IN THE DISTRICT COURT
AT WELLINGTON

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

[2021] NZACC 130 ACR 49/21

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPEAL UNDER SECTION 149 OF THE ACT
BETWEEN	RAYLENE DUNNAGE (as Executrix of the Estate of John David Black) Appellant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Hearing: 16 June 2021
Heard at: Wellington/Whanganui-A-Tara

Appearances: Mr A Beck for the Appellant
Mr C Light for the respondent

Judgment: 6 August 2021

RESERVED JUDGMENT OF P A CUNNINGHAM
[Personal Injury s 20, s 30 and s 67 Accident Compensation Act 2001]

Introduction.

[1] Mr Black died on 12 August 2017. His claim arises from when he was working in a freezing works owned by Alliance Group in Invercargill (AGL). It was his third season with ALG when in March 2011 he developed pain in his shoulder or shoulders. When his symptoms had not improved after a month, he went to see his GP who filled out a claim form. A claimant cover questionnaire stated that Mr Black had constant pain in his left shoulder. His task at the freezing works was to remove

any pelt left after another machine had removed most of it. He had to do some trimming with a knife using his left hand when performing this task.

[2] Mr Black's claim for a personal injury was declined by ACC in a letter dated 19 July 2011 on the basis that there was not clear evidence of a physical injury or damage. The problem was said to be with his posture. Mr Black applied for a Review of ACC's decision. That hearing was held on 23 October 2012. On 23 October 2012, the Review decision was published upholding ACC's decision.

This Appeal.

[3] This is the rehearing of an appeal. The claim for personal injury is that it meets the requirements for a gradual process work injury under s 30 of the Accident Compensation Act 2001 (the Act). If the Court decides they have not been met, then the case should be adjourned to enable the necessary information to be provided. Mr Beck also raised an issue that there was a deemed decision in favour of Mr Black under s 57 of the Accident Compensation Act 2001 ('the Act"). This is on the basis that AGL said it would be investigating the claim which required further information, so it had been placed on hold for 4 months. The argument here is that there was not a genuine assessment by AGL that it would take that long to investigate Mr Black's claim. AGL was giving itself a 2 month extension in every case before taking any steps to investigate. In other words, it was an automatic reaction to extend time and not a considered decision that more time than the statutory timeframe would be needed.

Background

[4] There is a note dated 4 March 2011, made by the nurse who worked at the freezing works that Mr Black had been applying ice with little improvement. He had discomfort in both shoulders, but the left was worse than the right. The pain was worse when using his arms over shoulder height, and he had pain at the tip of his shoulders. It was noted that he had not previously suffered injuries and had no medical conditions apart from having to take medication for his blood pressure.

[5] Mr Black saw his GP, Dr Allen on 5 April 2011. Dr Allen filled out an ACC claim form. He recorded a diagnosis of "? Impingement". He noted there was pain in shoulders, no specific injury as such. The form filled out by Mr Black, said that he had constant pain in the left shoulder. It ached with pain moving all the way down his shoulder. He had been having physio for four weeks and been on pain killers to no avail. He described his work tasks as trimming carcasses and pulling pelts. He said he had started to paint the ceiling in his lounge but had to stop because of the pain. Mr Black continued to work but he was on light duties. This is recorded in a file note by Tracey Henderson, Injury Prevention Officer on 3 May 2011.

[6] At the review hearing, Mr Black said he felt the pain was because of the repetitive work that he did. He was moving his shoulder all of the time. He said the pain was mainly in the left shoulder, but he did "get a bit of a tweak" in the other one. He described it as a "pinching pain". He never experienced this pain before he worked at Alliance. Eighteen months later (at the time of the review hearing) he still had the pain.

Report of Chris Gibb

[7] Mr Black went to see a physiotherapist Christine Gibb at the request of his employer. Ms Gibb provided a detailed letter dated 16 May 2011 to Mr Black's employer after she saw him. She said Mr Black had pain in his left shoulder for the last six weeks. It was intermittent on some tasks at work, usually when pulling the pelt by hand and trimming around the anus. He had a cortisone injection to the subacromial space which had helped. Mr Black had pain on horizontal flexion at the end of range. On x-ray he had elongation of his acromion and an ultrasound report stated there were no tears of his rotator cuff muscles but there was evidence of impingement. Ms Gibb went through the four tasks that Mr Black performed in some detail. Trimming was identified as the one that caused most discomfort:

> In this task, Mr Black holds a knife in his left hand and trims starting with his shoulder at 70 – 80 degrees flexion as the carcass moves by his shoulder moves into adduction and internal rotation. At the end of each carcass he sterilises the knife at right hip level.
>
> When he is finished trimming, he then reaches into horizontal flexion abduction and internal rotation to sterilise his knife. This puts Mr Black's glenohumeral

> joint into impingement position. He finds this task causes most of his discomfort.

[8] Ms Gibb said that the pain was probably due to his underlying anatomy. That an osteophyte on his acromion is probably related to age and to the work Mr Black had done over the past 40 years. That he was stiff through his thoracic spine, he had protracted shoulders and scapular which doesn't help the impingement.

[9] Mr Black had done physical jobs all of his life. He had worked on the family farm from 1966 until 1980 where he did general farm work. From 1980 to 1984 he worked on a farm in Dipton where he described his work as general farm hand. From 1985 until 2004 he worked for the Southland District Council as a foreman. His tasks were driving machinery, trucks, tractors and graders. He did farm work again from 2005 until 2008. This involved tractor and truck driving, mowing, bailing hay, and drenching sheep. He worked in a vineyard from 2008 until 2009 where the work was pruning, picking and spraying. He had also done some bulldozing work in 2008. Mr Black began working for AGL in 2008, as I understand it, this was during the "season".

[10] Dr David Ruttenberg, Occupational Medicine Specialist, was asked by AGL to review the file. Dr Ruttenberg referred to an x-ray and an ultrasound report of Mr Black's left shoulder taken on 12 April 2011. He said this revealed evidence of some slight anterior prolongation of the acromion,[1] with respect to the clavicle. He noted the absence of any acute injury. He referred to the report of Ms Gibb. Having taken that report into account, Dr Ruttenberg said that it was likely that the left shoulder pain is related to degenerative change but reflected by the need to adopt postures that are leading to impingement in his work environment.

