Administrative Appeals Tribunal

DECISION AND REASONS FOR DECISION

Woodfield and Telstra Corporation Limited (Compensation) [2019] AATA 1473 (26 June 2019)

Division: GENERAL DIVISION

File Number(s): **2016/1141**

Re: **Kerrie Woodfield**

APPLICANT

And **Telstra Corporation Limited**

RESPONDENT

DECISION

Tribunal: **A G Melick AO SC, Deputy President**

Date: **26 June 2019**

Place: **Hobart**

The decision under review is affirmed.

.....[sgd].....

A G Melick AO SC, Deputy President

COMPENSATION *– whether symptoms contributed to by employment to requisite degree – subacromial bursitis – decision under review affirmed*

Legislation

Safety, Rehabilitation and Compensation Act 1988 (Cth), ss 5A, 5B, 14

Cases

Tippett v Australian Postal Corporation [1998] FCA 335; (1998) 27 AAR 40

REASONS FOR DECISION

A G Melick AO SC, Deputy President

26 June 2019

1. The Applicant, Ms Woodfield, worked in customer service at Telstra and had done so since 2010. She was initially employed in Queensland but later moved to Tasmania.

2. The Applicant lodged a claim for compensation with the Respondent for *'subacromial bursitis'* in 2015. The Respondent denied the claim for compensation by decision dated 10 February 2016.[1]

ISSUES

3. It was agreed that the issues for the Tribunal to determine are:

   (a) Whether the Applicant's condition is an *'injury'* for which the Respondent is liable under s 14 of the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act);

[1] Exhibit 1, T24.

(b) What the appropriate diagnosis of the condition currently suffered by the Applicant is; and

(c) Whether the Applicant's condition was contributed to, or aggravated, to a significant degree, by her employment with the Respondent.

AGREED FACTS

4. The following facts were agreed between the parties.

5. The Applicant commenced employment with the Respondent on 29 July 2010. She was employed as a Customer First Champion in the Customer Service Call Centre in Hobart, Tasmania at the time of the subject incident. At all times she was an *'employee'* for the purposes of s 5 of the SRC Act.

6. The Applicant was injured on 24 August 2015 at approximately 7:00am. The Respondent was first notified of the injury on 26 August 2015 in an incident report lodged on behalf of the Applicant by her team leader. The Applicant subsequently made a claim for '*subacromial bursitis*' of the '*right shoulder, right wrist*' as a result of *'continuous use of keyboard and mouse'*.[2]

7. In patient summary notes obtained under summons from the Clarence GP Super Clinic, an entry dated 18 October 2012 notes *'onset Nov 2011; R shoulder and neck pain … aggravation thru (sic) work and repetitive use.*'

8. The incident report dated 26 August 2015 noted:

> *Employee has had an aggravation of an existing condition (Bursitis) – condition was first diagnosed in October 2014; symptoms had been evident since September 2012 in varying states of severity, with suggestion from GP at the time that the condition was a result of working environment (ergonomics).*

9. On 31 August 2015, the Applicant was certified unfit for work between 31 August 2015 and 8 September 2015 as a result of the condition. On 7 September 2015, the Applicant completed a '*Timeline of Right Shoulder'* which notes:

[2] Exhibit 1, T8.

29 July 2010 – Commenced employment with Telstra – Townsville QLD

1 June 2012 – Experienced pain in right shoulder and pins and needles in right hand.

Attended HealthLink Medical Centre, Doctor advised I had slept on it wrong. No more action to be taken other than rest.

September 2012 – Transferred to Tasmania. Due to commence work with Telstra Hobart on 4 October 2012.

Attended Clarence Super GP Clinic with pain in right shoulder. Doctor asked me what type of work I performed. Advised him I am a call centre sales consultant and my roles includes computer work.

He referred me to a shoulder x-ray. Results show a thickening of the lining in my right shoulder and he advised me to stop using the computer. He said if the problem persists then a steroid injection may help.

