IN THE DISTRICT COURT
AT WELLINGTON

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

[2021] NZACC 134 ACR 225/17

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

Hearing: 20 July 2021

Heard at: Christchurch/Otautahi

Appearances: Mr M Bell and Ms Barnett for the appellant
Mr C Light for the respondent

Judgment: 17 August 2021

RESERVED JUDGMENT OF JUDGE C J McGUIRE
[Personal Injury – Section 26(2); (4) Accident Compensation Act 2001]

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[1] The issue on this appeal is the correctness of ACC's decision of 11 December 2015 which suspended Ms Western's entitlements to treatment and weekly compensation.

[2] This issue turns on whether Ms Western's hip and lower back condition are due to a covered injury.

Background

[3] Ms Western has cover for two injuries to her back in the late 1990s. On 11 November 1996 she fell from a rock climbing wall landing on her back. She described it thus:

> I fell from a considerable height at the top outer limit of the wall, my feet clipped the edge of the bales which threw me slightly off a straight landing and I fell on my bottom onto the ground. It was extremely painful and I thought at the time that I had broken my tailbone.

[4] On 25 October 1998, Ms Western had another rock climbing accident. ACC accepted cover for a soft tissue injury to the lower back.

[5] No clinical records survive for these injuries.

[6] On 27 June 2015 she injured her right hip when she leaned forward to tip a load of liquefaction into a wheelie bin. She describes lifting one of the buckets and twisting to tip the liquefaction into the bin when she felt a popping/scrunching in her right buttock area with immediate onset of significant pain. She had to immediately stop what she was doing to rest and mitigate the pain through medication and heat application. She attempted to work for a number of weeks before finally realising she needed medical attention. A claim form was completed on 18 August 2015.

[7] Her GP was unsure of the nature of her injury and she was referred to Dr Anglem, Sports Physician, for assessment.

[8] Dr Anglem noted tenderness to the lower back, particularly on the right side of L5/S1. She was concerned there was a lumbar disc injury and the possibility of labral injury in the hip. At that point, she favoured discogenic pain as a primary diagnosis, but noted Racheal had features of hip joint pathology as well.

[9] An MRI scan conducted on 8 October 2015 revealed:

[a] L4/5, reduced signal. Shallow focal central protrusion without foraminal or spinal canal narrowing.

[b] L5/S1: severe loss of disc height and signal. Shallow disc bulge. No foraminal or spinal canal narrowing.

[10] Dr Anglem noted some disc change at the lowest two lumbar levels.

[11] The appellant was referred to Professor Shipton, a pain specialist medicine physician, who attended with her on 31 October 2015. He considered there to be post traumatic L4/5 central disc protrusion with right L5 nerve root irritation. He also considered there to be post traumatic tear of the anterior and superior acetabular labrum of the right hip, and early osteoarthritis of the right hip.

[12] Professor Shipton recommended the following procedures:

A transforaminal right L5 nerve block;
A transforaminal right L4 nerve block; and
A right sciatic nerve block.

[13] ACC referred Ms Western to Dr Hilliard, occupational physician, for a medical case review on 30 November 2015.

[14] Dr Hilliard diagnosed the appellant as having non-specific mechanical low back pain contingent upon degenerative changes at the L4/5 and L5/S1 changes in the lumbar spine. He noted the MRI scan of her spine of 8 August 2010 did not show any obvious disc bulges or protrusion causing any degree of nerve irritation or compression, nor any pathology that could be attributed as being of an injury related cause. Under the heading of 'causation' Dr Hilliard said:

> Low Back Pain
>
> …
>
> There appears to be no temporal and therefore no causal relationship with any event in June 2015.
>
> An MRI scan of the lumbar spine undertaken on 8 October 2015 was reported as showing shallow central disc protrusions at L4/5 without foraminal or spinal canal narrowing, and a severe loss of disc height at L5/S1 with minor disc bulge but no foraminal spinal canal narrowing.
>
> Disc protrusions can be traumatic or atraumatic can be symptomatic or asymptomatic. In this case the presence of shallow disc protrusions without any neural compression at the two lower levels of the lumbar spine, in the absence

> of any good evidence that these occurred after a specific event, is good strong evidence that these disc protrusions are of degenerative and slow onset origin.
>
> In this case I think it most likely that Mrs Western's lower back pain is of mechanical origin, and reflects abnormal postures or changes following the development of right hip pain.
>
> …
>
> I found no evidence on file or during my assessment of Mrs Western to conclude that any of her current incapacity is injury related. In this case, the fact that she reports developing back pain some considerable time after the event and in the presence of right hip incapacity, makes it then most likely that her mechanical back pain is due to intrinsic biomechanical factors, and most possibly as a result of poor postures consequent upon a right hip incapacity and pain.

[15] Dr Hilliard considered that the appellant's 2015 accident was not of sufficient energy or impact to have caused her labral tear. He said:

> It is just not plausible that leaning forward to tip a load of liquefaction into a wheelie bin, with a very slight movement of the hip would then be causative of a labral tear or early degenerative changes in that joint.