> The underlying bony anatomical change is an age related and constitutional finding. I would not go as far as to state that these bony changes relate to previous work tasks. There is no evidence in occupational medicine that would support this assertion.

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1 The acromion is a bone which sits over the top of the rotator cuff muscle.

[11] Dr Ruttenberg was also of the view that there is no obvious gradual process injury currently present. His opinion was that Mr Black's work tasks, in particular the postures that he adopts while trimming and sterilising the knife have led to impingement and his symptoms of pain. The ultrasound did not show any pathology present in his left shoulder.

[12] Dr Ruttenberg said that Mr Black is at greater risk of suffering injuries in his job type as a meat process worker and in terms of his shoulders. The types of injury one would expect relate to tears of the associated tendon structures and components of the rotator cuff, tendonitis of the affected structures and associated tendinopathy under the right circumstances.

[13] Dr Ruttenberg thought that there needed to be consideration of the ergonomic factors to enable Mr Black to work with minimal symptomology. If that was not possible, consideration of redeployment to a different part of the chain was appropriate.

Review decision

[14] Mr Black was not represented at the review hearing. I have set out in paragraph [6] his answers to questions he was asked about the pain in his shoulders.

[15] The Reviewer referred to the report of Ms Gibb, the x-ray and ultrasound examination and Dr Ruttenberg's reports. He also referred to relevant cases as authority for the fact that cover is not available for symptoms and there must be an injury. That meant there had to be some structural change caused by the accident. In *Harun v ACC,*[2] the Court held that rotator cuff impingement is a common condition and not necessarily the consequence or result of physical injury. *Harun* was such a case.

[16] The Reviewer concluded that the evidence did not support Mr Black having sustained any physical injury to his shoulder which resulted in the impingement condition. Therefore, the employer's decision to decline cover was correct.

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2 *Harun v Accident Compensation Corporation* [2010] NZACC 197.

[17] By 2015 Mr Peter Sara, lawyer of Dunedin, was representing Mr Black on behalf of the Otago-Southland branch of the New Zealand Meat Workers union. Mr Sara asked Dr Chris Walls, Occupational Medical Specialist, to comment on an MRI scan that had been undertaken on 6 October 2014.

Report of Dr Chris Walls

[18] Dr Walls review was conducted on 4 March 2015. He said that interpreting a scan result some 4 years after the onset of discomfort is fraught with error when attempting to define a likely pathological source of discomfort and from there the likely influence of work factors. He said that the most notable pathology and the one easily capable of causing shoulder pain, is the acromioclavicular joint disruption/injuries. The MRI scan also showed some tendinopathy but not a complete rupture or muscle belly contraction (which would indicate it was chronic). His interpretation was that there had been a partial tear of the supraspinatus tendon in the past but was unable to state with any confidence that this was Mr Black's pain generator. It would be likely that both the AC joint injury and the partial tear of the supraspinatus tendon contribute to the shoulder discomfort with activity.

[19] While Dr Walls had used the word injury, he said the acuteness of them cannot be determined at this distance in time. The work-related factors for shoulder muscular disorders are of:

- Force (heavy work as defined by the U.S. Department of Labor);
- Highly repetitive upper limb activities (one cycle of work every 30 – 60 seconds); and
- Sustained or repeated shoulder postures of more than 60° flexion (brining the arm up directly in front of the side of the chest wall) or abduction flexion (bringing the arm up directly away from the side of the chest wall).

These factors have been supported and supplemented by other studies. Most importantly, Van Rijn, who noted must the same factors for what was described as "subacromial impingement syndrome":

- Highly repetitive work;
- Forceful exertion at work;
- Awkward postures; and
- High psychosocial job demand.

[20] Dr Walls said that AC joint disruptions/strain or eventually arthritis are most commonly attributed to direct trauma. He referred to an up-to-date text which described acromial clavicular joint disorders as acute injuries, repetitive strain injuries, degenerative conditions and other conditions. The diagnosis of acute AC joint injury is often straight forward due to the presence of focal tenderness, swelling and deformities.

[21] Overuse inflammational chronic degeneration can be more difficult to diagnose, particularly if concomitancy shoulder problems exist. He said other texts noted the association with athletic activities like weight lifting or occupations such as working with jack-hammers and other heavy vibrating tools.

[22] Dr Walls referred to Mr Black's work history and said that he was assuming Mr Black's left hand was his dominant hand as he used it with the trimming knife. He said that the diagnosis was unclear but there were two pathologies capable of causing shoulder pain and they were the AC joint disruption and the supraspinatus partial tendon tear. He said that his opinion was that there is a considerable amount of evidence to support the contribution of a gradual process injury to the left shoulder arising from 32 years exposure to force, working at more than 60° flexion, some periods of highly repetitive activity and some exposure to hand/arm vibration in his work as a farm hand and a council contractor. That there was a further contribution from a series of events from working at AGL for 3 years which involved exposure to heavy work, highly repetitive work and considerable periods of time working at more than 60° flexion. On balance, Dr Walls thought that Mr Black's work activities had substantially contributed to the development of his left shoulder pathologies. He thought these would not have occurred but for his work.

Dr Causer

[23] Dr Causer, an occupational physician, provided comment to counsel for ACC in a memorandum dated 11 July 2017. He was asked whether Mr Black met the criteria for cover for a work-related gradual process injury. Dr Causer had seen the MRI and the report from Dr Walls. He said that the onset of supraspinatus pathology is unknown. An MRI is more sensitive than an ultrasound so it could theoretically have been present when the ultrasound was taken but missed. Alternative, it could have developed since 2011. He said that supraspinatus pathology was one of gradual development, starting with cellular level changes of the rotator cuff tendons and eventually progressing to becoming visible as tendinopathy and then later as partial tears. Rotator cuff degeneration, seen as thinning and fabulation of the tendons, is common by the 5th decade of life. As degeneration progresses, the repair mechanisms fail, and micro-tears develop which can then become macro-tears which are visible on radiological studies. It is often accompanied by inflammation of the subacromial bursa and pressure on the tendons when lifting the arm up, this is the phenomenon described as impingement.