October 2012 – Informed my new team leader, Gabby Wilson, of my right shoulder issues. She advised an assessment would be done. This did not happen.

January 2013 – Changed team leaders, Tracy Herbet. Advised Tracy of my shoulder issue. She advised me to note it on the work station check list and it would be followed up and assessment performed. Assessment did not happen.

30 October 2014 – In constant pain. I attended Long Beach Medical Centre, Dr Hunter. He referred me for an ultrasound. Results bursitis. He administered a steroid injection. Dr Hunter advised the pain was caused by repetitive use of computer keyboard and mouse. He advised me to try and limit the use of the keyboard and mouse.

After the first injection in October 2014, the pain subsided for around four months. In March 2015, I commenced a different role with the centre which meant I was not using the computer board and mouse constantly throughout the day. For the three months performing this role, I did not experience much pain at all in my right shoulder.

As of 1 July 2015, I started back at my normal role using the computer keyboard and mouse constantly every day. Within four weeks, the pain returned to my right shoulder and extended to my right wrist and across my shoulder to my neck. I have been experiencing constant pain every day since and find it very painful to use my arm and hand for anything.

24 August 2015 – Attended Long Beach Medical Centre, Dr Prowse. She referred me for another ultrasound and steroid injection.

1 September 2015 – Ultrasound performed, diagnosis bursitis.

4 September 2015 – Steroid injection given.

10. On 22 October 2015, the Applicant's team leader emailed to the Respondent's Liability Manager in relation to the Applicant's condition and noted:

> *Acting in her normal role (not including breaks), she would be required to use a keyboard and mouse for the majority of the time.*
>
> *…*

The workstations on our floor are on corner based stations fixed with set height (this height is adjustable as required). Consultants use two monitors (one 19", the other 22") with a keyboard and mouse positioned centrally to the monitors, and also a phone, amp and headset to answer and manage customer calls.

Every consultant is allocated 2 x 15 minute paid breaks on either side of their lunch break; the lunch breaks have been set at 30 minutes for most consultants since the beginning of the year due to the pressure and our customer queues, however we will be returning to an operational variation in lunch breaks from November onwards (choice of 30 or 45 minutes). In addition, every consultant is permitted up to 10 minutes of logged off time which is not questioned in mind of their expected scheduled adherence; any consultant requiring additional ad hoc breaks is free to discuss with their team leader (ie there is an expectation that consultants work their scheduled hours as scheduled, but flexibility is quite necessary.

Consultants quite often find themselves caught on a phone call with a customer that may extend beyond their scheduled break time; in the event, our expectation is they take their breaks as soon as they are able once the call has ended.

…

Kerrie called me on the morning of August 24 2015 to advise she wouldn't be attending work due to the pain in her shoulder. I believe she had been experiencing some light symptoms the day before, but didn't get to a point of feeling her pain was incapacitating until the morning of the 24th. Kerrie attended her doctor who treated her and diagnosed her with bursitis. She then came into the office on 26 August to discuss the matter with me, and advised of her diagnosis – at this time, we submitted HIRO incident INC – 1230427 to notify and begin the process of her workers' compensation claim.

Kerrie was on sick leave from August 24 until September 22. During this time, she continued receiving treatment for her symptoms via steroidal injections until her doctor cleared her as fit to return to her duties. We had arranged for her ergonomic assessment during this time, but couldn't complete it until she was back in the office.

…

I feel it's very pertinent to raise that Kerrie had raised her ergonomic needs with two previous team leaders via the workstation checklist; no action was taken on these previous requests (I assume as the TLs may have been unaware that the workstation checklist needed to be actioned by them and were not referred to a specialist department – this was a common misconception in the centre until recently). I was not aware of Kerrie's condition until the injury in August.

I have no concerns around performance or conduct. In my personal opinion, I believe Kerrie to be one of the most genuine members of our staff and one of the hardest workers.

11. In a workstation assessment dated 28 September 2015, it was noted that the Applicant:

… reported that she had recurrent pain since May/June 2012, when she experienced altered sensation of pins and needles in her right hand.

