IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 168 **ACR 263/20**

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

Hearing: 26 July 2022

Heard at: Auckland/Tāmaki Makaurau

Appearances: Appellant in person
Ms B Johns and Ms A Lane via AVL for the respondent

Judgment: 25 August 2022

RESERVED JUDGMENT OF JUDGE C J McGUIRE
[Personal Injury and Cover Issues, s 26 and Part 3 Accident Compensation Act 2001]

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[1] The issue for determination on this appeal is whether ACC's decision of 14 July 2020 declining to cover the diagnosis of lumbar intervertebral disc prolapse with right sided radiculopathy arising from an accident driving a bulldozer on 13 January 1995 was correct.

Background

[2] On 13 January 1995, Mr Robinson suffered an accident whilst driving a bulldozer. Injury by accident was accepted by ACC and in the schedule of claimant's injuries, they are noted as:

> Sprain or strain; chest
>
> Sprain or strain; neck, back of head vertebrae
>
> Cervicalgia – pain in neck

[3] Mr Robinson, in his submissions, describes the January 1995 accident as follows:

> In January 1995 while felling old pine on a ridge and in the process of pushing the logs into the gully with a bulldozer, Mr Robinson was catapulted headfirst into the safety cab of his bulldozer. The force was sufficient to split Mr Robinson's safety helmet and compressed his neck and spine before he dropped back down into the cab.

[4] No doubt, due in part to the effluxion of time, other contemporary descriptions of this accident are absent.

[5] In the documents before the Court, apart from the schedule of injuries, the first reference to the 1995 accident is in a brief report from Dr Grant Thompson musculoskeletal physician dated 1 June 2005. In this report, relating to a stiff neck and low back pain, the 1995 accident is referred to along with two other accidents on 30 June 1997 and 8 December 2000.

[6] The next report is in an Assessment Report and Treatment Plan from Dr Quin, musculoskeletal pain medicine specialist, dated 9 August 2005. Dr Quin notes:

> On the 1 February 1995, he was thrown off a bulldozer onto the steel canopy hitting his head. This cracked safety helmet open, and he was generally not too badly affected and saw a physiotherapist who settled the problem down somewhat.
>
> …
>
> He tells me also he has a history of low back pain which I did not delve into today.
>
> His past medical history includes low back pain …

[7] The injury is next mentioned in a report of 11 December 2008 from Dr Thompson. The accident is not commented on specifically, but under the heading "history", there is this:

> Since early 2005, John has had worsening low back pain, initially intermittent and now constant, often with apparent pain and tenderness at the muscle insertions.

[8] In a workplace assessment report of 28 April 2010, reference again is made to the 1995 accident as follows:

> On 13/01/1995, John was driving a bulldozer, when the blade caught and John was catapulted into the safety canopy injuring his neck. The safety helmet was destroyed and John sustained a laceration to his scalp. Ongoing neck problems since the injury have included headaches, neck stiffness and neck pain with reduced movement, radiation of pain down both arms and intermittent numbness in both thumbs and little finger on right hand. Over the past four years, John has been experiencing low back pain associated with the neck pain.

[9] The next reference to the accident causing injury is contained in orthopaedic surgeon, Mr Kelman's specialist medical review, from 2 June 2011

[10] What is recorded is this:

> Mr Robinson claims that on 13-01-1995, he was operating a bulldozer. He was clearing the number of pine trees from a ridge and pushing them down into the valley below. As he was doing so, the branch of a large pine tree became embedded in the ground preventing it from rolling down the hill. Mr Robinson moved his machine to push the tree down and as he did so, the bulldozer rose up and fell forward. In doing so, he was thrown from his seat forward and stuck his head on the metal cab. He stated that his helmet was split. He also had a laceration of his scalp. He did not lose consciousness. He was unable to continue work that day but attempted to work the following day. He then started attending physiotherapy twice a week. He also saw his general practitioner but no X-rays were taken initially. He was then referred to Dr Quin who carried out a number of injections to the trigger points in his cervical spine with only temporary improvement in his symptoms.

[11] ACC had asked Mr Kelman a number of questions including:

> *Is it likely that the pathology in his neck was as a result of the injury of 13-01-1995?*

and:

Alternatively, or additionally; has a disease, or aging process, or a pre-existing condition from some other injury become symptomatic?

