of several months to obtain specialist assistance for his shoulder injuries and MRI scanning, and so he decided to pursue treatment in Finland.

[11] On 9 May 2018, Dr Maria Siren, of the Helsinki Hospital District, diagnosed a right-sided rotator cuff tear or rupture. Mr Carmichael was later attended by Mr Sakari Orava, Orthopaedist, who ordered an MRI scan and referred Mr Carmichael to a Shoulder Specialist. The MRI scan indicated a supraspinatus tendon tear.

[12] On 3 September 2018, Dr Juha Ranne, a Finnish Orthopaedic Shoulder Specialist, diagnosed a supraspinatus tendon tear, as revealed by the MRI scan, as the cause of Mr Carmichael's symptoms. Dr Ranne assessed that a tear like that could occur by lifting and heaving a heavy object, and that the muscle structure was good and there were no degenerative changes in the muscles.

[13] On 5 October 2018, Dr Ranne conducted arthroscopic surgery for repair of Mr Carmichael's tendon injury. On 22 October 2018, the post-operation report by Dr Ranne included the following:

> … There are limitations in the range of motion and the shoulder naturally is sore and the patient is wearing the arm sling. The sling is to be worn another 2 weeks. …
>
> The tendon tear was traumatic. The operation was needed since the supraspinatus tendon was torn and had to be re-attached. Otherwise the tendon would not heal. The tendon tissue was of good quality. There [were] no pre-existing conditions. Before August 28 [2017] the patient had no trouble with his right shoulder.

[14] On 9 November 2018, Mr Peter Welsh, Orthopaedic Surgeon (in New Zealand), issued a report based on Mr Carmichael's medical records. Mr Welsh assessed that Mr Carmichael had incurred a shoulder sprain injury in lifting heavy trusses on 28 August 2017, but that he did not incur damages to the rotator cuff in this incident. Mr Welsh believed that the ultrasound of December 2017 was of excellent quality, and that it showed no tear injury or significant tendonopathic process that might predispose to such. Mr Welsh also advised that Mr Carmichael's shoulder sprain could not be seen to have been associated with injury precluding him from working as a builder.

[15] On 23 November 2018, Dr Ranne advised Mr Carmichael that an MRI was much more reliable than an ultrasound.

[16] On 17 December 2018, the Corporation issued a decision declining to cover a rotator cuff tear, on the basis that this was not evidenced in the ultrasound in December 2017. On 5 January 2019, the Corporation separately declined weekly compensation entitlements for Mr Carmichael, on the basis that there was insufficient information to determine that his current incapacity related to any reported event on 28 August 2017. Mr Carmichael lodged a review application of the Corporation's decisions.

[17] On 18 January 2019, Mr Welsh further reported, again referring to the lack of evidence on ultrasound scanning of any tendon disruption or tear.

[18] In February 2019, Mr Carmichael returned to work briefly, but he struggled to return to his pre-injury levels.

[19] On 14 May 2019, Dr Markku Kero, Specialist in General Practice (in Finland), advised that he had known Mr Carmichael since autumn 2018 and had been following his rehabilitation. Dr Kero advised that Mr Carmichael had been treated by Mr Orava and Dr Ranne, and they had both estimated that Mr Carmichael's rupture was caused by his accident in August 2017. Dr Kero noted that MRI was often preferred in Finland because it was considered more reliable than ultrasound, and that it was possible that a rupture might remain undetected by ultrasound.

[20] On 17 September 2019, Dr Ranne confirmed Mr Carmichael's supraspinatus tendon tear. Dr Ranne advised that the ultrasound pictures taken on 12 December 2017 were shown to radiologists at the local hospital, and the region where the tear was seen was "absolutely not normal" and a tear could not be excluded.

[21] On 4 June and 10 October 2019, review proceedings were held. On 7 November 2019, the Reviewer dismissed the review, on the basis that there was insufficient evidence to prove, on the balance of probabilities, that Mr Carmichael suffered a supraspinatus tendon tear in the August 2017 accident. The Reviewer also held that Mr Carmichael was not entitled to weekly compensation.