While working in a support role with minimal use of keyboard and mouse, Ms Woodfield reported that she experienced only occasional 'niggly' pain in her right

upper limb. Ms Woodfield reported that significant pain returned within two weeks of returning to the role involving 100% phone, keyboard and mouse use on 1 July 2015. Ms Woodfield reported this pain was in her right shoulder, right upper limb including wrist and a numb sensation in her right hand.

12. The task summary of the Applicant's position noted:

> *The customer first champions are responsible for receiving calls from the public using a headset and operating a computer keyboard and mouse. Full time consultants are entitled to a 30 minute lunch break with a 15 minute break in the morning and the afternoon. Consultants also have another 10 minutes available to leave for res and toilet breaks throughout the day which will not affect their performance metrics.*

13. The Applicant provided a statement regarding her workers' compensation claim in which she detailed that she had reported her pain to her team leaders who did not action her incident reports nor provide ergonomic assessments as requested. It was then stated:

> *Over the period from October 2015 until October 2014, I managed my pain with regular massage and anti-inflammatories.*
>
> *October 2014, attended a new doctor due to severe pain in my right shoulder and requested an ultrasound to be performed on my right shoulder and results from this ultrasound showed bursitis and he prescribed a cortisone injection. This injection ceased the pain in my shoulder until I returned to my normal role.*
>
> *January 2015 – team leader meeting super – this month was spent on training for NBN and had very little computer work.*
>
> *February 2015, I came out of training and info my normal role for approximately four weeks. I secured a secondment for a different role for a period of three months starting on 9 March and ending on 30 June 2015. During this time, I was not required to constantly use my computer as I would be walking around the centre providing support to consultants. My team leader for this role was Leo Crawford.*
>
> *1 July – returned to my normal role as consultant which meant I spent most of my shift using my mouse and keyboard. Within two weeks the pain in my shoulder returned slightly. I was able to manage with pain relief and anti-inflammatories until 24 August 2015. I awoke that morning with severe pain in my right wrist and shoulder. I could not move my arm without causing pain.*
>
> *I have not played any sport in over 20 years. I lead a very quiet life now. I work and I go home.*

14. At the hearing before the Tribunal, the Applicant gave evidence that her symptoms tended to increase while she was at work completing tasks at her work station and to decrease when she was not at work, on weekends and when on leave.

APPLICANT'S EVIDENCE

15. The Applicant gave evidence that she first experienced pins and needles in her right hand in around May or June 2012. She said she went to her general practitioner and was told it was due to the way she had slept. The pins and needles subsided but the Applicant subsequently noticed pain in her shoulder and wrist. She did not see a doctor.

16. In about August 2012 the Applicant relocated to Tasmania. She had approximately one month off work and drove from Townsville to Tasmania over a period of about a week. The Applicant shared the driving with family members. She had symptoms in her right arm the entire time and drove using her left hand.

17. The Applicant recommenced work with Telstra in October 2012. She still had symptoms and they worsened. The Applicant visited a general practitioner and was told the symptoms could be work-related, due to the use of a keyboard and mouse. She recalled being told she had a thickening of the lining and that she should change jobs. The Applicant said that was not an option for her. She did not have any treatment.

18. The Applicant stated that her symptoms continued and then worsened in October 2014 when she woke up one morning unable to move her arm. She saw a general practitioner, had an ultrasound of her shoulder and was diagnosed with subacromial bursitis. The Applicant was told the subacromial bursitis was possibly work-related. She had a cortisone injection in her shoulder and obtained instant relief.

19. The duties carried out by the Applicant at Telstra changed in late 2014 or early 2015 until she returned to her original duties in July 2015. The first six weeks of the new duties had involved training and for the last three months she was in a support role that involved minimal computer work. The Applicant said that within two weeks of returning to her old duties the pain in her shoulder and wrist had returned. She also had pain in her neck. The Applicant had another cortisone injection which was unsuccessful.

