IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 98 **ACR 111/19**

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPEAL UNDER SECTION 149 OF THE ACT
BETWEEN	PETER-DOUGLAS FRANKPITT Appellant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Hearing:	26 April 2022
Heard at:	Christchurch/Ōtautahi
Appearances:	The Appellant appeared in person Mr I Hunt for the Respondent
Judgment:	24 May 2022

RESERVED JUDGMENT OF JUDGE C J McGUIRE
[Section 58 Deemed decision; Conciliation – delay
Accident Compensation Act 2001]

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[1] This is an appeal against a review decision dated 11 April 2019 dismissing two applications for review lodged on behalf of the appellant on 28 February 2017.

[2] Both reviews, review 5122586 and 5122588 were lodged in terms of s 134(1)(b) of the Accident Compensation Act 2001 which provides:

> A claimant may apply to the Corporation for a review of—
>
> …
>
> (b) any delay in processing the claim for entitlement that the claimant believes is an unreasonable delay.

[3] In respect of review 5122586, the appellant claimed that:

> ACC has delayed in making a decision on Mr Frankpitt's claim for entitlement to surgery dated 15 December 2016.

[4] The reasons is stated in this application were that:

> ACC is deemed to have covered my client's injuries. Reasons will follow with written submissions.

[5] The decision sought in respect of review application 5122586 was that the appellant was entitled to the entitlements that were sought, namely, surgery.

[6] In respect of review 5122588, the review application claimed that:

> ACC has delayed making a decision on Mr Frankpitt's claim for entitlement to weekly compensation dated 15 December 2016.

[7] The reasons given for the application for a review were:

> ACC is deemed to have covered my client's injuries. Reasons to follow with written submissions.

[8] Both review applications were dismissed. They had been made pursuant to s 134(1)(b). The Reviewer concluded that with no primary decision having been made by the respondent as to whether the appellant had deemed cover, that was the extent of the reviewer's jurisdiction. Also, there was no unreasonable delay by the respondent in processing claims by the appellant for entitlements.

Background

[9] The appellant injured his right shoulder on 9 January 2015 while he was working, manually cleaning laminating plates at his workplace. He sought physiotherapy treatment on 28 January 2015 and a claim was lodged for a diagnosed right shoulder sprain for which cover was granted by the respondent.

[10] The appellant continued to suffer right shoulder pain and by February 2015 his employer noted that the appellant could no longer lift his right arm above shoulder height.

[11] An X-ray and ultrasound were undertaken on 9 April 2015. The ultrasound showed a low-grade partial thickness infraspinatus tear with mild overlying subacromial bursal thickening.

[12] Mr Mohammed, orthopaedic surgeon, provided a report on 6 May 2015 which was reviewed by the respondent's medical advisor, Dr Nazmi. The appellant underwent an MRI of his left shoulder on 11 August 2015 and a further report of Mr Mohammed was provided dated 13 August 2015.

[13] Dr Mohammed's reports and the radiological evidence were provided to Dr Hilliard who undertook an assessment and provided a report dated 1 September 2015. Dr Hilliard said amongst other things:

> On examination I found testing of the rotator cuff to be entirely normal and without any signs for shoulder impingement.

[14] Dr Hilliard said:

> In my view the cause of Mr Frankpitt's ongoing right shoulder pain is that of nonspecific right shoulder pain of unknown origin, there being no good evidence on examination to support the view that any current right shoulder incapacity is due to a rotator cuff tear/problem or due to shoulder impingement.
>
> ...
>
> There is also no good indication on file that any of Mr Frankpitt's current incapacity is due to mild AC joint arthropathy found on imaging, this being an incidental finding.
>
> There is no real good evidence on examination of his shoulder to support the view that current incapacity is actually due to either a tear of the right supraspinatus or right infraspinatus, tendons in the right shoulder.
>
> Although Mr Frankpitt's incapacity has been attributed to the tenderness tears in his right rotator cuff, I am not able to attribute any of his current incapacity to those tears, nor am I able to attribute any of his current incapacity to any findings on imaging. In my view, the cause of Mr Frankpitt's ongoing right shoulder pain is therefore at this stage unknown.

[15] Dr Hilliard then answered specific questions raised in the letter of referral:

> **Conclusion**
>
> In conclusion I would answer the specific questions raised in your referral letter dated 11 August 2015 as follows:

1. **What was the original accident event and what was the injury or condition caused by this event?**

Mr Frankpitt stated that he developed pain in his right shoulder the day after repetitively cleaning metal parts of a laminator machine. Specifically, there is no evidence on file to support the view that Mr Frankpitt developed right shoulder pain after any specific event or injury on 9 January 2015. The history on file, and given to me by Mr Frankpitt is that of waking up with right shoulder pain the day after repetitively cleaning metal parts from the laminator machine, which gradually worsened over the following 2-3 days. It appears that there is no temporal relationship between the development of shoulder discomfort and cleaning metal parts on the 9 January 2015.

Tears of any rotator cuff structures can either be of traumatic or atraumatic origin, and can either be symptomatic or asymptomatic.

In this case, as mentioned elsewhere in this report, I am not entirely sure that we can attribute Mr Frankpitt's current incapacity to any findings on imaging, including tears of the infraspinatus or supraspinatus tendons.