[12] Mr Kelman's response was:

> Mr Ronbinson is currently 55 years of age. There was no pre-existing conditions in his neck, shoulders or ankle prior to the injuries which have been sustained. There is no doubt that he will have suffered some degenerative changes as a result of the process of aging particularly with respect to his neck and lumbar spine and therefore in part I would consider that some of his symptoms relate to this process. Empirically, I would consider that his conditions which have resulted from injury account for 80% of his symptoms.

[13] On 1 September 2015, Dr Thompson, prepared an Assessment Report and Treatment Plan relating to his injury of 13 January 1995. The diagnosis was – pain in lumbar spine – chronic lumbosacral pain, ? internal disc disruption.

[14] Under the heading "impression", Dr Thompson wrote:

> I suspect that John's chronic lumbosacral pain is most likely due to internal disc disruption.

[15] An MRI was carried out on 17 September 2015.

[16] The conclusion was:

> L1/2 central annular tear, L4/5 diffuse annular disc bulge and left foraminal annular tear and L5/S1 central disc protrusion are present but there is no nerve root involvement.

[17] On 18 December 2015, Dr Thompson reported again to ACC, and said:

> Based on the history, clinical examination, and radiology, diagnosis, more likely than not, is lumbar internal disc disruption, either at L4-5 or L5-S1 level.
>
> I do not have sufficient information to date the L4-5 and L5-S1 lumbar disc lesions and this is not possible from the MRI scan. There is insufficient clinical records to make a contemporised link from an initiating event and the current symptoms.
>
> The long term prognosis for lumbar internal disc disruption is good. The pain does not indicate further tissue damage is occurring.
>
> …
>
> IDD usually arises from an earlier accident and is not an age-related problem or result from disease.

[18] On 28 February 2019, Dr Ng, musculoskeletal medicine specialist, forwarded an Assessment Report and Treatment Plan to the appellant's GP. It included the following:

> Diagnosis
>
> 24 years of lumbosacral pain following bulldozing accident.
>
> Currently increased lumbar pain.
>
> 1-2 years of right lower leg and foot paraesthesia; possibly L5 radiculopathy
>
> Link between symptoms and ACC covered personal injury – lumbar pain since injury in 1995.
>
> Management plan and prognosis – although John has had lumbar pain for 24 years, it is now worse. In addition, he now has paraesthesia in the L5 dermatomal distribution. It is possible that he has right L5 nerve compression or irritation. Therefore, I have requested a further MRI of the lumbar spine and will telephone John with result. Should the MRI demonstrate a significant abnormality, we may proceed to a fluoroscopically guided transforaminal steroid injection.

[19] A further MRI was carried out on 11 March 2019. The conclusion was as follows:

> Disc desiccation and shallow disc bulges are essentially unchanged as compared to the previous MRI.

[20] Further advice was given by Helen Shrimpton, branch medical advisor, on 10 July 2020.

[21] Amongst other things, she said:

> This is a temporal association of symptoms. While it is plausible that an axial force could cause an acute lumbar disc protrusion – the contemporaneous evidence does not support this. The client's lower back symptoms began ten years later and there are multi-level degenerative signs on imaging which is a more plausible explanation. There is no causal association supported by the medical notes on file between right radicular symptoms in 2015 and the acute accident in 1995…

[22] Mr Pai, independent orthopaedic assessor, carried out a paper file review dated 8 September 2020.

[23] Included in Mr Pai's report is the following:

> I have personally reviewed the MRI films which were performed in TRG radiology and in my opinion there is no indication to suggest any traumatic injury has occurred and the findings are consistent with normal age-related changes.
>
> …
>
> In my opinion the findings are consistent with generalised spondylosis which should be the first line of diagnosis in a 60 year old man in 2015 unless proved otherwise. The findings on his further MRI of 11/03/2019 remained unchanged with stable spondylosis with no nerve route compression.

[24] Mr Pai went on to say:

> I have not come across any case reports in world literature of anyone presenting with pain in the lumbar spine after 20 years following an injury event. I have gone through the findings as noted on the MRI and these are commonly seen in anyone who is 60 years of age with multi-level disc desiccation and facet joint arthritis and various changes in the annulus. Literature is very clear with regards difficulty to differentiate a traumatic disc prolapse and chronic degenerative disc disease. And the clinical cause, the mechanism of injury and MRI findings should be correlated and taken into account. In my opinion, the pathology in this case is of chronic disc degeneration and the relationship is speculative and temporal.

