**IN THE DISTRICT COURT**
**AT WELLINGTON**

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

**[2022] NZACC 164** **ACR 262/21**

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| UNDER | THE ACCIDENT COMPENSATION ACT 2001 |
| IN THE MATTER OF | AN APPEAL UNDER SECTION 149 OF THE ACT |
| BETWEEN | DAMIAN FOSTER<br>Appellant |
| AND | ACCIDENT COMPENSATION CORPORATION<br>First Respondent |

Hearing: 25 July 2022

Heard at: Auckland/Tāmaki Makaurau

Appearances: Mr B Hinchcliff for the appellant
Ms F Becroft for the respondent

Judgment: 23 August 2022

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**RESERVED JUDGMENT OF JUDGE C J McGUIRE**
**[Suspension of Entitlements s 117; Entitlement to Surgery S67 and Schedule1 Accident Compensation Act 2001]**

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[1] At issue on this appeal are two decisions of the Accident Compensation Corporation. The first, dated 15 December 2020 declining cover and surgery funding, and the other, a decision of 5 January 2021 suspending the appellant weekly compensation.

[2] The appellant's position is that he suffered rotator cuff tears in an accident on 22 January 2020 and that his need for surgery and incapacity arises from that injury.

[3] The Corporation's position is that the weight of medical evidence establishes that the appellant's ongoing symptoms and incapacity is as a result of an underlying calcific tendonitis rather than any injury caused in an accident in 2020.

## Background

[4] On 24 January 2020, an ACC injury claim form was completed on behalf of the appellant by White Cross Ascot. It listed the description of injury as:

> tripped over a metal spike – landed hard on R shoulder.

[5] An X-ray of the appellant's right shoulder was taken the same day which revealed the following:

> The humeral head is normally positioned in the glenoid with normal cartilage spacing. A thin line of soft tissue calcification is present in one view adjacent to the greater tuberosity. ? calcification in the rotator cuff system or an avulsed fragment of bone. No other suggestion of fracture is identified. AC joint alignment is normal.
>
> **Conclusion**
>
> Suggest ultrasound of shoulder as a further check of the rotator cuff mechanism and greater tuberosity.

[6] An ultrasound on the appellant's right shoulder was carried out on 30 January 2020. It included:

> **Indication:**
>
> Fall onto outstretched hand. Calcification seen on radiograph adjacent to greater tuberosity.
>
> …
>
> **Findings:**
>
> The mineralisation identified on the radiograph corresponds to a poorly defined serpiginous calcification within the supraspinatus tendon. This extends over a length of approximately 18 mm. Similar but less pronounced appearances are noted at the footprint of subscapularis. The tendons of the rotator cuff remain intact. The long head of biceps tendon is of normal calibre and echogenicity with a small volume of sheath fluid. There is no significant subdeltoid bursal effusion or thickening. No fluid or cystic changes identified at the posterior glenohumeral joint recess.
>
> **Conclusion:**
>
> Appearances are in keeping with supraspinatus calcific tendinosis rather than an evulsion fracture of the greater tuberosity.
>
> No evidence of rotator cuff tear.

[7] The appellant was certified unfit for work as he was unable to do any heavy lifting. The injury was covered on 29 January 2020 and weekly compensation payments commenced.

[8] A subsequent medical certificate on 4 February 2020 referred to a supraspinatus injury. This certificate was completed by Mr Foster, hand wrist and elbow surgeon, who saw the appellant that day and he also provided a report. Mr Foster noted:

> He fell over in metal peg on 22 January, initially injuring his wrist and then developed severe right shoulder pain. He was able to abduct to 90 degrees and flex to 90 degrees but his pain localises over the lateral aspect of his humerus.
>
> X-rays have shown some calcification and an ultrasound shows this to be a calcium deposit and not an avulsed bone.
>
> Therefore, his calcific tendonitis is secondary to trauma and this should be treated with expectant recovery, but if things don't settle in the near future, he could have an image guided steroid injection and needling of this calcification.

[9] Mr Foster provided another report on 15 June 2020 included the following:

> I saw him back in February and he was progressing reasonably well and has had X-rays and ultrasound which showed a calcium deposit rather than an avulsed bone.
>
> Things were going pretty well, but he recently stirred his shoulder up and has either exacerbated his calcific tendonitis or might have done a minor tear to the tendon.
>
> We have therefore sent him for repeat ultrasound to look at the state of his cuff and put in an image guided steroid injection to allow him to return to work in the near future.

