IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 150 **ACR 209/17 & 053/19**

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPEAL UNDER SECTION 149 OF THE ACT
BETWEEN	RAMARI HALBERT (aka RAMARI STIRLING) Appellant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Date of Hearing:	22 June 2022 (via AVL)
Appearance:	Appellant is self-represented with Ms Onekawa in support Mr Sumner for the respondent
Completion of evidence and memoranda:	22 July 2022
Date of Judgment:	29 July 2022

RESERVED JUDGMENT OF JUDGE DENESE HENARE
[Treatment Injury ss 20,26, 32 Accident Compensation Act 2001]

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[1] The appeals concern decisions of the Corporation declining cover for:

[i] plantar fasciitis and tendonitis and right peroneal tendon sprain/tendonitis as treatment injury said to have been caused by treatment; and

[ii] chronic regional pain syndrome (CRPS) as a consequential injury or mental injury said to have been caused by treatment.

[2] Ms Halbert claims her right leg was dropped during an examination and such treatment caused injury to her right ankle and foot. The Corporation does not dispute the examination is

treatment provided by a medical professional. However, the Corporation says the evidence does not support a leg dropping event and therefore treatment did not cause a personal injury, or any consequential injury as claimed.

Post hearing

[3] At hearing, gaps in the evidence before the Court were identified for the period May-August 2016 and from October 2016 to February 2017, together with a 2018 report said to have been prepared by Mr Rao, Orthopaedic Surgeon. Since Ms Halbert could not be represented by Mr Grove, lay advocate at hearing, the Court provided her with the opportunity to obtain further evidence, specifically:

[i] Prior general practitioner records from 2016 (a Doctor Bird from The Doctors Gascoigne in Hastings);

[ii] Details of change of name from Halbert to Stirling by way of an affidavit; and

[iii] A report she referred to from Mr Rao in or around 2018.

[4] The Court observes the name of Ramari Halbert is recorded on the Notice of Appeal prepared by Mr Grove, the signature of R Halbert appears on the Authority to Act and there is reference to R Stirling in some of the patient notes. The Court therefore takes notice of both names used interchangeably in the available evidence. Since the appeals were filed in the name of Halbert, reference will be made to this name in the judgment.

[5] The Court received evidence following hearing to support the fact that Ramari Halbert and Ramari Stirling are one and the same person. A signed statement from Ms Stirling was received on 15 July 2022 attesting to her life's circumstances, particularly the pain she has endured since an accident in 2005 and her interactions with the health system. In his memorandum dated 22 July 2022, Mr Sumner submitted, the Corporation and Counsel for the Corporation acknowledge the matters set out in the signed statement. The Court also acknowledges and empathises with Ms Halbert for her pain and suffering which she feels very strongly has impacted upon her physical and mental health wellbeing, and her overall enjoyment of life.

[6] These appeals are in the nature of a civil proceeding where the Court is required to make a decision on the claims for cover, applying principles of causation outlined by the higher courts, based on the available medical evidence.

[7] The following legal framework outlines the specific legal requirements.

Legal framework

[8] Under s20 of the Accident Compensation Act 2001 (the Act) there is an entitlement to cover for "personal injury." Section 20 relevantly provides:

> **20 Cover for personal injury suffered in New Zealand (except mental injury caused by certain criminal acts or work-related mental injury)**
>
> (1) A person has cover for a personal injury if—
>
> (a) he or she suffers the personal injury in New Zealand on or after 1 April 2002; and
>
> (b) the personal injury is any of the kinds of injuries described in section 26(1)(a) or (b) or (c) or (e); and
>
> (c) the personal injury is described in any of the paragraphs in subsection (2).
>
> (2) Subsection (1)(c) applies to—
>
> ...
>
> (b) personal injury that is treatment injury suffered by the person:

[9] The types of personal injury referred to in s26(1) include:

> **26 Personal injury**
>
> (1) Personal injury means—
>
> ...
>
> (b) physical injuries suffered by a person, including, for example, a strain or a sprain; or
>
> (c) mental injury suffered by a person because of physical injuries suffered by the person;
>
> ...

[10] Treatment injury is relevantly defined in s32 as follows:

> **32 Treatment injury**
>
> (1) Treatment injury means personal injury that is—

(a) suffered by a person—

...

(ii) receiving treatment from, or at the direction of, 1 or more registered health professionals; ..... and

(b) caused by treatment; and

(c) not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment, including—

(i) the person's underlying health condition at the time of the treatment; and
(ii) the clinical knowledge at the time of the treatment.

(2) Treatment injury does not include the following kinds of personal injury:

(a) personal injury that is wholly or substantially caused by a person's underlying health condition ...

(3) The fact that the treatment did not achieve a desired result does not, of itself, constitute treatment injury.

[11] In order for Ms Halbert to have cover under the Act, it must first be established there is a personal injury of a kind that is described in s 26(1). Here, a physical injury is required under s26 (1) (b).

[12] The primary question is whether treatment caused injury. The Courts have held it is first necessary to identify the physical injury with some precision.[1] Then a causal nexus must be established between that physical injury and the treatment.

[13] In *Ambros*[2], the Court of Appeal set out the principles on causation and the circumstances in which the Court may draw inferences as to causation:

> [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 ... 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 ...
>
> [70] ... The generous and unniggardly approach referred to in Harrild may, however, support the drawing of "robust" inferences in individual cases. **It must, however, always be borne in mind that there must be sufficient material pointing to proof of**

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1 *Accident Compensation Corporation v Studman* [2013] NZHC 2598; *Kliskey v Accident Compensation Corporation* [2007] NZACC 264.

2 *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340, at paragraphs [67] and [70].

causation on the balance of probabilities for a court to draw even a robust inference on causation. Risk of causation does not suffice.