20. At this time the Applicant submitted an incident report and a claim for compensation with the Respondent. She had approximately four weeks off work before returning but her evidence was that she has suffered pain ever since with it worsening when she returned to work. Other than seeing a physiotherapist and having her shoulder strapped, the Applicant's only treatment has been over-the-counter painkillers when needed.

RELEVANT LEGISLATION

21. The relevant legislative provisions are set out in ss 14(1), 5A(1) and 5B of the SRC Act:

Section 14 Compensation for injuries

1 Subject to this Part, Comcare is liable to pay compensation in accordance with this Act in respect of an injury suffered by an employee if the injury results in death, incapacity for work, or impairment.

Section 5A Definition of injury

1 In this Act:

"injury" means:

(a) a disease suffered by an employee; or

(b) an injury (other than a disease) suffered by an employee, that is a physical or mental injury arising out of, or in the course of, the employee's employment; or

(c) an aggravation of a physical or mental injury (other than a disease) suffered by an employee (whether or not that injury arose out of, or in the course of, the employee's employment), that is an aggravation that arose out of, or in the course of, that employment;

but does not include a disease, injury or aggravation suffered as a result of reasonable administrative action taken in a reasonable manner in respect of the employee's employment.

Section 5B Definition of disease

1 In this Act:

"disease" means:

(a) an ailment suffered by an employee; or

(b) an aggravation of such an ailment;

that was contributed to, to a significant degree, by the employee's employment by the Commonwealth or a licensee.

2 In determining whether an ailment or aggravation was contributed to, to a significant degree, by an employee's employment by the Commonwealth or a licensee, the following matters may be taken into account:

(a) the duration of the employment;

(b) the nature of, and particular tasks involved in, the employment;

(c) any predisposition of the employee to the ailment or aggravation;

(d) any activities of the employee not related to the employment;

(e) any other matters affecting the employee's health.

This subsection does not limit the matters that may be taken into account.

3 In this Act:

"significant degree" means a degree that is substantially more than material.

22. The Applicant submits that either she suffered subacromial bursitis as a result of her work with the Respondent in accordance with the evidence of Dr Sharman, or alternatively that her underlying subacromial bursitis was aggravated by her employment and that aggravation was contributed to, to a significant degree, by her employment.

MEDICAL OPINIONS

23. In November 2015 the Applicant was examined by Mr Haig, an orthopaedic surgeon. He reported in writing and also gave oral evidence at the hearing. Mr Haig's diagnosis was bursitis of the right shoulder and his opinion was that it was constitutional, not work related. In oral evidence he said that it was his view that the type of duties required in her employment, particularly using a mouse and keyboard, were not causative factors in developing bursitis. Mr Haig did accept that these types of duties could have aggravated some of the Applicant's symptoms.

24. Mr Haig also provided two supplementary reports.[3] He maintained his original diagnosis but conceded that the Applicant may have developed a chronic pain syndrome.

25. Dr Doig, an orthopaedic surgeon, saw the Applicant in August 2016 at the request of her solicitors and produced two reports.[4] He did not give oral evidence. Dr Doig diagnosed *'subacromial bursitis/impingement/rotator cuff syndrome at the dominant right shoulder'* and a *'soft tissue injury to the right side of her cervical spine'*.[5] His opinion was that the Applicant's employment had at least caused significant aggravation. Dr Doig was subsequently asked to comment on Dr Reiter's opinion and reported that he agreed with her clinical findings but noted that when he had examined the Applicant two months earlier there had been a positive impingement sign.[6]

[3] Exhibits 10 & 11.
[4] Exhibits 13 & 14.
[5] Exhibit 13, p 4.
[6] Exhibit 14.

