IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 222 **ACR 163/21**

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPEAL UNDER SECTION 149 OF THE ACT
BETWEEN	BRYAN KEEBLE Applicant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Hearing:	18 October 2022
Heard at:	Whangarei/Whangārei-Terenga-Parāoa
Appearances:	The appellant is self-represented, with his wife J Keeble F Becroft and L Hawes-Gandar for the respondent
Judgment:	29 November 2022

RESERVED JUDGMENT OF JUDGE D L HENARE
[Claim for cover and request for surgery funding; suspension of entitlements; clause 1 Schedule 1 and s117 of the Accident Compensation Act 2001]

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[1] The appellant, Bryan Keeble sustained injuries in June 2019 in an accident in his work as a mechanic. He stated:[1]

> I was up one of the work ladders at work, the car was right up top of the pulley, and I was trying to pull the gearbox over, and put a bolt in with the other hand, and I slipped on the ladder, so I was hanging. I twisted my knee when I slipped. Initially my calf and the back of my knee was really painful, I thought I just pulled a muscle and I left it for a couple of weeks, it wasn't improving, and I went to see Andrew [Osteopath]. He wasn't sure if I had done something to my knee or tore my calf muscle.

[2] Mr Keeble received cover for right knee and calf strains and a meniscal tear. Subsequently, he underwent surgery for arthroscopic repair of the meniscal tear. Mr Keeble claims ongoing support, including cover for right knee osteoarthritis and funding for surgery for right knee replacement.

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1 Initial client interview transcript dated 23 August 2019.

[3] The Corporation says the available evidence shows a degenerative condition is causing Mr Keeble's knee symptoms which are not caused by the accident. For this reason, the Corporation issued two decisions dated:

- 20 October 2020; declining cover and surgery funding for right knee degenerative changes.
- 21 October 2020; suspending entitlements in relation to a knee injury that occurred on 17 June 2019, on the basis that ongoing knee symptoms were not injury related.

[4] The parties filed the following agreed statement of facts.

Statement of facts

[5] Mr Keeble suffered a knee injury on 17 June 2019 when he twisted his right knee and calf at work.

[6] Mr Keeble was seen by Adrian Turner, Osteopath, on 25 June 2019 for treatment, and the ACC claim was filed on that day.

[7] Mr Keeble initially continued to work, but experienced ongoing pain.

[8] Mr Keeble had a telephone consultation with Dr Washer, his Auckland based General Practitioner, on 5 August 2019, and then saw Dr Washer on 9 August 2019. A specialist referral was arranged.

[9] On 11 August 2019 Mr Keeble advises he experienced intense pain, and, on the advice of Dr Washer, he presented to the Emergency Department at Whangarei Hospital. He was referred for x-rays and an ultrasound of the right knee. The x-ray, taken on 11 August 2019 reported, "minor joint space narrowing and osteophytic sharpening in keeping with early osteoarthritis of all compartments".

[10] Shortly thereafter Dr Washer filed a medical certificate certifying Mr Keeble as unfit for work, and weekly compensation payments began.

[11] On 20 August 2019 an MRI scan was taken which confirmed a meniscal tear and chondral loss.

[12] On 9 September 2019 Mr Keeble was seen by Mr Crawford, Orthopaedic Surgeon who administered a cortisone injection, but his pain continued.

[13] Mr Crawford reported again on 2 October 2019 confirming significant ongoing pain. He arranged for a further MRI scan to investigate.

[14] Another MRI scan was taken on 7 October 2019. In meantime, Mr Keeble was referred to Mr Street, Orthopaedic Surgeon, for a second opinion.

[15] Mr Street reported on 14 November 2019 confirming a meniscal tear and his view that that tear was injury related. Mr Street filed an assessment report and treatment plan seeking surgery funding to treat the tear.

[16] On 21 November 2019 Dr Burgess, Occupational Medicine Specialist, undertook a medical case review for the Corporation. He agreed that the meniscal tear was injury related.

[17] On 22 November 2019 the Corporation approved surgery funding to treat the meniscal tear and the surgery proceeded on 5 December 2019. Mr Keeble advises the surgery took longer than usual because of the damage present.

