IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 154 **ACR 155/20 and 297/21**

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

Hearing: 8 August 2022
Held by AVL

Appearances: B Hinchcliff for the Appellant
F Becroft for the respondent

Judgment: 16 August 2022

RESERVED JUDGMENT OF JUDGE P R SPILLER
[Claim for cover – ss 25-26; weekly compensation and suspension of entitlements - s 117(1), Accident Compensation Act 2001]

Introduction

[1] These are appeals from:

(a) the decision of a Reviewer dated 10 August 2020 dismissing an application for review of the Corporation's decision dated 10 July 2015. The Corporation declined Mr Byles weekly compensation entitlements and suspended all entitlements from 24 July 2015 (appeal ACR 155/20).

(b) the decision of a Reviewer dated 21 December 2021 dismissing an application for review of the Corporation's decisions dated 11 May 2021.

The Corporation revoked deemed cover for Mr Byles' osteoarthritis and declined weekly compensation entitlements (appeal ACR 297/21).

Background

[2] Mr Byles was born in 1961. He worked in the pest elimination division of Ecolab.

[3] On 23 March 2014, Mr Byles suffered a left knee injury while carrying a bookcase on some stairs. Mr Byles was granted cover for contusion of the knee.

[4] On 24 March 2014, an x-ray showed moderate loss of medial joint space with marginal osteophytosis involving three compartments of the knee.

[5] On 10 April 2014, Dr John Caldwell, GP, noted "x-ray suggestive of quite widespread OA". On 29 April 2014, Dr Caldwell referred Mr Bayles to an Orthopaedic Surgeon and noted "evidence of degenerative change" on the x-ray.

[6] On 12 May 2014, Mr Dean Schluter, Orthopaedic Surgeon, reported:

> Diagnosis? Medial meniscal tear left knee? Medial compartment OA. Thank you for your referral I reviewed Kenneth in clinic today. He is a 53 year old who presents with increasing pain in his left knee following an injury. He describes carrying a bookcase down some stairs when he lost his footing and tripped over. His left knee twisted with the fall. He had immediate onset of pain and this has persisted since. The injury was on 24.3.2014. He does not get any night pain, though he does take Brufen before he goes to bed at night. He rates the pain 6 out of 10. It is intermittent and it gets quite painful when he is walking after about 10 to 15 minutes. He describes a burning pain and it also aches while he drives. …
>
> Impression: Probable medial meniscal tear with background of some chondral thinning of his medial compartment.

[7] On 19 May 2014, an MRI scan was taken. Dr Richard Ng, Radiologist, noted that the scan showed moderate medial compartment osteoarthritis with the chondral loss approaching full thickness at the anterior half of the medial compartment.

[8] On 5 June 2014, Mr Schluter again reported, noting that the MRI showed a medial meniscal tear. Mr Schluter also noted areas of moderate generalised chondral

thinning throughout the medial compartment and this approached full thickness at the anterior half of the joint. He suggested arthroscopy and medial meniscectomy.

[9] On 6 June 2014, Mr Schluter completed an Assessment Report and Treatment Plan ("ARTP") with a surgery request. Under the heading "causal link", he advised:

> The twisting injury has torn his medial meniscus. He does have some general chondral thinning of the medial compartment, but he seems to be tender more over the joint line, consistent with a medial meniscal tear.

[10] On 17 July 2014, the surgery request was considered by Ms Jan Davies, Clinical Advisor, and Mr Peter Hunter, Orthopaedic Surgeon of the Corporation's Clinical Advisory Panel ("CAP"). They did not think that the radiological evidence supported an acute pathology and noted the substantial osteoarthritis in the knee, visible on an MRI scan just two months after the accident. They thought that it was the osteoarthritis rather than the meniscal tear that was causing Ms Byles' symptoms.

[11] On 23 July 2014, the Corporation issued a decision declining surgery funding. The decision letter advised the surgery required to treat a meniscal tear in the left knee was due to a gradual process condition.

[12] On 4 August 2014, Mr Schluter reported again, noting that the Corporation had declined surgery funding and that he would put Ms Byles on the surgical waiting list at the local hospital.

[13] On 5 August 2014, Mr Byles was interviewed by the Corporation and expressed the hope that it would assist him while he was off work from the surgery. On 6 August 2014, Mr Schluter provided a medical certificate for Mr Byles, certifying him as unfit for 42 days from 5 August 2014.

[14] On 6 August 2014, Mr Byles' weekly compensation request was reviewed by Dr Anne-Marie Lonergan, BMA. She noted that contusion of the knee generally settles within a couple of weeks, and that the requested incapacity was five months after the index event. Dr Lonergan did not think that there was sufficient medical information to support a causal nexus between the requested delayed incapacity and

the covered injury and advised that it was likely that underlying degeneration was causing the incapacity.

[15] On 13 August 2014, the Corporation issued a decision, suspending Mr Byles' entitlements, based on the 23 March 2014 injury. The decision was made on the basis that his current left knee condition was as a result of underlying degeneration not caused by the injury for which Mr Byles was granted cover. The same letter also declined Mr Byles' application for weekly compensation. Mr Byles applied for a review of the decision.

[16] On 14 August 2014, the Corporation wrote Mr Byles a further letter declining to reconsider its earlier surgery decline decision.

[17] On 25 August 2014, for the purposes of the review, Ms Davies and Mr Hunter reconsidered the matter. They confirmed their earlier view that Mr Byles' ongoing symptoms were in relation to pre-existing osteoarthritis. They noted Mr Byles had a horizontal meniscal tear reported on the MRI which was not the morphology of an acute tear; that clients with osteoarthritis will have a 69-90% chance of having associated degenerative meniscal pathology; and that Mr Byles had areas of full thickness chondral lesions which take years to develop.

[18] On 5 September 2014, Mr Byles' left knee surgery was conducted in the public system.