[24] He referred to a study (NIOSH) referred to by Dr Walls, which looked at the potential links between occupational tasks and shoulder disorders. This is often shoulder pain, rather than specifying which anatomical component is causing symptoms. In Dr Causer's view, it wasn't possible to draw any relevant conclusions from the study and apply them to specific shoulder disorders, such as rotator cuff pathologies.

[25] Dr Causer said that regarding the four risk factors of repetition and posturing (working with arms), the evidence is conflicting. There is a trend towards an increased risk with elevated posture and repetitious activities. As far as force is concerned, the evidence pointed towards no increase in risk. For heavy physical work, the larger body of evidence indicates there is no increased risk. He said there was conflicting evidence as to whether working with vibrating hand tools increased risk. Some studies show an increased risk, and some studies show no increase in risk. The evidence is most convincing for a cumulative effect from a combination of risk factors of posture and repetition force, but the evidence is insufficient to draw

any strong conclusions. He said that sustained shoulder postures with more than 60° of abduction or flexion are implicated. The duration of exposure required to significantly increase risk or rotator cuff tendinopathy is in the order of decades, rather than months or years.

[26] Given Mr Black's work history, Dr Causer said that there was no question his work roles will have involved heavy work and that exposure is lengthy. However, the risk factor of heavy work by itself has not been shown to increase risk of rotator cuff disorders. Literature did not support vibration exposure through jack-hammer risk as being a risk for rotator cuff disorders. Dr Causer noted that the detailed task descriptions of the farming or council roles and the nature of those tasks would have varied from time to time. But typically, in these roles, there is a regular repetitive exposure to sustained or repetitive elevated shoulder positions. Workers in these roles have not been shown to be at increased risk of rotator cuff disorders.

[27] Dr Causer referred to the specific tasks that Mr Black had been undertaking. One that had caused the symptoms was the work performed with an arm elevated at 70° - 80°. He said there is some degree of exposure to risk factors which may cause rotator cuff disorders. Perhaps 15 minutes in an hour, over three seasons of meat processing. Some arm elevation will occur during other tasks, but there is no indication that this is substantial or highly repetitive. He felt that three years of such activities was not long enough to give rise to rotator cuff injury by gradual process mechanisms. In most epidemiological studies, the subjects had at least 10 years of work experience. This work is likely to have generated symptoms and a condition which would have been developing far longer than 3 years, due to a natural process.

[28] Dr Causer went on to say that it is easy to look at the workplace and point the finger at any task involving the shoulders. But that does not explain why persons performing work tasks which do not involve the shoulder and any forceful actions, such as people working at computers all day, also develop these conditions. He said that approximately 24% of persons in the age range 40 – 60 years have partial thickness rotator cuff tears and this proportion increases with advancing age.

[29] Dr Causer said it was not possible to conclude that the AC joint disruption was secondary to an injury based on the information available. He also said it was not possible to conclude that the AC joint disruption/widening was a gradual process condition that would be covered under s 30.

Further comment by Dr Walls

[30] That report, was shown to Dr Walls, who stated:

> As I stated in my May 2015 letter this injury as with any gradual process injury is a result of cumulative exposures. As my May 2015 report notes, Mr Black's work history is of decades of exposure to a mixture of the relative risk factors.
>
> His three years of work in the meat process industry might be considered a series of events but this is too fine a distinction. I would prefer to consider this a gradual process injury occurring in a work of decades and exposure to the relevant risk factors.
>
> One can speculate that the work in the meat processing industry with its force, repetition and non-mutual postures accelerated and completed the gradual process injury but this speculation.

Report of Dr D McBride

[31] Mr Black's counsel then asked Dr David McBride to undertake a file review. Dr McBride is an occupational medicine specialist with 30 years' experience and an occupational epidemiologist by training from the University of Birmingham and the European Educational Programme in Epidemiology. Dr McBride had the reports by Ms Gibbs, Dr Ruttenberg, Dr Walls and Dr Causer. In his opinion the diagnosis was one of rotator cuff tendinopathy due to impingement and this arose during Mr Black's time as a meat worker. There was a lack of previous shoulder pain. Ms Gibb reported that the cortisone injection would have improved the inflammatory response and dulled the pain and he noted that Mr Black had pain on horizontal flexion at the end of the range and crepitus[3] in the shoulder.

[32] Dr McBride described Mr Black's work tasks as forceful pelting tasks at an ergonomic disadvantage by being left handed in a right handed work place. He said Dr Ruttenberg is quite clear about this, the posture has resulted in impingement and Mr Black was at greater risk of tendonitis and tendinopathy in the future. He said his

view was that the tendinopathy had already occurred, caused by the gradual process mechanism as described by Dr Causer and due to the ergonomic conditions at work. This made clinical sense as the steroid injection improved the symptoms by reducing the inflammation. Although there was no overt appearance of tendinopathy on the ultrasound, it might not have shown up. Dr McBride said he had not had time to look at the diagnostic properties of ultrasound in showing early tendon changes, that is to say, the sensitivity and specifity of ultrasound as a screening test.

[33] When working at a mechanical disadvantage, it is a well known fact that there is an increased risk of tendon damage. Dr Ruttenberg says so but fails to associate the tasks with the clinical findings described in the notes. These clinical findings as documented by Ms Gibb indicate there was not a risk of, but that it was present and further that it was work related due to the acknowledged adverse ergonomic conditions in the meat works.

Dr Causer comment – 11 December 2017

[34] Mr Causer was asked to comment on Dr Walls' letter of August 2017. In Mr Causer's memorandum to counsel for the respondent, he referred to a note made by Mr Greg Kassel, an orthopaedic surgeon, who saw Mr Black on 23 October 2013.