In this case, there does not appear to be any specific event on 9 January 2015 that could have been causative of any specific tear in either the supraspinatus or infraspinatus tendons of the right shoulder. Had Mr Frankpitt developed injury-related tears of either the right infraspinatus or right supraspinatus tendons, I would have expected there to have been immediate onset of severe pain in the right shoulder as a result of a specific event, and which clearly has not been the case here. In this case, Mr Frankpitt woke up the next day with pain in his right shoulder which is not at all consistent with tears from an injur-related case. Although the attributed the onset of pain in his shoulder to activities in work the previous day, it appears that there is no temporal and thus no causal relationship between the development of pain in the shoulder and any specific work activities.

I note that the initial physiotherapy record mentioned the possibility that incapacity may have been due to impingement, in capacity subsequently being attributed to tears in the rotator cuff when these were found on imaging, despite the fact that examination fot he rotator cuff appeared to be normal by the time that Mr Frankpitt was seen by Mr Mohammed in May 2015, an examination of the rotator cuff also being normal when seen by myself. This suggests that current incapacity is most probably not due to any specific problem of the rotator cuff, but rather represents pain from unknown origin.

The fact that Mr Frankpitt has been found to have multiple tears in both the infraspinatus and supraspinatus tendons, in the presence of bursal changes (and probable initial impingement), in the absence of incapacity having developed after any specific event would tend to suggest that his right shoulder incapacity reflects a slow-onset problem of the right shoulder rather due to acute injury.

Tears of the rotator cuff structures are frequently considered to be of degenerative origin, and tears are frequently considered to be the end point of degenerative change in rotator cuff structures.

Could repetitively cleaning metal parts with rotatory type movements of the shoulder at or above waist height be causative of multiple tears in the shoulder? The answer has to be definitive no. For tears of the rotator cuff to be injury related, it is generally considered that there has to be a high energy high impact event, such as an individual falling on to a shoulder, or for example falling off scaffolding and grabbing the scaffolding poles to arrest their fall, and which clearly has not been the case here. I would consider that the type of rotatory movements of the shoulder with arm in semi-abduction, as described by Mr Frankpitt when cleaning metal parts, to be a relatively low energy, low impact type mechanism of injury. There is also no good evidence in the medical literature that rotatory type movements of the shoulder or that elevation of the arm repetitively for one day in any position can then be causative of multiple tears in the rotator cuff structure or that this type of movement can frequently cause an impingement type problem of the shoulder.

This tends to suggest that the tears in the rotator cuff found on imaging reflect slow-onset changes most probably of degenerative origin and currently of very uncertain significance.

Is it plausible that acute that acute tears would become symptomatic some 12 hours later? Again, the answer has to be a definite no. Acute tears of the rotator cuff are considered to be extremely painful and it could be expected that pain would have arisen immediately or within a very short period of time later, rather than over 12 hours later.

I cannot preclude the possibility that when Mr Frankpitt first attend his Physiotherapist that he may have had a degree of shoulder impingement, this having settled by the time he first saw Mr Mohammed. I therefore have to consider any bursal changes/bursitis or possible initial impingement could have been caused by repetitive rotatory actions of the right shoulder for a sustained period for one single day. The answer again has to be a clear no. In general terms, bursal changes/bursitis or impingement are considered to be slow-onset problems, frequently of degenerative origin and it is thought these changes take months to years to develop, rather than as a result of one days repetitive actions with the shoulder in any position. I therefore cannot consider the onset of any bursal changes (and rotator cuff tears) as a 'series of events' type injury.

Theoretically, some commentators believe that bursitis/bursal changes can be caused by acutely, through a blow to the bursal area, presumably through bleeding into the bursa from a direct blow to the bursal area, although there is actually little evidence in the medical literature to substantiate this view. In this case, there is no history of a direct blow to the anterior aspect of the shoulder as a result of any event in January 2015, symptoms having first been noted one day after undertaking repetitive cleaning duties in work these worsening over a few days. I would consider that the reported activities to be a low energy, low impact-type of problem. In general terms, bursitis or slow onset problems of the shoulder, rather than ones that can be brought on acutely. Shoulder impingement is thought to take many months or years to develop, and clearly are likely to have pre-dated any activities in January 2015, the mechanism of injury on that date not being one that is thought to be causative of any bursal changes/bursitis-type picture.

The term Impingement Syndrome was coined by Neer. Most commonly it is proposed that subacromial bursal changes/bursitis arise as a result of complex factors, resulting in symptoms that are colloquially referred to as 'impingement'. These factors are broadly classified as intrinsic (intra-tendinous or extrinsic (extra-tendinous). These are further classified into primary or secondary causes for impingement, secondary causes being thought to be due to other processes, such as nerve, shoulder instability, etc.

Subacromial bursal changes involve the bursa that separates the superior surface of the supraspinatus tendon from the overlying coraco-acromial ligament, acromion and coracoid (the acromial arch from the deep surfaces of the deltoid muscle). The purpose of the bursa is to assist with motion of the supraspinatus tendon, particularly with overhead work.

Neer proposed three stages of impingement, indicating that impingement is a progressive process, that includes the presence of cuff tears as a third stage of impingement of the shoulder in symptomatic shoulders, as appears to be the case with Mrs Glimore. It is now thought that rotator cuff tears are part of a continuum of change within the rotator cuff, bursal changes and bursitis being an initial finding in many individuals. The presence of bursitis and the presence of changes on imaging in multiple tendons, would then strongly suggest that any bursal changes or previous impingement have arisen as part of this degenerative process, rather than having arisen independently of this degenerative process.

In conclusion, I cannot see any evidence on file to support the view that any changes seen on the ultrasound scan in January 2015 or MRI scan in June 2015. It is far more plausible that all of these changes represent degenerative rotator cuff changes, rather than acute tears or acute injury of the rotator cuff.