[19] On 16 October 2014, Dr Otis Shirley, Orthopaedic Registrar, noted that the surgical wounds had healed well, with no signs of inflammation or infection. Mr Byles was no longer getting the locking symptoms which he had prior to the procedure, but he still had ongoing medial joint line pain. Dr Shelley described the changes present in the medial compartment as mild and advised that the first line of treatment was regular analgesia.

[20] On 11 December 2014, review proceedings were held regarding the Corporation's decision suspending Mr Byles' entitlements. On 18 December 2014, the Reviewer decided:

> I quash ACC's decision and I substitute it with my decision. I am satisfied that the evidence is in balance. Therefore, in terms of the Court decision in *Ellwood*, ACC cannot be satisfied that Mr Byles' need for entitlements is not due to his accident. Furthermore, I am satisfied that Mr Byles' injury extends to the tear in the medial meniscus ... which has now been operated on and for all intents and purposes has resolved.

[21] Following that decision, the Corporation reinstated entitlements and calculated weekly compensation. Mr Byles had returned to work 8 October 2014, so weekly compensation was not ongoing.

[22] On 30 March 2015, Mr Byles saw Dr Caldwell, who recorded that Mr Byles' knee was still giving troubles and he was really struggling at work.

[23] On 7 April 2015, Dr Caldwell certified that Mr Byles was unfit for work from 7 to 27 April 2015.

[24] On 16 April 2015, Dr Surendra Senthi, Orthopaedic Registrar, noted that Mr Byles' arthroscopy demonstrated grade 2 and 3 changes (osteoarthritis) in the medial compartment of his knee. Dr Senthi reported that Mr Byles was not keen for any further non-operative management of his knee and wanted a surgical solution. Dr Senthi noted that Mr Byles was advised of the risks of further surgery, but he nevertheless wished to proceed. Dr Senthi observed that Mr Byles was seeking further assistance from the Corporation.

[25] On 24 April 2015, Dr Lonergan noted that Mr Byles was now claiming a subsequent incapacity (April 2015), in relation to post-meniscectomy pain in his left knee. Dr Lonergan noted the Reviewer's findings in regard to the medial meniscus, but also that the Reviewer accepted that the meniscus injury had "been operated on and, for all intents and purposes, has resolved". She advised:

> In the presence of pre-existing degenerative changes present in the left knee, which have not been caused by this or any prior accident, on balance, it is likely that these changes are the cause of any subsequent incapacity as the information supports the knee initially settled after treatment of the meniscal tear.

[26] On 6 May 2015, Dr Ranen Reddy, Orthopaedic Registrar, wrote a referral to Mr Schluter, stating:

> Based on the patient's account, it would seem that the history of fall at work was the inciting factor for triggering his pain, contrary to the imaging and arthroscopic findings of pre-existing arthritis.

[27] On 12 June 2015, Dr Lonergan considered Dr Reddy's report. She advised that it did not alter her previous opinion, noting that Dr Reddy only advised that pain had been triggered by the accident event.

[28] On 10 July 2015, the Corporation issued a further decision, suspending Mr Byles' entitlements with effect from 24 July 2015, and declining the application for weekly compensation from 7 April 2015. The Corporation advised that medical information showed that Mr Byles' current condition was no longer the result of his injury of 23 March 2014, but rather was due to the aggravation of pre-existing arthritis in his left knee.

[29] On 30 September 2016, Mr Byles underwent a total knee replacement in the public system. The operation note recorded that Mr Byles had been struggling with arthritis in his left knee for a number of years and that, due to a recent deterioration, the decision was made to proceed to a total knee replacement. Post-surgical notes recorded that the knee replacement surgery itself was straightforward, but unfortunately Mr Byles had experienced a very poor result with ongoing stiffness, pain and swelling in the knee.

[30] On 20 January 2017, further surgery was undertaken to try to improve Mr Byles' situation. Post-surgical reports confirmed no significant problems with regard to the knee replacement.

[31] On 8 February 2017, a treatment injury claim was filed relating to the knee replacement of 30 September 2016. The claim was investigated, with the Corporation seeking notes dating back to the operation.

[32] On 3 March 2017, the Corporation issued a decision declining Mr Byles' treatment injury claim, on the basis that there was no evidence of an injury suffered in treatment that was the cause of Mr Byles' ongoing problems. He applied for a review of that decision, relying on the additional comments from Mr Schluter, who suggested that Mr Byles should qualify for a treatment injury because the severe

persisting pain had not been relieved and in fact had been made worse by the surgery.

[33] On 13 July 2017, the matter went to review. On 9 August 2017, the Corporation's decision was upheld, on the basis that Mr Byles had been unable to identify that he had suffered a discrete physical injury caused by the surgical treatment he underwent on 30 September 2016.

[34] On 16 August 2017, a bone scan showed some loosening of Mr Byles' prosthetic. Mr Byles asked the Corporation to reconsider its decision based on this finding.

[35] On 26 July 2018, Mr Chris Fougere, Orthopaedic Surgeon, advised that the bone scan might be evidence of loosening of both of the existing components in his knee replacement.

[36] On 22 November 2018, the Corporation obtained a report from Mr Vasudeva Pai, Orthopaedic Surgeon, on the basis of a paper file review of Mr Byles' left knee replacement. Mr Pai concluded:

> … there is early failure of the left total knee replacement … the main issue here is of persisting pain since his total knee replacement. There are some changes as stated on his bone scan of 2017 suggestive of a possibility of loosening. In my opinion, his x-ray findings show satisfactory alignment without evidence of loosening.
>
> … In my opinion, the possibilities in this case are either low grade infection or aseptic loosening of the components.
>
> … In my opinion, the choice of surgery and the surgical technique was very satisfactory, and there were no intra-operative complications. In my opinion, in Mr Byles particular case loosening is a possibility and the incidence of loosening has been reported as being 24% of causation for early failure. The causation of the loosening is failure to integrate cement to the underlying cancellous bone. I cannot relate it to the surgical technique of his original surgery of 30/09/2016.