26. In September 2016 the Applicant was also examined by Dr Reiter, a rheumatologist. Dr Reiter provided two written reports and gave oral evidence.[7] Her diagnosis was myofascial pain syndrome. Dr Reiter rejected the diagnosis of subacromial bursitis because she said the pain would have been completely relieved by the cortisone injections. She reported that myofascial pain syndrome is a subset of fibromyalgia and that there is no evidence in scientific literature to support the notion that trauma, and therefore repetitive use of a limb such as keying and mouse work, is the cause of myofascial pain syndrome. In cross-examination Dr Reiter stated that fibromyalgia is a disease that evolves over time and an injury cannot be a stepping stone to the development of fibromyalgia.

27. In a supplementary report Dr Reiter maintained her original diagnosis and, although conceding that when the Applicant had been examined by Mr Haig and Dr Doig her signs and symptoms were consistent with subacromial bursitis/impingement syndrome, stated she did not believe these symptoms were due to computer use. In cross-examination Dr Reiter's evidence was that sitting at a desk keying does not cause subacromial bursitis. Rather bursitis occurs for the same reasons that rotator cuff syndrome does, being the lifting up of the arms.

28. Dr Marquis, an orthopaedic surgeon, saw the Applicant in May 2016 and subsequently provided a report dated 16 October 2016.[8] He was unsure of a diagnosis and considered that much of the symptomatology related to prolonged disuse. Dr Marquis noted that the timing of the symptoms in 2012 seemed to be independent of work and he did not think that work was the primary cause of the Applicant's symptoms, although it had caused significant aggravation in more recent times. He recommended a stretching and strengthening program and greater use of the shoulder.

29. Dr Sharman, a consultant occupational physician, saw the Applicant in May 2017 and provided two written reports.[9] He reported that it was likely that the Applicant initially developed subacromial bursitis but her current presentation suggested the disorder had become a more widespread pain syndrome. Dr Sharman said the underlying basis for the

[7] Exhibits 8 & 9.
[8] Exhibit 12.
[9] Exhibits 2 & 3.

condition was most likely functional thoracic outlet-type condition. He said it was unlikely it was constitutional and that her right-handedness, together with the nature of her work, made it likely that her condition was related to the static postures associated with computer and mouse-use in her employment.

30. When providing a diagnosis Dr Sharman stated that the Applicant had either subacromial bursitis or muscular dysfunction secondary to brachial plexus irritation that had gone on to cause a regional pain syndrome. In his supplementary report he opined that repetitive use of a mouse held in the right hand to navigate between different systems would be associated with repeated flexion and abduction movements of the right shoulder, probably in combination with a protracted scapular position.[10] Dr Sharman noted that a workstation inspection was necessary for a comprehensive and accurate analysis.

31. Dr Sharman also gave oral evidence. In response to a question about a causative link between the use of a mouse and the development of shoulder problems, he said that each case needs to be considered on its merits but that it was quite possible in his view, and it was relatively common, to develop shoulder pain in association with computer use. When cross-examined about the Applicant's initial presentation and her general practitioner's opinion that she had slept on her shoulder wrongly, Dr Sharman conceded this was possible. He also stated that it is not unusual for a patient to initially not recognise an association with work.

32. Dr Sharman was also asked about the possibility that the Applicant's history of associating symptoms with her work activities could be consistent with an injury from another cause and the use of a mouse being more painful as a result. He agreed this was possible. Dr Sharman also agreed that the Applicant's history of initial pins and needles which settled and subsequent right shoulder pain could indicate two different problems.

[10] Exhibit 3.

WHETHER THERE IS AN INJURY WHICH AROSE OUT OF, OR IN THE COURSE OF, MS WOODFIELD'S EMPLOYMENT OR A DISEASE THAT WAS CONTRIBUTED TO, TO A SIGNIFICANT DEGREE, BY HER EMPLOYMENT

33. The Applicant's case is that she either suffered subacromial bursitis, being a disease, as a result of her employment or that it was aggravated to a significant degree by her employment.

34. The Respondent agrees that subacromial bursitis is a disease within the meaning of the SRC Act and not an injury. The Respondent contends that the condition the Applicant now suffers is myofascial pain syndrome as diagnosed by Dr Reiter, although it concedes the Applicant did have subacromial bursitis from 1 September 2015 to 22 September 2016.