Mr Kassel's note – 23 October 2013

[35] Mr Kassel said that Mr Black had a three year history of left shoulder pain with no injury that he could recall. He is able to work but finds it difficult and painful. His pain is over the anterolateral aspect of the shoulder that radiates down towards the mid-portion of his humerus. The pain is worse with activity and better with rest. Dr Kassel referred to the previous treatment that had not worked and the ultrasound that showed no tears but showed sonological evidence of impingement with bursal thickness on abduction of the arm.

[36] Dr Kassel examined Mr Black and found that there was some pain over the posterior aspect of the greater tuberosity. He had pain with overhead motion. And

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[3] The cracking and popping that sometimes occurs in the shoulder when moving the arm.

positive impingement and a positive Hawkins[4] sign. His cuff strength was weak in the supraspinatus testing, but he thought this was limited because of his pain. Otherwise his strength was 5/5. Range of motion was full but painful in the mid-arch of elevation. No evidence of instabilities. No pain with cross body adduction. No pain with resisted biceps flexion.

[37] Dr Kassel stated his impression (diagnosis) of left shoulder impingement syndrome. In his view there should be a left shoulder arthroscopic subacromial decompression and possible rotator cuff repair. He said that Mr Black would like to proceed with surgery, and that he had explained to him the risks and benefits. He said "I have explained to him the waiting list process and will complete the appropriate forms today".

Dr Causer continued

[38] Dr Causer felt that Dr Walls had not defined what relevant work exposures were or gave any detail as to the recent exposure. He said Dr Walls had provided some details in his prior report. Dr Walls had noted he was hampered by not having physically assessed Mr Black, but he said diagnosis is not in doubt here, the issue relates to whether the accepted diagnosis and work exposure would enable Mr Black to meet s 30 criteria. Examining Mr Black would not shed any light on this. He said the question related back to the evidence on causative association between job tasks and injury to the rotator cuff and to the AC joint. Determining accurate work place exposure history would be helpful and both Drs Walls and McBride make this point, but fail to provide any further supporting information.

[39] Dr Causer went on to say that decades ago it was common to attribute musculoskeletal problems troubling an individual in a heavy manual occupation to that person's work. With the advent of research findings that look at specific work exposure, and whether they increase the risk of causing specific disorders, it is now possible and therefore necessary to look at specific work exposures before assigning causation to work. He said s 30 required this.

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[4] Flexing the arm at 90° and then forcibly internally rotating the shoulder. This pushes the supraspinatus tendon against the anterior surface of the coracoacromial ligament and coracoid process. Pain indicates a positive test for supraspinatus tendinitis.

[40] Dr Causer referred to his earlier letters where he had set out the factors for rotator cuff disorders, which was sustained or repeated postures with more than 60° of abduction or flexion which are the concerns. For sustained or repeated shoulder postures, the exposure needs to be quite significant in terms of intensity of exposure and duration of exposure for actual injury to be observed.

[41] Painters and meat processers are typical job roles that increase risk following many years of exposure. Farming and truck driving involve some elevated arm postures but not day in day out, such as painters and meat processers. The cumulative exposure is much lower in these roles.

[42] Dr Causer said that Mr Black's meat processing role would have placed him at increased risk, but his symptoms started in his third season in the role, which is not a sufficient degree of exposure to have materially caused degenerative rotator cuff tendinosis or tearing. It is more likely, on balance, that the meat processing role caused symptoms in an underlying shoulder condition, which was not work related.

[43] Dr Causer finished by saying that rotator cuff tendinopathy was extremely common in the general population. In that it would be expected to see changes of tendinopathy at Mr Black's age, regardless of occupation.

Final report by Dr McBride

[44] There was a final comment made by Dr McBride on 29 October 2018. Dr McBride referred to the memoranda from Dr Causer and the epidemiology of work related shoulder disorders. Dr McBride said he had not had an opportunity to assess this in depth as the tasks and activities undertaken by Mr Black have not been assessed as no one had asked him. In making an occupational association this is essential that epidemiological findings cannot be strictly applied to an individual case.

[45] Dr McBride gave the same opinion as he had in his letter of 30 November 2017. He commented on Dr Causer's assertion that for rotator cuff disorders a sustained or repetitive shoulder postures of more than 60° of abduction or flexion are the concern and that heavy work in isolation is not a risk factor, nor was vibration.

For repeated shoulder postures this exposure had to be significant in terms of intensity in exposure and duration of exposure for the injury to be observed. He referred to painters and meat processers being typical job roles that increased risk, following many years of exposure.

[46] Dr McBride commented as follows:

> As regard to painters, if referring to the study of Svendsen (2004), there were three occupations represented in the study, machinists (working in engineering machine shops), car mechanics and painters working in workshops. These three groups were included to provide contrasts and extra potential dose response relationships. The results showed exposure – response gradience, not in excess of tendonitis in painters. On the other hand, duration of exposure was negatively related to outcome due to a "healthy work effect" meaning that those who developed tendinitis were more likely to leave the causative job, thus biasing results towards the null.
>
> As regards the epidemiology, a study by Frost and Andersen (1999) shows quite clearly that meat processing work is associated with impingement, as identified at examination and in comparison to a control group. The prevalence odds ratio (OR) from impingement among slaughter house workers was 5.27, 95% confidence interval (95% CL) 2.09 to 13.26 and among former slaughter house workers OR 7.90, 95% CL 2.94 to 21.18. This is a significantly increased risk. Moreover, the risk starts to increase within the first 5 years of work. To avoid argument, this is a cross section study, but it is valid nevertheless.
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> In summary, we have a meat worker on the slaughterboard, who developed clinical symptoms after 3 seasons of work. The report of Ms Gibb makes it very clear that this was a tendonitis, a personal injury by gradual process.
>
> The properties of characters of the work which caused, or contributed to, the personal injury were forceful, repetitive movements of the upper limb, with both extension and elevation of the shoulder.
>
> The risk of shoulder tendinitis has been shown to be significantly greater for those exposed to this particular combination of risk factors and importantly in this occupation, that of a meat worker.