[37] On 29 November 2018, the Corporation declined Mr Byles' claim again, on the basis that the Corporation could not identify any aspect of treatment that had caused the loosening. Mr Byles applied for a review of this decision.

[38] On 24 October 2019, Mr Byles underwent revision surgery.

[39] On 4 November 2019, Mr Hinchcliff, for Mr Byles, asked the Corporation to review the surgical report and reconsider the treatment injury decision.

[40] On 8 November 2019, the Corporation confirmed cover for "ligamentous imbalance to the left medial collateral and lateral collateral ligaments following left total knee joint replacement". The date of injury was determined as 10 October 2016. Cover was accepted on the basis of the surgical results which showed gross instability, particularly in connection with significant ligamentous imbalance resulting in revision surgery.

[41] Mr Byles then provided the Corporation with a series of Work and Income medical certificates for the period between April 2015 (when the subsequent incapacity was claimed) and December 2019.

[42] On 3 December 2019, the Corporation wrote to Mr Byles referring to its 10 July 2015 decision, and noting that his entitlements on the 2015 claim had been suspended.

[43] On 14 February 2020, Mr Hinchcliff applied for a late review of the 10 July 2015 decision. He submitted that the application was late because of the stress that Mr Byles had been under at the time.

[44] On 14 February 2020, the Corporation declined to accept the late review application. Mr Byles applied for a review of that decision.

[45] On 24 April 2020, the Corporation agreed to accept the late review application.

[46] On 25 April 2020, Mr Daniel Harvey, Physiotherapist, reported that he did not think that Mr Byles had fully recovered from the original meniscal surgery. Mr Harvey assessed that Mr Byles' incapacity as of 10 July 2015 was ongoing pain and loss of function due to a failed partial meniscectomy.

[47] On 4 May 2020, Dr Shaun Xiong, Rehabilitation Specialist, undertook a paper review. Dr Xiong concluded:

> In my opinion the personal injury was the direct cause of meniscal tear (a specific physical injury) and sprain of the medial collateral ligament, that were the direct cause of his left knee pain as well as incapacity.
>
> This has obviously aggravated the osteoarthritis further but it would be wrong if we only attribute the symptoms and incapacity to the osteoarthritis itself. In other words, the injury itself namely the meniscal tear is the direct cause of his knee pain and subsequent loss of work capability with osteoarthritis only as a risk factor as well as a partial contributing factor.
>
> Overall, my conclusion is that Mr Byles' incapacity is substantially due to his meniscal injury as at 10.07.15 based on the clinical probability.
>
> Nevertheless, I would consider pre-existing degenerative osteoarthritis of the knee can be a risk factor for the significant clinical presentation and incapacity or a co-contributing factor for the incapacity.

[48] On 27 May 2020, Ms Kirsty Mourits, a physiotherapist, and the Corporation's Clinical Advisor, reviewed Mr Harvey's opinion but disagreed with it, concluding that Mr Byles suffered from pre-existing knee osteoarthritis which was not a covered condition. Ms Mourits advised that there was clear radiological and treating specialist evidence that Mr Byles had degenerative (osteoarthritic) changes which pre-dated the injury and were not caused by it.

[49] On 2 June 2020, Mr Byles provided a statement disputing Ms Mourits' advice.

[50] On 16 June 2020, Dr Chris Walls, Occupational Specialist, reported that Mr Byles' knee failed to settle following his injury, and he was incapacitated in July 2015. Dr Walls added:

> I gather the fall has been accepted as a causative event (of the meniscal tear and presumably some aggravation of any pre-existing arthritis/chondral damage).
>
> There is no real way of proving or disproving this, but this was a fall of some severity and although medial meniscal tears are usually described as degenerative, there is no reason why such a fall could not cause additional tearing to the meniscus or de nova tearing causing Ken's already somewhat arthritic knee decompensating.

[51] On 18 June 2020, proceedings were held in relation to the review of the Corporation's decision of 10 July 2015. The review was dismissed on the basis that

the Reviewer was not persuaded that the evidence available since the Corporation's decision was sufficient to overturn the decision.

[52] On 11 August 2020, a Notice of Appeal was lodged.

[53] On 17 November 2020, the CAP[1] reported on whether there was any evidence that Mr Byles' symptoms, as at mid-2015, were causally related to the covered strain, the meniscal tear, or the 2014 surgery:

> No, there is no convincing, objective evidence in any of the information provided that Mr Byles' symptoms were causally related to:
>
> - The ACC covered left knee contusion/sprain, because this soft injury was clinically expected to have resolved in a few days or weeks.
> - The medial meniscal tear, which resolved with the 5/9/2014 surgery, and/or,
> - The 2014 surgery, which was uncomplicated, as discussed in question 1.

[54] The CAP explained that the reason that Mr Byles required a total knee replacement in 2017, was his longstanding left knee osteoarthritis. The CAP noted the extent of changes present in the initial x-ray in March 2014 and confirmed that the changes were well-established and would have taken years to develop. The CAP also noted that the May 2014 MRI scan was somewhat underreported. The treating surgeon, Mr Schluter, however noted a range of indicators of the pre-existing damage present. The CAP also noted that Mr Schluter anticipated further surgery for the non-injury related osteoarthritis in the future, thus flagging that those pre-existing non-injury related changes would become problematic for Mr Byles at a later point in time.

[55] The CAP commented further:

> Mr Byles' osteoarthritis involved the meniscus, cartilage, subchondral bone, the medial collateral ligament and the muscles around the knee joint. His imaging showed the following osteoarthritic features:
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> - Cartilage thinning, because in osteoarthritis, the rate of breakdown of cartilage is greater than the rate of cartilage repair.

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[1] The CAP comprised five Orthopaedic Surgeons, a Sports Medicine Specialist, an Occupational and Environmental Medicine Specialist, and a General Surgeon.