[16] Mr Love, Orthopaedic Surgeon, reported on 1 December 2015. He considered the MRI scan was "essentially normal". He diagnosed left hip osteoarthritis with acetabular subchondral cysts and labral tearing.

[17] On 11 December 2015, ACC suspended the appellant's entitlements effective from 23 December 2015, on the basis that her symptoms were of slow onset and degenerative in nature and were not injury related.

[18] On 3 May 2016 the appellant saw Mr Burn, Orthopaedic Surgeon. He diagnosed the appellant as having damage to the L4/5 disc with shallow disc bulge and resorption of the 5/1 disc. He also noted early changes in her right hip, but considered that her problems were actually caused by an injury to her lower back with referred pain to the right hip area, with some arthritic change in the joint.

[19] Mr Burn reported again on 3 August 2016 after the appellant had had further scans. He noted:

> [a] In her right hip she had a small cyst anterosuperiorly. This relates to having a slightly shallow anterior wall to her hip.

[b] She has a disc bulge at 4/5 which is contained with disc desiccation.

[c] She has got complete loss of disc height at the 5/1 level.

[20] Mr Burn also noted:

> She tells me with regard to her back that she never had any issues until she was lifting and shovelling liquefaction, crawling under houses to level them. This almost certainly is a type of activity which can cause disc prolapse twisting and lifting.

[21] Mr Burn reported again on 31 October 2016. Amongst other things, he said:

> Racheal has long standing changes at the 5-1 disc and to a lesser extent at the 4-5 disc. These would certainly predate the date of her injury, 27.6.2015, as the 5-1 disc has complete loss of disc height without extrusion of disc material posteriorly, so it is all resorbed and these changes look chronic.
>
> She has a history of doing a lot of rock climbing and gymnastics and was quite flexible in my notes, and if she had landed heavily on her bottom at any time during these activities this could account for the changes that one sees in the lower back and it was only stirred up by her accident 27.6.2015.
>
> I would say that ACC are correct in not wishing to cover the bottom two levels of her back for the injury of 27.6.2015 and she should have an ACC number that relates to her previous injuries to her back and these would be valid.

[22] Mr Burn commented on Dr Hilliard's conclusion as follows:

> Dr Hilliard cannot conclude that it is a degenerative or slow onset origin, it is a previous injury in my opinion as all the other discs in the back have normal signal. Back pain often occurs at the time of injury then it subsides then gradually as the disc starts to change and fail back pain recurs.
>
> As regards the right hip, Mr Burn said he would need to do an arthrogram of the hip to see how much the problem was related to the hip, but he suspected it was related more to the back.

[23] Following receipt of information about her earlier covered injuries, Mr Burn reported again on 8 March 2017 stating that the accidents would be typical for causing isolated disc injuries.

[24] Mr Burn concluded his report by saying:

> In summary the fact that she has completely normal signal and grey line through the rest of her discs other than the 4-5 and 5-1, suggests a traumatic origin is the

> most likely cause of this and she has three episodes recorded with ACC which support an injury to this area.

[25] On 22 March 2017 Dr Mike Causer, occupational and environmental medicine specialist, carried out a medical case review.

[26] He considered that the 2015 accident was not of sufficient energy or a mechanism that would have caused a significant injury to her hip. On the issue of whether the appellant's lumbar spine changes were of traumatic nature rather than degeneration Dr Causer said:

> The changes described in Mrs Western's lumbar spine are typical of changes present in this age group. So much so that Mr Love reports that the lumbar spine scan is essentially normal. Degeneration affects the lower two lumbar discs more so than the upper lumber discs. Equally so the lower lumbar facet joints.
>
> I don't believe there is any evidence based method of looking at an MRI scan attributing disc changes to injuries many years prior. There are too many other factors contributing to lumbar spine changes the most important one being genetics.

[27] Regarding the 1996 accident Dr Causer said that the mechanism of injury was not described in sufficient detail in Mr Burn's report nor in the request for a report. He said that there was only a description of dropping heavily from the top of a climbing wall, which was 12-15 feet to the top. She landed badly and hobbled around in pain. Dr Causer said that he was not sure how she had landed, whether it was on her feet, on her back, or perhaps on her buttocks. He said that there could not be a conclusion that a twisting compression load had occurred without knowing these details.

[28] However, Dr Causer also noted that had such an injury occurred in the 1990s, he would have expected more significant health intervention would have been necessary, none of which is seen in Ms Western's medical history.

[29] Mr Burn was provided with a copy of Dr Causer's report, as well as statements given by Ms Western and Mr Hood, who described the two falls that occurred in the 1990s.

[30] Mr Burn did not accept that Ms Western had a genetic condition which caused disc degeneration. He reiterated his opinion that the 1990s accidents would likely have caused Ms Western's current symptoms.

