IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 225 ACR 11/20

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

Hearing: 4 March 2022
Heard at: Auckland/Tāmaki Makaurau

Appearances: The appellant in person via video link
Ms K Anderson for the respondent

Judgment: 29 November 2022

RESERVED JUDGMENT OF JUDGE C J McGUIRE
[Personal Injury -Causation Section 25 Accident Compensation Act 2001]

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[1] At issue on this appeal is ACC's letter of 10 June 2019 in which the Corporation said that it was unable to approve the appellant's request for a driving assessment and home help. The decision noted that cover for pain in lumbar spine "has now been revoked".

[2] The decision letter went on to say:

> The medical reports and scans available do not support your incapacity and symptoms relating to any of your back injuries caused by past accidents. The

> chronic pain is consistent with your pre-existing degenerative condition of spinal stenosis.

[3] At the hearing the appellant acknowledged that she was abandoning her claim for pain in her lumbar spine that was said to have arisen from her gardening activities on 25 January 2017.

[4] Accordingly, the focus of this appeal is on whether or not the appellant is eligible for certain entitlements (home help and a driving assessment) on the basis that such entitlements are causally related to a treatment injury suffered on 2 February 2016.

Background

[5] On 1 May 2015 Mrs Khan slipped on stairs and landed heavily on the edge of a tread on her right buttock.

[6] The diagnosis by Dr Charles Ng, musculoskeletal medicine specialist and physician was radicular pain and radiculopathy in the right leg and probable L5-S1 disc protrusion with nerve root compression.

[7] She had been referred to Dr Ng by her GP.

[8] Dr Ng reported the following history:

> On 01/05/15, she slipped on the stairs and landed heavily on the edge of a tread on her right buttock. She developed immediate pain in the right calf; the pain was so severe she could barely walk; she had to hop around and use a walking stick.
>
> …
>
> By the end of June the pain started to reduce but in recent weeks the pain has increased again – currently 65/100. The leg pain remains worse than the gluteal pain. There is no impulse pain. She continues to have right lower leg and foot numbness. The pain is aggravated by prolonged sitting and lifting. The right leg has felt weak.
>
> … she has not had this problem before.
>
> …
>
> Lumbar spine ROM:

> Flexion – fingertips reached the ankles causing right thigh and lower leg pain; extension causes right lumbar pain; side bending and rotation are normal.
>
> SLR (straight leg raising) left and right is 60 degrees; right SLR with dorsiflexion of the foot causes mild right thigh and lower leg pain.

[9] Dr Ng made reference to an x-ray of the appellant's lumbar spine dated 10 June 2015 which noted:

> Mild L5-S1 disc space narrowing.

[10] Under the heading "diagnosis" is this:

> 5-6 months radicular pain and radiculopathy right leg.
>
> Probably L5-S1 disc protrusion with nerve root compression.

[11] Dr Ng concluded there was a link between the symptoms and the appellant's ACC covered personal injury.

[12] He requested an MRI of her lumbar spine and planned to review the appellant afterwards to discuss the findings and further management. He noted:

> Should the MRI demonstrate a significant disc abnormality, we may need a fluoroscopically-guided transforaminal steroid injection.

[13] On 2 February 2016 Dr Ng performed a fluoroscopically-guided right L5-S1 transforaminal anaesthetic and steroid injection. He noted that her visual analogue score for index pain before the procedure was 45/100. Thirty minutes following the injection the pain visual analogue score was 0/100. He said:

> This immediate response is attributed to the local anaesthetic component of the injection.

[14] Dr Ng arranged a follow up in three weeks.