- Subchondral oedema of the bone, due to gradual remodelling of the underlying bone.
- Osteophytes or hypertrophy of the joint caps.
- Inflammation of the joint lining.

The CAP noted that Mr Byles' medial meniscus was so degenerated that it was extruded out of the Joint and caused ballooning of the medial collateral ligament. The changes on his MRI scan were advanced and associated with wasting of his surrounding knee muscles.

Some people continue to have low-grate osteoarthritis and others like Mr Byles, progress to more severe and symptomatic osteoarthritis requiring joint replacement. Mr Byles' knee replacement was for his chronic, longstanding knee osteoarthritis and was not causally related to any single episode of trauma. Mr Byles' left knee osteoarthritis was not causally linked to his ACC-covered 23/03/2014 accident, although that accident could certainly have rendered his osteoarthritis more symptomatic. …

Mr Harvey has not explained his opinion. There is no objective medical evidence to support Mr Harvey's impression of "failed" surgery. There was no treatment injury claim for Mr Byles 5/9/2014 left knee arthroscopy and partial medial meniscectomy surgery. There were no complications, problems or concerns about that surgery recorded anywhere in the clinical records, as discussed in question 1.

Mr Harvey has concluded that Mr Byles' ongoing left knee pain was the result of a failed partial meniscectomy surgery. There is no evidence to support Mr Harvey's opinion. All the medical information points to Mr Byles' left knee osteoarthritis as the cause of his pain.

Mr Harvey noted that Mr Byles had no prior left knee symptoms and continued working prior to his 23/3/2014 accident. CAP noted that knee osteoarthritis can remain asymptomatic and problem free for many years. Many asymptomatic individuals have knee osteoarthritis as discussed in question 4.

Mr Harvey seems to have misunderstood the medical records because his opinion was that Mr Byles' left knee osteoarthritis was not too bad. CAP noted, it was bad, bad enough for the 2014 arthroscopy and meniscectomy surgery and the 2016 total knee joint replacement surgery.

Mr Harvey does not seem to have considered Mr Byles' ongoing symptoms following his 5/9/2014 meniscectomy surgery from his longstanding osteoarthritis. As discussed above Mr Byles' left knee osteoarthritis, including the bone and cartilage changes and the medial meniscal tearing, can explain Mr Byles' history of worsening of left knee pain, even in the absence of trauma. Mr Byles pre-existing, longstanding osteoarthritis was the reason why his left knee symptoms had not "fully resolved" with the 2014 meniscectomy surgery.

… Mr Byles' "traumatic component" was the medial meniscal tear which resolved with the 2014 surgery. The remaining symptoms were from his longstanding osteoarthritis and not from "failed" meniscectomy surgery.

[56] On 17 November 2020, Mr Chris Fougere, saw Mr Byles and reported that overall he was very satisfied with his left knee replacement. Mr Fougere thought that Mr Byles had grounds for his claim with the Corporation in terms of his primary knee being initially unstable, as Mr Fougere thought that Mr Byles was struggling with some permanent limitation regarding work.

[57] On 22 January 2021, Mr Byles applied for cover for osteoarthritis of his left knee and weekly compensation.

[58] On 21 April 2021, the Corporation acknowledged deemed cover for left knee osteoarthritis because it had not responded to a new claim within the legislative timeframe which expired on 22 March 2021. The Corporation noted that it still needed to assess whether it was correct to accept Mr Byles' injury.

[59] On 11 May 2021, the Corporation issued a decision revoking deemed cover for osteoarthritis, on the basis there was no causal link between Mr Byles' left knee osteoarthritis and the accident of 23 March 2014. On the same day, the Corporation issued a decision declining weekly compensation entitlement, on the basis that there was no causal link between Mr Byles' covered injuries and his incapacity to work. Mr Byles applied for review of the Corporation's decisions.

[60] On 24 September 2021, Dr Xiong reported:

> In medical terms, based on the balance of probability it is more likely than not that the delay in meniscal surgery has contributed towards Mr Byles symptoms as well as subsequent development of deterioration of the arthritis of the knee joint. …
>
> In my opinion, after that I have carefully looked into this case and reviewed the documentation as well as the imaging files available, I do believe it is not likely, that the arthritis is wholly or substantially a pre-existing gradual process condition; as clearly, he has got a normal lateral compartment of the left knee and normal patella femoral component as well.
>
> It is however clearly established that he has got a meniscal tear that was subsequently surgically removed.
>
> In my medical opinion there is quite substantial contribution of the traumatic causation towards his osteoarthritis from the injury specifically the meniscal injury as well as the surgery.

> In other words, he has developed a post-traumatic osteoarthritis superimposed upon a pre-existing osteoarthritis (which is a degenerative condition) of the medial compartment.
>
> From my point of view, I would regard the meniscal injury and surgery as a partial contribution to his arthritis.
>
> In my opinion it is quite clear that we cannot attribute Mr Byles knee condition wholly or substantially to his pre-existing gradual process condition.

[61] On 26 November 2021, Dr Alex Rutherford, Orthopaedic Surgeon and Principal Clinical Adviser, responded to Dr Xiong's report:

> I refer you to the British Medical Bulletin article: Meniscectomy as a Risk Factor: A Systemic Review Volume 99, issue 01/09/2011 pages 89-106.
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> This article which has reviewed large numbers of retrospective studies regarding osteoarthritis after meniscectomy has concluded that the main risk factors for osteoarthritis after meniscectomy are the amount of meniscus removed and the time interval from meniscectomy to onset of symptoms, that is the highest risk for arthritis after meniscectomy occurs in children or adolescents having a total meniscectomy, whereas the least risk is in mature adults having a partial meniscectomy through minimally invasive surgery.
>
> In Mr Byles' case, although his MRI scan revealed a horizontal split tear of his meniscus which was undisplaced and no meniscal tissue had been removed from the time of his accident until the time of his surgery, making it most unlikely that the delay between his accident and surgery has caused any additional chondral injury other than what was already present from the pre-existing degenerative arthritis.
>
> Furthermore, at the time of surgery only a partial meniscectomy was performed leaving a significant amount of meniscus still present.
>
> Mr Byles already had signs and symptoms of medial compartment osteoarthritis to the extent that he required a knee replacement in 2016. It is most unlikely that the amount of meniscus removed and the time frame between the meniscectomy and the total knee replacement has contributed to the need for Total Knee Replacement. It is far more likely that this is the result of the gradual process osteoarthritic condition present prior to the client's accident of 23/03/2014.