[Emphasis added]

Issues

[14] The primary issues to be determined are

[i] Whether Ms Halbert's right leg was dropped during treatment; and if so

[ii] Whether treatment caused a personal injury; and if so

[iii] Whether consequential injuries were caused by treatment.

Issue one: Whether Ms Halbert's right leg was dropped during treatment

Background

[15] Ms Halbert underwent a whole person impairment assessment (WPI) by Dr Noonan, Occupational Medical Specialist on 27 May 2016 for her covered injuries relating to the lumbar spine and a sacroiliac ligament sprain caused by accident in 2005.

[16] Dr Noonan performed various examinations, including a straight leg raise examination of the lower extremities, and knee and ankle reflexes. He assessed Ms Halbert as having a 5% WPI rating for her covered injuries. There is no contemporaneous note from Dr Noonan that he dropped the right leg during the leg raise examination.

[17] On 18 July 2016, Ms Halbert consulted Dr Mabin GP. The patient notes of that consultation do not record a right leg dropping event. Rather, the consultation records Ms Halbert reporting "no one is listening to her re her back" and other issues arising from the back injury.

[18] In his patient notes dated 2 August 2016, Dr Gromer GP records the mechanism of injury "started when doctor lifted her leg up and let it fall down onto the bed and she hurt her ankle". Upon physical examination, he recorded skin normal and no swelling. Dr Gromer noted chronic pain syndrome and "no new injury to establish".

[19] In her review application challenging the WPI on 4 August 2016, Ms Halbert explained her positioning on the bed, the examination provided by Dr Noonan and the pain symptoms she experienced when her ankle hit the end of the bed following his dropping of her right leg. Ms Halbert stated:

> **On examination of my Work-Related injury, I was asked to hop on a bed lying on my back. Dr Noonan should have made sure I was high enough up the bed because when he told me he was going to raise my right leg to a 60 to70 degree angle. I naturally assumed he was going to catch it before it hit the end of the bed, but he didn't, and it came down so hard as soon as my ankle hit the bottom of the bed. It sent a sharp pain from my right foot straight to my Work-Related injury in my lower back, which arched to take the impact of my leg being raised, then I started crying uncontrollably even after the appointment was over. Is this how people with Chronic Back pain are supposed to be treated? My right leg foot has still not come right. I've had x-rays done on it because it keeps swelling up and is constantly bruised since 27 May 2016.**
>
> [Emphasis added]

[20] Dr Noonan reported on 2 September 2016 that he took no handwritten notes during the May 2016 assessment. He stated his practise is to dictate an opinion following consultation. He said the leg raise manoeuvre is controlled but it is plausible she may have sustained a minor contusion had he let her foot down very quickly which he did not think would have occurred. He stated:

> **I have looked at the examination couch (bed) in question and can confirm that although the end of this may be hard, there is no wooden board for her foot to strike. In my opinion, there is no possible biomechanical reason for this examination to cause an injury to the foot, let alone a perineal tendon strain or tendonitis and subsequent plantar fasciitis. It is perhaps plausible that she may have sustained a very minor contusion had I let her foot down very quickly at the end of the examination, but this is something I consider would not have occurred.**
>
> In conclusion, I believe this claim is not a biomechanically plausible cause of her described condition.
>
> [Emphasis added]

[21] On 27 April 2017, Dr Brown, Medical Advisor reviewed the file and commented:

> There are several factors to consider.
>
> **Firstly, the mechanism of injury. As noted above the intention of the SLR [straight leg test) is in assessing the range of maximum tolerable hip flexion. At no stage during this manoeuvre does the examining clinician relinquish support of the leg by the hand placed on the posterior ankle; until such time that the leg is returned, in a controlled supported fashion, back to a neutral position on the examination plinth.**

> **Other than due to collapse or loss of consciousness by the examiner, it seems inconceivable that the examiner would have intentionally or carelessly relinquished support of the leg, thus allowing the leg to drop. Even if such an event did occur, the normal active reflexive action by a conscious patient would be to elevate the hip flexors, preventing or controlling further descent of the leg...**
>
> A conscious patient would reflexively mitigate or minimise any uncontrolled descent of the unsupported leg by active hip flexion, and the standard examination plinth would usually provide adequate padding for all parts of the body in contact with the plinth, unless the claimant exceeded 1.80m in height.
>
> [Emphasis added]

[22] Dr Brown opined the mechanism of injury caused by treatment is "most unlikely". He reported no evidence of a contusion on file and opined it seemed unlikely Ms Halbert suffered a contusion or bruising of the heel.

[23] In the first review decision on 12 June 2017, the Reviewer held the evidence favoured Ms Halbert's leg was dropped during treatment. However, he found the evidence favoured the examination plinth on which the assessment took place was a padded plinth rather than directly on to a piece of wood at the end of the bed. The Reviewer directed the Corporation obtain an independent expert opinion whether a likely physical injury was sustained.

Discussion

[24] Mr Sumner submitted the medical evidence does not support a finding Ms Halbert's leg was dropped by Dr Noonan during his May 2016 treatment.

[25] Mr Sumner submitted in the event the Court finds Ms Halbert's leg was dropped for reasons identified by the Reviewer, it is implausible Ms Halbert struck her right foot on a wooden board because Dr Noonan, Dr Brown and Mr Brownlee all confirmed the wooden base of the examination plinth is lined with padding and vinyl.

[26] The Court takes into account the lack of contemporaneous notes about the leg being dropped does present evidential difficulties, including that Dr Mabin in July 2016 did not mention such accident in his patient notes or any issues relating to her right foot or ankle.

[27] The Court also takes into account the evidence of the medical specialists that have commented on the mechanics of a straight leg raise manoeuvre, including Mr Brownlee, Dr Murphy, Mr Pai and Dr Callaghan, who considered it was unlikely or implausible for

Dr Noonan to have dropped Ms Halbert's leg. Dr Brown opined that it would be "inconceivable" the examiner would intentionally or carelessly relinquish support of the leg, allowing it to drop. Further, Dr Noonan is an experienced assessor with the evidence showing he had been performing the straight leg raise manoeuvre for many years.