[25] Mr Pai goes on to note:

> Low back pain with or without sciatica can be precipitated spontaneously with or without trauma.
>
> …
>
> In my opinion, his presentation is not consistent with an acute traumatic disc prolapse in 1995.

Appellant's submissions

[26] Mr Robinson told the Court that the ramifications of his bulldozer injury in 1995 did not come to light until years later and that in the meantime, in 1996, a truck crash crushed his leg.

[27] He said that is when the battle with ACC started. He said that the mechanism of the accident in the bulldozer damaged his lower spine.

[28] He refers to the report of orthopaedic surgeon Mr Herbert dated 29 June 2001 where he notes a history of pain in multiple sites including the shoulders, elbows, the spine and the right hip.

[29] He submits that his "crash" injury could only be caused by the accident and that an acute prolapsed disc is different. In this regard he refers to the evidence of Mr Thompson.

[30] He notes that ACC appears to rely "totally" on the paper review by Mr Pai. He submits that the 2015 MRI scan basically reveals that there was less degeneration in his back than with other people of a similar age.

Respondent's submissions

[31] Ms Lane says that causation is central to this case and that changes coming about as a result of a gradual process will not suffice.

[32] ACC's position is that there is no record of the appellant suffering symptoms of a lumbar disc prolapse until at least six years after the accident which is inconsistent with the accident itself causing the lumbar disc prolapse.

[33] She submits that neither of the medical practitioners who support the appellant's claim have explained delay in the onset of symptom.

[34] In any event, ACC says that the lumbar disc prolapse is caused by age-related degeneration and that the independent expert evidence of Mr Pai is to be preferred.

[35] She took the Court through a number of the reports in the bundle.

[36] She referred to Mr Kelman's specialist medical review of June 2011 and notes that at page 11 of his report, there is no reference to lumbar spine pain listed under the heading "current status".

[37] It is noted however that on the previous page of Mr Kelman's report, where reference is made to the 1995 accident, he does say:

> He (the appellant) said that gradually the pain from his neck spread to his upper thoracic and to his lumbar region.

[38] She submits there is insufficient evidence therefore that the lumbar disc prolapse was caused by the 1995 accident.

[39] She notes that the delay in the onset of pain in the lower back is not explained.

[40] She refers to the definition of accident in the s 25.

[41] She refers to Mr Pai's paper file review of 8 September 2020. There Mr Pai says:

> I have not come across any case report in world literature of anyone presenting with pain in the lumbar spine 20 years following an injury event.

[42] She submits therefore that there is not enough evidence in this case before the Court to reach a robust inference of causation.

[43] She also notes that at page 17 of Mr Kelman's report, one of the diagnoses is degenerative mechanical back ache.

[44] She refers to Dr Walls' report of 3 June 2014 in which he also notes a diagnosis of cervical and lumbar spondylosis. She submits that the Court can be satisfied on the balance of probabilities that the appellant's presentation is age-related and not traumatic.

Decision

[45] The issue for determination on this appeal is whether or not ACC's decision of 14 July 2020 declining to cover an additional diagnosis of lumbar disc prolapse was correct. What seems clear from the file is that the appellant, who is now 67, has suffered a great number of accidents causing injury during his life.

[46] The accident under the spotlight today is that which occurred on 13 January 1995 when he was driving a bulldozer clearing logs.

[47] Although complete records relating to this accident appear to no longer exist, his description of it whether brief or long is consistent. A relatively full description of it appears in Mr Kelman's specialist medical review of 2 June 2011. Mr Kelman says:

> Mr Robinson claims that on 13-01-1995, he was operating a bulldozer. He was clearing a number of pine trees from a ridge and pushing them down into the valley below. As he was doing so, the branch of a large pine tree became embedded in the ground preventing it from rolling down the hill. Mr Robinson moved his machine to push the tree down and as he did so, the bulldozer rose up and then fell forward. In doing so he was flung from his seat forward and struck his head on the metal cab. He stated his helmet was split. He also had a laceration of his scalp. He did not lose consciousness. He was unable to continue work that day but attempted to work the following day. He then started attending physiotherapy twice a week. He also saw his general practitioner but no X-rays were taken initially.