[10] The appellant received a steroid injection on 23 June 2020.

[11] On 9 July 2020, the appellant underwent an unrelated hernia operation.

[12] From 20 February 2020 through to 24 July 2020, the appellant attended a physiotherapist almost every week. The physiotherapist reported on 14 July 2020:

> Shoulder feels really, good now with no pain. Is ready to go back to work once he is cleared from the hernia.

[13] On 24 July 20209 the physiotherapist reported:

> Damian is going ok, had a little pain in his shoulder but he will need to manage how he is going with work.
>
> Has improved in strength and is going quite well.

[14] On 23 July 2020, Habit Rehabilitation wrote to the appellant's treating practitioner and asked for a medical clearance. The letter noted that the appellant was seven months post injury; he had engaged in specific functional rehabilitation; he had made significant progress and rehabilitation had only stalled because of the effects of the recent hernia operation. The letter advised:

> Mr Foster reported that the steroid injection administered has relieved his symptoms of discomfort and he feels ready to return to work. He had a conversation with his employer who stated that he is able to return to work from 27/7/2020 completing light duties and reduced hours and to self directedly grade these up over time. The Habit physiotherapist agrees that Mr Foster can safely return to reduced work.

[15] Mr Smart, GP, provided a medical certificate on 27 July 2020 clearing the appellant as fit for normal duties from that day.

[16] On 28 July 2020, the Corporation issued a decision advising that the appellant was no longer eligible to receive weekly compensation.

[17] On 13 August 2020, a further medical certificate was filed certifying the appellant as unfit to work from 11 August 2020 due to recurrent severe right shoulder pain. The certificate indicated that the appellant was fit to work for 24 hours a week on light duties only.

[18] On 26 August 2020, Mr Foster, orthopaedic surgeon, provided a report diagnosing a recalcitrant calcific tendonitis to the right shoulder. He also noted:

> He underwent an image guided steroid injection on 23 June and has had a good six weeks of accident pain relief. Unfortunately, however, in the last few weeks he has noticed some recurrence and is now back to light duties.

[19] Under the heading "treatment plan", Mr Foster noted:

> Our next option is a further injection if things do not settle and possibly consider an arthroscopic debridement through one of the shoulder surgeons.

[20] On 5 October 2020, Mr Foster referred the appellant to Mr Boyle, orthopaedic surgeon, for a surgical review.

[21] On 12 October 2020, the Corporation sought further advice from the appellant's general practitioner as to why the appellant's sprain injury had not resolved within the normal time frame. Dr Smart, GP, also responded to the Corporation's question advising:

> Damian suffered an injury to his right shoulder on 22 January after falling on his outstretched hand. He had a USS of his right shoulder soon after this injury which showed calcium deposition. As stated by Dr Mike Foster in his review on 4 February 2020, this calcific tendonitis is clearly from trauma.
>
> Given this additional finding with his sprain, it does fit with the longer course that has taken for his injury to resolve. It was identified early on (initially by Dr Mike Foster) that this pain may take longer to settle and the possibility of steroid injections being required.

[22] Another ultrasound injection was undertaken on 15 October 2020. The report from that injection indicated that there was no pain prior to or following the injection at rest.

[23] Mr Boyle, orthopaedic surgeon, reported on 13 November 2020. He diagnosed calcific tendonitis, reporting that the recent steroid injection had not improved symptoms. Mr Boyle noted significant bicipital groove tendinosis with a relatively preserved range of motion. In terms of imaging, he said:

> Damian has undergone plain X-rays previously on 24 January 2020 which demonstrate calcific changes within the region supraspinatus tendon footprint. Interestingly, repeat X-rays on 15 October 2020 demonstrate no significant calcification. Damian has undergone an ultrasound scan of his right shoulder at ARG radiology on 30 January 2020 which demonstrates supraspinatus calcific tendinosis with no significant rotator cuff tear.

[24] Mr Doyle, Associate Professor Radiology, reported on an MRI of the appellant's right shoulder on 18 November 2020. He said:

> The AC joint has very small osteophytes and adjacent bone oedema. The distal supraspinatus are mostly intact. At the junction with infraspinatus at the insertion, there is a focal bursal surface partial thickness tear containing some fluid and measuring 5x2 mm. No full thickness tear is visible. Subscapularis contains minimal high signal at the insertion with no definite tear. The muscle bellies are all normal. The biceps tendon is normally located and the biceps

> anchor is normal. Glenohumeral cartilage is normal and the glenoid labarum normal.
>
> **Conclusion**
>
> Small partial thickness bursal surface tear at the junction of the insertion of supra and infraspinatus.