[28] Notwithstanding these considerations, by a margin this Court is inclined to adopt the finding of the Reviewer at the first review that Ms Halbert's leg was dropped in the assessment. The Reviewer did not find that her right foot hit a wooden board located directly under the lip of the vinyl plinth of the bed during the examination. However, this Court has viewed the photographs of the assessment bed taken at the premises where the assessment was provided. Whilst the top of the bed is a vinyl covered plinth, there is a wooden board directly below the lip of the bed. The Court is therefore prepared to accept Ms Halbert's right ankle contacted this wooden board following the leg drop, for the reasons that follow.

[29] First, this Court has no reason to discount the evidence of mechanism of injury from Ms Halbert and Ms Onekawa who was present at the examination and who provided a signed statement at review. Ms Onekawa also confirmed the right ankle contacted "the wooden end of the bed." Both Ms Halbert and Ms Onekawa were present at review. The evidence of Ms Halbert and Ms Onekawa were not directly challenged, a point made by the Reviewer at the first review.

[30] Secondly, Dr Noonan's evidence does not entirely refute the fact he may have dropped the right leg. His evidence is the leg raise examination is a controlled manoeuvre. However, he said "it is perhaps plausible that she may have sustained a very minor contusion had I let her foot down very quickly at the end of the examination, but this is something I consider would not have occurred". Further, he said there was no wooden board for her foot to strike.

[31] Thirdly, there are no direct handwritten contemporaneous notes in evidence from Dr Noonan. Rather, his evidence appears more focussed on the question of injury rather than mechanism when he noted "this claim is not a biomechanically plausible cause of her described condition".

[32] Fourthly, the evidence of mechanism of the medical specialists is predicated on what normally would have happened in a straight leg raise examination rather than any direct

knowledge of what actually took place. The evidence of Ms Halbert and Ms Onekawa appears simply discounted.

[33] Fifthly, photographs of the assessment bed show it is vinyl padded with a wooden board located directly underneath the end of the bed. Ms Halbert's evidence is she lay lower on the bed and as a result her right ankle hit the wooden section under the lip of the bed.

[34] Sixthly, the Reviewer at the first review heard the evidence of mechanism directly from Ms Halbert.

Conclusion

[35] The Court adopts the finding of the Reviewer at the first review and concludes by a margin Ms Halbert's right leg was dropped during the straight leg raise examination and her right ankle hit the wooden board under the lip of the assessment bed.

Issue two: Whether treatment caused a physical injury

The case for the appellant

[36] In his written submissions, Mr Grove submitted

[i] The treatment on 27 May 2016 caused plantar fasciitis and tendonitis, and right peroneal tendon sprain/tendonitis injuries.

[ii] Mr Grove submitted the reports of Mr Pai, Dr Murphy and Dr Callaghan are dismissive of Dr Jessop's diagnosis of plantar fasciitis. Mr Grove submitted there was an initial soft injury involving inflammation of the plantar fasciitis and tendonitis as explained by acute pain from the Achilles enthesopathy. This was then overlaid by "the renewal" of existing chronic pain symptoms caused by the 2005 injury which developed into a complex regional pain syndrome.

[iii] Mr Grove submitted the evidence of Dr Jessop GP and pain specialists, Dr Tong and Dr Eccles support the case for the appellant.

[37] Ms Halbert's signed statement refers to the radicular pain she experienced up the leg to her lower back and the swelling of her right foot and bruising at the back of her ankle.

Background

[38] On 2 August 2016 Dr Gromer arranged an x-ray noting indications of "ongoing pain in right ankle following fall 2 months ago" that "radiated up the right leg to the hip region." He noted no injury. Dr West, Radiologist reported the x-ray findings the next day which noted no significant soft tissue swelling, no fracture or dislocation. However, Dr West reported a calcified enthesophyte at the insertion of the Achilles.

[39] A claim for cover for a right foot injury was lodged by Dr Jessop, GP following consultation on 12 August 2016. She reported pain in the right lateral foot and around the heel as a result of the assessment in May 2016. She noted the x-ray showed no problem and there was minimal swelling. Dr Jessop questioned whether an injury occurred when she wrote "confirmed? plantar fasciitis and tendonitis". Notwithstanding this uncertainty, Dr Jessop filed a treatment injury claim (in the family name of Stirling/Halbert) on the same date as the consultation, recording the condition of "R foot peroneal tendon sprain/tendonitis and R foot plantar fasciitis", of which she expressed uncertainty. Dr Jessop noted the absence of contemporaneous notes and that "I cannot confirm this with any reports in her notes from ACC".

[40] On 18 August 2016, Dr Gromer reported Ms Halbert presented with pain to her right hindfoot area and she was walking on crutches. He questioned whether there was a condition of "spondyarthritis? with peripheral enthesopathy?"

[41] Some twelve days later, Dr Gromer reported no real difference in swelling between both the right and left ankle. He queried whether a complex chronic pain syndrome was present. Dr Gromer reported his clinical findings to the Corporation on 2 September 2016 of minor swelling of the right foot compared to the left foot, and impaired range of movement in the ankle "but this was difficult to test". He reported chronic pain syndrome and allodynia. Dr Gromer commented that his clinical findings might be due to trauma in May, but he was uncertain. He did not identify a specific injury. He stated:

> … in her very specific situation **the minor trauma** (which usually wouldn't let us exspect (sic) these massive deterioration) **might be related to the trauma experienced in May.**
>
> [Emphasis added]

[42] Dr Turei, Radiologist reported ultrasound findings on 25 August 2016 that the lateral part of the right ankle was normal. He concluded there was an Achilles enthesopathy without tear, and both the ankle and plantar fascia anatomy were normal.