35. The majority of medical experts believe that initially the Applicant suffered from subacromial bursitis. Whilst Dr Reiter did not necessarily share that view she did concede that the earlier clinical examinations were consistent with the diagnosis. However, there is no consensus as to the cause. Dr Sharman opined that the Applicant's right handedness, repetitive computer work and static postures made it likely her employment was responsible. Mr Haig thought it was constitutional and Dr Reiter thought it impossible that it was work-related. Dr Marquis did not think work was the primary cause. Dr Doig thought the Applicant's ergonomic situation at work had predisposed her to the condition.

36. Given the majority of medical evidence supports the conclusion, I accept that the Applicant suffered subacromial bursitis, at least for a period. I also accept that it is a disease within the meaning of s 5B of the SRC Act.

37. The next question is whether the bursitis was contributed to, to a significant degree, by the Applicant's employment. I was most persuaded by the evidence of Mr Haig. His opinion was that the Applicant had a predisposition to develop subacromial bursitis and therefore it could develop with no other causal factors. Mr Haig was adamant that only activities that involve repetitive above-shoulder-height use, such as swimming, can cause bursitis. When questioned about a school of thought that mouse-use can be causative, he said he did not believe the evidence in that school rises to a sufficient standard. I accept Mr Haig's opinion and note its similarity to that of Dr Reiter. It follows that I accept that the Applicant's subacromial bursitis was not contributed to, to a significant degree, by her employment.

38. I have also considered the Applicant's more recent diagnosis, about which there is also a lack of consensus, and accept that it is no longer subacromial bursitis. Only one of the specialists who has examined the Applicant since September 2016 thinks she may still be suffering subacromial bursitis. That was Dr Sharman and he also thought it had developed into a more widespread pain syndrome. This is consistent with Dr Reiter's opinion that if the condition were subacromial bursitis the symptoms would have settled with a cortisone injection. That is what happened when the Applicant had a cortisone injection in October 2014 but not when she had subsequent injections.

39. The current diagnoses are possible chronic pain syndrome (Mr Haig, although he has not carried out an examination since 2015), myofascial pain syndrome (Dr Reiter) and subacromial bursitis or muscular dysfunction secondary to brachial plexus irritation that had gone on to cause a regional pain syndrome (Dr Sharman). Therefore the preponderance of evidence is that the Applicant initially suffered subacromial bursitis but is now suffering a pain syndrome of some form. I accept the pain syndrome had developed by the time of the examination by Dr Reiter in September 2016.

40. There is a very firm disagreement, particularly between Dr Sharman and Dr Reiter, as to the role of Ms Woodfield's employment in the pain syndrome. However having accepted that there was no significant contribution from the Applicant's employment to the original subacromial bursitis it follows that there was also no significant contribution from Ms Woodfield's employment to the subsequent pain syndrome.

41. Furthermore, even if it does not so follow I prefer the opinion of Dr Reiter and find that whatever condition the Applicant now suffers was not materially contributed to by her employment.

WHETHER MS WOODFIELD HAS SUFFERED AN AGGRAVATION OF A DISEASE, WHICH HAS BEEN CONTRIBUTED TO, TO A SIGNIFICANT DEGREE, BY HER EMPLOYMENT

42. Most of the medical experts accept that the Applicant's employment has at least increased her symptoms. The question is whether this amounts to an aggravation of a disease contributed to, to a significant degree, by her employment for the purposes of the SRC Act. *'Significant degree'* is defined as a degree that is substantially more than material.

43. The relevant medical opinions are:

(a) Mr Haig accepts that using a mouse and keyboard could have aggravated some of her symptoms;

(b) Dr Doig's opinion was that her employment had at least caused significant aggravation; and

(c) Dr Marquis thought work had caused significant aggravation in recent times.