[18] Mr Street provided post-surgical reports on 19 December 2019 and 16 January 2020. He noted a slightly slower recovery than usual.

[19] In the following months Mr Keeble received physiotherapy. His symptoms were noted to gradually improve, but they did not resolve.

[20] Dr Burgess completed another medical case review on 31 July 2020. He noted a flare up in symptoms in the last 3 weeks, although Mr Keeble maintains that his pain had remained constant. He thought that the covered injury, i.e., the meniscal tear had resolved and that the cause of ongoing symptoms was underlying right medial joint arthrosis.

[21] On 3 September 2020, another MRI scan was undertaken.

[22] On 10 September 2020 Mr Street reported noting meniscal pathology in the knee and discussing surgical options. Mr Street then filed another assessment report and treatment plan seeking funding for total knee replacement to treat what he described as post-traumatic degenerative changes in the knee.

[23] The file was: subsequently considered by Mr Candy, Clinical Advisor and Mr Brownlee, Orthopaedic Surgeon. They concluded that the covered injury had resolved and that ongoing symptoms requiring a total knee joint replacement originated from a pre-existing degenerative condition.

[24] The Corporation's two decisions were issued thereafter, John Miller Law applied for reviews of those decisions on Mr Keeble's behalf.

[25] For the review, Mr Van Niekerk, Orthopaedic Surgeon provided a further report dated 25 February 2021. He confirmed that the original injury was a meniscal tear and wondered whether there was now an inflammatory condition at work.

[26] On 24 March 2021 another MRI scan was undertaken,

[27] On 1 April 2021 Mr Street provided a further report supporting his view that the pathology was injury related.

[28] Mr Van Niekerk then reported again on 6 April 2021 and was not sure whether the condition was injury related or not.

[29] Dr Washer provided a letter of support on 6 April 2021.

[30] The review proceeded in May 2021 and a review decision dated 14 June 2021 dismissed both applications in reliance on the evidence from Dr Burgess.

[31] A Notice of Appeal was filed.

[32] For the appeal the Corporation has filed a report from the Clinical Advisory Panel dated 29 November 2021. They provide reasons why they think that the knee degeneration is unrelated to the accident.

Issues

[33] The underlying issue is whether the pathology in the knee, which is categorised as degeneration, is caused by the accident or injuries suffered in the accident, or whether that pathology is separate from, and pre-existing to the accident.

[34] There is also a question whether the Corporation had sufficient basis to conclude, in October 2020, the covered knee injuries had resolved.

Issue One-Whether the pathology was caused by the accident or covered injuries in the accident of 17 June 2019

Medical evidence

[35] Mr Keeble was referred to Mr Crawford, Orthopaedic Surgeon, for assessment and an MRI some two months post injury. He continued to suffer a painful right knee with "ligamentous versus meniscal injury". Mr Crawford noted significant pain palpating over the medial joint line and a meniscal tear. Reviewing the MRI, Mr Crawford commented:

> Radiographs-MRI scan- This confirms some thinning of the articular cartilage in the medial and lateral compartment. He has some subchondral changes in the compartment as well. His medial meniscus is extruded and torn. He has a small tear in the lateral meniscus as well.

[36] Mr Crawford injected cortisone into the knee joint and noted "complete resolution of the pain". He noted possible PVNS.[2] He indicated a further MRI should be arranged in 12 months' time.

[37] Mr Crawford reported again on 2 October 2019 and indicated that Mr Keeble had pain in the suprapatellar pouch region and around the patellofemoral joint. Mr Keeble reported episodes of catching and locking. He arranged a further MRI scan to investigate.

[38] An MRI scan of the right knee on 7 October 2019 showed stable appearances. There was no evidence of a focal enhancing mass and no other evidence to suggest PVNS.

[39] On 21 October 2019, Mr Keeble resigned from his position at Advanced Automatics.

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2 Pigmented Villonodular Synovitis. Synovial proliferation forming brown nodular masses, probably caused by hemangiomas of synovial membrane that result in inflammation... Dorlands Medical Dictionary (32nd ed).