[48] Following that, he sought assistance from other practitioners.

[49] This accident causing injury resulted in three claims being accepted by ACC:

> Sprain or strain; chest
>
> Sprain or strain; neck, back of head vertebrae
>
> Cervicalgia – pain in neck

[50] At the time of the accident, the appellant was 39 years old.

[51] I find that the inference to be taken from the appellant's file and his work record, is that, injury not withstanding, he was a person that got on with his life.

[52] In the same report Dr Kelman notes that the appellant later came under the care of Dr Thompson who carried out medial branch blocks under X-ray control in his cervical spine but that these treatments gave only temporary relief from pain. He continued with physiotherapy, but he told Mr Kelman that gradually the pain from his neck spread to his upper thoracic and to his lumbar region.

[53] On 18 December 1996, he had another accident when a truck he was travelling in rolled. This resulted in his right ankle being crushed resulting in an open compound fracture of the right distal fibula and a chip off the distal tibia.

[54] There is a report on the file from Dr Grant Thompson dated 28 July 1997 describing the degree of injury and the treatment provided for it.

[55] It is plain that during 1997, the effects of the ankle injury predominated.

[56] The first report in the bundle of documents that includes material of relevance to the issues before the Court today is that of orthopaedic surgeon Mr Herbert dated 29 June 2001.

[57] In Mr Herbert's report, the injury of January 1995 is not specifically referred to. The report says:

> Mr Robinson reports being involved in heavy manual activities since he started work at the age of 15, initially in the forestry area pruning trees with a chainsaw. He describes intermittent discomfort in both upper limbs particularly on heavy activity since the very early stages of his career.

[58] Mr Herbert noted:

> The history was difficult to obtain and it is difficult to offer a precise diagnosis. Mr Herbert thought it likely that his presentation represents a gradual process injury as a result of heavy and continued physical activity and not the result of a specific accident.

[59] Mr Herbert went on:

> This is not in my view related to degenerative change or to any underlying rheumatologic disorder. It is, given the history of pain at multiple sites including the shoulders, elbows, the spine and the right hip, reasonable to suggest that this may be developing into a chronic pain syndrome.

[60] While the fact that the appellant did not raise with Mr Herbert the specific accident causing injury of 13 January 1995, remains something of a mystery, it is nevertheless fair to say that Mr Herbert's report provides evidence of the appellant reporting pain in his spine as at June 2001.

[61] Next, there is the work rehabilitation medical assessment of 10 June 2002. At page 2 of Dr Gollop's report, the doctor notes this:

> In 1997 while working in forestry, Mr Robinson developed a burning sensation in his upper arms, from his shoulders to his elbows, both L and R. When this is severe, he also develops pain in the back of his neck and in his lower back. …

> He has difficulties sleeping because of pain in the back and shoulders.

[62] Throughout this time, it is noted that the appellant continued to have pain from the compound fracture of his right ankle.

[63] The next report on the file of relevance is that of Dr Thompson of 1 June 2005. The 1995 neck and upper back injury is specifically referenced. Dr Thompson noted:

> I reviewed John today. He has had a stiff neck and low back pain radiating to the sides.

[64] The next reference is that of Dr Paul Quin, musculoskeletal pain medicine specialist of 9 August 2005.

[65] Dr Quin notes:

> On 1 February 1995, he was thrown off a bulldozer onto the steel canopy hitting his head. This cracked his safety helmet open, but he was generally not too badly affected and saw a physiotherapist who settled the problem down somewhat.

[66] Dr Quin also noted:

> He tells me he also has a history of low back pain which I did not delve into today.

[67] Next there is the report from Dr Thompson dated 15 September 2005 which records:

> He has had years of low back pain, continuous in the last 6-9 months with pain rated 2-7/10 being like a slight muscle strain at best, to being hard to mobilise at worst, aggravated by sitting, driving, or bending. He can have low back pain in bed at night …
>
> **Examination**
>
> Moderate springing pain over L4 and L5

[68] The next document in the bundle that is relevant, again referring to the 1995 accident (amongst others), is the Assessment Report and Treatment Plan of Dr Thompson, dated 11 December 2008, where it is noted:

> Since early 2005, John has had worsening low back pain, initially intermittent and now constant, often with apparent pain and tenderness worse at the muscle insertions.

