IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 145 ACR 92&144&145/21

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

Hearing: 29 June 2022
Heard at: Auckland/Tāmaki Makaurau

Appearances: Mr B Hinchcliff for the Appellant
Mr L Mailand and Ms F Becroft for the Respondent

Judgment: 26 July 2022

RESERVED JUDGMENT OF JUDGE C J McGUIRE
[Causation/Personal Injury s 20 Accident Compensation Act 2001]

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[1] Three accident events are relevant to these appeals.

- An accident on 28 June 2018, where cover was granted for a lumbar sprain suffered when the appellant lifted a 20-Litre oil container at her work.
- An accident on 13 July 2018, where cover was granted for a lumbar sprain suffered when the appellant lifted and fell on her tailbone.
- An accident on 29 January 2019, where cover was granted for a lumbar sprain suffered when bending over and reaching into a food elevator to pick up frozen food.

[2] Three appeals are for determination.

- ACR 145/21 – This is an appeal against a decision of 15 July 2019 which revoked deemed cover for a complete tear of the right hip. ACC's position is that this decision was overtaken by the decision of 30 September 2019 which is at issue in ACR 92/21.

- ACR 92/21 – this is an appeal against a decision dated 30 September 2019 which declined cover and surgery funding for a right hip labral tear. The Corporation maintains that the decision is correct as the appellant did not suffer a right hip labral tear in any of the three accident events.

- ACR 144/21 – this is an appeal against a decision dated 17 June 2020 revoking deemed cover for a disc prolapse with radiculopathy. The Corporation maintains that the decision is correct as the appellant did not suffer a disc prolapse with radiculopathy in any of the three accident events.

Background

[3] On 28 June 2018, the appellant had an accident at work when lifting a 20-Litre oil container.

[4] The same day, her GP, Dr Nadela, completed an ACC injury claim form seeking cover for a lumbar sprain and certifying the appellant unfit for work for two days.

[5] The appellant had another accident on 13 July 2018 when she slipped on a wet floor and hurt her back. The claim form records lumbar sprain left side.

[6] The appellant had a lumbar spine X-ray on 16 July 2018. No acute changes were shown on the X-ray.

[7] Dr Nadela completed a medical certificate dated 20 July 2018 certifying the appellant fully unfit for work from 13 to 29 July 2018, "because still having

significant back pain, even sitting is uncomfortable". The certificate said the appellant would be fit for light duties from 30 July to 5 August 2018.

[8] Another medical certificate dated 30 July 2018 certified the appellant fully unfit from 30 July to 5 August 2018, "because of ongoing low back pain".

[9] There is an undated initial client interview script from ACC which under the heading – "How did you accident happen?" says:

> Slipped on wet floor in kitchen, it didn't hurt straight away. It was later when it started.

[10] The interview also recorded that the appellant was receiving private physio for her injury.

[11] On 2 August 2018, the Corporation granted cover for the lumbar sprain suffered on 13 July 2018.

[12] On 3 September 2018, the appellant obtained a medical clearance from her doctor. The following is noted:

> No back pain.
> No Pu/BO problem.
> No saddle anaesthesia.
> …
> Full ROM of the back.
> …
> Fit for work.

[13] The appellant returned to work and there was no further engagement with the Corporation for several months.

[14] On 12 November 2018, following her GP's referral, she was examined by Dr Kevin Bell, Sports and Exercise Physician. Dr Bell reported that the appellant:

> Has had persisting pain from the midline of her lumbosacral junction down the back of her right leg to the heel. Her pain increases if she is more active at work.

…

> It is my impression that Snezana has a severe case of right sided sciatica. Given her persisting symptoms, I have requested an MRI scan.

[15] Amongst the MRI findings was the following:

> Although there is shallow right foraminal protrusion at L4/5 and very small left paracentral extrusion at L3/4, there is no evidence of compromise to the couda equina nerve roots or exiting nerve roots structures to account for the patient's right sciatica.

[16] Dr Bell noted that the Radiologist had suggested that she undergo a repeat MRI scan to check the focus of abnormal signal. He recommended she have this done in approximately six months.

[17] The appellant had a second MRI on 15 January 2019. Radiologist Dr Blair reported:

> When compared to the previous MRI, the small focus of abnormal signal within the epidural adipose tissue posteriorly at L3/4 has decreased in size and not associated with enhancement or blood products. Given its location, signal characteristics and decrease in size, I wonder if this most likely represents a dural tear at the site of previous lumbar spine injection and further clinical correlation is suggested. The appearances elsewhere within the lumbar spine have not altered significantly.

[18] The appellant had another accident on 29 January 2019. She suffered a lumbar sprain while picking up some frozen food from an elevator at her workplace.

[19] ACC accepted cover for the lumbar sprain on 1 February 2019.

[20] An X-ray taken on 4 February 2019 found normal appearances with vertebral bodies and disc spaces intact.

[21] The appellant saw Dr Chin on 12 February 2019. He noted that she had been making good progress until the January 2019 accident where she felt a sharp in her lower back similar to the July 2018 injury. The appellant now reported persistent pain from the right leg to the calf which was worse than the last incident. On examination, she had very limited and painful lumbar movements. Dr Chin noted that the appellant had bilateral L4/5 radiculopathy with more so on the right and the

left and considered this more likely to be an extension of the disc extrusion seen earlier. He referred the appellant for another MRI.