Submissions of the appellant

[47] The appellant submitted that cover was declined by AGL on the grounds that there was no physical injury. A review of the medical evidence supports the conclusion that Mr Black suffered a physical injury.

[48] The MRI scan showed tendinopathy and damage to the AC joint. The radiologist's report stated that this was consistent with previous injury.

[49] Dr Walls identified from the MRI scan that Mr Black had some tendinopathy but not complete rupture nor muscle belly contractions. He considered this pointed to a partial tear in the cuff. He also identified acromioclavicular disruption. He described both of these as injuries.

[50] Dr Causer explained the process of tendinopathy and then partial tear. This is referable to a physical injury. His argument is not that there was no injury but rather Mr Black's exposure was not long enough to give rise to the particular rotator cuff injury.

[51] Dr McBride identified rotator cuff tendinopathy and described this as tendon damage. He noted that a steroid injection had resulted in improvement by reducing inflammation. This indicates there had been tissue damage which is a physical injury. Dr McBride described the diagnosis as tendinitis, a personal injury caused by gradual process. Once again, he had clearly identified a physical injury.

[52] The medical evidence is therefore supportive of the existence of a physical injury.

[53] The next issue is whether the elements of s 30 concerning gradual process injuries have been met. Section 30(2) set out the conditions that have to be met.

> **30 Personal injury caused by work-related gradual process, disease, or infection**
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> …
>
> (2) The circumstances are—
>
> (a) the person—
>
> (i) performs an employment task that has a particular property or characteristic; or
>
> (ii) is employed in an environment that has a particular property or characteristic; and
>
> (b) the particular property or characteristic—
>
> (i) causes, or contributes to the cause of, the personal injury; and
>
> (ii) is not found to any material extent in the non-employment activities or environment of the person; and

(iii) may or may not be present throughout the whole of the person's employment; and

(c) the risk of suffering the personal injury—

(i) is significantly greater for persons who perform the employment task than for persons who do not perform it; or

(ii) is significantly greater for persons who are employed in that type of environment than for persons who are not.

[54] AGL did not undertake any investigation of the requirements of a gradual process work injury because they took the view that there was no physical injury. AGL's inquiry was essentially cursory because of the conclusion reached regarding the absence of a physical injury. There may be a lack of evidence on this point. To the extent that any gap is a result of an absence of investigation, that is a matter which is required to be addressed by ACC before proceeding to litigation. In *Ambros*[5] the Court of Appeal said, at paragraph [64]:

> [64] ... The inquisitorial approach should generally mean that, to the extent this is practical, all aspects of the claim (including causation) have been investigated by the Corporation before matters reach the courts. …

[55] If there is a gap that cannot be filled, it is incumbent on the Court to ensure the necessary material is put before making a determination of the matter. It is not a proper ground for dismissal of claims. The Court of Appeal had endorsed the inquisitorial approach that is appropriate in this jurisdiction. Nonetheless, the appellant contends there is sufficient material before the Court that the s 30 requirement meets.

[56] The first question concerns whether there are particular properties that have contributed to Mr Black's injury. Ms Gibb identified that Mr Black held the knife in his left hand with his shoulder at 70° flexion. Following the trimming, he reached into horizontal flexion abduction and internal rotation which put his glenohumeral joint into the impingement position. She noted the particular disadvantages of being left handed in the work space. Dr Ruttenberg considered the work tasks, as described by Ms Gibb, led to impingement. Dr Walls considered the work related factors were heavy work, highly repetitive upper limb activities and sustained repeated shoulder postures of more than 60° flexion or abduction. Dr Walls felt that

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5 *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.

Mr Black's work tasks had substantially contributed to the development of his left shoulder pathology. Dr Causer accepted Mr Black had been exposed to tasks that caused rotator cuff disorders. Dr McBride said that the meat work environment was adverse and was such that it could have contributed to Mr Black's injuries. He considered that the impingement along with force and adverse posture was a likely cause of the tendinopathy. Therefore, the medical evidence supports the conclusion the work tasks contributed to Mr Black's injuries.

[57] The second issue is whether the risk of injury is greater for those who perform the employment tasks and those who do not. Dr Ruttenberg said that Mr Black was at greater risk of suffering injury because of his job. The risk of injury related to tears of tendon structures and rotator cuff, tendinitis and tendinopathies.

[58] Dr Causer appears to accept that there was an increase risk with elevated posture and repetitious activities. Sustained shoulder posture of more than 60° of abduction or flexion were implicated and the cumulative exposure is particularly relevant.

[59] Dr McBride said it was well known that working to mechanical disadvantage results in an increased risk of tendon damage. Risk of shoulder tendinitis is greater for those engaged in the occupation of meat workers. Dr McBride adverted to the problems of being left handed in a right handed work space and considered Mr Black was at greater risk because of the posture he had to adopt.

[60] The thrust of the evidence is that the tasks performed by meat workers, such as Mr Black, exposes them to significantly greater risk of injury than those who do not perform the tasks. While Dr Causer expressed doubts over whether Mr Black was exposed to the risk for a sufficient length of time, he accepted the risk of injury was present.

The deemed decision issue

[61] Section 57 of the Act requires that ACC investigates the claim within 2 months or decide it cannot make a decision without additional information and advises the claimant an extension will be required. AGL wrote a letter to Mr Black on 5 April

saying that it would be investigating the claim. Due to the nature of the claim, it required further information and advised that the claim had been placed on hold for 4 months.

[62] In order to obtain extension under s 57 ACC have to make a decision that it is unable to make a decision without additional information. In *Carter*[6] the High Court held that it is the decision that further information is needed that triggers the extension rights. This can only arise when ACC legitimately claims it is unable to make a decision without such information.

[63] There was no evidence that any such decision was made in this case. The only documentary material provided by AGL is the letter itself. That did not state that AGL was unable to make a decision without further information. The letter send by AGL on 5 April is a standard form letter which is sent to all ACC claimants. Letters in similar form have been obtained in relation to claims by other AGL employees dated 2 February 2017 and 15 March 2018. Therefore AGL was not following any statutory decision making process but was arrogating to itself the right to a four month extension in every case, regardless of the information is actually required to make a decision.