[62] On 2 December 2021, the review proceedings were held. On 21 December 2021, the Corporation's decisions revoking deemed cover and declining weekly compensation were upheld, on the basis that Mr Byles' left knee osteoarthritis was not caused by the 2014 accident and so he was not entitled to cover for osteoarthritis or for weekly compensation.

Relevant law

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

[64] Section 65 of the Act provides:

> (1) If the Corporation considers it made a decision in error, it may revise the decision at any time, whatever the reason for the error.
>
> (2) The Corporation may revise a decision deemed by section 58 to have been made in respect of any claim for cover, but may not recover from the claimant any payments made by it, in respect of the claim, before the date of the revision unless the claimant has made statements or provided information to the Corporation that are, in the opinion of the Corporation, intentionally misleading.
>
> (3) A revision may—
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> (a) amend the original decision; or
>
> (b) revoke the original decision and substitute a new decision.

[65] Section 117(1) of the Act provides:

> The Corporation may suspend or cancel an entitlement if it is not satisfied, on the basis of the information in its possession, that a claimant is entitled to continue to receive the entitlement.

[66] In *Bartels*,[2] Gendall and Ronald Young JJ stated, in relation to the Injury Prevention, Rehabilitation, and Compensation Act 2001, section 390 (equivalent to section 65(1) above):

> [28] … the process under s 390 requires the Corporation to examine the earlier decision. It is after all, in the words of s 390, for the Corporation to establish "that the decision was made in error". We are satisfied, however, that it is entitled to do so using material not available to it at the time of the original

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2 *Accident Compensation Corporation v Bartels* [2006] NZAR 680.

> decision but which has become available since. We stress, however, that material must clearly establish that the original decision was made "in error" before it can invoke s 390. …
>
> [31] ... We are satisfied that all Parliament meant was that the Corporation can today, with the factual and other material it now has, look back at the decision previously made and decide if it was "made in error". A simple example will illustrate the position. A claim is made for a broken arm. An x-ray is inspected which confirms the break and thus cover accepted. Later it is discovered that either the x-ray has been misread or someone else's x-ray has been read and that the x-ray of the claimant reveals no break. This is "new evidence" and would be highly relevant to a decision under s 390 to revoke the original decision as made "in error". …
>
> [33] Finally, we agree with the Corporation's submissions … that where decisions previously made are clearly made in error that those decisions should not be left to advantage or disadvantage either claimants or the Corporation. This is a publicly funded insurance scheme for those who suffer personal injury by accident. Those who suffer personal injury by accident should have cover under the Act and those who do not should not get cover when none is due.

[67] The Court has, on several occasions, accepted that the Corporation was entitled to revisit and revoke an earlier decision that it had made.[3]

[68] In *Atapattu-Weerasinghe*,[4] Williams J held:

> [22] … it seems clear that s 65(1) and (2) cover two different situations. The first, where a decision has been made and is now felt to be erroneous; the second, where no decision has been made, cover is deemed to be granted, and the Corporation wishes to revisit that. *Bartels* does not speak to the second situation.
>
> [23] … The reverse onus, as provided for in *Bartels*, only makes sense because an actual error has been identified by the Corporation in the earlier decision. It seems entirely fair that, in that situation, the Corporation should be required to justify the change. But in the absence of such error, reversal of the onus makes no particular sense. …

[69] In *Johnston*,[5] France J stated:

> [11] It is common ground that, but for the accident, there is no reason to consider that Mr Johnston's underlying disc degeneration would have manifested itself. Or at least not for many years.

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3 *Stowers v Accident Compensation Corporation* DC Christchurch 167/2009, 5 October 2009; *Paku v Accident Compensation Corporation* [2017] NZACC 143; *Crosswell v Accident Compensation Corporation* [2019] NZACC 37; *Garing v Accident Compensation Corporation* [2019] NZACC 63; and *Herbst v Accident Compensation Corporation* [2020] NZACC 109.

4 *Atapattu-Weerasinghe v Accident Compensation Corporation* [2017] NZHC 142, followed in *Singh v Accident Compensation Corporation* [2019] NZACC 102, at [112].

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

> [12] However, in a passage that has been cited and applied on numerous occasions, Panckhurst J in *McDonald v ARCIC* held:[6]
>
> > "If medical evidence establishes there are pre-existing degenerative changes which are brought to light or which become symptomatic as a consequence of an event which constitutes an accident, it can only be the injury caused by the accident and not the injury that is the continuing effects of the pre-existing degenerative condition that can be covered. The fact that it is the event of an accident which renders symptomatic that which previously was asymptomatic does not alter that basic principle. The accident did not cause the degenerative changes, it just caused the effects of those changes to become apparent ..."
>
> [13] It is this passage which has governed the outcome of this case to date. Although properly other authorities have been referred to, the reality is that the preceding decision makers have concluded that Mr Johnston's incapacity through back pain is due to his pre-existing degeneration and not to any injury caused by the accident.
>
> [14] … I consider it important to note the careful wording in the McDonald passage. The issue is not whether an accident caused the incapacity. The issue is whether the accident caused a physical injury that is presently causing or contributing to the incapacity.