[40] On 14 November 2019 Mr Street, Orthopaedic Surgeon reviewed the MRI scans and indicated they showed a fragmented and torn medial meniscus. He stated, "the vast majority of joint surfaces were within normal limits, with possibly the slightest irregularity". He said that calling the knee arthritic, is an "overcall." He thought the knee pain, locking and giving way, might be related to the meniscal tear although he did not exclude some chondral irregularity. He thought it was reasonable for the Corporation to cover the pathology.

[41] The same day, Mr Street filed an assessment report and treatment plan ("ARTP"). In terms of causation, he stated:

> The patient's injury to the knee where there was a high energy twist appears to have torn his medial meniscus. There is only the slightest chondral change, but there is very significant meniscal change in this knee, suggesting that a significantly unstable meniscal tear is wholly and substantially the cause of his locking and giving way.

[42] A medical case review was undertaken by Dr Burgess, Occupational Specialist, on 21 November 2019. He diagnosed a medial meniscal tear with post traumatic synovitis, although he noted that there appeared to have been significant resolution in the synovitis. He agreed surgical intervention would be beneficial. He thought that the mechanism of injury was consistent with a meniscal tear.

[43] On 22 November 2019, the Corporation approved surgery funding. The surgery proceeded on 5 December 2019.

[44] Mr Street provided a post-surgical report on 19 December 2019. Mr Keeble was at that stage walking well but did not feel he could return to work and Mr Street certified him as unfit for a further 2 weeks.

[45] Mr Street reported again on 16 January 2020 and noted Mr Keeble was experiencing a slower recovery than usual from the surgery. He considered Mr Keeble could try a return to work. Since Mr Keeble did not have a job to return to, he was referred for vocational assistance, and an initial occupational assessment was undertaken on 28 April 2020.

[46] The review which the employer brought against the cover decision proceeded in June 2020. The Reviewer issued a decision on 21 July 2020 dismissing the review application and finding the Corporation's decision to accept a work-related injury, was correct.

[47] Dr Burgess completed another medical case review on 31 July 2020 and noted since the surgery, Mr Keeble had continued with physiotherapy and was having to use anti-inflammatories on a regular basis. However, a gradual improvement was noted. There was a flare up of symptoms in the last 3 weeks. However, Dr Burgess noted Mr Keeble, although otherwise well, had some left hip pain.

[48] Dr Burgess confirmed the original injury was a meniscal tear and this pathology had been treated in the recent surgery. He considered the current cause of symptoms was related to right medial joint arthrosis, being non-injury pathology.

[49] A further MRI was undertaken of the right knee on 3 September 2020 that showed:

> Medial meniscal tear is similar in extent to the previous MRI scan of October 2019 but with the new displaced flap of meniscus within the medial paratibial recess.
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> Mild thinning of the cartilage at the medial tibiofemoral compartment, similar to the previous scan.
>
> Lateral meniscal tear, similar to the previous scan.

[50] Mr Street reported on 10 September 2020 noting this MRI scan had shown some further meniscal pathology, with "significant loss of medial articular cartilage from the medial aspect of the knee". He discussed surgical options. Mr Keeble's preference was to have a knee replacement. Mr Street expressed a concern that the outcome of a total replacement was more effective in patients with more arthritic change. He also opined the Corporation would decline the claim, "stating that trauma, albeit significant, has flared an underlying asymptomatic process".

[51] Mr Street prepared an ARTP on 16 September 2020 seeking funding for a total knee replacement in relation to post-traumatic degenerative changes in the right knee. In terms of causation, he commented:

> The patient's significant knee injury tore his medial meniscus and may have sheared some of his articular cartilage — the force was by no means minor. **There appears to have been deterioration in his joint surfaces since that time, but there has also been further fragmentation of his meniscus which has then loaded the joint surfaces, exacerbating a wear process and now culminating in a request for joint replacement.** The degree of chondral loss is not significant, but an extremely careful look at the MR scan shows a degree of extreme medial joint narrowing which would not be usefully helped with arthroscopy.
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> [Emphasis added]

[52] The file was reviewed by Mr Candy, Clinical Advisor on 29 September 2020, whether there was sufficient evidence to suspend entitlements. Reviewing all the evidence, he concluded there was sufficient material to be not satisfied of Mr Keeble's continuing eligibility for entitlements. Mr Candy noted the meniscal injury which had been covered had been treated in surgery, that any soft tissue injury would have resolved by that time. He concluded the need for ongoing assistance was due to a symptomatic aggravation of an established non-accident related degeneration in the knee.