[22] The appellant had a third MRI on 13 February 2019 which Dr Chin reported on, noting:

> A lesion on the posterior epidural space which was there from the first scan and has increased slightly in size and would not be giving her a leg pain and the L4/5 disc is similar in size to the previous scan – patient to come in to discuss scan and management.

[23] Dr Chin saw the appellant again on 19 February 2019 and reported:

> She came in today to go through the scans and the disc is slightly smaller in my opinion and she is in less pain by about 40% and is walking straighter but she says she has to have tramadol … for the pain, which I have advised to reduce if possible.

[24] Dr Teo, GP, completed a medical certificate dated 20 February 2019 in respect of the 29 January 2019 accident and certified incapacity because of "disc prolapse causing lumbar pain…"

[25] The Corporation wrote to the appellant on 21 February 2019 to advise that it had received the claim for a disc prolapse and that it was awaiting medical records in order to assess the claim.

[26] Dr Chin referred the appellant to Mr Somerville, Orthopaedic Spine Surgeon, who, on 19 March 2019, reported:

> …
>
> Examining Snezana, she is very uncomfortable even at rest. She walks very cautiously with a decreased stance phase on the right leg and an antalgic gait if she walks without her crutch. Any range of motion testing of her right hip is limited with severe discomfort both over the region of her iliac crest, over the greater trochanter and felt down to the level of her knee. Her reflexes are brisk at the knee and ankle. There are one or two beats of clonus but this is a little difficult to test because of pain. She finds it difficult to do a single leg stands on the right side.
>
> She has had scans of her lumbar spine but I really don't think it is coming from her back. I think she needs a scan done of her pelvis and right hip but at this point, I am at a bit of a loss to explain her discomfort. If the MRI is non-contributory, then we may need refer her through for an assessment through the public hospital system.

[27] The appellant had an MRI scan of her right hip on 1 April 2019 which found:

> Labral tear of the right hip shows an expanded volume of labral tissues which remain. There is minimum articular damage. No separate sign of cause for pain, in particular no cystic changes of the acetabulum or femoral head are shown. There is an established synovial cyst correlating with the mild impingement. Inflammatory changes of the gluteal tendons are minimal with stable hamstring and psoas attachments.

[28] On 9 April 2019, Mr Somerville referred the appellant to Mr Willoughby, Orthopaedic Surgeon. In his letter of referral, he gave the appellant's diagnosis as:

> Labral tear anterior right hip.

[29] Mr Somerville sought advice from Mr Willoughby as the appellant was "really struggling at the moment with pain".

[30] On 5 June 2019, Mr Willoughby reported:

> On examination today, she struggles to walk with two crutches. She has minimal movement of the hip either active or passive due to pain. She is tender over the lower sacrum and coccyx. She is also tender laterally over the trochanteric bursa. It is almost impossible to do any rotation of her hip due to pain. She is also tender anteriorly in the groin.
>
> …
>
> An MRI scan of her hip shows a labral tear that is quite extensive change with the labarum with a small para labral cyst. The cartilage of her hip looks well preserved. She may have some subtle reduced femoral head neck offset but no major cam lesion.
>
> ….
>
> She is desperate for pain relief. In the first instance, I have arranged a steroid injection into her right hip which hopefully will afford her some pain relief and allow her a period of relief. They are very keen to have a labral repair which we have discussed today. We talked about the risks and benefits and they have an information sheet to read.

[31] The appellant had a right hip ultrasound injection on 14 June 2019 without complication.

[32] On 25 June 2019, the Corporation wrote to the appellant advising her that she had deemed cover for "complete tear, hip ligament – right;" and the Corporation would continue investigating this condition.

[33] Ms Hughes, Physiotherapist/Clinical Advisor provided advice dated 3 July 2019 noting the complexity of the appellant's presentation. In particular, she advised that the symptoms described by the appellant earlier in the claim were not the same as those now reported by Mr Somerville and Mr Willoughby. Ms Hughes was of the opinion that there was insufficient evidence to accept cover for her lumbar disc prolapse with radiculopathy and that the appellant's symptoms were not consistent with an L4/5 pattern.

[34] Ms Hughes said:

> The client describes a mechanism that could have caused a hip injury. However, her initial symptoms are not consistent with her hip injury.

[35] Ms Hughes also said:

> It is currently unclear what the diagnosis is. The client should be having a follow up appointment with Mr Willoughby after her hip injection…

[36] On 15 July 2019, the ACC case manager wrote to the appellant and enclosed a copy of the clinical advisor's comments. The letter went on to say:

> As a result, ACC has had to revoke the decision of 25 June and will revoke cover for your right hip.

[37] Mr Willoughby completed an assessment report and treatment plan dated 24 July 2019 seeking surgery funding for an arthroscopy of the hip and a labral repair. He linked the need for surgery to the July 2018 accident and explained:

> The forced flection and adduction that occurred during the fall resulted in the labral tear.