[70] In *Ambros*,[7] the Court of Appeal envisaged the Court taking, if necessary, a robust and generous view of the evidence as to causation:

> [65] The requirement for a plaintiff to prove causation on the balance of probabilities means that the plaintiff must show that the probability of causation is higher than 50 per cent. However, courts do not usually undertake accurate probabilistic calculations when evaluating whether causation has been proved. They proceed on their general impression of the sufficiency of the lay and scientific evidence to meet the required standard of proof ... The legal method looks to the presumptive inference which a sequence of events inspires in a person of common sense …
>
> [67] The different methodology used under the legal method means that a court's assessment of causation can differ from the expert opinion and courts can infer causation in circumstances where the experts cannot. This has allowed the Court to draw robust inferences of causation in some cases of uncertainty -- see para [32] above. However, a court may only draw a valid inference based on facts supported by the evidence and not on the basis of supposition or conjecture … Judges should ground their assessment of causation on their view of what constitutes the normal course of events, which should be based on the whole of the lay, medical, and statistical evidence, and not be limited to expert witness evidence …

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6 *McDonald v ARCIC* [2002] NZAR 970, at [26].

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

[71] In *Furst*,[8] Judge Barber stated:

> [13] ACC must have a "*sufficient basis before it is not satisfied that a claimant is entitled to continue to receive the entitlement*". If the position is uncertain, "*then there is not a sufficient basis*" *The "not satisfied" test is not met in these circumstances*". *Ellwood v the Corporation* [2007] NZAR 205. The "*not satisfied*" test requires a positive decision … equivalent to being satisfied that there is no right to entitlements. This test would not be met where the evidence was in the balance or unclear: *Milner v the Corporation* (187/2007).
>
> [14] Section 26 of the Act defines "*personal injury*" as physical injuries suffered by a person. Personal injury caused "*wholly or substantially*" by a non-work gradual process, disease, or by the ageing process is excluded. If medical evidence establishes there are pre-existing degenerative changes which are brought to light or which become symptomatic as a consequence of an event which constitutes an accident, it can only be injury caused by the accident and not the injury that is the continuing effects of the pre-existing degenerative condition that can be cover: *MacDonald v ARCIC* [2002] NZAR 970, at 26.
>
> [15] There must be a causal nexus between the covered injury and the condition of the claimant for which entitlements were sought at the time of ACC's decision to suspend or decline entitlements: *Milner*.
>
> [16] Causation cannot be established by showing that the injury triggered an underlying condition to which the appellant was already vulnerable, or that the injury accelerated the condition which would have been suffered anyway: *Cochrane v ACC* [2005] NZAR 193.

[72] In *Stewart*,[9] Judge Barber stated:

> [28] As the issue of causation is essentially a medical question, it must be determined with reference to medical evidence. Evidence provided by the appellant as to her symptoms and experience is, of course, useful and is required by the medical experts in order for them to make the appropriate determination. However, in itself, evidence by the appellant cannot establish the required causal link because the appellant is not medically qualified to determine the issue of causation.
>
> …
>
> [33] The cases consistently highlight that the question of causation cannot be determined by a matter of supposition. There must be medical evidence to assist the respondent Corporation, and now the Court, to determine that question. A temporal connection, in itself, will be insufficient. There needs to be a medical explanation as to how the ongoing condition has been caused by the originally covered injury. In this case the evidence does not establish this.

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8 *Furst v Accident Compensation Corporation* [2011] NZACC 379. See also *Ellwood v Accident Compensation Corporation* [2012] NZHC 2887; and *Booker v Accident Compensation Corporation* DC Huntly 205/00, 17 August 2000.

9 *Stewart v Accident Compensation Corporation* [2003] NZACC 109.

Discussion

The Corporation's decision of 10 July 2015 (appeal ACR 155/20)

[73] The issue in this appeal is whether, on 10 July 2015, the Corporation correctly suspended Mr Byles' entitlements, and declined his application for weekly compensation, on the basis that the medical evidence did not establish his ongoing, unresolved symptoms and resultant incapacity were causally related to an injury suffered in an accident on 23 March 2014.

[74] Mr Byles' personal injury does not include personal injury caused wholly or substantially by a gradual process, disease, or infection.[10] A temporal connection between Mr Byles' originally covered injury and his ongoing condition is, in itself, insufficient, and there must be medical evidence to determine the matter.[11] If medical evidence establishes Mr Byles had pre-existing degenerative changes which were brought to light or which become symptomatic as a consequence of an accident, only the injury caused by the accident and not the continuing effects of the pre-existing degenerative condition can be covered.[12] The Corporation is entitled to suspend Mr Byles' entitlements if it is not satisfied, on the basis of the information in its possession, that he is entitled to continue to receive them.[13] Where the available evidence is in the balance or unclear, the "not satisfied" test is not met.[14]

[75] The submissions for Mr Byles are:

- When the Corporation made its decision on 10 July 2015, it failed to discharge the onus of showing that Mr Byles' injury of 23 March 2014 had fully resolved; and failed to show that Mr Byles' injury was wholly or substantially related to a pre-existing gradual process condition.

- The reports of Dr Lonergan on which the 2015 decision was based were flawed.

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10 Section 26(2) of the Act.
11 See n 9 *Stewart*, at [33].
12 See n 5 *Johnston*, at [12].
13 Section 117(1) of the Act.
14 See n 8 *Furst*, at [13].

- Dr Shirley stated that Mr Byles' condition was due to the 2014 injury, with only mild osteoarthritis found.

- The later report of Dr Xiong, who found that Mr Byles' condition had not resolved at the time of the Corporation's decision, should be preferred.

- Dr Walls assessed that the evidence as to whether the condition had resolved was unclear.

[76] This Court acknowledges the above submissions. However, the Court refers to the following considerations.