[43] In his patient note on 30 August 2016, Dr Gromer queried whether Ms Halbert had complex chronic pain syndrome. He stated:

> No findings explaining her pain. Ramari upset with that, emphasised that this is not discounting, just that no explanation found. Ramari so upset that she left the room (not using crutches, just running out of the room).
>
> D/with her caregiver who stayed: this problem can't be solved here in the practice, what I can do for Ramari is trying to find a way and then making the appropriate referrals…..
>
> Needs to see pain specialist to d/her use of medication…..

[44] Dr Noonan's report of 2 September 2016 acknowledged a minor contusion might have been sustained but it was "biomechanically implausible" that treatment caused plantar fasciitis and tendonitis.

[45] On 27 September 2016, following medical advice from Dr Brown, the Corporation issued the first decision declining the claim because it did not meet the criteria for a treatment injury.

[46] On 10 October 2016 Ms Halbert presented at the emergency department at Hawkes Bay hospital. The discharge summary records chronic back pain and chronic right ankle pain/strain. However, no diagnosis of injuries could be made having regard to the x-ray and ultrasound findings. The report notes:

> .. chronic back pain p/w **chronic R ankle pain. Hit corner of the bed with R lateral foot, swelling has never gone down since May. Continues to have pain and no diagnosis despite XR, US.** On morphine and gabapentin for back injury and also on nortriptyline and no relief of pain. … GP referred to ortho when she saw him last week.
>
> [Emphasis added]

[47] Ms Halbert underwent an MRI scan of her right ankle on 8 February 2017. On the same date, Dr West, Radiologist reported his findings of the pathology were "normal":

> Comparison is made with previous plain radiograph from August 2016
> The talar dome is intact
> Normal appearances of distal tibia and fibula
> Intact medial and lateral collateral ligaments
> Intact distal syndesmofic ligaments
> No ankle effusion
> Normal appearances of posterior subtalar joints
> Normal appearance of flexor and extensor tendons
> Normal Achilles tendon, plantar fascia and sinus tarsi
> Normal bone marrow signal

[48] Dr West concluded there was "no cause for the patient's symptoms demonstrated".

[49] On 28 February 2017, Dr Tong, Pain Specialist, assessed Ms Halbert and reported she had been referred by Mr Bernard, Psychologist who expressed concerns she had a complex regional pain syndrome. Dr Tong reported:

> Ramari presents with a nine month history of right ankle pain. This started after her foot was dropped during a physical examination striking the edge of the examination bed. She was being assessed by medical assessor for ACC. She sustained a bruising and swelling in posterior aspect of her ankle. Over the last nine months the swelling and pain has been ongoing. Associated with this was colour changes involving the foot, allodynia and a feeling of cold sensation ...
>
> ... **She has been investigated with an MRI of the ankle which did not show any structural lesions. Examination today is consistent with a diagnosis of complex regional pain syndrome ...**
>
> ... **CRPS is a poorly understood pain condition where the most pronounced symptom is pain and is usually out of proportion to the inciting event. In many cases the inciting event can be quite minor. There is no specific investigation to diagnose CRPS and is a clinical diagnosis ...**
>
> ...The current understanding is that CRPS is a disease of the nervous system but unfortunately a clear and concise explanation remains elusive. The mechanisms thought to contribute to this condition include changes at the small nerve that sends the message to the brain, sensitization where there is amplification and spread of the pain signal, altered autonomic nerve activity, inflammatory process and neuroplastic changes that happen in the brain.
>
> [Emphasis added]

[50] In April 2017 Dr Brown referred to Dr Gromer's report of "pain in the right ankle, radiating up the whole right leg to hip region", and opined this pattern is "much more likely to be radicular nerve pain in origin, as consistent with [Ms Halbert's] known chronic lumbar back pain. In other words, pain arising in the spinal region and radiating into the leg".

[51] On 13 July 2017, Mr Pai, Orthopaedic Specialist, conducted a file review noting he could not confirm any physical injury had occurred. Mr Pai opined that:

> Following any structural new pathology from an injury event, pain is going to be instantaneous and dramatic with pain being much more on the following day. It is common practise in the presence of significant pain to see a doctor either on the same day or within a week, but from the documents provided this is not the case. There is no indication that [the appellant] was limited due to her right foot between 27/05/2016 to 02/08/2016 from the documents available to me.

[52] Reviewing the history, clinical cause, x-ray and ultrasound imaging, Mr Pai concluded there was no objective structural pathology to support an acute injury.

[53] On 21 July 2017, the Corporation issued a second decision declining a physical injury caused by treatment.

[54] At the second review on 15 February 2019, the Reviewer upheld the second decision on the basis there was no evidence to support a physical injury caused by an acute event.

[55] On 20 December 2017, Mr Brownlee, Orthopaedic Surgeon, noted Ms Halbert had reported bruising on the heel. However, Mr Brownlee opined there was no contemporaneous evidence of bruising. He commented:

> **Symptoms have been evidently activated by the injury event, but the underlying degenerative tendinopathic process and not the traumatic event, is causative. The clinical evidence supports a pre-existing tendinopathy, and the proposal that a direct contusion event, as described, is causative, is not in my opinion plausible.**
>
> [Emphasis added]

[56] Mr Brownlee noted that at the time of presentation, x-rays of the heel had been undertaken which showed a calcified enthesophyte at the Achilles tendon insertional area. The ultrasound also demonstrated Achilles enthesopathy without any Achilles tendon tear. Mr Brownlee opined:

> **Neither of these radiological features would conceivably have been the consequence of a direct contusion to the heel/lower Achilles tendon ten weeks previously. These changes would be expected to take many months to become evident. They are features of long standing age related degenerative Achilles insertional tendinopathy. This is a common condition. Symptoms have been evidently aggravated by the injury event, but the underlying degenerative tendinopathic process and not the traumatic event, is causative.**
>
> [Emphasis added]

[57] Dr Eccles, Pain Management specialist assessed Ms Halbert on 12 January 2018 and reported since consultation a couple of years prior, Ms Halbert had developed CRPS "after a leg injury sustained during the course of a physical examination". Dr Eccles did not describe the nature of the leg injury. Dr Eccles noted the markers of CRPS at the time of the assessment, were temperature and colour alteration compared to the non-affected side. Dr Eccles stated CRPS is a clinical diagnosis.