At this stage, I have to conclude that any findings of bursal changes on imaging are of doubtful significance, given the lack of any findings on examination that Mr Frankpitt has any incapacity from the shoulder bursa or that he has any degree of impingement.

It is not plausible that repetitively cleaning metal parts for one single day could then be causative of a small labral tear in the right shoulder. Labral tears can either be of traumatic or of non-traumatic degenerative origin. Where labral tears are considered to be traumatic, there has to be significant trauma to the right shoulder, such as an individual falling onto their shoulder with significant strain-type movements of the shoulder which clearly has not been the case here. In this case there is no good evidence on file to support the view that any small labral tear has caused or is causing any current incapacity. The presence of this small labral tear is therefore likely to reflect an incidental finding on MRI scan as if often the case with small labral tears. I entirely agree with Mr Mohammed who indicated that these are unlikely to be causing him any incapacity at present.

Any AC joint arthropathy of the right shoulder appears to be an incidental finding on imaging and it is just not plausible that cleaning metal parts of a machine repetitively for one day could cause an arthropathy of this joint, as this is a condition that is thought to take many years to develop.

Also there is no evidence on file to support the view that this is causing any current incapacity. It is therefore likely to reflect an incidental finding, AC joint arthropathy being extremely common on imaging of shoulders in individuals over the age of 50, with increasing incidence and prevalence with increasing age.

Although the MRI showed the possibility of non-specific synovitis, there is no good evidence on the examination to support the view that Mr Frankpitt has any incapacity from right shoulder synovitis, there being no good evidence on the examination to support the view that he has any particular irritation of the right shoulder. Also, it is just not plausible that rubbing or cleaning metal parts of a machine repetitively for 1 day could then be causative of what is considered to be a slow-onset problem of the shoulder. It therefore would appear that any synovitis reported on MRI scan is most probably in an incidental finding, and unlikely to be of any significance at all with respect to any opinion about the cause of current incapacity.

In conclusion I cannot see on file any good evidence to support the view that Mr Frankpitt had an accident on 9 January 2015, or that he sustained any injury to his right shoulder as a result of work on 9 January 2015. It is most plausible that the imaging finding in the right shoulder reflects slow-onset degenerative changes in the right shoulder.

Given the lack of any temporal relationship between the development of right shoulder pain and cleaning metal parts on one day in January 2015, I then have to conclude that there is unlikely to be any relationship between any work tasks undertaken by Mr Frankpitt on one day in January 2015 and the development of shoulder pain the next day. It is most likely that right shoulder pain developed entirely independently of any tasks undertaken on one day in January 2015.

I have considered whether Mr Frankpitt's type of work may have been caused due to his work as a Work Related Gradual Process Injury (WRGPI).

From the description of Mr Frankpitt's work, I think it unlikely he will meet the criteria or threshold for a WRGPI, as his reported tasks at work do not have a quality that could have been causative of rotator cuff degenerative changes. For work to be deemed to be causative of rotator cuff degenerative changes, there has to be exposure to a high level of forceful repetitive elevation of the affected shoulder at or above 60° and for sustained or prolonged periods of time. Exposure periods are considered to be long, usually somewhere in the region of 10 years. I would therefore not consider that Mr Frankpitt's work to be in any way comparable to occupations that are thought to have an increased risk of rotator cuff problems of the shoulder, for example in construction workers.

2. What is Doug's current condition or diagnosis?

The cause of Mr Frankpitt's right shoulder pain is unclear and I would consider this to represent non-specific right shoulder pain of unknown origin.

Although Mr Frankpitt's incapacity has been attributed to a rotator cuff tear seen on imaging, this cannot be reconciled with a normal examination of the rotator cuff when seen initially by Mr Mohammed and more recently by myself. It is therefore most plausible that any small rotator cuff tear is most probably currently asymptomatic. Specifically I cam also unable to attribute current incapacity to any findings on imaging, these changes likely to represent incidental findings on imaging, as is often the case with any form of imaging.

3. **Is Doug's current condition, diagnosis, symptoms, level of function, or incapacity caused by the original accident event?**

Mr Frankpitt's current right shoulder pain is related to any event on 9 January 2015. There is no good evidence on file to support the view that current right shoulder incapacity is due to an injury related cause.

Although the cause of Mr Frankpitt's right shoulder incapacity is not really currently known, it would appear to me that imaging findings are of uncertain significance in this case but most certainly represent slow-onset problems of the right shoulder rather than due to any work tasks or activities on 9 January 2015.

The answer to this question is extensively discussed extensively in my answer to question 1.

4. **Do you have any recommendations for any further treatment investigations, pharmaceuticals, rehabilitation options?**

This is covered in the management section of this report.

[15] The respondent agreed to seek further comment from Mr Mohammed who responded on 14 October 2015 as follows:

Attached are the notes we have on Douglas. They state diagnosis, recommendation and history of the accident. We do not define a causal link unless surgery is recommended. We do not have any further information and this patient has been discharged.

[16] Following this report, the respondent issued its decision on 13 October 2015 suspending entitlements on the then current claim, with effect from 6 December 2015.

[17] On 3 November 2015, the appellant wrote to Mr Mohammed requesting another appointment, but this was declined.

[18] Following a meeting between the respondent and the appellant, the respondent offered to fund an orthopaedic review by Mr Mohammed or another shoulder specialist and on 22 December 2015 requested that the appellant's general

practitioner arranging a review with Mr Malone, Orthopaedic Specialist. However, Mr Malone declined to provide a review stating in response to Dr Wilson on 20 January 2016 that:

> After discussion with Mr Mohammed's rooms, he has recommended the appropriate treatment for Peter is to pursue an extensive physiotherapy programme which ACC is happy to endorse. Evidently Peter has not adhered to this recommendation.
>
> In the first instance, it would be appropriate if he pursues a physiotherapy regime and then seek a further review with Mr Mohammed if his shoulder has not settled.