[77] First, there is clear and cogent medical evidence that, at the time of Mr Byles' injury in March 2014, he had appreciable osteoarthritis in the knee:

- the x-ray taken the day after the accident showed joint space narrowing, cartilage thinning and osteophytosis involving three compartments of the knee;

- Dr Caldwell, GP, noted that the x-ray showed degenerative change and was suggestive of quite widespread osteoarthritis;

- Mr Schluter, Orthopaedic Surgeon, noted, in light of the x-ray, that Mr Byles had some chondral thinning (osteoarthritis) of his medial compartment;

- an MRI scan taken eight weeks after the accident showed moderate medial compartment osteoarthritis with the chondral loss approaching full thickness at the anterior half of the medial compartment;

- Mr Hunter, Orthopaedic Surgeon, noted that the MRI scan confirmed the x-ray report of substantial osteoarthritis in the knee.

- Dr Senthi, Orthopaedic Registrar, noted that Mr Byles' arthroscopy demonstrated grade 2 and 3 changes (osteoarthritis) in the medial compartment of his knee.

[78] Second, the meniscal injury in March 2014, for which Mr Byles had cover, was successfully treated by surgery on 5 September 2014 and appears to have been resolved with this surgery:

- the operation record of Dr Misur, Orthopaedic Surgeon, noted that the surgery was for a left medial meniscal tear;
- a week after the operation, Dr Shirley, Orthopaedic Registrar, noted that the surgical wounds had healed well, with no signs of inflammation or infection, and Mr Byles was no longer getting the locking symptoms which he had prior to the procedure;
- the records of Dr Caldwell between 8 and 18 September 2014 noted no signs of infection and that the wound healed well;
- Mr Byles returned to work on 8 October 2014;
- at the review hearing on 11 December 2014, Mr Byles stated that he had about three weeks off work before the surgery and then three to four weeks off work recovering, he simply wanted the leave time reimbursed, he had recovered from the surgery, and he was back at work with no issues. The Reviewer's conclusion was that the tear in the medical meniscus had for all intents and purposes resolved.

[79] Third, the first medical report of Mr Byles' further knee issues was the note of his GP, Dr Caldwell, on 30 March 2015, that Mr Byles' knee was still giving trouble and he was struggling at work. The following month, Dr Caldwell certified that Mr Byles was unfit for work for 21 days.

[80] Fourth, in April 2015, Dr Lonergan, Branch Medical Adviser, assessed that, in the presence of pre-existing degenerative changes present in the left knee, which had not been caused by any prior accident, it was likely that these changes were the cause of subsequent incapacity, as information indicated that the knee initially settled after treatment of the meniscal tear. The Corporation subsequently issued its decision suspending Mr Byles' entitlements with effect from 24 July 2015 and declining the application for weekly compensation from 7 April 2015 onwards.

[81] Fifth, the CAP, comprising five Orthopaedic Surgeons, as well as a Sports Medicine Specialist, an Occupational and Environmental Medicine Specialist and a General Surgeon, advised that there was no convincing, objective evidence that Mr Byles' symptoms, as at mid-2015, were causally related to the covered strain, the meniscal tear, or the 2014 surgery. The CAP found that Mr Byles' covered left knee meniscal tear resolved with the 2014 surgery but his osteoarthritis did not; and his osteoarthritis led to further symptoms and work incapacity, culminating in his September 2016 total knee joint replacement surgery. The CAP noted, *inter alia*, that:

(1) the x-ray done on 24 March 2014 showed classic signs of well-established osteoarthritis which would take years to develop and not have developed in the 24 hours after the accident;

(2) the MRI scan of 19 May 2014 showed full thickness loss at the reciprocal surfaces of the anteromedial compartment and patchy cartilage thinning elsewhere in the medial joint space; and

(3) the medical evidence showed that Mr Byles' osteoarthritis was advanced, chronic and longstanding, and not causally related to any single episode of trauma, although the March 2014 accident could have rendered the osteoarthritis more symptomatic.

[82] Sixth, this Court finds that the above evidence outweighs the reports relied upon by Mr Byles. The Court notes that, of the following medical practitioners, only Dr Shirley is an orthopaedic specialist:

(a) Dr Shirley, Orthopaedic Registrar, reported on 16 October 2014 that Mr Byles' medial arthritis was mild, and that there was a knee injury which led to his pain. However, Dr Shirley's characterisation of Mr Byles' medial arthritis as mild appears to be out of line with the x-ray and MRI findings and the views of the orthopaedic specialists, noted above. Further, Dr Shirley noted that Mr Byles was somewhat dismayed

that the Corporation was not covering his injury, and that he (Dr Shirley) tried to explain that this was because arthritis was a degenerative injury.

(b) Mr Harvey, Physiotherapist, reported on 25 April 2020 that he did not think that Mr Byles had fully recovered from the original meniscal surgery, and assessed that Mr Byles' incapacity as at 10 July 2015 was ongoing pain and loss of function due to a failed partial meniscectomy. However, as noted above, medical evidence indicates that Mr Byles' meniscectomy surgery was effective. Further, the CAP pointed out that there was no objective medical evidence to support Mr Harvey's opinions, and that Mr Harvey appeared to have missed significant features in the case, and misunderstood or misinterpreted the clinical record and radiological evidence available.

(c) Dr Xiong, Rehabilitation Specialist, reported on 4 May 2020, in a paper review, that he thought that Mr Byles' meniscal tear was the direct cause of his knee pain and subsequent loss of work capability. However, Dr Xiong noted that causation of incapacity was a complex issue. Further, Dr Xiong acknowledged that Mr Byles' osteoarthritis was a risk factor and a partial contributing factor, and that the meniscal tear *aggravated* the osteoarthritis further.

(d) Dr Chris Walls, Occupational Specialist, reported on 16 June 2020 that Mr Byles' knee injury failed to settle, and that there was no reason why Mr Byles' fall of some severity could not cause additional tearing to the meniscus or *de nova* tearing, causing his already somewhat arthritic knee decompensating. However, Dr Walls conceded that there was no real way of proving or disproving his suggested view.