[38] Another medical certificate dated 31 July 2019 certified the appellant unfit for work until 23 October 2019. The diagnoses were listed as lumbar sprain and complete tear, hip ligament.

[39] Mr Somerville reported again on 1 August 2019 following another review of the appellant. He noted that her discomfort had rapidly increased since the last time he saw her and that she indicated the tip of the coccyx as the area of maximal discomfort. He arranged for a further MRI.

[40] An MRI of the pelvis and coccyx took place on 8 August 2019 but did not identify a cause of the appellant's ongoing symptoms.

[41] Dr Nedala completed another medical certificate dated 23 August 2019 certifying the appellant as unfit for work from 23 August to 27 October 2019.

[42] Mr Somerville reported again on 27 August 2019 after seeing the appellant in reviewing the most recent MRI. He said:

> Unfortunately, I don't have an easy answer for the genesis of her discomfort. There are some minor changes around the exact anatomy of the tip of the coccyx but I do not think that this is pathological and certainly do not think that any intervention here would likely change the clinical situation.

[43] The respondent sought advice from its principal clinical advisor Mr Atkinson, Orthopaedic Surgeon. He noted:

> For months following the injury event, no functional problems of the right hip were reported. There was significant dysfunction with the lumbar spine recorded as right-sided sciatica. There were significant symptoms of pain in the sacrococcygeal region.

[44] Mr Atkinson concluded:

> The labral pathology is not consistent with traumatic pathology consequent on the injury event of 13/07/2018.

[45] The Corporation wrote the appellant on 30 September 2019 declining cover for right hip labral tear and declining to fund surgery to repair the same.

[46] Dr Teo certified the appellant unfit for work on the January 2019 claim.

[47] Dr Prestage, Consultant Occupational Physician, reported on 22 October 2019 following a medical case review. He was of the opinion that there was no specific discreet injury likely to account for the appellant's presentation and thought that there was likely a degree of central sensitisation contributing to her condition. He noted the disc prolapses but did not comment on causation and did not think they were clinically relevant.

[48] Mr Willoughby provided another report dated 6 November 2019 in response to questions from the Corporation. Mr Willoughby maintained that the appellant had a labral tear in her hip which he thought likely caused by her fall with a forced flection hip injury at the same time. He noted her coccygeal pain which was likely to have been caused by landing directly on her backside during her fall.

[49] Dr Farnell, Pain Specialist, reported on 19 November 2019. He observed that Dr Chin had initially presumed that the appellant had suffered a lumbar disc injury in her July 2018 accident but noted that there was no clinical sign of that. Dr Farnell concurred with the opinions of Dr Somerville and Dr Willoughby.

[50] Another medical certificate dated 26 November 2019 certified the appellant unfit for work from the July 2018 accident, from 29 November 2019 to 26 February 2020. The certificate sought to add cover for "contusion of coccyx" suffered in relation to the 2018 injury. It also stated that the appellant's hip and tailbone injuries were related to the July 2018 accident.

[51] In December 2019, the appellant completed an 8-month long pain management programme.

[52] On 14 January 2020, Dr Pai, Orthopaedic Surgeon, conducted a medical case review. He considered the three accident events:

- the lifting of the 20-Litre container of oil on 26 June 2018 resulting in a lumbar sprain;
- the incident on 13 July 2018 when she slipped on a wet floor and fell on her buttocks; and
- the incident of 29 January 2019 when she was trying to bend and lift food stuffs from a food elevator weighing around 15kg and which resulted in sharp pain in her lower back and in the lateral aspect of the thigh and lateral aspect of her leg to the ankle.

[53] With regard to the hip, Mr Pai diagnosed a symptomatic right hip irritation, the symptoms of which far outweighed the clinical pathology of a labral tear. He did not think the labral tear was accident related. As to the spinal issues, Mr Pai did not think that the disc prolapses were caused by any of the accidents. He considered that the July 2018 accident had significantly aggravated symptoms of nerve route irritation due to two pre-existing disc prolapses at L3/4 and L4/5.

[54] The respondent sought further comment from Mr Atkinson who reported on 22 January 2020.

[55] Referring to the accident of 16 July 2018, he said:

> A fall onto the tailbone would not result in traumatic tearing of the acetabular labrum in the right hip.
>
> The initial presentation recorded no symptoms to the right hip and no signs of hip dysfunction.
>
> Traumatic labral tearing would result in a immediate pain to the right groin region in the hip with limited function in the affected hip joint. As I have previously commented, the labral pathology seen on MRI scanning is not consistent with traumatic pathology consequent upon the injury of 13/07/2018. A thickened acetabular labium is noted. There is an anterior femoral neck synovial cyst. There was some mild developmental bony changes which would contribute to femoroacetabular impingement.
>
> The changes seen on MRI scanning of the hip are likely to be an inflammatory and attritional aetiology and not the consequence of a single event of trauma.

[56] Technical specialist's advice dated 23 January 2020 noted that ACC had not made a cover decision in respect to the disc prolapse claim and advised that deemed cover arose.

[57] Mr Willoughby wrote to Dr Nadela on 9 March 2020 advising that the appellant would be having her surgery through the public system and was to be placed on the waiting list.