[53] The surgery request was considered by Mr Brownlee, Orthopaedic Surgeon on 19 October 2020. He noted the history and that the arthroscopy in December 2019, the torn medial meniscus was trimmed. Medial compartment degenerative change was then noted. He considered Mr Crawford's suggestion of possible shearing of the articular cartilage, and stated:

> The degenerative changes in the knee were evident at the time of the arthroscopy, which was undertaken some 6 months following the injury event hence, the condition can be concluded to be pre-existing and of degenerative basis.

[54] For the review, a report dated 25 February 2021 was obtained from Mr Van Niekerk, Orthopaedic Surgeon. He noted that initially the scan showed a displaced medial meniscal tear, but the latest scan showed bone on bone arthritis on the medial side with a displaced medial meniscus. He advised:

> ... I think initially the injury definitely looks like a medial meniscal tear which in my assessment initially was probably not arthritic but then would be very interested to find out the operative findings of Richard Street in December 2019 and if there was evidence of arthritis at that stage. I also am suspicious that there is some underlying inflammatory condition going on here given his significant pain of the patellofemoral and lateral compartments and this may need further looking into.

[55] On 24 March 2021, another MRI of the right knee was undertaken. It showed similar appearances of the meniscal pathology.

[56] On 1 April 2021, Mr Street noted on the first MRI there was some chondral abnormality medially, with a little wear around the patellofemoral joint. He went on to say the initial imaging showed "little to no degenerative change". He concluded it was more likely than not the magnitude of the trauma to the knee caused ongoing symptoms, rather than some possible, but extremely minor, chondral thinning.

[57] Mr Van Niekerk reported again on 6 April 2021. He indicated the recent MRI confirmed quite significant articular cartilage loss on the inside of the knee with an extruded meniscus. He said since the arthroscopy, the condition had progressed significantly over time and added:

> **It is very difficult to be completely sure as if this is caused by the original trauma you experienced when you had the meniscal tear, or this was just the start of the medial compartment degenerative process.**
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> **My feeling is that it is very hard to argue this either way.**
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> At this point in time, I suspect given the level of symptoms that perhaps a joint replacement would not be unreasonable and perhaps the sensible thing is to have this assessed at the Whangarei Base Hospital in the future.
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> [Emphasis added]

[58] On 6 April 2021 Dr Washer, GP provided a letter of support for Mr Keeble at review.

[59] The Reviewer issued a decision on 14 June 2021 dismissing both review applications. He was not satisfied the degeneration was post-traumatic and upheld the Corporation's suspension decision.

[60] For the purposes of appeal, the Corporation filed a new report dated 29 November 2021, from the Clinical Advisory Panel (CAP) who stated:

> Knee osteoarthritis is a whole-joint disorder. Mr Keeble's cartilage thinning is a hallmark of osteoarthritis, but the condition also involves the joint (synovial) membrane, menisci, subchondral bone and soft tissues. Mr Keeble's osteoarthritis had cartilage thinning, lateral and medial meniscal features and bone oedema or "stress reaction" where the bone is stripped of its cartilage and becomes painful. Knee osteoarthritis is caused by genetic, metabolic and anatomical factors and is generally not related to trauma.
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> Mr Keeble's right knee symptoms - pain, discomfort, intermittent swelling, catching and difficulty with activities - are most likely the result of his previously asymptomatic right knee osteoarthritis. The degree of osteoarthritis has no correlation with the individual's knee symptoms.
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> No-one knows why some people with mild imaging changes develop severe symptoms, and some people with severe features remain problem-free. Up to half of people aged 50 years and over report knee pain during the course of a year, and a quarter have disabling pain in the absence of trauma.
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> The CAP noted that the meniscal tearing could have been part of Mr Keeble's knee osteoarthritis. Normal menisci are rarely found with knee osteoarthritis, and a strong association between Mr Keeble's right knee osteoarthritis and his medial and lateral meniscal tears is likely.