[15] Dr Ng provided an ACC specialist report on 9 March 2017. He elaborated on what had occurred on 2 February 2016 and said:

> I carried out a right L5-S1 transforaminal steroid injection (TFI) on Mrs Khan on 02/02/2016. Following the insertion of the spinal needle into her back, the needle was gradually advanced towards the right L5-S1 transforaminal space. At one stage during the advancement of the needle, Mrs Khan felt pins and

needles, i.e. paraesthesia in her toes. The needle was partially withdrawn and repositioned before the injection of omnipaque contrast which confirmed current needle placement, then injection of 1 ml of lignocaine to exclude intra-arterial needle replacement. Subsequently the steroid dexamethasone and bupivacaine anaesthetic were injected into the epidural space. Then the needle was removed from her back. Following the injection, her pain score for the radicular leg pain that was being treated reduced from VAS 45/100 to 0/100, i.e. no pain and she had numbness in the foot for the duration of the bupivacaine anaesthetic action (which is normally up to about 6 hours after the injection). The following day Mrs Khan had reduced leg pain but had numbness in the right 3rd, 4th and 5th toes. I advised her that the numbness needed several weeks to resolve and I would review her at the follow up appointment three weeks later. She did not turn up for the follow up appointment and I have not seen or heard from her since then.

During the advancement of the needle towards the right L5-S1 transforaminal space, it is possible for the needle to contact the right L5 nerve root which could elicit radicular pain or paraesthesia in the leg. Mrs Khan's paraesthesia in the toes is likely to have resulted from contact with the L5 nerve root. In my experience, needle contact with the nerve root can occur in one in five of TFI procedures. Once the needle is withdrawn from nerve contact, the paraesthesia resolves within a few seconds. In Mrs Khan's case the paraesthesia persisted.

The possibility of nerve root contact is explained to all patients prior to undergoing TFIs. It is explained to the patient that the nerve contact does not normally result in any permanent nerve damage. Of the more than 1000 TFIs I have performed, there has not been a previous case of permanent paraesthesia or numbness resulting from nerve root contact or the injection. Although the tip of the needle can touch/contact the nerve root during the procedure, in my experience, it has never resulted in a permanent nerve injury before.

Mrs Khan had had nine months of radicular pain and radiculopathy in the right leg prior to the injection. This was caused by L5-S1 disc protrusion compressing the right S1 nerve root. The radiculopathy consisted of a reduced ankle reflex, grade 4/5 weakness in extension of the great toe and numbness in the L4, L5 and S1 dermatomes. The weakness and numbness where not confined to the S1 myotome and S1 dermatome respectively as one would have expected with S1 nerve root compression. As I have not reviewed Mrs Khan following the TFI, I have not been able to verify the nature of her symptoms and signs that remain following the injection. Therefore, I cannot determine whether her current symptoms are the same or different to those before the injection and whether she has developed symptoms as a result of the injection in particular the right L5 nerve root contact.

Please let me know if you require any further information. I am willing to reassess Mrs Khan and discuss her condition if she wishes.

[16] In March 2017 ACC accepted that L5 nerve root injury arising from the TFI was a covered injury.

[17] Mrs Khan was assessed at the Auckland Regional Pain Service on 24 April 2018.

[18] In his report dated 27 April 2018 Dr Sainsbury, pain medicine and anaesthesia Fellow noted under the heading "pain history" the following:

> She initially experienced an injury to her back following a fall on the stairs. She had ongoing right lumbar pain and leg pain and was referred to musculoskeletal physician, Dr Charles Ng, for assessment and management. He performed a transforaminal injection and during the procedure he contacted the nerve. From that time forward, she has experienced numbness in the distribution of her L5 nerve root. Her symptoms are relatively stable.
>
> …
>
> Mrs Khan's major issue is her right leg numbness. She describes numbness in her right lower leg is over the lateral aspect of her shin down towards her big toe. She doesn't describe any sweating or colour changes to her leg. She doesn't really note any exacerbating or relieving features and doesn't find that any position causes her any relief.

[19] On examination of her Dr Sainsbury noted:

> On examination of her legs she has normal power throughout her left leg and very mildly reduced power 4+/5 throughout her right leg. She has normal tone. She has normal sensation on the left and she has a loss of sensation in the distribution of L4 on the right. …
>
> Discussion
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> We had a long discussion today with Mrs Khan about the implications of her leg numbness. Mrs Khan is very much troubled by her sensory radiculopathy and feels that she will never be "normal".
>
> …
>
> We have decided to refer Mrs Khan for nerve conduction studies in order to clearly delineate the injury and the resultant effect on her left leg. After this has been performed we will review her again.