[25] The surgery request was then considered by Dr Rutherford, orthopaedic surgeon and principal clinical advisor. In his report of 4 December 2020, he attributed the appellant's symptoms to calcific tendonitis explaining that it was a form of tendonitis which can occur in any tendon of the body but most commonly in the tendons of the rotator cuff, particularly the supraspinatus. He indicated that the cause of calcific tendonitis was believed to be multifactorial. He said there was no evidence that it was a traumatic condition and noted that the ultrasound just a few days after the accident showed no evidence of acuity, e.g. haemorrhage or fluid in the subacromial bursa.

[26] Dr Rutherford provided further comment on 11 December 2020 as follows:

> I accept that the MRI scan of 18/11/2020 does demonstrate partial thickness supraspinatus and infraspinatus tears. However, there is no evidence that these tears are causally related to the accident of 20/1/2020. The reason for this is that the ultrasound scan of the shoulder taken just 8 days later shows no evidence of an acute traumatic injury and in particular no evidence of haemorrhage or hematoma. An acute tear occurring on 22 January would have shown on significant features of acuity on an ultrasound scan taken within 8 days.
>
> No causal link can be established.

[27] On 15 December 2020, the Corporation issued a decision declining surgery funding and cover for the right shoulder calcific tendonitis on the basis that the need for the surgery was not injury related.

[28] Mr Hinchcliff obtained a report from Mr Harvey, physiotherapist, dated 14 August 2021. Amongst other things, Mr Harvey said:

> The claimant's US scan was reported as being free of rotator cuff tears. The evidence from the literature is clear, the diagnostic accuracy of US scan results for detecting full thickness rotator tear is comparable to MRI. However, for partial thickness rotator cuff tears, US scan has less diagnostic accuracy than MRI with lower levels of specificity and sensitivity, partial rotator cuff tears can be present but missed at assessment. The claimant's US scan also showed no

> signs of bursitis or haemorrhagic effusion or hemarthrosis. It should be noted that these features are more likely to be present with full thickness rotator cuff tears.
>
> The claimant had an MRI on 18/11/2020 and this confirmed a small partial thickness bursal surface tear at the junction of the insertion of the supraspinatus and infraspinatus tendons. The MRI was free of any signs of degeneration including fatty infiltration or tendinosis indicating this injury was likely caused by trauma.
>
> …
>
> On the balance of probabilities, the fall on the outstretched arm on 22 January 2020 is likely to have caused a partial thickness rotator cuff tear.
>
> The early US scan and X-ray which highlighted the likely asymptomatic calcific tendinitis and ruled out a full thickness rotator cuff tear – likely focused the management on the claimant's calcific tendinitis. The client's initial physical presentation was not typical calcific tendinitis and was more likely to be of a partial rotator cuff tear. As the claimant fail to respond to conservative management, he had an MRI scan and the full thickness tear was detected. It could be argued if the claimant had an MRI earlier in the process, the partial thickness tear would have been detected more quickly.

[29] The respondent's clinical advisory panel reported on 7 March 2022, amongst other things, the panel said:

> - A sprain is a soft tissue injury which is clinically expected to resolve in a few days or weeks without long term consequences, which was the case here.
>
> - Mr Damian Foster also stirred up painful, persistent symptoms of his pre-existing, previously asymptomatic calcific tendinitis, which is not normally known to be related to trauma. The calcific tendinitis was not caused by the 22/01/2020 accident as discussed below.
>
> It is true that this mechanism of injury is known to cause rotator cuff tendon tears, but there is no convincing evidence of acute rotator cuff tearing in this case. This is because:
>
> - The initial general practitioner examination findings four days after the covered accident – a limited range of motion – were non-specific and could be consistent with a contusion, strain or more serious injury such as a tear. They do not point to a specific cause.

[30] The report went on to note that X-ray and ultrasound did not show any acute pathology. The report went on to say:

> Current medical studies indicated that modern ultrasound scans are just as good as MRI scans for diagnosing partial thickness tears nowadays, with similar sensitivity and positive and negative predictive values.

**Appellant's submissions**

[31] Mr Hinchcliff submits that the medical evidence proves an injury in this case because the mechanism of injury was likely to cause a rotator cuff tear.

[32] He notes that the MRI carried out on 18 November 2020 and the operation note described a bursal sided supraspinatus partial rotator cuff tear.