[22] On 5 December 2019, a Notice of Appeal was lodged.

[23] On 5 February 2020, Dr Niemi Pekka, a Radiologist in Finland, noted that the 2017 ultrasound showed "some irregularity of the supraspinatus tendon ... [and] the presence of tear cannot be ruled out on the basis of these images".

[24] On 27 October 2020, Dr Ranne confirmed that Mr Carmichael suffered right shoulder trauma in August 2017, with painful movements and "hard to lift up" which were typical for a cuff tear.

[25] On 30 May 2021, Dr Peter Gendall, Specialist Musculoskeletal Radiologist, responded to questions put by Mr Carmichael's counsel:

> **1. Please briefly explain the difference between ultrasound and MRI technology and whether the latter technique is superior and revealing the type of injury (supraspinatus tendon tear) at issue in this case.**
>
> Ultrasound uses soundwaves and the reflection of soundwaves from tissue interfaces to form an image of the underlying anatomy in patients. MRI is a combination of magnetic fields and radio waves to interrogate tissues and determine the amount of water and tissue.
>
> Neither technique is necessarily superior. Ultrasound is capable of greater spatial resolution (that is more precise measurement of distance) than MRI. This applies particularly to measurement in the plane of the ultrasound beam which can be accurate to less than 1/10 of a millimetre. On the other hand ultrasound is not as good at distinguishing different tissues and differentiating abnormal tissue from normal tissue as MRI because MRI can show a oedematous change (higher percentages of water) in diseased tissue.

To recognise a tear in tendons such as the supraspinatus tendon there generally needs to be a small amount of fluid within the tear.

Various studies have shown a little difference in sensitivity between ultrasound and MRI in detection of tears, but some difference in specificity with ultrasound being of lower specificity then MRI. This means a negative MRI is more powerful in excluding a rotator cuff tear than a negative ultrasound.

Some of the reason for this is that part of the rotator cuff (in particular part of supraspinatus tendon) is hidden from ultrasound by the overlying bony acromion process.

The art of successful shoulder ultrasound depends on positioning the patient's arm in such a way that the maximum possible amount of supraspinatus tendon is demonstrated on ultrasound, and not hidden by the bony acromion.

2. Please review the ultrasound scan and report dated 20 December 2017. Is there any observable damage or are regularity of the right supraspinatus tendon and (if so) what is your impression of the images?

In my view the study is sub optimal, particularly in the imaging of the supraspinatus tendon. This is because the insertion of supraspinatus on the greater tuberosity ("The footplate") is held at an angle of approximately 20° to the ultrasound beam. Ideally this should be at 90° to the ultrasound beam. An angle of 90° will pull more of the supraspinatus tendon free from the bony shadow of the acromion and the ideal ultrasound resolution within the tendon is when the beam of the ultrasound is at right angles to the tendon fibres.

I also feel the focal zones are not set at the ideal position for the supraspinatus tendon. Some may have very personal feelings about where the focus should be, I accept there may be differences; my opinion relates to personal use of a GE Eg machine similar to the one used for this particular study.

The study shows subacromial bursitis with a thickened subacromial bursa. There is a small lucency far laterally within the lateral margin of the supraspinatus which has the appearance of a small insertional tear. To my eye there is no sign of a full or partial thickness tear of the tendon.

When comparison is made with the MRI study one can understand why the tear shown on the MRI is not visible on the ultrasound images. I have measured the distance from the margin of the greater tuberosity to the tear as shown on the MRI coronal plane images, this is approximately 20 mm. When this distance is measured on the appropriate ultrasound image (right shoulder SST LS ANT) the distance puts one into an area where there are virtually no echoes within the tendon (Due to the obliquity of the tendon to the beam). If there is no return of sound from the tendon we will be unable to see pathology in that part of the tendon.

3. Please compare the MRI scan and report dated 3 September 2018 with the December 2017 ultrasound.

(a) What is your impression of the pathology on MRI, with particular focus on the supraspinatus tear?

(b) Is that tear likely to have been present in December 2017 and earlier?

(a) I found interpretation of the shoulder MRI difficult Despite the fact that this MRI was performed on a 3T scanner resolution on the critical T2 fat saturated oblique coronal and a oblique sagittal sequences is poor.