Mr Keeble's current symptoms are entirely related to his progressive, symptomatic, right knee osteoarthritis and not related to any single episode of trauma, including the 17/06/2019 accident.

Mr Keeble's contemporary records were not consistent with an acute meniscal tear, where the person usually reports severe pain and swelling and the knee locks and cannot straighten out. Mr Keeble's initial medical notes recorded calf pain. The CAP acknowledged that ACC has already accepted and treated the right knee medial meniscal tear, and that resolved with the 05/12/2019 ACC-funded arthroscopic partial meniscectomy.

The positions of the parties

[61] Mr Keeble gave evidence at hearing:

[i] That he had always been very fit and active throughout his life before the accident. His past work included maintenance on lighthouses.

[ii] Mr Keeble stated it took a great deal of time to obtain medical assistance to treat the damage caused to his right knee.

[iii] He said a week after the accident, he saw a local doctor who had no idea of diagnosis and treatment. He was told to leave matters for two or three weeks. He took high doses of ibuprofen for pain relief. The pain increased to a severe level. His GP in Auckland, Dr Washer whom he had consulted over 40 years, was overseas. He saw a locum. Radiographs were arranged. It took more than two months to obtain an MRI.

[iv] He was referred to Mr Crawford who saw him some 2-3 months after the accident. By this stage, he could not drive himself because his knee was locked. Mr Crawford provided cortisone treatment on the day of consultation, but this did not alleviate the pain. Rather, it was the local anaesthetic that numbed the pain for a time. Further, Mr Crawford twisted his knee again during examination, and made it worse. In consequence, he lost confidence in Mr Crawford. He was referred to Mr Street who performed arthroscopy surgery on the meniscal tear.

[v] In July 2020, Mr Keeble saw Mr Secker physiotherapist who undertook post-operative rehabilitation. There was some improvement. However, Mr Keeble continued to suffer flare ups and ongoing pain.

[62] Mrs Keeble is a health worker. Referring to a paper from Arthritis New Zealand, Ms Keeble stated there is no timeframe for arthritis. It can be pre-existing. It can also set in immediately upon injury. Once an injury occurs it can be aggressive or slow moving. She said two months after the accident was sufficient time for arthritis to show in a joint. Mrs Keeble submitted the degeneration was triggered by the accident.

[63] Mrs Keeble stated comments made by various medical practitioners that Mr Keeble had no swelling, were wrong. She said the knee had been swollen the entire time since the accident. She said the surgery lasted a lot longer than expected because a lot more cartilage had to be removed from the area. When they met with Mr Van Niekirk some two years later, he had noted more chondral loss in Mr Keeble's knee.

[64] Ms Becroft submitted CAP's views are supported by the earlier reports of Dr Burgess and Mr Brownlee. Dr Burgess considered the meniscal tear had been treated in the arthroscopy and the ongoing symptoms were not injury related.

[65] Ms Becroft submitted the following factors support the CAP's views on causation:

a) At best the injury suffered in the 2019 accident was a meniscal tear which was treated and resolved in the December 2019 surgery.

b) Mr Keeble's symptoms are entirely related to progressive symptomatic right knee osteoarthritis.

c) The radiological evidence showed a natural progression of right knee osteoarthritis as would be clinically expected in the absence of trauma. No traumatic features were noted.

d) Post-traumatic osteoarthritis can occur, but only after a significant injury which did not occur here.

e) An x-ray taken on 11 August 2019 already showed osteoarthritic changes in three compartments of the right knee, confirmed on the MRI scan taken 2 months after the accident. Those changes could not have developed in those short timeframes. They are changes which are common in asymptomatic individuals.

f) If there had been acute cartilage damage then the contemporaneous notes would confirm documented deep knee pain, a reduced range of motion and stiffness. Those symptoms were not reported here, with symptoms developing more insidiously over the following period.

Discussion

[66] There is no doubt that from the date of the accident, Mr Keeble has had significant issues. The evidence before me is striking with regard to the difficulties the various physicians who assessed or treated Mr Keeble have had in attempting to diagnose both the source and the cause of Mr Keeble's problems that arose following the accident.