[64] To justify the 4 month extension, it was necessary for AGL to have a proper basis for reaching a conclusion it was not possible for it to make a decision on the claim without further information. A further period of extension could only be made if AGL could show it had not been able to make a decision within the initial period. In this case the letter was sent before AGL had even begun to take the investigation.

[65] This is not a matter that can be trivialised as the statutory scheme has to be followed. The onus rests on AGL to make out a case if it wishes to invoke the exception and obtain an extended period. The consequences of failure to act in accordance within the statutory limited are significant, a decision will be deemed in favour of the claimants. That is an indication the legislature regards compliance as a matter of high importance. The consequence is that the appellant is entitled to a deemed decision.

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6 *Carter v Accident Compensation Corporation* [2016] NZHC 1140.

Submissions for the respondent

[66] Mr Light referred to s 20(2)(e) which provides cover for personal injury caused by a work-related gradual process, disease, or infection suffered by the person in the circumstances described in s 20(1), namely a personal injury suffered in New Zealand on or after 1 April 2002. A personal injury can include a physical injury.[7] A personal injury caused wholly or substantially by work related gradual process, disease, or infection is not excluded from cover.[8]

[67] Work related gradual process is defined in s 30 of the Act. In *JBDB*[9] Panckhurst J considered the equivalent provision in the 1992 Act. His Honour said:

> To my mind a dominating feature in this case is the policy which plainly underlies s 7(1) of the Act. Personal injury is defined elsewhere in the Act. The purpose of s 7 is to prescribe when a particular type of personal injury, namely that caused by gradual process, disease or infection in the course of employment, is established. The essential focus of the section is upon causation. … three cumulative statutory preconditions which must be satisfied. First that the employment task had a particular causative property or characteristic. Next that such property or characteristic is not materially found in the person's non-employment activities. Third, that persons performing the particular employment task are known to be at significantly greater risk of suffering the injury in question. It follows that the onus upon a claimant is a particularly heavy one. … Where injury may be attributable to work place effects, but also to other non-work activities, causation would not be established. Likewise, unless there was a known significant risk to persons performing the employment task, the case will not be recognised.

[68] In *Knox*[10] William Young described the test for cover:

> Section 7(1)(c) requires the decision-maker to make three assessments. The first is to assess the risk of a person carrying out the relevant work task in the relevant work environment developing the injury concerned, say x. The second step is to assess the risk persons who do not perform that task in that environment have of suffering from that personal injury, say y. The third step is to decide whether x is "significantly greater" than y. If it is, s 7(1)(c) is satisfied. If not, then a claim for cover must fail.

[69] It follows in the statutory test for cover that if a claimant has a pre-existing condition that becomes symptomatic in the workplace, even if there is a work task or

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7 See s 26(1)(b).
8 See s 26(2)
9 *JBDB v Accident Rehabilitation and Compensation Insurance Corporation* [2000] NZAR 385.
10 *Knox v Accident Rehabilitation and Insurance Corporation* (2001) 6 NZELC 98,619, [2000] NZAR 609 at para [23].

workplace trigger, there is no cover. This is because the employment task or environment have not caused or contributed to the cause of the condition.[11]

[70] It is accepted that Mr Black had a physical condition in his left shoulder, indeed Mr Black had a bilateral shoulder condition because he also had pain in the right shoulder as well. Pain does not constitute a physical injury and there has to be evidence of physical change as caused to the shoulder as a result of Mr Black's work tasks, and that those changes were not due to degeneration.

[71] The various diagnoses made are as follows:

[a] Dr Ruttenberg – left shoulder pain because of degenerative change and as a result needing to affect postures that can lead to impingement;

[b] Mr Kassel – left shoulder impingement syndrome;

[c] Dr Walls – said that there were two pathologies that could cause shoulder pain, namely AC joint disruption and a supraspinatus tendon partial tear;

[d] Dr Causer – said that two conditions were present, namely supraspinatus tendinopathy/supraspinatus partial tear and a widening of the AC joint; and

[e] Dr McBride – rotator cuff tendinopathy due to impingement.

[72] The MRI scan on 6 October 2014 was reported as showing supraspinatus tendinopathy (not a tear) and fluid in the acromion and AC joint. There was also widening of the AC joint in keeping with the previous injury. As Dr Walls noted in his first report, interpreting scan results four years after the onset of discomfort was potentially fraught with error in attempting to define the likely pathological source of discomfort and from there, the likely influence of work factors. In other words, the MRI scan shows Mr Black's condition as at October 2014 but this does not mean it

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[11] See for example *Tran v Accident Rehabilitation and Compensation Insurance Corporation* [1998] NZACC 220 page 22; *Food Solutions Ltd v Accident Compensation Corporation* [1999]

was the same in 2011 when the claim for cover was made. Dr Causer said that the condition could have developed since 2011.

Was the condition caused or contributed by work tasks?

[73] Mr Black was 60 when he first reported experiencing pain in his shoulders in 2011. Dr Causer said that rotator cuff degeneration is common by the 5th decade of life. About a quarter of persons in this age have partial thickness rotator cuff tears and this increases with advancing age. Furthermore, he said, there is insufficient evidence to establish that Mr Black's work tasks also contributed to his left shoulder.

[74] There is a difference between Mr Black's response that he gave in the claimant cover questionnaire on 5 April 2011 and Ms Gibb's worksite assessment. It appears that Dr Walls did not have Mr Black's claimant cover questionnaire and he was therefore unaware of the variety of Mr Black's previous work tasks.

[75] Ms Gibb's conclusion that Mr Black's working life had consisted of mainly driving heavy machinery is incorrect, when contrasted with Mr Black's detailed account of his work history and the work tasks given in the claimant cover questionnaire. In fact Mr Black spent more time doing farm work than driving heavy machinery. It is therefore inaccurate to describe his work history as one where most of his working life he had mainly driven heavy machinery. Mr Black did farm work for 22 years.