[19] In late 2016 and early 2017, representations were made to the respondent by the appellant's then counsel, Mr Foster, who asserted, amongst other things that cover for tendon tears and gradual process injuries had not been investigated nor subject to a decision. He also asserted that requirements for deemed cover for a claim for tendon tears were met at the time that an assessment report and treatment plan was lodged on 6 May 2015 and that a further claim for cover for tendon tear, chondrolabral separation, bursitis atrophy was lodged on 11 August 2015 when an MRI arthrogram was sent to ACC. Claims for entitlements to treatment and weekly compensation were also advanced at that time, and similar representations were made on 9 January and 16 February 2017.

[20] In his letter to ACC dated 15 December 2016, Mr Foster, amongst other things, sought cover on behalf of the appellant for tendon tears and gradual process injuries that had not been investigated or the subject of a decision.

[21] Under the heading "deemed cover pursuant to s 58", Mr Foster said:

> [16] I consider that the criteria for a claim for cover for tendon tears was met when an ARTP was lodged on 6 May 2015.
>
> ...
>
> [20] If ACC accept that claim (s) was/were lodged, I believe that Mr Frankpitt is deemed to have cover for those injuries by operation of s 58.

[22] On 29 December 2016, ACC responded saying amongst other things:

> ACC cannot accept reported findings in medical imaging to be accepted as a request to lodge a new diagnosis. Any consideration of a new diagnosis or

additional diagnosis must be provided by a medical expert qualified to diagnose. To date Mr Mohammed, being the treating specialist, has not made any such request. Nor has Mr Mohammed made any requests for funding of further treatment, diagnostic or otherwise.

[23] On 9 February 2017, the respondent again emailed Mr Foster saying:

> I can confirm that ACC's position is that neither the medical information on the claim to date, or the letter you sent ACC on 15 December 2016 constitute an application for additional cover. In order to make an application for cover, please can you either:
>
> 1. Arrange for Mr Frankpitt's treatment provider to lodge ACC 45s appropriately; or
>
> 2. Provide information to ACC from a treatment provider (similar to that on ACC forms) which addresses relationship between the accident and any additional injuries being claimed.

[24] In an email dated 9 June 2017, Mr Foster on behalf of the appellant said this:

> [1] The investigative onus sits with ACC pursuant to *Ambros* and ss 56 – 58. The fact that ACC has failed to investigate to the extent necessary to make a decision within the statutory timeframes is one of the grounds for failure to comply with ss 56 and 57 which leads to deeming pursuant to s 58.
>
> [2] The applicant's case proceeds on the basis that ACC failed to investigate to the extent reasonably necessary to make a decision and therefore s 58 applies.
>
> [3] Whether or not further investigation is required is a matter for any reviewer exercising discretion under the Act to make the decision again for ACC in accordance with the guidelines.
>
> ...
>
> [5] The applicant would be open to conciliating this matter.

[25] The suggestion of conciliation was taken up by both parties and the following agreements and understandings were reached:

> [1] ACC agrees to arrange a fresh orthopaedic assessment with a Christchurch based specialist of Mr Frankpitt's choice. The specialist will be provided with the available medical notes/records. The specialist will be asked, amongst other things, to undertake a physical examination of Mr Frankpitt and to comment on the injury(ies) in Mr Frankpitt's right shoulder and the likely cause(s) of those injuries. Mr Hunt and Mr Foster will liaise over the appropriate questions to be put to the specialist. ACC agrees to fund the costs of this assessment and any radiological investigation specialist deems necessary.

[2] On receipt of those specialist's report, ACC will issue a fresh decision(s) confirming any injury(ies) it accepts cover for and any injury(ies) it does not accept cover for. The decision(s) will carry review rights.

[3] The parties agree to return to conciliation either before or after ACC issues the fresh decision(s) to determine whether any outstanding issues in the dispute can be resolved.

[4] The parties agree and request that, until further notice, the reviewer grant an adjournment of the current review applications 5122586 and 5122588 in order that the matters outlined in [1] – [3] above can be completed. Either party will advise Fairway Resolution if they consider it is appropriate for the review(s) to proceed to a hearing.

[5] The parties agree to file joint memorandum of counsel to the District Court to advise the Court of the current conciliation process in the terms of this agreement.

[6] ACC agrees to pay Mr Foster's representation costs for return travel to the conciliation, lodgement of the review applications, preparation and attendance at the conciliation (three hours attendance) at the regulated amounts. Mr Foster will provide ACC with an invoice for these costs.

[26] On 12 September 2017, consistent with the terms of this agreement, counsel for the respondent provided Mr Foster a draft letter of instruction to Mr Mohammed – the specialist of the appellant had nominated. As advised to Fairway on 21 September 2017, the response to that draft correspondence was at that time still awaited from Mr Foster, and that remained a position when on 1 November 2017 further enquiry was made.

[27] On 2 November 2017, Mr Foster said he would provide the appellant's response shortly and apologised for the delay. There was further follow up on 5 December 2017 and since there had been no response from Mr Foster by that time, on 14 March 2018, the position was further outlined with attempts being made by Mr Clayton (of Fairway) to advance matters. There was also a direction by the reviewer Ms Thomson that a review hearing be scheduled with a date of hearing of 15 June 2018 suggested.