[58] Dr Lee, Radiologist reported an x-ray of the right ankle on 12 February 2018 and the following findings:

> Soft tissue swelling inferior and medial to the medial malleolus. The medial aspect of the navicular demonstrates cortical indistinctness, which may be due to underlying erosion. Further evaluation with MRI suggested.
>
> No joint effusion.
>
> No acute fracture. Small plantar and calcaneal spurs.

[59] Dr Eccles reported again on 16 March 2018:

> ... **she has ongoing foot and ankle pain after this injury almost two years ago now. She has always had symptoms consistent with a CRPS of that foot and ankle since that incident.**
>
> Whilst she feels that there has been no progress since I last saw her, the foot looks essentially the same as her unaffected side today. Therefore, there were no differences in colour or temperature that were obvious today. The foot was not swollen this morning ...
>
> **She continues to be concerned that there are some underlying injuries which are driving her symptoms and so I have organised an ultrasound to exclude any sinister pathology. I have told her that I expect this to return a normal result.**
>
> [Emphasis added]

[60] An MRI scan of the right ankle was reported by Dr Turei on 9 May 2018:

> **Findings**
>
> The tibialis posterior, flexor hallucis longus and flexor digitorum tendons are intact with no tear or tendinosis identified. Trace of fluid about the tibialis posterior tendon, within normal physiological limits.
>
> The peroneus previous and longus tendons are intact.
>
> The anterior talofibular and anterior inferior tibiofibular ligaments are deficient.
>
> No ankle joint effusion.
>
> **Conclusion**
>
> Deficient anterior talofibular and anterior inferior tibiofibular ligament suggest chronic rupture.

Intact tendons about the ankle.

No effusion or synovitis about the ankle joint.

[61] Dr Eccles reported again on 22 June 2018 and supported the diagnosis of CRPS and that Ms Halbert "had an injury in 2016… resulting in CRPS". However, Dr Eccles did not say what the injury was in 2016 or provide medical reasoning CRPS was caused by the unidentified injury.

[62] Dr Murphy, Sport and Exercise Medicine Specialist, reported on 5 September 2018. He referred to the x-ray of 2 August 2016 and opined there was no evidence the enthesophyte was caused by the event of May 2016. He went into great detail about the nature of the enthesophyte and plantar fasciitis:

> **The presence of an enthesophyte suggests a chronic long-term process which occurs without the need for trauma.**
>
> The timeframe between the alleged injury event on 27/05/2016 and the x-ray on 02/10/2016 is far too short for the emergence of an enthesophyte as a consequence of trauma. Enthesophytes typically take years to occur in response to a chronic inflammation or irritation or traction stress. In the event that injury may have been a causative factor, this would typically need to be significant trauma with ongoing evidence of injury and inflammation at the site where the enthesophyte formed.
>
> In this case, **the client had numerous investigations at various points in the timeline, and none of these (including significantly the x-ray of the right ankle) show any evidence of any acute, semi acute or chronic injury to the site of enthesophyte.**
>
> **This makes the suggestion that the enthesophyte was caused by the event of 27/05/2076 implausible.**
>
> [Emphasis added]

[63] Dr Murphy concluded there is no evidence of plantar fasciitis, nor any evidence the plantar and calcaneal spurs were caused by the event on 27 May 2016. He commented plantar fasciitis is a gradual process degenerative condition of the plantar fascia origin and is not an accident or injury related condition.

[64] Dr Murphy also commented on the trace of fluid about the tibialis posterior tendon noted on the ultrasound of 9 May 2018, which was within normal physiological limits noted by Dr Turei. He opined this is not evidence of actual harm or damage to the body and is a common and normal finding in an ultrasound. He concluded there is "absolutely no evidence" that the cause of this fluid is related to any accident or injury process.

[65] In relation to the deficient talofibular and anterior tibiofibular ligament noted on the MRI of 9 May 2018, Dr Murphy explained:

> These ligaments can be injured when an ankle sprain or worse injury occurs. The mechanism by which these two distinct ligament injuries occur is typically different, implying that there may have been two accident related conditions to the ankle at various times in the past. The noted deficiency of these suggests the possibility of a longstanding (or historical) accident or injury episode ...
>
> ...**There is no evidence to suggest that either of these ligament injuries occurred on 27/05/2016. To rupture either of these ligaments requires a significant force mechanism of injury, which would have undoubtedly been noted had it occurred at some stage. More specifically in this case, the alleged mechanism of injury by which a straight leg raise test being performed may have led to a leg being dropped would not be a mechanism by which either of these ligaments could have been injured. This is not plausible**...
>
> ...As the ultrasound report of 09/05/2018 noted, the deficiency of these ligaments does suggest chronic rupture being an injury- related phenomena. **It would reasonably be considered more likely that the chronic rupture of these ligaments would be related to an accident or injury related process as opposed to simply being age related, or a gradual process condition. With that said the mechanism of injury by which the client alleges a treatment injury has occurred, is not a mechanism by which such an injury could have occurred.**
>
> [Emphasis added]

[66] Dr Murphy concluded there was no evidence to indicate Ms Halbert suffered an acute physical injury on 27 May 2016. Furthermore, he opined the clinical and radiological information collected at the time and subsequently, gives no indication of an acute injury as having occurred on this date that would have led to any subsequently identified pathological conditions.

[67] On 15 February 2019, the Reviewer, upheld the Corporation's second decision on the basis there was no evidence to show the existence of an identifiable physical injury which caused CRPS.