[20] Mrs Khan underwent a further assessment at the Auckland Regional Pain Service Clinic on 27 April 2018. She was assessed by Dr Aamir, pain medicine specialist. Dr Aamir noted:

> At this stage she stated that she has very little pain in her lumbar area and no pain in the leg. Her main problem is numbness in her right calf.
>
> Due to her numbness, she walks very slowly and has to be very careful. She is concerned about the risk of falls.
>
> …
>
> She feels very frustrated with her condition and would like to be "normal".

[21] Under the heading "impression and recommendations" Dr Aamir notes:

> Mrs Khan is a 57 year old Fijian Indian lady who has presented with a history of probable injury to a nerve during a transforaminal injection. She currently does not experience significant pain, however, has persistent numbness in her leg. It also appears she has not had a nerve conduction study done. We will arrange for a nerve conduction study examination. She will be reviewed after the nerve conduction study and at that stage depending on the result we will have a discussion with her about any pain management options which can be offered to her at the Auckland Regional Pain Service to derive an assessment relating to Mrs Khan on 14 June 2018.

[22] The report records Mrs Khan's concern with her right lower limb sensation and not being able to "feel the car pedals" using her right lower limb when driving. On the basis that Mrs Khan "has failed to participate in a full driving assessment, she has been advised that we are unable to determine how her right lower limb injury impacts on her ability to drive in a safe manner".

[23] The appellant underwent a nerve conduction study on 28 June 2018. Dr Frith reported the following:

> Summary:
>
> Nerve conduction studies in the lower limbs showed reduced peroneal – EDB motor amplitudes bilaterally but the sensory potential recorded from the symptomatic area was normal. Needle EMG showed neurogenic change in quadriceps muscles with lesser patchy change in some more distal muscles. All muscles examined showed reduced voluntary activation.
>
> Interpretation:
>
> There is electrophysiological evidence for patchy denervation and reinnervation in right L3-4-5 innervated muscles. This could represent either multilevel root disease or patchy plexopathy. At least some of the weakness appears due to reduced voluntary effort.

[24] Dr Sainsbury and Dr Aamir reviewed the appellant's nerve conduction studies. In his report, dated 24 July 2018 Dr Sainsbury said:

> Although there was some evidence of patchy denervation/reinnervation in L3/4/5, some of the weakness was due to reduced voluntary effort which I expect we would be able to improve with physiotherapy.

[25] Dr Sainsbury noted that the appellant was happy to engage in an appropriate programme with the Auckland Regional Pain Service. In a brief report of the same

date Dr Aamir agreed with Dr Sainsbury's recommendation and noted that he would like to catch up with the appellant in about six months to assess her progress.

[26] The appellant's file was referred to clinical adviser to ACC, Dr Shrimpton. She reported on 5 November 2018.

[27] She noted that the nerve conduction study did not show a definitive L5 nerve root injury. She acknowledged there is evidence of patchy changes to L3, 4, 5 which is in keeping with the original ACC claim.

[28] Dr Shrimpton goes on to say that:

> The client c/o (complains of) numbness in the distribution L5 right leg but there is no objective evidence of this on nerve conduction studies.

[29] Dr Shrimpton notes:

> There is voluntary weakness – that is the test is supportive of lack of effort by the client of the requested movement.

[30] She goes on to say:

> The nerve conduction studies support that the L5 radiculopathy is no longer present. There is also no evidence of any effects of the earlier small disc protrusion seen on MRI Nov 2015. The client has chronic back pain from her degenerative condition of spinal stenosis. She has been advised some psychological input and physiotherapy by TARPS to address her symptoms of chronic pain and voluntary weakness. This is not an accident related condition.

The Appellant's Submissions

[31] Mrs Khan recounted how she had an accident on 1 May 2015 when he fell on stairs injuring her back. As a result of this ACC covered her for a lumber sprain.

[32] She first saw Dr Charles Ng, musculoskeletal surgeon, on 22 October 2015.

[33] He diagnosed a probable L5-S1 disc protrusion with nerve root compression and linked the symptoms to her ACC covered personal injury.