[28] In March 2018, the appellant indicated that Mr Foster was no longer acting on his behalf and he provided a revision of the proposed letter to Mr Mohammed. That was the subject of correspondence into which Fairway via Mr Clayton was copied.

[29] Eventually, agreement was reached on the terms of the letter to Mr Mohammed which was finally settled and sent to him on 3 August 2018 along with various annexures.

[30] Mr Mohammed responded on 19 August declining to provide a further report. He said:

> I don't feel it would be appropriate for me to see Mr Frankpitt for this medical legal assessment. I agree with the comprehensive and detailed report of Dr Hilliard. It is appropriate that an occupational physician like Dr Hilliard has performed a medical legal report and you will see from this that this is a very detailed, long and specialised assessment. My practice as an orthopaedic surgeon is focused on patient care rather than specialised medical legal assessments.

[31] Following that response, further engagement with the appellant was sought regarding obtaining an independent assessment. No progress was made and there was no response from the appellant.

[32] In the meantime, the review application was scheduled for a hearing. This took place on 22 March 2019. The appellant did not attend the review hearing but filed written submissions.

[33] The reviewer, Ms Thomson, issued her decision on 11 April 2019.

[34] Ms Thomson noted that the applications for review were lodged under s 134(1)(b) of the Act. That is to say, the appellant was alleging "delay and processing the claim for entitlement that the claimant believes is an unnecessary delay".

[35] The reviewer found that Mr Frankpitt did not have cover or deemed cover for additional injuries. She referred to s 67 of the Act noting that cover for an injury was a prerequisite to a claimant receiving entitlements for the injury.

[36] She noted:

> I do not know the current status of the conciliation agreement and whether the option of ACC finding an orthopaedic assessment and report on causation is still available; Mr Frankpitt may wish to discuss with ACC.

> Based on the evidence available to me, I find that there has been no unreasonable delay by ACC in processing a claim by Mr Frankpitt for entitlement.

[37] The reviewer also noted that the applications for review under s 134(1)(b) did not identify any decision by the respondent that the appellant had cover or deemed cover, for additional injuries in respect of his 2015 claim.

[38] Following the review decision and the lodgement of the notice of appeal, the progress of the matter to this hearing has been marked by 8 judicial minutes. One of the minutes, that of Judge Henare dated 18 February 2020, noted because the appellant had agreed to a referral to an orthopaedic surgeon, directions as to submissions were not appropriate and steps were then to be taken to arrange for such referral.

[39] A further minute of this Court, dated 19 March 2021, noted that there had been a joint request for a further report from orthopaedic surgeon Mr Beadel. Mr Beadel is an orthopaedic oncology, arthroplasty upper limb and trauma surgeon. Under the heading "in summary", Mr Beadel said in his report of 9 September2020:

> I think the repetitive axial loading and impingement type position with activity that Douglas undertook for the day may well have been contributory in the development of bursitis and potentially intra substance tendon tearing due to overload type phenomena. There was also synovitis within the rotator interval which can be due to adhesive capsulitis and adhesive capsulitis could also be secondary to a repetitive shoulder injury such as this described. Douglas does have mild restriction of shoulder motion mainly external rotation on review today and this would also be consistent with a previous episode of adhesive capsulitis. Therefore it is my belief that the repetitive strain injury may have contributed to Douglas's rotated cuff partial tears, bursitis and an element of adhesive capsulitis in his right shoulder.
>
> In view of Douglas's ongoing right shoulder symptoms and signs, I think it is appropriate to get up to date imaging by way of plain X-rays and MRI scan of the shoulder to reassess.

[40] On 18 November 2020 an MRI of the appellant's right shoulder was undertaken. This revealed:

> Severe supraspinatus tendinosis with near full width longitudinal intra substance tear. Slight increase in size compared with 2015. No tendon retraction. ... Moderate AC joint arthropathy with periarticular bone marrow oedema and mild to moderate bursitis. Mild glenohumeral joint changes.

[41] The management plan was for a referral for guided cortisone steroid injection, acromioclavicular joint and subacromial bursa.

[42] Mr Beadel saw the appellant again on 2 December 2020. His brief report noted the findings of the MRI scan. Mr Beadel said:

> The MRI scan in addition to the rotator cuff in bursal changes has also highlighted significant bone marrow oedema around the acromioclavicular joint and clinically some of his discomfort certainly relates to the superior aspect of his shoulder/acromioclavicular joint and he is tender in this region with a positive AC joint compression test although there is always a lot of cross over between these tests.
>
> With regards his rotated cuff, although there has been a slight increase in size of the intra substance tear since 2015, it is good news that there has been no progression to a full thickness tear. Therefore hopefully we can continue to manage Doug's shoulder overall non-operatively.

[43] In response to a further email from ACC relating to causation, Mr Beadel in a letter dated 24 March 2021 said:

> I believe I have already answered this to the best of my ability and confidence in defining exactly the cause of this man's right shoulder injury in my summary in my clinical letter of 09.09.2020.

[44] ACC requested the clinical advisory panel comment on Mr Beadel's reports. The clinical advisory panel's report dated 8 June 2021 amongst other things, said:

> The CAP acknowledged that Mr Frankpitt's hard work when cleaning the plates and cassettes on 09/01/2015 was painful and strenuous. However, a causal link with the common, age related changes in his right shoulder imaging cannot be established.