[58] The appellant and the Corporation reached a mediated agreement dated 23 March 2020. The appellant agreed to provide a further report from an orthopaedic surgeon providing their clinical opinion and reason to why they considered that the

labral tear was caused by the July 2018 accident. The Corporation agreed to pay the cost of obtaining that report and then, as soon as possible, issue a new decision.

[59] Clinical advisor Ms Hughes commented on 26 May 2020 that cover for the disc prolapse had been sought on the January 2019 claim but MRIs showed that it had predated that accident. She recommended that deemed cover be revoked.

[60] The Corporation issued a decision dated 17 June 2020 advising that deemed cover for a disc prolapse with radiculopathy arose as of 31 October 2019. The same letter revoked deemed cover. (This is the decision at issue in ACR 92/21.)

[61] The Corporation suspended entitlements on the January 2019 claim in a separate decision letter also dated 17 June 2020. The letter explained the reasons why the Corporation did not accept the disc prolapse was caused by the January 2019 accident.

[62] In response, the appellant emailed the Corporation. She said:

> I have got a letter from ACC saying they will stop with my payments. In the letter it says that after they examined by case, they decided that my current condition has not nothing to do with ACC, which it does. They put down that it was my… left lumbar sprain which is not correct. I have injured my right side. I have a surgery for my right hip next Tuesday 23.06.2020, so I am a little bit confused and don't know how they come up with the conclusion that my current situation has nothing to do with my injury, which it certainly does. I still use my crutches and am unable to sit or lie down properly. I was 100% fit before I slipped and fell down…

[63] The appellant emailed the Corporation again indicating her confusion. Included in this email is the following:

> Ritu Nair told me that ACC accepted my injury and everything about my injury, but ACC needs more evidence for surgery. And everything on that time (contact between me and ACC) was during COVID-19. I got a letter from Waikato Hospital about accepting me on public list and I had a phone call from anaesthesiologists about my condition. I said, that is ok … Finally everything will be done … I have appointments with Mr Somerville 6.08.2020 and with Mr Willoughby 5.08.2020. Misunderstanding between me and Dr Chin was beginning on my problem. (English is my second language, I always said).
>
> Yes, I'm happy to see any other doctor, specialist and finally finish with this misunderstanding.

> I slipped and fell (directly on my tailbone (or low back)) on the wet floor. My second injury was just over the top of the first one… (first one was not treated properly). I lost my job… I'm still on a high level of pain, using a lot of medication, walk with crutches… and I'm not happy at all. My life is miserable.

[64] Mr Willoughby performed right hip surgery on 23 June 2020. Under the heading "Intraoperative findings" of his operation report, Mr Willoughby said:

> Large labral tear with labral cartilaginous junction fraying.

[65] He also noted that the labral tear was repaired using two suture anchors.

[66] On 5 August 2020, Mr Willoughby provided a six-week follow up report. In that report, he said:

> The findings at the time of surgery were that there were no significant signs of arthritis in the hip. She had the labral tear which may well be traumatic. There was certainly no major cam identified at surgery.
>
> The mechanism for her with the flection of the hip and some rotation is certainly adequate to cause a labral tear. My impression is that the forced flection during the fall is what caused her labral tear.

[67] Mr Somerville saw the appellant and reported on 6 August 2020. Included in his report is this:

> Snezana has had a very difficult time and I think the primary cause of her incapacity at the moment is likely to be coccydynia in spite of my earlier report.
>
> Her mechanism of injury was a fall on 13 July 2018. At the time she was working as a chef in a full time position. The floor had mopped, she was carrying two plates and her feet went out from underneath her and she landed directly on her buttock and tip of her coccyx on a hard polished concrete floor. She was aware of discomfort at the time and it has been largely this pain that has bothered her since. She did have a second injury on 29 January 2019 when she was removing some frozen goods from the service elevator. She needed to place her head and shoulders inside of the lift in order to be able to remove the goods. She describes a sudden and dramatic increase in discomfort in the region of the sacrococcygeal joint rather than lumbosacral junction, and I think this has probably been an aggravation of her underlying problem from July 2018.
>
> To put in context her level of disability, prior to 2018, she was working as a chef full time. She attended a fitness center two times a week, she would climb Mount Maunganui up to two times a week in the summer and was running twice a week. Subsequently, she is unable to drive, she is on regular Oxynorm and Tramadol and cannot sit for more than 30 minutes and is unable to work.

[68] Ms Hughes considered Mr Somerville's report and reviewed the appellant's clinical trajectory. Her opinion was that the clinical record did not support an accident related coccyx injury.

[69] A medical certificate dated 24 August 2020 sought to add a diagnosis of fracture of coccyx to the July 2018 claim.

[70] Mr Willoughby provided another report dated 4 November 2020 after reviewing the appellant 5 months following hip surgery. Mr Willoughby noted that the appellant was more comfortable than she was pre-surgery but was still in significant discomfort.