There is evidence of a prominent subacromial bursitis. The acromioclavicular joint is degenerate and a prominent effusion is present in this joint as well as a prominent inferior spur.

There is indeed a tear in the anterior supraspinatus tendon deep to the acromion. The more posterior part of this tear is of partial thickness, on the bursal surface, and about 8 mm retracted. Its AP diameter is around about 10 mm and it is probably full thickness more anteriorly.

There is also a small far anterior and insertional tear as shown on the ultrasound.

(b) From the appearance on the MRI I would think the supraspinatus tear would be symptomatic. It is likely to have been the cause of impingement symptoms suffered by Mr Carmichael. I cannot estimate the age of the tear based on its MRI appearance.

4. Looking at Mr Carmichael's overall rotator cuff pathology, is it likely that his supraspinatus tear was caused by his accident in August 2017? Alternatively is it more likely to be wholly or substantially due to a natural gradual process? Please give reasons for your answer.

I don't have enough evidence to answer this question. If a tear had been shown on the Ultrasound of 2017 then the appearance of the margins would be helpful in answering the question.

Here we have a continuous clinical history which is consistent with tendon symptoms from a tear.

A negative ultrasound study has been used as a way of excluding a tear at a point in time early in the history. My opinion is that the Ultrasound was not a good enough study to have excluded this particular tear. The images provided of this study show it is deficient in the area that the tear was found on the MRL.

Unfortunately this is a difficult region for ultrasound to "uncover" and is, in my opinion , one of the underlying reasons that ultrasound is not as specific as MRI in diagnosis of rotator cuff tears. (ie a negative ultrasound study of the shoulder has less chance of excluding a rotator cuff tear than a negative MRI study).

[26] On 30 July 2021, Mr Welsh commented that the damage to Mr Carmichael's rotator cuff was degenerate in origin unrelated to accident injury, and specifically had no relationship to lifting heavy trusses at work in August 2017. Mr Welsh provided the following answers to questions posed:

1. In your medical opinion what was the accident of 28.8.17 and what was the physical injury caused by this event?

> It is seen that in lifting heavy trusses in the course of his work on 28 August 2017 Ronald Carmichael incurred a sprain impingement injury to both shoulders provoking symptoms relating to longstanding rotator cuff impingement damage with a partial thickness symptoms bursal sided supraspinatus tear and reactive bursitis.
>
> **2. What is the condition requiring operative repair?**
>
> The operative repair of 5 October 2018 was undertaken to deal with longstanding attritional wear and tear damage to the rotator cuff in the form of a bursa! sided partial thickness supraspinatus tear.
>
> **3. Was the condition requiring operative repair caused by the original accident as per Question 1?**
>
> No. The pathology attended to was of gradual process origin.
>
> **4. In your medical opinion was incapacity for work on 28 August 2017 causally related to the index event and would such likely lead to the client being unable to engage in any substantial preemployment as a builder?**
>
> It may be seen that the sprain incident was likely responsible for work limitation for two to three months. Beyond that time symptom expression and pain limitation relates to degenerative rotator cuff disease unrelated to accident injury.

Relevant law

[27] Section 20(2)(a) of the Act provides that a person has cover for a personal injury which is caused by an accident. Section 26(2) states that "personal injury" does not include personal injury caused wholly or substantially by a gradual process, disease, or infection (unless it is personal injury of a kind specifically described in section 20(2)(e) to (h)). Section 25(1)(a)(i) provides that "accident" means a specific event or a series of events, other than a gradual process, that involves the application of a force (including gravity), or resistance, external to the human body. Section 25(3) notes that the fact that a person has suffered a personal injury is not of itself to be construed as an indication or presumption that it was caused by an accident.

[28] Section 103(2) provides:

> The question the Corporation must determine is whether the claimant is unable, because of his or her personal injury, to engage in employment in which he or she was employed when he or she suffered the personal injury.