[67] The central issue in the case is causation -what caused Mr Keeble's the pathology in his right knee that now requires knee replacement surgery. Section 20 of the Accident Compensation Act 2001 requires that unless the injury was caused by an accident it cannot be covered by the Corporation. Likewise, pursuant to s25 notwithstanding an injury has been suffered, it is not an indication or presumption it was caused by an accident.

[68] In assessing causation, I am guided by the principles set out by the Court of Appeal in *Ambros*[3]:

> [67] The different methodology used under the legal method means that a court's assessment of causation can differ from the expert opinion and courts can infer causation in circumstances where the experts cannot. This has allowed the court to draw robust inferences of causation in some cases of uncertainty ... However, a court may only draw a valid inference based on facts supported by the evidence and not on the basis of supposition or conjecture ... 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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> [68] Spigelman CJ in *Seltsam* said that the only time that a Judge is not able to draw a robust inference of causation are cases where medical science says that there is no possible connection between the events and the injury or death ... If the facts stand outside an area in which common experience can be the touchstone, then the Judge cannot act as if there were a connection. However, if medical science is prepared to say that there is a possible connection, a Judge may, after examining all the evidence, decide that causation is probable. He referred in this regard to the comments of Herron CJ in *EMI (Australia) Limited v BES* at 242. In the case at hand Spigelman J, reversing the trial judge's findings, did not consider the evidence sufficient to infer causation. He was joined in that view by Davies A-JA. Stein JA dissented.
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> ...
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> [70] ... It must, however, always be borne in mind that there must be sufficient material pointing to proof of causation on the balance of probabilities for a court to draw even a robust inference on causation. Risk of causation does not suffice.

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3 *Accident Compensation Corporation v Ambros* [2008] 1 NZLR 340, and in particular paragraphs [67]-[70].

[69] Having considered all the evidence before me in detail, I find the analysis of CAP, supported by the reports of Dr Burgess and Mr Brownlee, to be persuasive. I find their conclusions are consistent with the imaging reported by specialist radiologists, the contemporaneous notes and the surgical operation note. Their reports consider the features of Mr Keeble's osteoarthritis, the mechanism of injury, his age demographic, the meniscal tearing and the contemporaneous notes and conclude the compartments of the right knee already had osteoarthritis prior to the accident, even though it was previously asymptomatic. CAP explains that osteoarthritis is a whole joint condition, marked by cartilage thinning. They conclude the progression of changes including chondral loss, cartilage thinning in the compartments and medial bone marrow oedema, resulted in the gradual process of bone-on-bone wear and these changes were not caused by the 2019 accident. They are changes seen in asymptomatic persons.

[70] Significantly, CAP reviewed the operation notes for the right knee arthroscopy with partial medial and debridement of "a number of partial thickness flaps" on the medial femoral condyle. Mr Street reported softening of the tibial surface and lateral femoral surface which CAP explained are indicators of degenerative osteoarthritic changes in the knee joint.

[71] The Court observes too that CAP had the email exchange between Mrs Keeble and the opinion of a member of the Arthritis Foundation who noted "there is no magic time that OA may or may not occur after an injury". The Court notes the opinion is a general one rather than it specifically addressed this case. It should also be stressed that CAP acknowledged that post-traumatic osteoarthritis could occur, but it did not occur here for reasons it explained.

[72] CAP pointed to the radiological evidence reported by specialist radiologists which shows evidence of degeneration from the time the first x-rays were taken 12 days after the accident, and on the MRI scan two months after the accident. They noted the bony changes take a long time to develop and they could not have developed in a few days, weeks or months after the accident. They concluded the degeneration was pre-existing and not due to trauma.

[73] Against this evidence, I find the reports of Mr Street and Mr Van Niekirk do not enable this Court to draw a robust inference on the issue of causation. I find their conclusions are largely based on the temporal link between the accident and the onset of symptoms with their

reports understandably focussing on diagnosis and treatment rather than cause. At best, their opinions support a risk of causation.