[34] At a follow up appointment on 2 February 2016 he performed a fluoroscopically-guided right L5-S1 transforaminal anaesthetic and steroid injection.

[35] The anaesthetic component brought immediate pain relief and the medium term benefit of the steroid component of the injection was to be assessed in a follow up appointment three weeks later.

[36] This appointment did not take place with Mrs Khan saying that she did not return to Dr Ng because she "got a bad fright" from what occurred on 2 February 2016.

[37] Dr Ng said in his letter to ACC of 9 March 2017:

> During the advancement of the needle towards the right L5-S1 transforaminal space, it is possible for the needle to contact the right L5 nerve root which could elicit radicular pain or paraesthesia in the leg. Mrs Khan's paraesthesia in the toes is likely to have resulted from contact with the L5 nerve root. In my experience needle contact with the nerve root can occur in 1 in 5 of TFI procedures. Once the needle is withdrawn from nerve contact, the paraesthesia resolves within a few seconds. In Mrs Khan's case the paraesthesia persisted.

[38] Mrs Khan told the Court that when this occurred during the procedure she screamed.

[39] She said she reported what occurred to ACC who she said told her to "call us back in two years' time".

[40] She says the numbness in her right leg and foot is still there. It hasn't repaired.

[41] She says she loses balance and falls. She has to be very careful when she walks. She says her leg bends without her knowing.

[42] She says that ACC is overlooking what Dr Frith has included in his report.

[43] She says that as a result of what has occurred her driver's licence is on hold. She is not allowed to drive.

[44] She says she has been told by ACC that she can apply for orthotics. However, ACC says her condition is "non accidental".

[45] She says her leg does not have any strength and that what has occurred has affected her mentally and emotionally.

[46] Mrs Khan added that she is not pursuing an appeal in respect of a claim for pain in lumbar spine arising from her gardening activities on 25 January 2017.

[47] She reiterates however that the numbness in her leg is still there and that has not gone away.

The Respondent's Submissions

[48] Ms Anderson says that ACC accepts what the appellant is experiencing but that the causative link has not been established between the procedure on 2 February 2016 which caused Mrs Khan to feel pins and needles in her toes and her current presentation.

[49] She notes that the appellant did not return to Dr Ng for the scheduled follow up appointment.

[50] She refers to the nerve conduction study which noted that all muscles examined showed reduced voluntary activation.

[51] She refers to mention in Dr Frith's report of "patchy plexopathy" which she says describes a state and does not go to causation.

[52] She refers to the Auckland medical advisor ACC Dr Shrimpton and an MRI report of 9 November 2015 noting canal stenosis and facet joint ligamentum flavum hypertrophy and a short pedicles.

[53] Ms Anderson submits that the canal stenosis and the facet joint ligamentum are degenerative conditions.

[54] She relies on Dr Shrimpton's four conclusions:

(a) The current diagnosis is a degenerative lumbar spine with some canal stenosis at L3/4/5/S1 (multilevels) which is due to multiple factors and will have occurred over time and is supported as showing some patchy denervation in distribution L3, 4, 5 to muscles and reinnervation over time. This multilevel degeneration is causing chronic low back pain. The client complains of numbness in the distribution L5 right leg but there is no objective evidence for this on nerve conduction studies. There is voluntary weakness – that is the test is supportive of a lack of effort by the client in the requested movement.

(b) The client has prior back injury claims and imaging which demonstrates multilevel degenerative changes which are likely to have been aggravated by the covered injuries rather than a causal association. The client underwent TFI on 2 February 2016 for a disc protrusion thought to have been impinging on L5 nerve root at that time (MRI Nov 2015) – but demonstrated to having no effect (if the small disc protrusion still persists).

(c) The client has cover on this claim for L5 radiculopathy as a TI – for which there is no evidence on nerve conduction studies. The note supports that the cause of ongoing impairment if chronic low back pain from degenerative changes coupled with some anxiety about following her brother's pattern of illness, leading to a lack of effort affecting physical ability. This is not related to the TI or any earlier claim.