[69] The workplace assessment report of 28 April 2010, includes:

> On 13/01/1995, John was driving a bulldozer, when the blade caught and John was catapulted into the safety canopy injuring his neck. The safety helmet was destroyed and John sustain a laceration to his scalp. Ongoing neck problems since the injury have included headaches, neck stiffness and neck pain with reduced movement, radiation of pain down both arms and intermittent numbness in both thumbs and little finger on right hand. Over the past four years, John has been experiencing low back pain associated with the neck pain.

[70] Given the above references, I am surprised that Mr Pai says in his response to question two of the questions asked by ACC:

> I cannot relate findings as noted to the injury event of 1995 or 1996 considering his clinical course as discussed above of presenting with back pain after 20 years following the initial injury event and his imaging findings.

[71] The conclusion I draw from reviewing the evidence is that the appellant's 1995 bulldozer accident was significantly overshadowed by the effects of the compound fracture of his ankle the following year when the truck he was driving rolled.

[72] The other focus is on the MRI scan taken on 17 September 2015 and repeated on 11 March 2019.

[73] The conclusion of the 2015 MRI scan was as follows:

> L1/2 central annular tear, L4/5 diffuse annular disc bulge and left foraminal annular tear and L5/S1 central disc protrusion are present but there is no nerve route involvement.

[74] Mr Thompson compiled an ACC medical case review on 18 December 2015. In it he included the complete radiologist's report of the MRI.

[75] Dr Thompson said:

> Based on the history, clinical examination, and radiology, the diagnosis, more likely than not is lumbar internal disc disruption either at L4-5 or L5-S1 level.

[76] Dr Thompson goes on to say:

> The long term prognosis for lumbar internal disc disruption (IDD) is good. The pain does not indicate further tissue damage is occurring.
>
> …

> IDD usually arises from an earlier accident and is not an age-related problem or result from disease.

[77] The MRI was repeated on 11 March 2019, some three and half years after the first MRI. The radiologist's conclusion was:

> Disc desiccation and shallow disc bulges are essentially unchanged as compared to the previous MRI. No new nerve route compression. In particular, no evidence of L5 nerve route compression.

[78] Commenting on the 2019 MRI, Dr Ng said:

> His MRI on 11/03/19 shows no change from that of 2015.

[79] Mr Pai on the other hand was of the opinion that the findings of the 2015 MRI "are consistent with generalised spondylosis which should be the first line of diagnosis in a 60 year old man in 2015 unless proved otherwise. The findings on this further MRI of 11/03/2019 remain unchanged with stable spondylosis with no nerve root compression."

[80] Mr Pai disagrees with Dr Thompson in his interpretation of the 2015 MRI. In Mr Pai's view, there is no indication to suggest any traumatic injury has occurred and that the findings are consistent with normal age-related changes.

[81] Conversely, Dr Thompson says that internal disc disruption usually arises from an earlier accident and is not an age-related problem or result from disease.

[82] Mr Pai does not address the latter proposition from Dr Thompson directly but acknowledges that the findings of the further MRI of 11 March 2019 remain unchanged.

[83] In this case, Dr Thompson who has been involved with the appellant since 1997, as a musculoskeletal physician gave an opinion on 18 December 2015 following an MRI scan that the appellant's internal disc disruption "usually arises from an earlier accident and is not an age-related problem or result from disease". He went on to say that the long term prognosis was good, with pain not indicating further tissue damage was occurring.

[84] I conclude that as the appellant was aged 60 when the 2015 MRI scan was taken, if the internal disc disruption was as a result of degeneration with age, then there would have been further detectible degeneration on the MRI scan taken three and half years later on 11 March 2019 with the appellant then aged 63.

[85] No further degenerative change was reported.

[86] I find that this fact tips the balance in favour of a conclusion that the appellant's internal disc disruption is injury related rather than age-related.

[87] Accordingly, the appeal is allowed and ACC's decision of 14 July 2020 declining cover for additional diagnosis of lumbar disc prolapse is reversed.

[88] If there are any outstanding issues relating to costs, the parties have leave to file memoranda in respect thereof.

Judge C J McGuire
District Court Judge

Solicitors: Claro, Wellington.