New evidence on appeal

[68] Dr Callaghan, Clinical Adviser reported on 19 March 2020 that she could not "reconcile" Dr Jessop's clinical diagnosis of plantar fasciitis and tendonitis on the injury claim form, as the "plantar fascia is not a tendon and so there can be no plantar tendonitis". Dr Callaghan also referred to the diagnosis of right peroneal tendon sprain/tendonitis on the treatment injury claim form. Dr Callaghan commented the "peroneal tendons travel from the

calf around the outside of the ankle and into the foot and are not anatomically related to the attachment of the plantar fascia into the heelbone (the calcaneus)". Dr Callaghan supported the opinions of Dr Brown, Mr Pai, Dr Murphy and Mr Brownlee.

[69] Dr Callaghan discussed the mechanics of leg dropping in a straight leg raise test as follows:

> **If a leg was dropped during a clinician-led straight leg raise test, it would likely be the posterior aspect of calcaneus that would impact the plinth. The plantar aspect of the calcaneus/attachment of the plantar fascia would not connect with the plinth - unless, and as noted by Dr Brown, the knee was flexed (bent) - which it is not in the picture provided by the advocate as discussed below.**
>
> I note the picture provided by the advocate (EOS 25/10/18). This also clearly shows the posterior aspect of the lower limb impacting the plinth — the plantar aspect is off the plinth. As best I understand the picture provided by the advocate, the picture shows that after the posterior aspect of the heel hit the plinth, Ms Halbert's foot then rotated laterally.
>
> Due to the nature of the joints in the lower limb (unless there is gross disruption of the ankle joint), when the foot everts (rolls laterally) beyond its natural resting position, the hip must also rotate (roll outwards) and the knee flex (bend).

[70] Dr Callaghan concluded the May 2016 treatment did not cause a personal injury on the basis that plantar fasciitis and peroneal sprain/tendonitis could not have been caused by the mechanism of accident described, and the contemporaneous notes do not support any other diagnoses that would be caused by the event. Dr Callaghan concluded while a weak temporal association is identified, this is insufficient to suggest the cause of the CRPS can be causally linked to the May 2016 event. Dr Callaghan stated Ms Halbert met the diagnostic criteria for a complex regional pain disorder at her consultation with Dr Tong in February 2017. However, CRPS would not be described as a mental injury

[71] Mr Sumner requested further comment from Dr Callaghan in relation to the differences between CRPS and complex regional pain syndrome, and why CRPS would not be described as a mental injury.

[72] Dr Callaghan reported on 21 August 2020:

> Complex Regional Pain Syndrome is a formal diagnostic entity recognised by the International Association for the Study of Pain. It has formal diagnostic criteria — the Budapest Criteria.
>
> None of the above apply to chronic regional pain syndrome. It is a non-specific (and hence inconsistently used) descriptor term only ...

> ... Complex Regional Pain Syndrome is not an Axis I psychiatric disorder according to categorical systems such as DSM-IV/DSM-5 or ICD — 10. The diagnostic criteria (previously provided) are not psychological or psychiatric in nature and they do not represent clinically significant behavioural or cognitive dysfunction.
>
> Please note, an individual with a Complex Regional Pain Syndrome may have co-existing, preceding or consequential psychological or psychiatric conditions.

[73] In a letter to Dr Callaghan dated 31 August 2020, Mr Grove (former advocate for Ms Halbert) noted the following in respect of Dr Callaghan's report of 19 March 2020:

> We are surprised and concerned that you have accepted without question this illustrated report which has clearly provided misleading and incorrect medical facts concerning the region of the underfoot occupied by the plantar structures, which includes the first branch of the lateral plantar nerve which is immediately adjacent to the heel. The illustration of this is attached for your information. All, of this appears reinforce (sic) the accuracy of the original GP diagnosis on the ACC 45 and calls into question why successive medical opinions from Dr Brown, Murphy and Brownlee fail to take into account the correct region occupied by the plantar structures, in relation to the heel and the medial calcaneal branch nerve nearby.

[74] Mr Grove attached various Google search illustrations of the "Achilles enthesopathy of right foot" and a journal page article with a chart discussing additional aetiologies of heel pain. Mr Sumner subsequently sought comment from Dr Callaghan in response to Mr Grove's letter.

[75] Dr Callaghan reported on 6 September 2020:

> Mr Grove has suggested that I, Dr Brown, Dr Murphy and Mr Brownlee have provided incorrect information about the anatomy of the plantar structures. Mr Grove notes the first branch of the lateral plantar nerve. He then concludes that "[all], of this appears reinforce the accuracy of the original GP diagnosis ..."
>
> The GP's original diagnosis was plantar fasciitis and tendonitis.
>
> Another diagnosis that was raised was R foot peroneal tendon sprain/tendonitis.
>
> Mr Grove has sent multiple illustrations from a google search of "Achilles enthesopathy of the right foot". Dr Murphy has provided comprehensive comment on enthesopathy.
>
> Mr Grove has also sent a page from a journal article with a chart discussing additional aetiologies of heel pain. There is some text as well as a figure noted "in chronic neurologic heel pain, both the medial calcaneal nerve branches and the first branch of the lateral plantar nerve may be implicated".
>
> Unfortunately, I am unclear about the specific nature of Mr Grove's concern and any relevance of the first branch of the lateral plantar nerve. A nerve is a different anatomical structure from a fascia or a tendon. The first branch of the lateral plantar nerve is not part of the aetiology of plantar fasciitis or peroneal tendon sprain/tendonitis or Achilles enthesopathy.