[76] In the context of farm work, there is no factual basis for Dr Walls' assumption that the farm work would contain prolonged periods of heavy work and intermittent but sustained periods of work at or above 60° shoulder flexion. There is no factual basis for Dr Walls' assumption that the farm work would also include an exposure to repetitive work or highly repetitive work and upper limb vibration would be likely. Depending on the type of farming, it may be a fair assumption the work would be heavy, but it is improbable that in general farming with a variety of work tasks the work entailed sustained periods of work at or above 60° shoulder flexion and that

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NZACC 211; and *Grice v Accident Compensation Corporation* [2015] NZACC 366 at [16] – [20].

there was some positive exposure to repetitive and highly repetitive work or upper limb vibrations.

[77] There is no factual basis for Dr Walls' overall conclusion that Mr Black had worked in an environment where for 32 years he was exposed to force and work at more than 60° flexion and had some periods of highly repetitive activity and some exposure to hand/arm vibration. At best there is evidence that Mr Black worked as a Council Contractor for 20 years driving heavy machinery and was exposed to a degree of vibration. The other fact or conclusion is not supported by Mr Black's own account of his work activities over a working life of over 40 years.

[78] According to Dr Causer's review of the literature, vibration exposure is not a risk factor for rotator cuff disorders. Dr Walls refers to the NIOSH factors and to the Van Rijn and others studies, but he says these do not include vibration as a risk factor. His only source for this factor is referenced to a text which re-dates the Van Rijn study and there is an association between vibrating tools and shoulder conditions.

[79] It is accepted on the basis of Dr Causer's opinion there is evidence in support of a risk factor for sustained shoulder posture of more than 60° of abduction or flexion. The duration of exposure required to significantly increase the risk of rotator cuff tendinopathy was decades rather than months or years. Dr Causer said that only one of the tasks as a meat worker in a 15 minute rotation out of 4 tasks was performed with the arm elevated to 70° - 80°. Dr Causer said three years was not long enough to give rise to rotator cuff injury by gradual process mechanism. He said that in most epidemiological studies the subjects had at least 10 years of work experience.

[80] It is submitted in Mr Black's case the work was likely to have generated symptoms in a condition that had been developing due to a natural process for far onger than 3 years.

[81] Dr McBride's conclusion was that Mr Black had to carry out forceful pelting tasks at an ergonomic disadvantage by being left handed in a right handed work

space and this caused the tendinopathy. Dr McBride's comment ignores the fact that Mr Black initially reported that both of his shoulders were painful but the left was worse than the right.

[82] Mr Black's actual work tasks over his working life have varied. It was only recently that he began working as a meat worker and was exposed to some extent to a potential risk factor, but the period was too short to be causative. It is more plausible, as Dr Causer said, that the changes in the shoulder were due to degeneration. The shoulder became symptomatic as a result of his work but the condition was not caused by work.

The deemed decision issue

[83] The claim for cover was a personal injury caused by work related gradual process and therefore a complicated under s 57(1)(b). Without an extension, AGL had two months to make a decision under s 57(2). If AGL needed further time, the period could be extended for up to 2 months.[12] The total period for making a cover decision was therefore 4 months.

[84] It was submitted it was obvious that an investigation was likely to take longer than 2 months. Dr Ruttenberg only reported on 16 June 2011 and this was out of the initial 2 month period. A decline of cover was dated 19 July 2011 and therefore was within the 4 month period. Although AGL decided at the outset the period needed to be extended, the fact that the extension was advised to Mr Black on the same day as the claim was lodged is immaterial.

[85] In *Esapour*[13] Judge Beattie rejected an argument that the extended 2 month period started from the date it was delivered rather than the end of the initial 2 month period. *Esapour* has been applied by Judge Henare in *Harvey.*[14]

[86] In *Carter,*[15] Dobson J rejected a similar argument on behalf of the appellant. His Honour said:

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12 See s 57(2)(b)(2).
13 *Esapour v Accident Compensation Corporation* [2009] NZACC 155.
14 *Harvey v Accident Compensation Corporation* [2015] NZACC 314 at [57].

> I would not accept that analysis of the effect of s 57(2)(b)(ii). The scheme of this part of the Act, and s 57 in particular, works better in the administrative sense, and limits any prejudice to a claimant, if the period of extension under s 57(2)(b) runs consistently from the end of the initial two month period for responding to the claim, irrespective of when the Corporation decides that it needs to obtain further information, triggering the need for an extension of time. That is an interpretation clearly open on the terms of the section and which I am satisfied reflects the Parliamentary intention. Mr Orpin's alternative would introduce perverse pressures for the Corporation to delay communicating to a claimant the need for an extension of time, so as to gain the largest possible part of the initial two month period before the two month extension period began to run.

[87] There is no obligation on ACC or in this case AGL as an accredited employer to wait until it was deeper into the 2 month before determining it needed more time. Section 57(2) permits ACC or the accredited employer to take either step, that is make a decision within 2 months or extend the period as soon as practicable and no later than 2 months after the claim is lodged. Section 57(2) is not worded in a way to support the argument for an appellant that the termination to extend the time period can only be made once a certain period of time has elapsed. If that was Parliament's intention, then the wording in s 57(2) would have been different to make it clear that the extension cannot be advised at the beginning of the 2 month period or until after the expiry at a certain period, that is not the way the subsection is worded. This argument requires the words to be read into the section giving it a strained meaning when its meaning is plain and obvious.

[88] In *Tonga*[16] Judge McGuire considered a deemed cover argument for the appellant. AGL, in a similarly worded letter, on receipt of the claim for cover, advised that AGL would need 4 months to investigate the claim. Judge McGuire referred to *Carter* and rejected the argument for Mr Tonga that he was entitled to deemed cover. His Honour said:

> Accordingly, I find that AGL's letter of 2 February 2017 satisfies the requirements of s 57(2)(b)(ii) in that it advised Mr Tonga that it could not make a decision on the claim without additional information and that it was extending the time for making a decision.

[89] It is therefore submitted that no deemed decision arose, and a question of cover is therefore a matter to be determined by this Court.