[29] Schedule 1, Part 2, Clause 32 of the Act provides:

> The Corporation is liable to pay weekly compensation for loss of earnings to a claimant who-
>
> (a) has an incapacity resulting from a personal injury for which he or she has cover; and
>
> (b) was an earner immediately before his or her incapacity commenced.

[30] In *Johnston*,[1] France J stated:

> [11] It is common ground that, but for the accident, there is no reason to consider that Mr Johnston's underlying disc degeneration would have manifested itself. Or at least not for many years.
>
> [12] However, in a passage that has been cited and applied on numerous occasions, Panckhurst J in *McDonald v ARCIC* held:
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> > "If medical evidence establishes there are pre-existing degenerative changes which are brought to light or which become symptomatic as a consequence of an event which constitutes an accident, it can only be the injury caused by the accident and not the injury that is the continuing effects of the pre-existing degenerative condition that can be covered. The fact that it is the event of an accident which renders symptomatic that which previously was asymptomatic does not alter that basic principle. The accident did not cause the degenerative changes, it just caused the effects of those changes to become apparent ..."
>
> [13] It is this passage which has governed the outcome of this case to date. Although properly other authorities have been referred to, the reality is that the preceding decision makers have concluded that Mr Johnston's incapacity through back pain is due to his pre-existing degeneration and not to any injury caused by the accident.
>
> [14] … I consider it important to note the careful wording in the McDonald passage. The issue is not whether an accident caused the incapacity. The issue is whether the accident caused a physical injury that is presently causing or contributing to the incapacity.

[31] In *Ambros*,[2] the Court of Appeal envisaged the Court taking, if necessary, a robust and generous view of the evidence as to causation:

> [65] The requirement for a plaintiff to prove causation on the balance of probabilities means that the plaintiff must show that the probability of causation is higher than 50 per cent. However, courts do not usually undertake accurate probabilistic calculations when evaluating whether causation has been proved. They proceed on their general impression of the sufficiency of the lay and scientific evidence to meet the required standard of proof ... The legal method looks to the presumptive inference which a sequence of events inspires in a person of common sense …

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1 *Johnston v Accident Compensation Corporation* [2010] NZAR 673.

2 *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.

> [67] The different methodology used under the legal method means that a court's assessment of causation can differ from the expert opinion and courts can infer causation in circumstances where the experts cannot. This has allowed the Court to draw robust inferences of causation in some cases of uncertainty -- see para [32] above. However, a court may only draw a valid inference based on facts supported by the evidence and not on the basis of supposition or conjecture … Judges should ground their assessment of causation on their view of what constitutes the normal course of events, which should be based on the whole of the lay, medical, and statistical evidence, and not be limited to expert witness evidence …

[32] In *Sparks*,[3] Judge Ongley stated:

> [29] By s26(2) and (4) of the Injury Prevention, Rehabilitation, and Compensation Act 2001, personal injury does not include personal injury caused wholly or substantially by a gradual process, disease, or infection, or by the ageing process. The legal test for entitlements requires sufficient evidence to show that need for assistance arises as a consequence of the covered injury. Where there is an accompanying degenerative or gradual process condition, entitlements will not be available if the personal injury is caused wholly or substantially by that condition. In the present case therefore, the appellant has to be able to point to evidence demonstrating that the condition, as it was when the need for surgery was identified in August 2004, was substantially and effectively caused by the covered injury and not by a pre-existing process.

[33] In *Dickson-Johansen*,[4] Judge Powell stated:

> [32] The question that arises for consideration in this case is what is the procedure where a claimant like Ms Dickson-Johansen wishes to add cover for other injuries after cover has been granted. Does the fact of cover having been granted for an injury arising from a particular accident absolve the Corporation of responsibility to investigate claims for other injuries claimed to have been suffered in the same accident which are subsequently identified by the claimant?
>
> [33] A close consideration of s 48 shows that this cannot be the effect of the section. The claim for cover is for the claimant's personal injury. It is not for the accident generically and all the consequences of that accident. As a result any fresh claim for a different injury arising from a particular accident must be considered by the Corporation in accordance with Part 3 of the Act.