(d) The nerve conduction studies support that the L5 radiculopathy is no longer present. There is also no evidence of any effects of the earlier small disc protrusion seen on MRI Nov 2015. The client has chronic back pain from her degenerative condition of spinal stenosis. She has been advised some physiological input and physiotherapy from TARPS to address her symptoms of chronic pain and voluntary weakness. This is not an accident related condition.

[55] Ms Anderson says that the appellant has not brought forward any medical evidence to counter Dr Shrimpton's advice.

[56] She says there is nothing in the evidence that would allow the Court to draw a conclusion of causation and that little weight can be placed on Mrs Khan's temporal connection.

[57] She acknowledges that under s 145(2) ACC has the onus of establishing that the original decision was made in error. She also refers to s 65 which allows ACC to revise decisions made in error.

[58] At the conclusion of the hearing it was agreed that the appellant would file two further documents, a 2015 MRI Report and a letter relating to a consultation at Greenlane Hospital, with the respondent being accorded the right of reply.

[59] After delays, the court was provided with a copy of an MRI lumbar spine report of Dr Reeves, diagnostic radiologist, dated 9 November 2015 requested by Dr Ng.

[60] Dr Reeves noted in his report:

> At the L5/S1 level, there is broad based posterocentral and paramedian protrusion, with inferior migration which appears to be impinging on the right S 1 nerve root.

[61] Ms Khan has also provided an assessment report and treatment plan from Dr Keith Laubsher, musculoskeletal and pain specialist dated 27 August 2017. Amongst other things Dr Laubsher noted:

> She is already in discomfort, walks with a very slow gait with the aid of a walking stick on the right.
>
> …
>
> Despite her experiences of residual numbness in the right foot…

[62] Ms Anderson on behalf of ACC responds that the MRI report of 9 November 2015 is already before the court and its findings are discussed in the Clinical Advisory Panel's report of 5 November 2018. The Panel concluded that "there is no objective evidence for [numbness] in the nerve conduction studies. There is voluntary weakness …"

[63] As to Dr Laubsher's Assessment Report and Treatment Plan, Ms Anderson acknowledges that Dr Laubsher noted that "nerve injury is a rare but recognised complication despite good technique".

[64] However, she notes, that Dr Laubsher makes no comment on whether Mrs Khan's right foot numbness has been caused by her previous transforaminal corticosteroid injection and that the June 2018 nerve conduction study did not

support a conclusion of nerve injury caused by transforaminal corticosteroid injection.

[65] I find that given the tentative and inconclusive nature of this further evidence it does not materially advance either party's position.

Decision

[66] This appeal is summarised in the four conclusions of the ACC medical advisor Dr Shrimpton.

[67] Dr Shrimpton's first point is that there is no objective evidence of numbness in the distribution L5 right leg. At the same time she points out that there is voluntary weakness which supports a lack of effort by the client for the requested movement.

[68] Lack of effort by the client must be accepted. At no stage has the appellant sought to challenge that conclusion.

[69] As to numbness in the distribution L5 right leg, while Dr Shrimpton says there is no objective evidence of this on nerve conduction studies., However that is not the same as saying the numbness condition does not exist.

[70] In his report of 9 March 2017 Dr Ng says:

> At one stage during advancement of the needle, Mrs Khan felt pins and needles, i.e. paraesthesia in her toes. The needle was partially withdrawn and repositioned before the injection of omnipaque contrast which confirmed correct needle placement.

[71] Dr Ng goes on:

> The following day Mrs Khan had reduced leg pain but had numbness in the right 3rd, 4th and 5th toes. I advised her that the numbness needed several weeks to resolve and that I would review her at follow up appointment three weeks later. She did not turn up for the follow up appointment and I have not seen or heard from her since then.

[72] In other words Dr Ng confirms that the following day Mrs Khan confirmed that numbness in her toes continued. Dr Ng went on to say:

> In Mrs Khan's case the paraesthesia persisted.

[73] Dr Ng's candour is welcomed. Mrs Khan told the Court that she screamed during the transforaminal steroid injection when she said Dr Ng accidentally hit a nerve. This is consistent with the narrative given by Dr Ng when Mrs Khan felt pins and needles and Dr Ng partially withdrew the needle.