44. Both parties referred the Tribunal to the case of *Tippett v Australian Postal Corporation* [1998] FCA 335 (*Tippett*). Finkelstein J said in that case:

> *Pain is the most common symptom of an injury. If the pain arising from an underlying condition is aggravated, that is increased or intensified, as a result of an employee's employment then the employee will have suffered a compensable injury: Commonwealth Banking Corporation v Percival [1988] FCA 240; (1988) 20 FCR 176 at 179-180. The same is true if the pain caused by an underlying condition has dissipated but returns as a consequence of the activities that are undertaken during the course of an employee's employment: Canberra Abattoir Pty Ltd v Asioty (unreported, Full Court, Federal Court, 26 April 1988) a proposition which was not disturbed on appeal at [1989] HCA 40; (1989) 167 CLR 533.*
>
> *However, as was pointed out by the Full Court in Beattie, supra, at 378 per Evatt and Sheppard JJ:*
>
> > *it does not follow in every case that a worker with a pre-existing injury, who carries out work and as a result suffers pain, will have suffered an aggravation of his injury. A worker whose fractured leg is encased in plaster will be unable to put it to the ground without suffering pain and other disability. But that is not a case of aggravation. In such a case any incapacity for work arises only by reason of the pre-existing injury.*
>
> *This passage draws a very important and perhaps obvious distinction between the case of a worker who has a pre-existing injury that causes the worker to suffer pain whether or not the worker is at work and the case of a worker who has a pre-existing injury and it is the activities at work that cause the worker to suffer pain or to suffer pain more intensely. It is only in the latter case that it can be said that the worker has suffered an aggravation of his or her pre-existing injury.*

45. It is therefore necessary to determine whether the Applicant suffers pain whether or not she is at work or whether it is her work activities which cause her to suffer pain or to suffer pain more intensely.

46. The written submissions filed on behalf of the Applicant helpfully include a chronological summary written in September 2015 (and which is also contained in Exhibit 1) however it does not provide a complete picture of the history of the Applicant's pain and other

symptoms. For example, the chronology does not mention the drive to Tasmania in 2012, which was apparently accompanied by significant pain. The Applicant's evidence was that she had pain in her right arm for the entire period of the drive and up until she recommenced working for the Respondent in Hobart in October 2012.

47. In fact it appears that the Applicant's only pain-free period since 2012 was after she had her first cortisone injection in November 2014. The relief lasted until approximately mid July 2015, after she had returned to her usual role from a number of months in another role that involved less computer work. The Applicant lodged her compensation claim a few weeks later after waking up one morning unable to move her arm. Her evidence was that her pain has continued to worsen since then and she is now always in pain, although less so when not at work. However, the Applicant also stated that the pain caused her significant difficulties at home and she cannot peel vegetables, wash her hair or sleep in her own bed because of the pain the activities cause. The Applicant's evidence is consistent with Dr Marquis' observations in 2016, that is, that she avoids the use of her shoulder most of the time.

48. I accept that the Applicant suffers pain most, if not all, of the time and that she experiences it more intensely when she uses her shoulder. This occurs both at work and in her home life. I do not accept that the increased pain at work is an aggravation contributed to, to a significant degree, by her employment. Rather her increased pain is akin to the worker with the fractured leg who feels pain if he places it on the ground whether at work or not. As noted in *Tippett*, such pain is not an aggravation of the underlying injury (or disease in this case).

DECISION

49. The decision under review is affirmed.

I certify that the preceding 49 (forty -nine) paragraphs are a true copy of the reasons for the decision herein of A G Melick AO SC, Deputy President

.....[sgd].....

Associate

Dated: 26 June 2019

Date(s) of hearing:	**25 July 2017, 17-18 May 2018**
Date final submissions received:	**4 July 2018**
Counsel for the Applicant:	**Mr B Hilliard**
Solicitors for the Applicant:	**Slater and Gordon**
Counsel for the Respondent:	**Mr J Wallace**
Solicitors for the Respondent:	**McInnes Wilson Lawyers**