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15 *Carter v Accident Compensation Corporation* [2016] NZHC 1140.

Discussion

[90] There is no doubt that Mr Black's work at AGL pulling any remaining pieces of the pelt and trimming carcasses caused pain in his shoulders, the left one in particular. I am in no doubt that being left handed with the knife in a right handed workspace was part of the cause. Mr Black was a man who did physical work for 40 years prior to working at AGL. The work tasks of his prior jobs have not been analysed in any detail by anyone.

[91] It is inevitable that in the various roles he had over that 40 year period prior to working at AGL Mr Black would have performed tasks that required him to have his arms in flexion overhead at 60 degrees and higher. Take for example farm work back in the late 60s and in the 70s. Work on farms was far less mechanised then than it is now. Items had to be stacked in sheds over shoulder height and feed thrown from the back of a truck are two tasks that come to mind. If he was milking cows this also requires overhead work reaching for the hoses that attach to the cows. I note that Mr Black was working in a vineyard during 2008 and 2009. Any picking, spraying or pruning over shoulder height would be relevant. I am surprised and disappointed that this exercise has never been undertaken by AGL or ACC. In my view this was a failure to properly investigate this claim.

[92] The only person to take a proper history of Mr Black's work tasks at AGL and give an opinion on the cause of his problems was Christine Gibb the physiotherapist. Fortunately, her report is detailed and helpful. In light of her clear view that a work task at the freezing works had led to Mr Black's problems, it was incumbent on AGL to have an occupational medicine doctor examine Mr Black including to take a history of his tasks at previous employment given that this was a gradual process claim. These are the group of specialists who know how to undertake and evaluate such claims. Not doing this was a failure to properly investigate Mr Black's claim. Asking Dr Ruttenberg to do a file review only was inappropriate.

[93] The medical opinion that I found most compelling was Dr McBride's. My reasons include: that Dr McBride is clear that because impingement arose from

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[16] *Tonga v Accident Compensation Corporation* [2020] NZACC 137.

Mr Black's time as a meat worker and there was a lack of previous shoulder pain, and that the cortisone injection (which reduces inflammation) had helped, makes sense to me. The tasks Mr Black was performing put him at greater risk than others because of the ergonomic disadvantage of his workplace, one not suited to a man who used his left hand to use the knife and no doubt both arms to pull the remaining parts of pelts off. This involves some speculation, but this reveals how poorly this case was investigated. No one ever asked Mr Black (or his family or union representative) whether he was left handed or whether his right shoulder hurt when he pulled pieces of pelt off.

[94] Dr McBride said he thought that Mr Black was at greater risk of tendonitis and tendinopathy in the future because of the impingement, in fact he thought this had already happened. This was because of the conditions Mr Black had been working under.

[95] The thing that is missing from Dr McBride's opinion is whether 3 seasons of these work tasks were enough to have caused a gradual process condition. Dr Causer said it would take decades rather than months or years. And that 3 years was not long enough. This has not been directly responded to by Dr McBride, except to say that a study he quoted by Frost and Andersen showed that meat processing work is associated with impingement, and that the risk of impingement starts to increase in the first five years. If Dr McBride clearly said tendonitis can develop from doing this work over three seasons, I would have had no hesitation in granting the appeal.

[96] If the three seasons of the work Mr Black did was said by Dr McBride to be enough to have cause the shoulder tendonitis on Mr Black's left shoulder, that is one basis on which the appeal could have been granted. Alternatively, if a longer time is required to develop the tendonitis, and Mr Black was doing tasks in all or some of them that would have contributed to his left shoulder tendonitis, I would also have granted the appeal.

Result

[97] I am referring this case back to the Corporation to investigate the issues above. Namely, could 3 seasons at AGL doing the tasks Mr Black did cause his tendonitis in

his left shoulder. Alternatively, did previous work Mr Black did, plus the work he did at AGL cause the tendonitis in his left shoulder. If the answer is yes to either of these questions, ACC should grant cover.

[98] It follows that the review decision is quashed because I have held that the case was not properly investigated by AGL/ACC.

Comment

[99] This case calls out for a resolution. The delays in this case must have been taxing on Mr Black and his family. The treatment of Mr Black by AGL in terms of investigating his claim was poor. I noted that when Mr Sara wrote to AGL in 2014 to ask them to fund the MRI the answer was no. The letter stated that Dr Walls an occupational physician had said one was required to determine the shoulder pathology. In my view it was wrong of AGL to refuse to pay for the MRI. The fact that it took some three years before the union instructed Mr Sara is another factor which has caused delay. The failure to obtain all relevant details from Mr Black is the biggest failure, including the fact he was never properly assessed for his ACC claim by an appropriately qualified physician including taking the history of his tasks in previous occupations. That has caused this ultimate delay.

[100] The fact that the previous appeal decision contained an error and had to be reheard has not helped. I would like to have been able to have made a final decision to bring the case to a conclusion for his family. But I find myself unable to do so because of the gaps in information I have referred to. I am unable to adjourn it to obtain the evidence as I retire at the end of next week.

Deemed decision

[101] I reject the appellant's argument on the deemed decision issue, that ACC had to legitimately claim that it was unable to make a decision before exercising the time extension. While it may have been a form letter that was sent to Mr Black, it was not unreasonable in my view for AGL to decide on receipt of a gradual process claim that it would need more than the statutory time period of two months.

[102] In *Carter*,[17] Dobson J dealt with an argument that the two months extension could only be made from the time ACC makes the decision that it needs more than the two month statutory time period. Dobson J rejected this argument, stating that s 57 works better in an administrative sense if the period of extension under s 57(2)(b) runs consistently from the end of the initial two months period for responding to a claim.

[103] Given that this was a gradual process claim, it would be an almost automatic decision that investigating it was going to take more than 2 months. In those circumstances I do not agree that the decision to decide it would need an extension was going to require a testing period to see if it was the case.

[104] This aspect of the appeal is dismissed.

Judge PA Cunningham
District Court Judge

Solicitors: Ford Sumner, Wellington for the respondent

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