[83] Overall, the Court finds that, on 10 July 2015, the Corporation correctly suspended Mr Byles' entitlements, and declined his application for weekly compensation, on the basis that the medical evidence did not establish that his ongoing symptoms were causally related to an injury suffered in an accident on 23 March 2014. The Corporation was entitled to suspend Mr Byles' entitlements on

the basis that it was not satisfied, on the basis of the information in its possession, that he was entitled to continue to receive them.

The Corporation's decisions of 11 May 2021 (appeal ACR 297/21)

[84] The issue in this appeal is whether, on 11 May 2021, the Corporation correctly revoked Mr Byles' deemed cover for osteoarthritis and declined weekly compensation entitlements, on the basis that the medical evidence did not establish that his ongoing symptoms arising out of osteoarthritis were causally related to an injury suffered in an accident on 23 March 2014. The Corporation is entitled to revoke its deemed decision in favour of Mr Byles, and the onus of proof rests with him to establish that he is entitled to cover, according to the principles set out above.[15]

[85] The submissions for Mr Byles are as follows. He has osteoarthritis as a result of injury sustained in the 23 March 2014 accident, and, as such, he is entitled to weekly compensation. On 18 December 2014, a Reviewer directed the Corporation to provide cover for Mr Byles' left knee medial meniscal injury, and the doctrine of *res judicata* means that this issue may not be pursued further by the Corporation. The Corporation incorrectly revoked deemed cover for left knee arthritis, as the meniscal injury contributed to the osteoarthritis condition and this was not wholly or substantially caused by a gradual process condition. Dr Xiong assessed that Mr Byles' arthritic condition was accident-related, and Mr Harvey assessed that the meniscal surgery caused the degenerative knee condition. The reports of Dr Lonergan, Ms Mourits and the CAP are flawed. Mr Byles is entitled to reinstated cover for left knee arthritis, and weekly compensation from 12 February 2021 to 11 May 2021.

[86] This Court acknowledges these submissions. However, the Court notes the following considerations:

[87] First, as outlined in paragraph [77] above, there is clear and cogent medical evidence, that, at the time of Mr Byles' injury in March 2014, he had *pre-existing* degeneration in the knee, with established osteoarthritis.

[88] Second, as outlined in paragraph [80] above, in April 2015, Dr Lonergan, Branch Medical Adviser, noted the presence of *pre-existing* degenerative changes present in the left knee, *which had not been caused by any prior accident*.

[89] Third, as outlined in paragraph [81] above, the CAP (comprising five orthopaedic surgeons and other specialists) noted that the medical evidence showed that Mr Byles' osteoarthritis was *advanced, chronic and longstanding, and not causally related to any single episode of trauma*, although the March 2014 accident could have rendered the osteoarthritis more symptomatic.

[90] Fourth, on 27 May 2020, Ms Kirsty Mourits, Physiotherapist, concluded that Mr Byles suffered from *pre-existing* knee osteoarthritis which was not a covered condition. Ms Mourits advised that there was clear radiological and treating specialist evidence that Mr Byles had degenerative (osteoarthritic) changes which *pre-dated the injury and were not caused by it*.

[91] Fifth, the doctrine of *res judicata* does not apply in this appeal. *Res judicata* applies where a matter has been previously adjudicated upon between the same parties suing in the same right. The Reviewer's decision of 18 December 2014, directing the Corporation to provide cover for Mr Byles' left knee medial meniscal injury, was in response to Mr Byles' claim that his meniscal tear and resultant incapacity were caused by his injury of March 2014. The present matter concerns a claim by Mr Byles that his osteoarthritis was caused by his injury of March 2014.

[92] Sixth, Dr Rutherford, Orthopaedic Surgeon, advised that it was most unlikely that the amount of meniscus removed in Mr Byles' meniscectomy operation, and the time frame between this operation and his total knee replacement, had contributed to the need for the replacement. Dr Rutherford considered it far more likely that Mr Byles' condition was the result of the gradual process osteoarthritic condition present *prior to* the client's accident of 23 March 2014. Dr Rutherford based his assessment on a published article which had reviewed large numbers of retrospective studies regarding osteoarthritis after meniscectomy.

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15 Section 65(2) of the Act and *Atapattu-Weerasinghe*, See n 4, at [22]-[23].

[93] Seventh, this Court prefers the above evidence to the opinions of Mr Harvey and Dr Xiong. Mr Harvey's view, as a physiotherapist, of Mr Byles' meniscal operation has been discussed at paragraph [82(b)]. Dr Xiong assessed that Mr Byles developed a *post-traumatic* osteoarthritis superimposed upon a *pre-existing* osteoarthritis of the medial compartment. This Court finds the opinion of Dr Xiong, as a rehabilitation specialist, to be unpersuasive, particularly when set against the views of orthopaedic specialists.

[94] Overall, on balance, the Court finds that, on 11 May 2021, the Corporation correctly revoked Mr Byles' deemed cover for osteoarthritis and declined weekly compensation entitlements, on the basis that the medical evidence did not establish that his ongoing symptoms arising out of osteoarthritis were causally related to an injury suffered in an accident on 23 March 2014.

Conclusion

[95] In light of the above considerations, the Court finds that:

(a) the decision of a Reviewer dated 10 August 2020 is upheld: the Reviewer correctly dismissed an application for review of the Corporation's decision dated 10 July 2015, declining Mr Byles weekly compensation entitlements and suspending all entitlements from 24 July 2015 (appeal ACR 155/20).

(b) the decision of a Reviewer dated 21 December 2021 is upheld: the Reviewer correctly dismissed an application for review of the Corporation's decisions dated 11 May 2021, revoking deemed cover for Mr Byles' osteoarthritis and declining weekly compensation entitlements (appeal ACR 297/21).

[96] This Court notes, for completeness, that Mr Byles may have a possible claim for weekly compensation in the two-month period preceding its decision revoking deemed cover. Such a claim will need to be assessed by the Corporation in the usual manner.

[97] These appeals are dismissed.

[98] There are no issues as to costs.

P R Spiller
District Court Judge

Solicitors for the Respondent: Medico Law.