[71] Mr Hinchcliff emailed the Corporation enquiring whether deemed cover arose for a coccyx injury. This was considered by technical specialist Mr Burgess on 6 January 2021. Mr Burgess concluded deemed cover arose for "fracture of coccyx" and "contortion of coccyx" because Dr Nadela had sent an ACC 18 to the Corporation on 24 August 2020 listing these diagnoses, but no decision had been issued.

[72] The Corporation wrote to the appellant on 11 January 2021 confirming that on her July 2018 claim she had deemed cover for contusion and fracture of coccyx, from 13 September 2020.

[73] The respondent sought further advice from Mr Pai who provided the supplementary report dated 7 February 2021 addressing the possibility of a coccyx injury.

[74] His view was that if there had been a traumatic coccygial injury, it would have been evidenced on the MRI which was not so in her case.

[75] Mr Pai went on to say:

> However, coccygial pain may be secondary to refer pain from a lumbar pathology or secondary somatisation, and it is not uncommon in the presence of psychosocial stresses. The incidents of co-existence of lumbar spine disorder and coccygial pain is being reported as high as 15% to 77%.

[76] ACC obtained a report from its clinical advisory panel dated 7 October 2021. In the report, the panel said:

> The CAP agreed Ms Stojicevic's diffuse pain problems were unlikely to be coming from her back. She appears to have developed new right hip symptoms for no apparent reason, which were not present after her 28/06/2018 and 13/07/2018 ACC covered accidents. These were new symptoms, possibly from her acetabular labral tear, which most likely arose spontaneously months after, and not related to the ACC claims. There was no evidence of a causal link between any of Ms Stojicevic's ACC covered accident and her various symptoms.

[77] As to the right hip acetabular labral tear, the panel said:

> Mr Somerville referred Ms Stojicevic for an MRI scan of the right hip. On 01/04/2019, this reported acetabular labral tear and para labral cyst.

[78] The CAP noted that there has been no mention in the GP clinical consultation notes of any right hip symptoms until 08/04/2019. Directly after the hip MRI scan results, 9 months after the 13/07/2018 accident, Dr Nadela noted:

> Getting pain on the coccyx area and on R hip.

[79] Later in its report, the panel says:

> The hip acetabular labrum can be torn with high velocity, high force accident such as falls from a height, car accidents and severe body injuries. When the labium is torn acutely, this often associated with adjacent injuries such as fractures, dislocations, ligament and tendon tears. People usually present within a few hours or days with a history of significant injury to the hip and severely painful right hip symptoms which are unrelenting, unmissable and alter most usual activities.
>
> The accident described by Ms Stojicevic is not similar. She did not describe the immediate severe hip impairment from sharing forces across her right joint. She described back and leg problems as noted above. Her clinical records her right hip problems are most consistent with a gradual onset of hip and other pain over some months.

Appellant's submissions

[80] Mr Hinchcliff referred to the three injury events being the occasion on 26 June 2018 when lifted a heavy container; secondly when she slipped on the floor on 13 July 2018 and the third injury event while lifting fish on the 12 January 2019.

[81] He submits that the labium injury derived from the accident of 13 July 2018 and that her disc injuries arose from all three claims.

[82] Mr Hinchcliff refers to Dr Chin's report and notes that the epidural treatment improved the condition in her lumbar spine. He notes that on 15 January 2019, Dr Chin recorded that the lesion seen in the first scan at L3/4 had decreased in size. He submits that the fact of the disc injury resolving makes it more likely than not that it was caused by the accident of 13 July 2018.

[83] He refers next to the report Mr Somerville of 19 March 2019. This was following the third accident when she reached into a service elevator to remove some frozen goods.

[84] He notes that Mr Somerville said:

> She has had scans done of her lumbar spine but I really don't think that it is coming from her back. I think she needs a scan done of her pelvis and right hip but at this point, I'm at a bit of loss to explain her discomfort.

[85] He next refers to Mr Willoughby's report of 5 June 2019 that

> An MRI scan of her hip has shown a labral tear that is "quite extensive".

[86] Likewise, Mr Willoughby notes that the appellant is desperate for pain relief and that the appellant is struggling to walk with two crutches.

[87] Mr Hinchcliff says that this is where ACC's confusion steps in as to whether the symptoms are related to a lumbar disc prolapse or a labral tear of the right hip. He submits that the clinical advisor failed to take into account the traumatic mechanism of the slip accident on 13 July 2018. This led ACC to revoke cover for her right hip in its decision of 15 July 2019.

[88] He refers to Mr Willoughby's report of 25 July 2019 and notes that a steroid injection gave the appellant 50% improvement in pain in her right hip.

[89] He next refers to an MRI scan of 8 August 2019 which notes some minor changes of the coccygeal bony contour.

[90] Mr Hinchcliff next refers to the report Dr Prestage Consultant Occupational Physician who at ACC's request reported on the appellant on 22 October 2019.

[91] Dr Prestage noted the appellant's extreme pain on virtually all movements and history suggesting a back injury on 28 June 2018. As a result of lifting a 20-Litre container of oil.

[92] In his opinion, her symptoms did not appear to be directly related to the lumbar spine but thought that there was a degree of central sensitisation contributing to the appellant's condition. He said:

> In my opinion, there is no specific discreet injury likely to account for Ms Stojicevic's presentation.