[74] Mr Street was involved in the early stages of the claim. In his report of November 2019, he referred to two separate pathologies. Mr Street had initial concerns whether knee pain, locking and giving way was related to the meniscal tear, given the evidence of chondral loss or damage. I find Mr Street appears unsure about the pathologies shown on the imaging. On the one hand, though he acknowledged chondral irregularity in the knee, he disagreed the knee was arthritic, saying this was an "overcall". On the other hand, he said there is possibility of finding more chondral change than the imaging suggests, a proviso he said he gives to all patients aged 40 and over. An inconsistency in theory makes it difficult to place reliance on the opinion. However, I accept Mr Street did acknowledge chondral irregularity in his first report notwithstanding the comment in his later report in April 2021 that initial imaging showed little to no degenerate change.

[75] When Mr Street prepared the ARTP for total knee replacement, he related the significance of the mechanism of injury to the meniscal tear. Mr Street reiterated the right knee twisting taking all the force. CAP noted the contemporaneous notes including Mr Keeble's own account that initially the right calf and the back of the right knee "was really painful", noting no initial problem of trauma to the knee joint. The ARTP also records the possibility Mr Keeble "may" have sheared some of his articular cartilage in the accident.

[76] Most telling though is the causation section in the ARTP where Mr Street says "there has been further fragmentation of his meniscus which has then loaded the joint surfaces, **exacerbating a wear process**, now culminating in a request for joint replacement". I find this opinion on causation is expressed equivocally.

[77] Mr Street too appeared hesitant to proceed with knee replacement surgery and flagged the Corporation might decline the claim, which again suggests he appreciated the evidence of pre-existing changes in the knee.

[78] I find Mr Street's reports are sufficient to support cover and surgery for the meniscal tear leading to meniscal repair which then resolved as agreed by Dr Burgess and Mr Brownlee. However, I am not persuaded that Mr Street's opinion supports substantial causal

connection between the accident and the widespread evidence of degenerative changes in the three knee compartments as explained by CAP.

[79] Mr Van Niekerk is equivocal in his opinion on causation that it is "very hard to argue this either way." It appears that he too envisaged cover difficulties, recommending referral to the public system. Further, Mr Van Niekirk does not address the early imaging showing chondral loss. At best, he acknowledges the possibility rather than the probability that the chondral changes occurred post-accident. In response to Mr Van Niekerk's evidence, CAP stated:

> The CAP noted that there was already early, tricompartmental osteoarthritis on Mr Keeble's right knee x-ray done 18 days after the accident. The cartilage changes were noted on the MRI scan done two months afterwards. Cartilage thinning was noted in all three compartments of the right knee on 20/8/2021 and this is most unlikely to be related to trauma.

[80] Taking these matters together, I have no hesitation in finding that the claim to cover and need for total knee replacement surgery is not shown to be due to any injury suffered on 17 June 2019. On balance, I find the weight of the evidence shows Mr Keeble's problems were most probably caused by gradual process exacerbated or aggravated by the accident rather than caused by the accident itself.

Issue two: Whether the Corporation had sufficient basis to conclude in October 2020, the covered knee injuries had resolved

[81] Regarding the suspension decision, I accept the weight of the available evidence shows the covered meniscal tear was treated in the earlier surgery, and Mr Keeble's ongoing symptoms due to gradual process excluded under the Accident Compensation Act 2001.

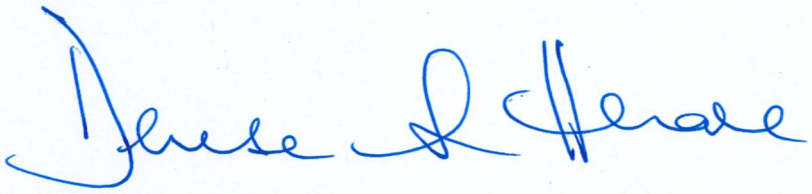
[82] There is no evidence the covered sprain injuries were still in play by October 2020, rather they resolved, as confirmed by Mr Candy. Rather, the ongoing symptoms and flare ups related to the right knee degenerative changes which are not caused by the accident in June 2019.

[83] For these reasons, I find the Corporation had sufficient basis to be satisfied Mr Keeble was no longer entitled on this claim

Decision

[84] Accordingly, for the foregoing reasons, the appeal is dismissed.

[85] There is no issue as to costs.



Judge Denese Henare
District Court Judge

Solicitor: Medico Law Limited for the respondent.