[34] In *Gazzard*,[5] Judge Beattie stated:

> [28] It is a basic principle of the Act that a claimant only has a right to a statutory entitlement when that claimant can establish that entitlement arises as a consequence of the personal injury by accident for which cover was granted. In the case of weekly compensation the requirement must be that a claimant is

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3 *Sparks v Accident Compensation Corporation* [2006] NZACC 45.

4 *Dickson-Johansen v Accident Compensation Corporation* [2016] NZACC 314.

5 *Gazzard v Accident Compensation Corporation* [2001] NZACC 313, upheld on appeal (HC Wellington, CIV 2005-485-2388, 22 May 2006, Miller J).

> incapacitated, as that condition is defined under the Act. The incapacity must be caused by or as a consequence of the personal injury by accident. In other words there must be a direct causal nexus between the injury which was suffered in the accident and the physical condition which is causing the incapacity at the time when that enquiry is being made.

Discussion

Cover for rotator cuff tear

[35] The first issue in this case is whether the Corporation, in its decision of 17 December 2018, was correct to decline cover for Mr Carmichael's rotator cuff injury. Mr Carmichael is required to show, on the balance of probabilities, that his personal injury of a right-sided rotator cuff tear was caused by his accident of 28 August 2017. The Court may draw robust inferences of causation based on its common-sense appreciation of the whole of the lay and medical evidence presented.[6]

[36] The Corporation submits that the evidence does not support the conclusion that Mr Carmichael's right-sided rotator cuff tear was caused by an accident on 28 August 2017. The Corporation relies primarily on the ultrasound report of 20 December 2017 and the reports from orthopaedic specialist Mr Welsh.

[37] This Court acknowledges the submissions of the Corporation, the ultrasound report and the medical reports from Mr Welsh. However, the Court also notes the following considerations.

[38] First, Mr Carmichael's evidence is that, prior to his accident on 28 August 2017, he never experienced any problems with his shoulders, and that, following this accident, he experienced ongoing pain in his left shoulder and limited power in his right arm, through to his corrective surgery on 5 October 2018. Mr Carmichael's evidence is supported by GP notes and physiotherapy notes following his injury.

[39] Second, there are serious questions as to the accuracy of the ultrasound report of 20 December 2017, which concluded that Mr Carmichael's rotator cuff was intact:

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6 Section 20(2)(a) of the Act; and *Ambros*, above n 2, at [65] and [67].

(a) Dr Ranne, Orthopaedic Shoulder Specialist, advised that: an MRI was much more reliable than an ultrasound; and later that the ultrasound pictures were shown to radiologists at the local hospital, and the region where the tear was seen was "absolutely not normal" and a tear could not be excluded.

(b) Dr Pekka, Radiologist, noted that the ultrasound showed some irregularity of the supraspinatus tendon and that the presence of a tear could not be ruled out on the basis of these images.

(c) Dr Gendall, Specialist Musculoskeletal Radiologist, considered that the ultrasound was sub optimal, particularly in the imaging of the supraspinatus tendon. His advice was that that the ultrasound was not a good enough study to have excluded Mr Carmichael's particular tear, and the images showed that it was deficient in the area that the tear was found on the MRI.

[40] Third, this Court finds that the opinions expressed by Mr Welsh are of limited weight. This is because Mr Welsh's advice was formed without the opportunity to meet with, interview or examine Mr Carmichael, and was based essentially on the ultrasound report.

[41] Fourth, Dr Maria Siren, of the Helsinki Hospital District, diagnosed that Mr Carmichael had a right-sided rotator cuff tear or rupture.

[42] Fifth, an MRI scan conducted in 2018 on Mr Carmichael revealed that he had a supraspinatus tendon tear.

[43] Sixth, Dr Ranne, the Orthopaedic Shoulder Specialist who attended and examined Mr Carmichael from 2018 and conducted surgery for the repair of his tendon injury in that year, repeatedly advised that a supraspinatus tendon tear was the cause of his symptoms. Dr Ranne further assessed that: a tear as revealed in Mr Carmichael's MRI scan could occur by lifting and heaving a heavy object; that the shoulder trauma he suffered in August 2017 and its effects were typical for a cuff

tear; and that his muscle structure was good and there were no pre-existing conditions or degenerative changes in the muscles.