> **The first branch of the lateral plantar nerve can become entrapped - a condition known as Baxter's neuropathy. I have seen no information suggesting that Ms Halbert has been diagnosed with Baxter's neuropathy and the accident mechanism would not lead to this condition.**
>
> [Emphasis added]

Discussion

[76] There is no doubt the evidence shows Ms Halbert experienced severe pain from her back injuries and she was diagnosed with CRPS prior to the May 2016 treatment. Mr Grove's written submissions suggest treatment aggravated the existing back pain symptoms. Mr Grove submitted:

> ... the fact that Ramari had that pre-existing pain then impacts itself on the GP assessment in August 2016 [sic]... there was a complex pain scenario that she was dealing with and there was pain down in the heel ... **So when the leg was dropped, it aggravated pain symptomology which was highly confusing because the pain syndrome meant that pain was down the leg, it was right down to the heel but not confined to the heel that had the effect of masking the source of the injury.**
>
> [Emphasis added]

[77] The question is whether there is an identifiable physical injury caused by the treatment performed by Dr Noonan. The decision in the case rests ultimately on the weight to be given to the medical evidence. Pain by and of itself does not constitute a physical injury. Pain may be symptomatic of an underlying physical injury, however, that is not necessarily so. The physical injury must first be identified with some precision.

[78] The difficulty for Ms Halbert is the medical evidence before the Court overwhelmingly shows no identifiable physical injury caused by the treatment. While the treatment likely aggravated a pre-existing condition of Achilles enthesopathy and accelerated the pre-existing pain symptomology, treatment did not cause injury for the reasons that follow:

[a] Ms Halbert was provided with the opportunity to obtain contemporaneous medical evidence from her GP. This evidence has not been produced. Mr Sumner submitted the Corporation has not located or identified any evidence that would support claims of a personal injury caused by the treatment of May 2016. Further, the Corporation does not hold any GP records or reports from Mr Rao;

[b] The patient notes of Dr Mabin on 18 July 2016, two months after treatment, make no mention of the treatment or symptoms or injury to the foot or ankle.

Furthermore, Dr Mabin does not report any bruising that would support a contusion to the foot or ankle;

[c] While Dr Gromer recorded pain in the foot, his patient notes of 2 August 2016 are clear there is "no new injury to establish";

[d] There is no report of swelling or bruising by Dr Mabin and Dr Gromer. Dr Tong's opinion that Ms Halbert had "sustained bruising and swelling in the posterior aspect of her ankle" is not based on any contemporaneous or objective medical evidence. Even if swelling was reported as at the date of treatment or immediately thereafter, swelling is not a physical injury, being commonly recognised as a symptom;

[e] Dr Jessop's differential diagnosis of plantar fasciitis and tendonitis on the injury claim form dated 12 August 2016 was not subsequently confirmed by radiological imaging. Dr Jessop simply questioned whether plantar fasciitis and tendonitis were possible diagnoses. This uncertainty is why she referred Ms Halbert for imaging;

[f] The x-ray of 3 August 2016 and ultrasound of 25 August 2016 were reviewed by Drs West, Turei, Brown, Murphy, Mr Pai and Mr Brownlee who opined the imaging shows no objective acute structural pathology basis of an acute injury;

[g] "Blunt trauma to calcaneus. Painful proximal fascia and later ankle" were recorded only as possible clinical indications by Dr Jessop. However, these conditions were not confirmed in the imaging findings of Dr Turei. Rather, the ultrasound showed an underlying condition of "Achilles enthesopathy, but without a tear." Dr Turei reported "the remaining ankle and plantar fascia anatomy are normal, intact plantar fascia", indicating normal plantar fascia;

[h] The orthopaedic surgeon, Mr Brownlee, reported that neither of the radiological features on the August 2016 x-ray and ultrasound "would conceivably have been the consequence of a direct contusion to the heel/lower Achilles tendon ten weeks previously". Rather, Mr Brownlee considered these were "features of long standing age-related degenerative Achilles insertional tendinopathy";

[i] Dr Murphy supported the opinion of Dr Brownlee that the presence of an enthesophyte suggests a chronic long-term process which occurs without the need for trauma. He explained in considerable detail that the calcaneal spur seen on the x-ray in August 2016 is an interchangeable term with enthesophyte. They take a considerable time to form and may be associated with the presence of plantar fasciitis which is a chronic stress or degenerative process. He discussed plantar fasciitis is not considered an injury related condition, regardless if it is present, but occurs in consequence of longstanding use or overload. Plantar fasciitis is a degenerative condition.

[j] Dr Murphy opined there was no evidence to indicate an acute personal injury was caused by treatment on 27 May 2016. Dr Murphy opined that none of the investigations conducted "(including most significantly the x-ray of the right ankle) show any evidence of any acute, semi acute or chronic injury to the site of the enthesophyte". Dr Murphy commented the suggestion that the enthesophyte was caused by the accident is "implausible";

[k] Whilst focussed on pain, Dr Tong and Dr Eccles speculated as to possible conditions but did not identify a discrete physical injury or the nature of that injury.

[79] Against these factors is a diagnosis by a registrar some five months after the May 2016 treatment of ankle strain/sprain referred to in the discharge report by the Hawkes Bay Hospital. There is no medical reasoning to support such diagnosis. The diagnosis is outlier and not supported elsewhere in the medical evidence.

Conclusion

[80] The possible diagnosis of plantar fasciitis and tendonitis by Dr Jessop has not been carried forward by any of the medical specialists who have since provided comment on this matter or supported by the imaging. While Dr Tong and Dr Eccles recorded that an injury arose from treatment, neither specialist identified any discrete physical injury or changes in the structural pathology to support a physical injury.

[81] Whilst the Hawkes Bay hospital diagnosed a soft tissue sprain to the ankle, the hospital discharge summary does not provide medical reasoning to support any causal nexus to the May 2016 treatment.