[45] The panel concluded that the appellant's bursitis was not consistent with an acute injury nor was his capsulitis related to a single episode of trauma. It concluded that his other imaging changes were chronic and not related to a single episode of trauma. Under the heading "Conclusions", it said:

> The CAP explained that rotator cuff tendinopathy and tendon tearing is a chronic insidious process that occurs slowly overtime. It is a common cause of shoulder symptoms in the general population. Our body slowly changes our tendons over time, and it starts with slow "intra substance" sharing of the tendon fibres within the tendon as seen in Mr Frankpitt's imaging. His bursal thickening, chondrolabral tearing, shoulder joint arthritis, acromioclavicular joint osteoarthritis, biconcave glenoid and other imaging features also developed slowly over time.

> We could find no clinical evidence to support the impression of an acute cause suggested by Mr Beadel. We consider that the most likely cause of Mr Frankpitt's supraspinatus and infraspinatus tendon tearing and other imaging features were slow changes common in his demographic. A causal link to the 09/01/2015 event has not been established and is most unlikely.

Appellant's submissions

[46] Mr Frankpitt told the Court that his claim for cover was lodged on 15 December 2016. In this regard, he refers to the letter of that date from his then barrister Mr Foster which says amongst other things:

> [1] This letter is important as it notifies you of the need for a cover decision or deemed cover, and lodges claims for cover and entitlements to surgery and weekly compensation pursuant to s 48.
>
> ...
>
> [5] The reason given for declining entitlements on the 10030014299 claim is that the need for entitlements is not caused by the covered sprain/strain in my client's shoulder for which cover has granted. Instead, it is obvious that the surgery is required to treat a tendon tear, which I now ask you to consider in terms of cover and entitlements.

[47] The appellant's counsel's letter went on to say:

> I lodge claims on Mr Frankpitt's behalf pursuant to s 48 in accordance with the specifics in this letter. Please process these new claims in accordance with the timeframes at ss 56-58 of the Accident Compensation Act 2001.

[48] Counsel's letter went on to say to the Corporation:

> If you believe that this claim does not specify the nature in the central characteristics of what Mr Frankpitt is seeking, please advise me of what additional information you require as soon as possible so that I can provide further information with a view to promptly completing the process of lodging a claim.
>
> As there seems to be no dispute that Mr Frankpitt suffers from tendon tears in his shoulder, there is no dispute that the appropriate treatment for tendon tears is as set out by Mr Mohammed and Mr Walker.
>
> It appears to me that the question is simply one of causation in relation to the tendon injuries, i.e., whether the injury is covered under the Accident Compensation Act 2001, s 20(b).

[49] The letter went on to deal with the deemed cover pursuant to s 58 saying:

> I consider that the criteria for a claim for cover for tendon tears was met when an ARTP was lodged on 6 May 2015.
>
> ...
>
> Can you please advise ACC's position on whether or not these claims have met the legal criteria for a claim and if ACC does not accept that they do, please advise why and provide full reasons.
>
> If ACC accepts that claim(s) was/were lodged, I believe that Mr Frankpitt is deemed to have cover for those injuries by operation of s 58.

[50] Mr Frankpitt submits that the legislation must be used as it was intended and that the reply to him was not a decision within the meaning of s 64.

[51] He said he is looking for deemed cover, as the legislation provides, in order to protect people in his position.

[52] In submissions in reply, he expanded on what he had said earlier saying that Mr Foster applied for a new cover not a duplicate cover and that it was a claim for a specific problem namely the tendon tears, that is to say, a problem that was beyond the initial cover for sprain or strain.

[53] Mr Frankpitt says that the conciliation process was resorted to, to progress matters with the Corporation as the Corporation had been doing nothing. He says nevertheless that the conciliation process does not override the law.

[54] He says that where there is delay in processing the claim, s 134(1)(b) is the only remedy available to the claimant. Therefore, he says the concept of deemed cover must be considered by the Court before anything else.

[55] He submits that the fact that a decision was sent to him on 22 April 2022 is acknowledgment by ACC that a decision was required. He says however it is four years and ten months too late.

[56] He submits that a deemed decision must take effect at the expiry of the statutory time limit so therefore he has cover from that time.

Respondent's submissions

[57] Mr Hunt referred to Mr Frankpitt's first review decision dated 5 June 2016. He says that this review decision provides context. In this decision the reviewer had to decide whether ACC was right to suspend entitlements to the appellant on the basis that there was no causal link between the injury the appellant suffered on 9 January 2015 and his current symptoms.

[58] In that decision, the reviewer found that ACC had sufficient basis, both to conclude that the appellant's symptoms/incapacity were not caused by an injury suffered in the accident of 9 January 2015, and to suspend his entitlements accordingly.

[59] Mr Hunt notes that an appeal filed in relation to this decision was later withdrawn by the appellant.

[60] Mr Hunt then referred to the second review decision, Review 5122586, whether there was an unreasonable delay by ACC in making a decision on a claim for treatment. He also referred to Review 5122588, whether there was an unreasonable delay by ACC in making a decision on a claim for weekly compensation. These are the two review decisions that have been taken on appeal to this Court.

[61] Mr Hunt noted that ACC had accepted cover for the sprain caused to the appellant by an accident on 28 January 2015 when he was cleaning a metal plate at work on 9 January 2015.

[62] The reviewer's decision in this case noted that the parties had attempted to resolve the dispute via conciliation with ACC agreeing to fund a new orthopaedic assessment with a Christchurch based specialist of Mr Frankpitt's choice.

[63] Mr Hunt notes that the reviewer recorded:

> Unfortunately despite repeated requests over many months, Mr Foster did not engage with Mr Hunt about the questions to be put to Mr Mohammed, the specialist nominated by Mr Frankpitt.