[93] While a current diagnosis was uncertain, Dr Prestage was of the view that the following should be considered:

> A left sided L3/4 disc extrusion; right sided L4/5 disc extrusion; right sided L4/5 disc protrusion; labral tear right hip; and central sensitisation that may be serving to amplify what would otherwise be relatively mild symptoms from the above conditions.

[94] He next refers to Mr Willoughby's report of 6 November 2019 where he said:

> It remains my opinion that she has a labral tear in her hip which is likely to have been caused by her fall with a forced flexion plus or minor rotation injury to her hip at the same time. She has coccygeal pain which is likely to have been caused by landing directly on her backside during this fall.

[95] Mr Hinchcliff submits that Mr Willoughby is consistent in his reports as to causation.

[96] He next refers to the report of Dr Farnell of 19 November 2019. Dr Farnell was of the view that it was the acute labral tear that had become symptomatic.

[97] He refers to Mr Willoughby's further report of 5 August 2020 in which he says his impression was that the forced flection during the appellant's fall caused her labral tear.

[98] He next refers to Mr Somerville's report of 6 August 2020. Mr Somerville thought the primary cause of that incapacity was likely to be coccydynia "in spite of my earlier report". He related that to the injury from the fall on 13 July 2018.

[99] Mr Hinchcliff refers to *Ambros*[1] and submits that despite the widely varying views of the doctors and specialists there is undeniably a close temporal relationship between her accidents and her injury presentation.

Respondent's submissions

[100] Mr Mailand acknowledges that in this case there is "a lot of medical evidence" and this case is something of a medical "who done it". He acknowledged the three events of accidents on 28 June 2018, 13 July 2018 and 29 January 2019. He also acknowledges a "huge" variety of investigation which first was directed at the lumbar spine and then hip and finally the coccyx.

[101] He says that none of these had certainty. He submits that the GP's note of 3 September 2018 is "crucial" in that the appellant reported feeling a lot better with full range of movement and no back pain.

[102] He notes that the appellant's pain returned in late 2018 with Dr Bell diagnosing severe right sided sciatica on 12 November 2018.

[103] He acknowledges that things got worse after the January 2019 with Spine Specialist Mr Somerville on 19 March 2019 concluding that he did not think the pain was coming from her back and ordered the MRI scan of her pelvis and right hip. This revealed "a grossly abnormal labium" with a labral tear of the right hip being diagnosed.

[104] He notes that the appellant's hip surgery on 23 June 2020, some two years after the first accident didn't completely fix things so the focus turned to the coccyx.

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

[105] He refers to the report of Mr Pai of 14 January 2020 whose view was that the labral tear was most likely degenerative. He notes that Mr Atkinson too discounted a traumatic tear. He notes that Mr Willoughby is prepared to say that the labral tear "may have been traumatic" but does not address the concerns that Mr Atkinson had.

[106] He refers to the clinical advisory panel report which he says is most consistent with the scans taken and clinical presentation.

[107] Accordingly, he says that ACC is right in saying there is insufficient evidence of causation in this case based on her recovery recorded in the GP notes, the MRI scans and the symptoms reported immediately after the accident events.

Decision

[108] The appellant has three covered accidents. The first occurred on 28 June 2018 when she lifted a 20-Litre oil container and injured her back. The injury was coded as a lumbar sprain. She was found to be unfit for work for two days.

[109] Her second accident occurred on 13 July 2018 two weeks after she returned to work from the first accident. This time she slipped on a wet floor and landed heavily on her buttocks.

[110] This injury appeared to resolve itself and on 3 September 2018, her GP considered her fit for work. She reported feeling a lot better with no back pain. She was found to have full range of movement of the back.

[111] The next medical note is dated 6 November 2018 and is again from her GP. It says:

> injured back in 2018 and has never come right
> easily aggravated with minor things
> back again pretty sore, no cauda equina symptoms
> taking Brufen already, no better
> worse over the last couple of weeks again
> o/e: posture stiff
> gait fine

> sl tender more on paravertebral muscles on lower lumbar
>
> …

[112] As a result, she was referred Mr Bell, Sports and Exercise Physician, who saw her on 12 November 2018. He reported:

> On examination, Snezana was very slow to transfer and mobilise. She had forward flexion to her mid shins limited by lumbar pain. She has a lot of pain with extension in side flexion. She was tender over L5 and S1. Slump test was positive on the right. She had a 40 degree straight leg raise on the right and a positive lasegue test compared with 80 degrees on the left.

[113] Dr Bell's impression was that she had a severe case of right sided sciatica.

[114] A follow up MRI showed a shallow right foraminal protrusion at L4/5 and a very small left para central extrusion at L3/4. There is no evidence of compromise to the cauda equina nerve roots or exiting nerve root structures to account for the patient's right sciatica.

[115] Unfortunately, there was a further accident event for the appellant on 29 January 2019. The description of accident on this occasion was:

> Hurt back while picking up frozen stuff from elevator which was left by the delivery guy.