[33] He says that ACC has not commented on whether the accident could have caused a partial tear. He notes also that the lack of a fatty infiltration and no tendon retraction argues against a gradual process condition.

[34] He submits that Dr Rutherford and the clinical advisory panel rely on the initial ultrasound not showing rotator cuff tears and he submits that this was because the initial focus was on calcific tendinitis and a fracture.

[35] He submits that the ultrasound likely missed the tendon tear because it was not a mid tendon tear. It was at the bone and had no retraction.

[36] He also notes that the contemporaneous X-ray did not show any gradual process condition.

[37] He refers to *W*,[1] at paragraph [65] where High Court found that a material contribution to the injury would be sufficient.

[38] He says that the evidence of Mr Harvey should be preferred because he has commented on the mechanism of injury and the resultant tears, it is an opinion that should be preferred as it is the most comprehensive.

[39] He also refers to Mr Boyle's comment that the heavy fall onto an outstretched hand being the cause of injury, resulted in an immediate right shoulder pain.

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[1] *W v Accident Compensation Corporation* [2018] NZHC 937, [2018] 3 NZLR 859, [2018] NZAR 829.

[40] He notes that both the cover decision and the decision relating to weekly compensation rely on whether or not there was a rotator cuff tear.

[41] Mr Hinchcliff also submits that the contemporaneous factual evidence of the accident supports his submission.

[42] He refers to the appellant's account of injury at the initial client interview on 13 February 2020, some three weeks after the accident, where the appellant said:

> 22/01, I was at work, I was walking around the site, I tripped over a metal spike, fell onto my right arm, with my arm out.

[43] The appellant also said at that interview:

> I had a good sleep last night, that was the first good sleep I have had.

[44] Mr Hinchcliff submits that the appellant had a mechanism of injury that could have caused a rotator cuff tear. He reminds the court that the appellant did not have a full thickness tear and because of the tear's location, on this occasion, it was not picked up on ultrasound. He submits that Mr Harvey's report and diagnosis should be preferred.

**Respondent's submissions**

[45] Ms Becroft on behalf of the respondent notes that following the accident on 22 January 2020, the appellant visited the White Cross Ascot emergency department on 24 January 2020 and that the X-ray on 24 January 2020 queried whether there was calcification in the rotator cuff system and the ultrasound scan that followed on 30 January confirmed supraspinatus calcific tendinosis with no evidence of rotator cuff tear.

[46] She refers to Mr Boyle's assessment report and treatment plan following the consultation of 13 November 2020 which by then noted that repeat X-rays on 15 October 2020 demonstrated no significant calcification.

[47] It wasn't until an MRI scan was completed on 18 November 2020 that a partial thickness tear was observed at the junction with infraspinatus at the insertion of supra and infraspinatus.

[48] She notes that the issue is a narrow one and that until that point there was no evidence of tears.

[49] She submits that the only evidence the appellant has that the accident caused the tear is from the physiotherapist Mr Harvey. She notes that the clinical advisory panel says that Mr Harvey is wrong in saying that tears don't show up on ultrasound with the panel saying:

> Current medical studies indicate that modern ultrasound scans are just as good as MRI scans for diagnosing partial thickness tears nowadays, with similar sensitivity and positive and negative predictive values.

**Appellant's reply**

[50] In a brief reply, Mr Hinchcliff submitted in reliance upon *W v ACC*, that in this case the mechanism of injury meant there was still likelihood that it caused the rotator cuff tear.

**Decision**

[51] The ultimate question to be answered in this case is whether the appellant's accident on 22 January 2020 caused a rotator cuff tear resulting in the need for surgery and whether ACC's resulting decision suspending weekly compensation was correct.

[52] It seems to be common ground that the mechanism of injury in this case is capable of causing a rotator cuff tendon tear, a fact acknowledged by the clinical advisory panel.

[53] Indeed, two days after the accident on 24 January 2020, the radiologist at the Ascot Radiology Clinic, Ms Vogel noted in her report:

> Suggest ultrasound of shoulder as a further check of the rotator mechanism and greater tuberosity.

[54] The ultrasound took place on 30 January 2020 and although a calcific tendinosis was found the radiologist found no evidence of rotator cuff tear.

[55] It was not until an MRI scan of the appellant's right shoulder was carried out on 18 November 2020, some ten months after the accident that a small partial thickness tear was found.