...

However, on 19 August 2018, Mr Mohammed declined to provide a report on causation. He said:

> I don't feel it would appropriate for me to see Mr Frankpitt for this medical legal assessment. I agree with the comprehensive and detailed report of Dr Hilliard. It is appropriate that an occupational physician like Dr Hilliard has performed a medical legal report and you will see from this that this is a very detailed, long and specialised assessment. My practice as an orthopaedic surgeon is focused on patient care rather than specialised medical legal assessments.
>
> ...

Mr Frankpitt did not respond to Mr Hunt's subsequent enquiries as to whether he (Mr Frankpitt) wish to be assessed by another orthopaedic specialist.

[64] Mr Hunt points out that the review found that there was no deemed cover, with the Reviewer saying:

> These applications for review do not identify any decision by ACC that Mr Frankpitt has cover/deemed cover for additional injuries on his 2015 claim, presumably because no such decision exists.

[65] Mr Hunt referred to the conciliation agreement and the attempt to get a fresh orthopaedic assessment with a Christchurch based specialist of Mr Frankpitt's choice. He says it was unfortunate that Mr Mohammed felt unable to provide the report needed.

[66] Mr Hunt referred to the further efforts by ACC to obtain the sought after assessment from Mr Beadel but Mr Beadel did not provide the required report. It was then that everything was referred to the clinical advisory panel.

[67] Mr Hunt acknowledges that this case has an unusual background.

[68] Mr Hunt says that ultimately the evidence that we have indicates that neither an acute nor gradual process injury occurred on or about 9 January 2015 while the appellant was working manually cleaning laminating plates at his workplace.

[69] Mr Hunt submits that if a deemed decision was found to have arisen, the evidence that ACC has gathered supports the declining of cover.

[70] Mr Hunt submits that it is not appropriate for the appellant to assert that failure to issue a decision has occurred in circumstances where the respondent has specified, as it is entitled to under s 52, the manner in which it requires a claim to be presented to it. He says it is reasonable to expect the claimant to comply with those requirements and that has not occurred.

[71] He says that over a considerable period of time and at some considerable expense, the respondent has sought to advance a reasonable and proper approach to the appellant's situation as agreed at conciliation and when attempts to obtain such evidence failed, the respondent has taken the equally responsible step of obtaining an assessment by the clinical advisory panel.

Decision

[72] The appellant injured his right shoulder on 9 January 2015 whilst he was manually cleaning laminating plates at his workplace. He sought physiotherapy treatment on 28 January 2015 and a claim was lodged for a diagnosed right shoulder sprain for which cover was granted to the appellant.

[73] The ACC injury claim form lodged by the treatment provider, Sports Med Canterbury Limited, noted a diagnosis of "sprain shoulder/upper arm right".

[74] On 30 January 2015, ACC wrote in its standard letter to the appellant, accepting his injury for cover.

[75] The appellant received physiotherapy treatment. However, he continued to suffer shoulder pain, and approximately a month after the injury his employer noted that as well as pain, the appellant could not lift his right arm above the shoulder height. Accordingly, an X-ray and ultrasound were undertaken on 9 April 2015, with the ultrasound showing a low grade partial thickness infraspinatus tear with mild overlying subacromial bursal thickening.

[76] Then followed a report from orthopaedic surgeon Mr Mohammed on 6 May 2015, which was reviewed by the respondent's medical advisor Dr Nazmi.

[77] An MRI scan was undertaken on 11 August 2015, and Mr Mohammed provided a further report on 13 August 2015.

[78] Dr Hilliard undertook a specialist medical case review in respect of the appellant's right shoulder incapacity and provided a 17-page report to ACC on 1 September 2015.

[79] The respondent agreed to seek further comment from Mr Mohammed, who responded on 14 October 2015, saying:

> We do not define a causal link unless surgery is recommended.

[80] The respondent wrote to the appellant on 30 October 2015 saying:

> The medical information available at this time suggests that your right shoulder symptoms do not relate to the described event at work on Friday 9 January 2015, but instead represent slow onset problems of the right shoulder.
>
> ACC can no longer support you with your symptoms as they do not relate to the injury you sustained in the accident on 9 January 2015. Your entitlements to weekly compensation, treatment and rehabilitation on this claim will cease from Sunday 6 December 2015.
>
> A copy of the decision rationale has been enclosed for your information. Should any new medical information become available, ACC will be happy to review it. Should it prove that your right shoulder symptoms relate to the event described on Friday 9 January 2015, we may reconsider this decision.

[81] Accordingly, as at 30 October 2015, the Corporation having received the appellant's claim, had, in terms of s 56, investigated the claim at its own expense and to the extent reasonably necessary to enable it to make a decision, granted cover. Entitlements that followed included weekly compensation and physiotherapy.

[82] As s 58 provides, the appellant was reasonably required to undergo any other assessments at the Corporation's expense and did so. In particular, the appellant underwent a specialist medical case review with Dr Hilliard on 31 August 2015.

[83] Dr Hilliard provided a detailed assessment of the appellant's injuries said to have arisen from 9 January 2015.

[84] Dr Hilliard found:

> No good evidence on file or an examination to support the view that Mr Frankpitt's current right shoulder pain is related to an event on 9 January 2015.
>
> There is no good evidence on file to support the view that current right shoulder incapacity is due to an injury related cause.

[85] Therefore, in terms of what the Accident Compensation Act 2001 provides for, the steps taken by the Corporation to make reasonable decisions in a timely manner (s 54), have occurred. Likewise, the appellant has met his responsibilities under s 55 to undergo a medical assessment when reasonably required to do so at the Corporation's expense.