[116] The GP notes of the same day record the following:

> Had problems with her back in the past. Works as a chef. This morning lifted frozen stuff from the elevator which was left by the courier and since has been having pain in lower back. Pain localised to lower back which is radiating into the right lower limb.
>
> …
>
> O/e
>
> Afebrile
>
> Tender in the lumbar region to palpation
>
> Restricted extension and lateral flexion. Forward flexion ok.

[117] The plan was for analgesia and she was advised to come back for review on the following Monday if not improving.

[118] She returned to her GP on 4 February 2019. The surgery notes record that her pain was worse and going down to her right leg. She was taking Naproxen, Codeine and Ibuprofen.

[119] The treatment plan included a referral to orthopaedics and potentially a further MRI and that she was to be off work for two weeks.

[120] A further MRI was undertaken on 13 February 2019 on this occasion there was no evidence of the disc protrusion at L3/4 from the earlier scan.

[121] As for the L4/5 disc, the report said:

> Prior scans have shown a right foraminal disc protrusion at this level, and this lesion is again seen as a subtle focal bulge in the annulus. It has not changed.

[122] The Radiologist Dr Davis suggested a further scan in two to three months. The report said that it is unlikely that the patient's symptoms relate to a signal abnormality noted at the L3/4 level.

[123] The appellant returned to her GP for an ACC 18 update and more pain killers, on 20 February 2019. She returned again on 25 February and reported she was getting minimum relief from Tramadol and Codeine. She reported that the pain started in her back and goes right down her right leg with numbness and tingling. She was unable to lift her leg into the car without physically lifting it with her hands.

[124] In further consultations, with her GP, through to July 2019, there is reference to ongoing pain and having to use crutches to mobilise.

[125] In the consultation of 25 June 2019, it is noted that apart from hip pain, she has pain in the coccyx area and the comment is recorded "but she feels like she hasn't explained it properly to the specialist as the pain is also noted at the back – tailbone area".

[126] She saw Mr Willoughby, and in his report of 5 June 2019, he notes:

> On examination today, she struggles to walk with two crutches. She has minimal movement of the hip either active or passive due pain. She is tender

> over the lower sacrum and coccyx. She is also tender over the trochanteric bursa. It is almost impossible to do any rotation of her hip due to pain. She is also tender anteriorly in the groin.
>
> X-rays of her hip had not been done that I can find. An MRI scan of her hip shows a labral tear that is quite extensive change with the labrum with a small para labral cyst. The cartilage of her hip looks well preserved. She may have some subtle reduced femoral head neck offset but no major cam lesion.

[127] Mr Willoughby then noted:

> She is desperate for pain relief. In the first instance I have arranged a steroid injection into her right hip which hopefully will afford her some pain relief and allow her a period of relief. They are very keen to have a labral repair which we have discussed today.

[128] On 14 June 2019, Dr Kevin Gilbert, Radiologist, carried out an ultrasound guided hip joint injection. De Gilbert noted:

> I note the patient is relatively debilitated by symptoms currently. I would be interested in your findings at operation if undertaken.

[129] Mr Willoughby saw the appellant again on 24 July 2019 and in his report said this:

> Snezana has returned following her steroid injection. This has given her almost 50% improvement in her pain, but a month following this injection, the effects have worn off and she is back to where she was. She remains very sore and rotation of her hip causes her pain.

[130] Mr Somerville reviewed her again on 1 August 2019. In his report, he said:

> Snezana was reviewed again today. She really is struggling now where previously she was able to stand reasonably comfortably for two hours, she is now limited to perhaps no more than 15 minutes. She is walking using bilateral elbow crutches with only a brief period of weight bearing on the right leg. She indicates that tip of the coccyx as the area of maximal discomfort.
>
> She is in a terrible state really, finding this increasingly frustrating and really does want to get back to her previous level of function and activity.

[131] Following this, she saw Dr Prestage on 22 October 2019. Following a comprehensive review of her file, an interview, and an examination of the appellant Mr Prestage concluded that her current diagnosis was uncertain with the L3/4 and L4/5 disc conditions as well as the labral right hip tear and central sensitisation, each

been considered. On 29 January 2019, Dr Prestage said it was more likely that the appellant suffered an aggravation of her pre-existing symptoms.

[132] Mr Willoughby reported again on 6 November 2019 saying:

> It remains my opinion that she has a labral tear in her hip which is likely to have been caused by her fall with a forced a flection plus or minus rotation injury to her hip at the same time. She has coccygial pain which is likely to have been by landing directly on her backside during this fall.

[133] On 19 November 2019, Dr Farnell tellingly says:

> I completely understand the confusion in diagnosis because of the ACC yellow flags, slightly poor English, physical findings and related pathology seen on imaging of the hip, particularly the effusion and swelling, I think make acute labral tear being symptomatic, this is the diagnosis which further treatment should be directed at.

[134] The reports continued. Some of the reports are of limited value given the prescriptive questions asked of the medical professionals by ACC. For example, the medical professionals were often asked to relate her then current presentation to for example her first accident event rather than to ask for an assessment of her injury or injuries arising from the three accidents.

[135] On 23 June 2020, Mr Willoughby carried out the labral tear repair in surgery.