[82] Dr Callaghan reported she could not "reconcile" the diagnosis of plantar fasciitis as the "plantar fascia is not a tendon so there can be no plantar tendonitis". Dr Callaghan noted the "peroneal tendons travel from the calf around the outside of the ankle and into the foot and are not anatomically related to the attachment of the plantar fascia into the heelbone (the calcaneus)". Dr Callaghan's evidence unequivocally shows the diagnoses of plantar fasciitis and peroneal tendonitis could not have been caused by treatment.

[83] Standing back and considering all the evidence, I conclude the opinions of the orthopaedic surgeons are overwhelming. Mr Brownlee, Mr Murphy and Mr Pai have provided comprehensive medical reasoning that no physical injury was caused by treatment. As Mr Brownlee opined, the radiology in August 2016 reported features of Achilles enthesopathy, a pre-existing condition. At best, the treatment in May 2016 aggravated symptoms arising from the pre-existing pain condition and as well it aggravated an ongoing degenerative process of the Achilles enthesopathy, but it did not cause a new physical injury.

[84] The imposition of the added stress was an accelerating factor that does not attract cover under the Act.

[85] While the Court has sympathy for Ms Halbert's plight, this is not a matter where, on the balance of probabilities, the evidence is robust to support causation. Risk of causation does not suffice, as held by the Court of Appeal in *Ambros*.

[86] For these reasons, the Court is satisfied the requirements for a physical injury caused by treatment have not been established in this case.

Issue three: Whether consequential injuries were caused by treatment

Discussion

[87] Since the Court has found there was no physical injury caused by treatment, there is no need to consider the claim for CRPS as a consequential or mental injury. However, for the sake of completeness, I turn to consider this issue.

[88] At the outset, the High Court held in *Studman*,[3] that CRPS does not constitute a physical injury under the Act, because pain of itself is not a physical injury.

[89] The available evidence shows CRPS is not the same as complex regional pain syndrome which was diagnosed by Dr Tong. Complex regional pain syndrome differs from chronic regional pain syndrome (CRPS) and are terms which cannot be used interchangeably in Dr Callaghan's opinion.

[90] Dr Eccles stated CRPS is a clinical diagnosis and is not classified as a mental injury.

[91] This view is supported by Dr Callaghan's evidence that CRPS is "not an Axis 1 psychiatric disorder according to categorical systems such as DSM-IV/DSM-5 or ICD-10. The diagnostic criteria are not psychological or psychiatric in nature and they do not represent clinically significant behavioural or cognitive dysfunction". Dr Callaghan noted that a person with CRPS may have co-existing, preceding or consequential psychological or psychiatric

[92] Dr Callaghan is the only medical specialist who raises Baxter's neuropathy. However, Dr Callaghan noted that there was no information supporting Baxter's neuropathy.

[93] The Court accepts the weight of the evidence does not meet the causation requirements on the basis that no physical injury has been identified, and there is no evidence that CRPS was caused by the treatment.

[94] Mr Grove submitted *Walker*,[4] applies. Here, the Court held the appellant was entitled to cover for CRPS as a treatment injury following surgery on her right foot. In that case, the appellant sustained a physical injury, being nerve injury, in the course of surgery. The type of injury was rare and therefore not an ordinary consequence of the treatment. The facts of *Walker* are distinguishable from this appeal as no physical injury is established as a result of the treatment.

[95] The Court is satisfied there is no evidence of any consequential or mental injury caused by the event of May 2016.

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3 *Studman v Accident Compensation Corporation* [2014] NZHC 574.
4 *Walker v Accident Compensation Corporation* [2020] NZACC 192.

[96] Mr Grove submitted the covered physical injury in 2005, being pain in the lumbar spine, led to CRPS. The Court records if Ms Halbert wishes to progress this argument, the correct approach is to bring a claim for cover for CRPS as a result of the 2005 accident with supporting evidence.

Conclusion

[97] CRPS is not an Axis 1 psychiatric disorder. Further, the evidence does not support cover for a mental injury under the Act because there is no evidence to support a physical injury caused by treatment.

Decision

[98] The Court has every sympathy for Ms Halbert. However, the appeals cannot succeed for the reasons set out in this judgment. The weight of the available medical evidence does not identify any physical injury caused by the treatment in May 2016, or that the claimed injuries of plantar fasciitis and tendonitis, right peroneal tendon sprain/tendonitis were caused by trauma or that CRPS is a consequential or mental injury.

[99] The Court finds while it is prepared to accept the right leg was dropped during treatment and the right ankle hit the wooden board, the weight of the evidence shows at best treatment likely aggravated pre-existing conditions but did not cause a physical injury and therefore personal injury under the Act, or consequential or mental injuries.

[100] Accordingly, the Court is satisfied:

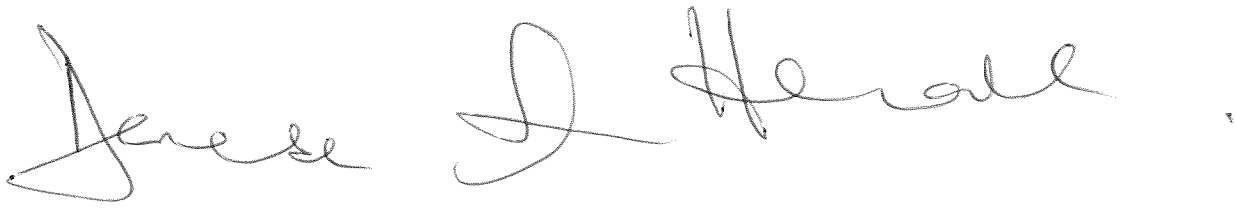
[a] No physical, and therefore no personal injury was caused by treatment on 27 May 2016;

[b] No mental injury or consequential injury or injuries were caused by treatment on 27 May 2016; and

[c] CRPS is not an Axis 1 psychiatric disorder and was not caused by treatment on 27 May 2016.

[101] The appeals are dismissed.

[102] There is no issue as to costs.



Judge Denese Henare
District Court Judge

Solicitors: Ford Sumner, Wellington for the respondent.