[56] Physiotherapist, Daniel Harvey, who provided a report on 14 August 2021 to appellant's counsel said this:

> The evidence from the literature is clear, the diagnostic accuracy of US scan results for detecting full thickness rotator tear is comparable to MRI. However, for partial thickness rotator cuff tears, US scan has less diagnostic accuracy than MRI and with lower levels of specificity and sensitivity. Partial rotator cuff tears can be present but missed at an assessment.

[57] Mr Harvey goes on to say:

> The client's initial physical presentation was not typical of calcific tendinitis and was more likely to be of a partial rotator cuff tear. As the claimant failed to respond to conservative management, he had an MRI scan, and the partial thickness tear was detected.

[58] The clinical advisory panel in its report noted that the prevalence of small sized, partial thickness tears increases with age:

> which suggests that a tear may occur at any age and the chances are higher in older people.

[59] At the time of the accident, the appellant was 50 years old.

[60] The clinical advisory panel notes that:

> Current medical studies indicate that modern ultrasound scans are just as good as MRI scans for diagnosing partial thickness tears nowadays, with similar sensitivity and positive and negative predictive values.

[61] The panel then refers to research publications, the first being from Orthop J Sports Med. 2020 entitled "Detecting Rotator Cuff Tears: A Network Meta-analysis of 144 diagnostic studies."

[62] The article noted:

> … A network meta-analysis of diagnostic tests revealed that high-field MRA has the highest diagnostic value for detecting any tear, followed by low-field MRA, high-field MRI, high-frequency US, low-field MRI, and low-frequency US.

[63] A second publication is referred to, entitled "Accuracy of Ultrasonography and Magnetic Resonance Imaging for Detection of Full Thickness Rotator Cuff Tears" – International Journal s\ Shoulder Surgery 2009, which said:

> The overall accuracy of the ultrasound was 88.89% as compared with 89.09% for the MRI.

[64] It is noted that that study related to full thickness rotator cuff tears whereas we are dealing with a partial rotator cuff tear.

[65] I conclude that while the studies do indeed tell us that that ultrasound is comparable to MRI with an accuracy in both cases of 88 – 89%, as a matter of logic the accuracy of both MRI and ultrasound when dealing with partial thickness rotator cuff tears, must be lower.

[66] Included in the bundle of documents are the assessment notes from the physiotherapist Neil Davis. He treated the appellant on a weekly basis from 20 February 2020 until 24 July 2020. It is from the initial consultation that the focus was on the appellant's supraspinatus tendon of the right shoulder.

[67] The appellant's progress through his physiotherapy treatment appears to have been generally good although not entirely so. On 27 May 2020, he reported "doing ok" but then he was "woken up by pain" and there was "slight catching on first shoulder press".

[68] The report during June 2020 continued to mention pain.

[69] The report of 14 July 2020 noted:

> Shoulder feels really good now, with no pain. Is ready to go back to work.

[70] The final report on 24 July 2020 said:

> Damian is going ok, the little pain in his shoulder but will need to manage how he is going with work.

[71] Reviewing these notes, with the exception of the entry of 14 July 2020, what is reported is a long rehabilitation with pain persisting through most of the period.

[72] Although the physiotherapy notes are by no means diagnostic of partial thickness rotator cuff tear, the persistence of pain in his shoulder effectively throughout his rehabilitation period certainly does rule out the same being present.

[73] In addition, referring to medical research from the dedicated medical website research website "Pub Med", Mr Harvey says this:

> The claimant's US scan also showed no signs of bursitis or haemorrhagic effusion or hemarthrosis. It should be noted that these features are more likely to be present with full thickness rotator cuff tears.

[74] The scientific studies acknowledge that for both MRI and ultrasound, accuracy is slightly less than 90%. It follows that statistics cannot conclusively answer the question of causation.

[75] I conclude that what tips the balance in favour of the appellant in this case is his long history of pain recorded by his physiotherapist which appears to have been only temporarily relieved at the time of the consultation of 14 July 2020, following five months of physiotherapy.

[76] Accordingly, I conclude that on the balance of probabilities, the appellant has established that his accident of 22 January 2020 caused a partial rotator cuff tendon tear. Accordingly, ACC's decision of 15 December 2020 declining cover and surgery funding is reversed as is ACC's decision of 5 January 2021 suspending the appellant's weekly compensation.

[77] Accordingly, the appeal is allowed.

[78] Should there be any issue as to costs, counsel have leave to file memoranda in respective of within one month.

Judge C J McGuire
District Court Judge

Solicitors: ACC and Employment Law, Ellerslie
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