[136] Mr Willoughby maintained the view throughout that her fall was adequate to cause a labral tear.

[137] Likewise, Mr Somerville in his report of 6 August 2020 was of the view that at that point the primary cause of her incapacity was likely to be coccydania arising from the fall of 13 July 2018. Mr Somerville said:

> To put in context her level of disability, prior to 2018, she was working as a chef full time. She attended a fitness centre two times a week, she would climb Mt Maunganui up to two times a week in the summer and was running twice a week.
>
> Subsequently, she is unable to drive. She is on regular Oxynorm and Tramadol, and she cannot sit for more than 30 minutes and is unable to work.

[138] Finally, there is the clinical advisory panel report of 7 October 2021.

[139] The panel agreed that the appellant's diffuse pain problems are unlikely to be coming from her back. It went on to say:

> There was no evidence of a causal link between any of Ms Stojicevic's ACC covered accidents and her various symptoms.

[140] The panel noted that there was no mention in GP clinical consultation notes of any right hip symptoms until 8 April 2019, some nine months after the 13 July 2018 accident.

[141] The panel agreed that her right hip labral pathology was most likely on gradual onset, not traumatic and not related to any of her ACC covered accidents.

[142] The size of ACC's file and the sheer number of referrals to and reports from medical experts in this case is testament to the fact that the issues involved with the case have been far from straightforward. Part of this has been due to the fact that there were discreet accidents on 28 June 2018, 13 July 2018 and 21 January 2019.

[143] I am reminded that at paragraph [67] of *Ambros*,[2] the Court of Appeal approves the earlier decision in *Smith v Auckland Hospital Board*[3] that, "Judges should ground their assessment of causation on their views of what constitutes the normal cause of events, which should be based on the whole of the lay, medical and statistical evidence and not be limited to expert witness evidence".

[144] In this case too, we have the added challenge that English is the appellant's second language and reference is made in the reports to the language issue possibly playing a part in the evaluation of the appellant's condition at various times.

[145] The appellant presents as fit, active and hardworking. I conclude that following the accidents, she had over the period of 7 months between June 2018 and January 2019, her primary objective to get well and to get back to work.

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2 See *Ambros* note 1.

3 *Smith v Auckland Hospital Board* [1965] NZLR 191 at 214 (CA) per McGregor J and at 220 per Gresson J.

[146] The medical specialist who knows most about her condition on a longitudinal basis is Mr Willoughby who performed the labral surgery. He had ongoing engagement with the appellant, and I find it significant that prior to her operation, Mr Willoughby reported on 24 July 2019, that a steroid injection provided the appellant with a 50% improvement of her hip pain.

[147] I acknowledge that on 3 September 2018, her GP declared her as fit for work. However, just over two months later on 12 November 2018, Dr Bell diagnosed a severe case of right sided sciatica. I conclude that the GP's record that she was fit for work on 3 September 2018 does not weigh sufficiently to displace the longitudinal investigations and conclusions reached by Mr Willoughby.

[148] Furthermore, I note that in the three consultations prior to that of 3 September 2018, the appellant has prescriptions of Voltaren, Tramal and Maxalon and Zopiclone. When the appellant returned to her GP on 6 November, the entry is:

> injured back in July 2018 and has never come right
> easily aggravated with minor things.
> Back again pretty sore
> …
> Taking Brufen already, no better
> Worse over the last couple of weeks again

[149] This sequence of consultations suggests that prior to her clearance, she was prescribed substantial pain relief medication and that her use of analgesia was ongoing. Accordingly, I do not accord her fitness for work finding of 3 September 2018 as decisive of the issue of whether at that stage she was pain free.

[150] I conclude therefore that all three accidents on 28 June 2018, 13 July 2018 and 29 January 2019 were each accidents causing injury which were coded lumbar sprains for the purposes of the 2001 Act.

[151] I find that each of these accidents in turn exacerbated the symptoms of the prior accidents.

[152] In respect of ACR 145/21, I find that the respondent's decision revoking a cover for a tear of the right hip was wrong.

[153] So far as ACR 92/21 is concerned, I find that ACC's decision of 30 September 2019 declining cover and surgery funding for a right hip labral tear was wrong and that on the basis of the evidence of Mr Willoughby, the appellant suffered a right hip labral tear as a result of the accident of 13 July 2018.

[154] So far as appeal ACR 144/21 is concerned, this was an appeal against a decision of 17 June 2020 revoking deemed cover for a disc prolapse with radiculopathy. In respect of this appeal, I find that the disc prolapse was not caused by the accidents in question. The evidence in respect of the state of her L3/4 and L4/5 discs has given way to the more compelling evidence relating to her labral tear and coccygial damage arising from the 13 July 2018 accident.

[155] Accordingly, the appeal is allowed in part.

[156] On account of the complexity of the matters before the Court and the numerous decisions made by the respondent relating to them, Counsel have leave to seek further clarification of the outcome as it affects ACC's decisions, should they need to do so. The Court's expectation is that such recourse will only be taken by counsel if after conference between them and impasse remains.

[157] Counsel also have leave to file memoranda relating to costs if these cannot be agreed between them.

Judge C J McGuire
District Court Judge

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