[44] In light of the above evidence, this Court finds that that the preponderance of evidence supports the conclusion that Mr Carmichael's right-sided rotator cuff tear was caused by his accident on 28 August 2017.

Weekly compensation

[45] The second issue in this case is whether the Corporation, in its decision of 5 January 2018, was correct to decline to pay weekly compensation. Mr Carmichael is entitled weekly compensation for loss of earnings if he has an incapacity resulting from a personal injury for which he has cover, and he was an earner in employment immediately before his incapacity commenced.[7]

[46] The Corporation submits that, because cover for Mr Carmichael's right-sided rotator cuff tear is not available, its decision declining to pay weekly compensation in respect of that injury was correct. The Corporation does, however, now accept that it should give consideration to whether incapacity is established for some two to three months, as a consequence of the shoulder sprain injury for which Mr Carmichael has cover.

[47] This Court acknowledges the Corporation's submissions. However, the Court refers to its finding above that Mr Carmichael's right-sided rotator cuff tear was caused by his accident on 28 August 2017. The Court also refers to the following evidence.

[48] First, Mr Carmichael's uncontested evidence is that:

(1) at the time of his accident on 28 August 2017, he was an earner in employment as a builder and carpenter, and had had no previous trouble with his right shoulder;

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7 Section 103(2) and Schedule 1, Part 2, Clause 32 of the Act.

(2) from the time of his accident, he was unable to raise his right arm above shoulder height, and his arms and shoulders especially on the right side were painful and the right arm had limited power;

(3) as a result, he was then unable to work and had to hire others to fulfil his contracts; and

(4) in February 2019, he returned to work briefly, but struggled to return to his pre-injury levels.

[49] Second, Dr Cruikshank, GP, noted (on 21 November 2017) that Mr Carmichael's right shoulder remained sore, and that he had been unable to work since 28 August 2017 and had had to hire others to fulfil his contracts. Dr Cruikshank submitted a medical certificate to this effect, to the Corporation.

[50] Third, the post-operation report by Dr Ranne (dated 22 October 2018) noted that:

(1) before 28 August 2017, Mr Carmichael had had no trouble with his right shoulder;

(2) his supraspinatus tendon was torn and had to be re-attached, otherwise the tendon would not heal; and

(3) after the operation, there were limitations in Mr Carmichael's range of motion, his shoulder was sore, and he had to wear an arm sling for another two weeks.

[51] Fourth, on 30 July 2021, Mr Welsh, Orthopaedic Surgeon, commented that the incident on 28 August 2017 was likely responsible for work limitation for two to three months.

[52] This Court finds, on the basis of the above evidence, that Mr Carmichael is entitled to weekly compensation for loss of earnings in that he had an incapacity resulting from a rotator cuff personal injury for which he should be granted cover,

and he was an earner in employment immediately before his incapacity commenced. The period of incapacity appears to run from the date of the injury in 28 August 2017, possibly to his return to work in February 2019.

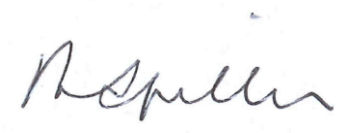
Conclusion

[53] For the above reasons, the appeal is allowed, and the review decision of 7 November 2019 is set aside. This Court finds:

(a) the preponderance of medical evidence shows that the Corporation incorrectly declined cover for Mr Carmichael's rotator cuff injury in its decision of 17 December 2018; and

(b) in light of the finding of cover for rotator cuff injury, and the evidence of Mr Carmichael's resultant incapacity to engage in employment in which he was employed when he suffered this personal injury, the Corporation incorrectly declined to pay weekly compensation in its decision of 5 January 2018. The matter of weekly compensation is remitted back to the Corporation to ascertain the exact period of incapacity and the amount of compensation involved.

[54] Mr Carmichael is entitled to costs. If these cannot be agreed within one month, I shall determine the issue following the filing of memoranda.



P R Spiller
District Court Judge

Solicitors for the Appellant: Schmidt and Peart Law.
Solicitors for the Respondent: Young Hunter.