[74] It is also consistent with what Mrs Khan told the Court namely "I got a bad fright from Dr Ng. That is why I haven't gone back".

[75] The other supporting evidence of the appellant's position in this regard is what she told Dr Sainsbury at the Auckland Regional Pain Service on 24 March 2018 when she confirmed that from the time of the transforaminal injection she experienced numbness in the distribution of her L5 nerve root "in her right lower leg over the lateral aspect of her shin, down towards her big toe".

[76] Likewise, Dr Aamir's report of 27 April 2018 again from the Auckland Regional Pain Service, notes a history of probable injury to a nerve during a transforaminal injection.

[77] Furthermore, in ACC's transport for independence assessment dated 14 June 2018, occupational therapist Ms Scott records:

> Nigar reported she last drove her car eight months ago and confirmed her driving tolerance using her injured right lower limb is 5-6 minutes. Consequently, she reported feeling unsafe driving in this manner due to numbness, reduced sensation and poor reaction time.
>
> Nigar reported she had attempted to drive her vehicle by crossing her functional left lower limb across her body to operate the pedals. However, she does not feel safe driving in this manner either.

[78] Although these comments rely on the self reporting of the appellant I find that it is credible evidence of a person sufficiently frustrated by numbness in her right lower limb to attempt to drive her vehicle with her left lower limb across her body to

operate the pedals. It speaks of the near desperation of a person having to adjust to a physical condition that she did not have before.

[79] Dr Shrimpton's second summary point is that the appellant's imaging demonstrates multilevel degenerative changes. This is accepted. However, I disagree with Dr Shrimpton's statement that the impinging on L5 nerve root is now demonstrated to be having no effect. The extraordinary lengths that the appellant has gone to to attempt drive her vehicle using her left foot on the pedals powerfully argues against the proposition that there is no effect from an L5 nerve root impingement.

[80] Dr Shrimpton says under her summary point three that there is no evidence of a treatment injury, L5 radiculopathy, on nerve conduction studies.

[81] With respect, I do not take Dr Frith's report as saying that.

[82] Under the heading "interpretation" Dr Frith says:

> There is electrophysiological evidence for patchy denervation and reinnervation in right L3-4-5 innervated muscles. This could represent either multilevel root disease or patchy plexopathy. …

[83] In acknowledging that denervation and reinnervation could be due to patchy plexopathy, which is a disorder of the network of nerves that may be caused from local trauma to the plexus. Dr Frith appears open to the appellant's condition being caused by injury.

[84] In this case ACC accepted that a treatment injury occurred and granted cover.

[85] Section 65(1) allows the Corporation to revise its decision when it considers it made the decision in error.

[86] As the High Court said in *Bartels*[1] at paragraph [34]:

> [34] … A decision will not be made in error if there are credible differences of opinion between experts. "Error" requires the identification of factual material

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

> significant to the original decision which has now been exposed to clearly wrong. It will not be sufficient to establish error for others to have a different opinion unless the new opinions are based on fresh and new evidence which was not in the possession of the original decision makers and which undermines their decision to a degree from which one can conclude, with that information that their decision was clearly wrong.

[87] I find that the evidence in this case at this point is that ACC have not produced evidence that their earlier decision granting cover was clearly wrong.

[88] It is acknowledged that the appellant has not assisted her cause by failing to have the further assessment from Dr Ng or some other suitably qualified medical professional. Likewise, she has not assisted her case by reduced voluntary effort in her consultation with Dr Frith.

[89] It may be that with further assessment more clarity may be obtained. However, for now, I find that there is no new evidence which undermines ACC's original decision to a degree that I can conclude, with that information, that ACC's decision was clearly wrong.

[90] Accordingly, the appeal is allowed. ACC's decision of 10 June 2019 rejecting Mrs Khan's request for a driving assessment and home help is reversed.

[91] There is no issue as to costs.

Judge C J McGuire
District Court Judge

Solicitors: Katherine Anderson, Barrister Auckland for the respondent