[86] However, in his letter of 15 December 2016, the appellant's then barrister, Mr Foster alleges that:

> ...ACC has failed to turn its mind to material demonstrating that an investigation and decision is required in relation to the tendon tear injury identified in other documentation held by ACC.

[87] Mr Foster's letter goes on to say that cover for the tendon injury and cover for any consequential gradual process injuries under s 20(2)(g) needs to be established.

[88] The letter then says:

> Please process these new claims in accordance with the timeframes at ss 56-58 of the Accident Compensation Act 2001.

[89] The letter claims that Mr Frankpitt is deemed to have cover pursuant s 58 for tendon tears. It says:

> [16] I consider that the criteria for a claim for cover for tendon tears was met when an ARTP was lodged on 6 May 2015.
>
> [17] I consider that a further claim for cover for tendon tear chondrolabral separation, bursitis, and atrophy was lodged on 11 August 2015 when the MRI arthrogram was sent to ACC.
>
> ...
>
> [20] If ACC accepts that claim(s) was/were lodged, I believe that Mr Frankpitt is deemed to have cover for those injuries by operation of s 58.

[90] However, I reject this submission.

[91] The claim form in this case has the diagnosis "sprain shoulder/upper arm right".

[92] Such diagnosis by a physiotherapist is normal in cases like this. It is the initial step that triggers ACC's responsibilities under s 56 to investigate the claim at its own expense and to give notice of its decision on the claim to the claimant.

[93] In this case these are done within the statutory timeframe.

[94] Section 65 allows the Corporation to revise its decisions and in its letter to the appellant of 30 October 2015, it has done so by advising the appellant that "the medical information available at this time suggests that your right shoulder symptoms do not relate to the described event at work on Friday 9 January 2015 but instead represent slow-onset problems of the right shoulder".

[95] This revised decision is plainly based on the detailed report of 1 September 2015 from Dr Hilliard.

[96] Therefore, in the circumstances, the argument on behalf of the appellant that there is deemed cover for tendon tears, chondrolabral separation, bursitis and atrophy is not accepted.

[97] The appellant sought and obtained a cover for shoulder sprain. This loose terminology, while seemingly vague and unhelpful, is no doubt designed, at least in part, to ensure that its statutory obligation under s 56 to investigate the claim is not inhabited by a narrow description of the injury in the claim form at a time when the extent of the injury is very often not known.

[98] Here the investigations that have followed included CT and MRI scans as well as the detailed assessment by Dr Hilliard.

[99] The issues raised by the appellant as being the subject of deemed cover namely the tendon tear, chondrolabral separation, bursitis, and atrophy, I find to be

covered by the "umbrella" claim for "sprain shoulder" entered in the injury claim form of 28 January 2015.

[100] Accordingly, I find that the appellant's claim for deemed cover has no merit and is rejected.

[101] It follows that the "late" letter from ACC dated 22 April 2022 declining claims for tendon tears and gradual process injuries simply formalises the position.

[102] I have no criticism for ACC for the lateness of this decision letter. I find that ACC has in this case throughout endeavoured to act fairly as exemplified in its willingness to have recourse to conciliation and its significant endeavours to obtain further information from Mr Mohammed to clarify matters, as well as obtaining reports from Mr Beadel and finally by referring the matter to the clinical advisory panel.

[103] In terms of causation, I find the clinical advisory panel's report decisive. It found that the mechanism of injury was not consistent with acute rotator cuff tendon tearing; that the appellant's bursitis is not consistence with an acute injury and that his capsulitis was not related to a single episode of trauma.

[104] It also found that the appellant's other imaging changes were chronic and not related to a single episode of trauma.

[105] The clinical advisory panel noted that rotated cuff tendinopathy and tendon tearing is a chronic insidious process that occurs slowly over time and that it is a common cause of shoulder symptoms in the general population. It considered the most likely cause of the appellant's supraspinatus and infraspinatus tendon tearing and other imaging features were slow changes common in his demographic.

[106] On the balance of probabilities therefore this presentation was not caused by an accident event on 9 January 2015.

[107] In this case, the appellant has appealed against Reviewer, Ms Thomson's two review decisions, 5122586 and 5122588, dated 11 April 2019.

[108] The issue in respective review 5122586 was whether there was an unreasonable delay by ACC in making a decision on a claim for treatment and in respect of review 5122588 whether there was an unreasonable delay by ACC in making a decision on a claim for weekly compensation.

[109] The history of what occurred in this case following the appellant's injury on 9 January 2015 by and large describes appropriate steps taken by ACC in a timely fashion albeit constrained in this case by the availability and willingness of medical professionals to provide reports.

[110] ACC's willingness to engage in a conciliation process contraindicates the allegation of delay.

[111] So far as the appellant's claim for entitlement to surgery is concerned, that required proper consideration of whether the appellant had an entitlement to surgery as a result of an accident causing injury.

[112] In this regard, ACC's position was justified following the report of Dr Hilliard.

[113] As to delay in making a decision on the appellant's claim for entitlement to weekly compensation, as the reviewer said in her decision of 11 April 2019, the appellant had options, including proceeding with his appeal and lodging a claim to cover for additional injuries.

[114] I find in this case that ACC's responses to the issues that this case presented were in general, timely and appropriate, and this included its willingness to enter conciliation. Accordingly, I must dismiss this appeal. There is no issue as to costs.

Judge C J McGuire
District Court Judge

Solicitors: Young Hunter, Christchurch