[31] Amongst other things he said:

> Racheal does not have a genetic condition that causes disc degeneration. She has entirely normal signal to all the discs above the 4-5 level from the lumbar 3-4 all the way up, she has the black line through the middle of the disc which is very important and is the segmental line through the sclerotomes of the body. It is unusual to see such healthy looking discs in a 49 year old with these grey lines so clearly shown. This is of significance.
>
> …
>
> The lower two discs do experience usually the greatest load when the flexible segment meets the more rigid segment of the pelvis. However, all the above discs are normal and therefore there is no a constitutional failure of discs and it is likely that this has been caused by trauma and indeed going back through the history there are several episodes of specific trauma likely to have caused this.
>
> …
>
> If she had injured her back in 1996 a history of low back pain on and off and resorption of the bottom disc and changes in the adjacent 4-5 disc, would be in keeping with a long history.
>
> A lot of patients who are hardy types and don't complain if they are busy with their lives. It is unlikely that her symptoms are coming from the bottom disc but now the 4-5 disc which is now the first mobile segment. A lifting injury with the spine flexed and the core abdominal muscles not able to support the load would likely give an annular tear posteriorly which would result in low back pain and if it is out to the side associated leg pain as well.
>
> As I have already mentioned the fall in 1996 and then lifting liquefaction which is effectively wet sand, are both typical events that could cause injury to the spine.
>
> With regard to the labral tear, I would agree with Dr Causer that a mild degree of dysplasia is more common and in particular with rock climbing or positioning of the limb in extreme ranges of movement this causes impingement on the labrum at the extreme ranges and can cause chondral damage and cyst formation as a result of fluid passing through splits into the cartilage into the bone.
>
> I would not try and discriminate between degenerative and traumatic in this particular situation.
>
> …
>
> If the patient had experienced a high load on the right hip lifting a bucket of liquefaction and her foot had slipped on a surface going into wide abduction or

> into a position that caused sudden extreme stress on the hip, that could cause a labral tear but I don't have any history to suggest that was the mechanism of action.
>
> … we know that the changes in the disc after sudden axial loading may not show up for a delayed period of time i.e. the disc shows the normal hydration signal even though it has been damaged.

[32] The respondent sought advice from the Clinical Advisory Panel. In a report dated 24 September 2018 the Panel considered whether it was likely that the events of 11 November 1996, 25 October 1998 or 27 June 2015 were the cause of the appellant's hip and lower back pain in June 2015 and thereafter. The Panel said:

> The accident of 27/06/2015 is not a likely cause of Mrs Western's hip and lower back problems.
>
> It is of note that there were two ACC covered episodes of 11/11/1996 and 25/10/1998 but there are no contemporaneous clinical records from the time available. It appears that the injuries were relatively minor and the client did not appear to have sustained any significant injury in either of the events. There is no further input from those two injuries until 2015.
>
> These two accident events do not support a direct causal link of the current condition …

[33] The Panel also said:

> The lumbar spinal problem of L4/5 and L5/S1 represents multilevel degenerative lumbar disc disease with degenerative disc narrowing, loss of signal/desiccation, and degenerative disc bulge/protrusion, a common age-related gradual process condition. The view of the CAP is that the disease of the hip and lumbar spine is the whole or substantial cause of the client's condition.

The Appellant's Submissions

[34] Mr Bell refers to the case of *Mehrtens v ACC*[1]. Mr Bell notes that although the two injuries in the 1990s were described as sprains or strain of the lower back, the use of the term sprain or strain is common to indicate injuries that may be minor or may be serious.

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1 *Mehrtens v Accident Compensation Corporation* [2012] NZACC 25.

[35] He says there is no dispute that the 2015 MRI scan disclosed a shallow central disc protrusion at L4/5 and severe loss of disc height at L5/S1 with minor disc bulge. All other findings showed no significant disc abnormality in the lumbar spine.

[36] Mr Bell also refers to the significance and seriousness of the accidents and in particular the mechanism of injury. Here various medical reports assume that the injuries were minor because the appellant did not receive further treatment apart from seeing her doctor.

[37] However, in her statement of evidence, the appellant says:

> I fell from a considerable height at the top outer limit of the wall, my feet clipped the edge of the bales which threw me slightly off a straight landing and I fell on my bottom onto the ground. It was extremely painful and I thought at the time I had broken my tailbone.
>
> I went to the doctor and was advised that there was little to do but wait and see if the pain subsided as I healed myself. I was in severe pain for some weeks and hobbled about getting on with daily life. The pain did eventually subside but my mobility was slightly lessened and I could no longer climb over boulders as my feet would pop out from under me when I leant forwards. I did see a massage therapist for a couple of months. This was a combined treatment and relaxation therapy.
>
> In 1998 we set up a climbing wall for a gym in Methven, we would climb there regularly but one day fell awkwardly and this hurt my back again. Even though this felt slightly less painful than the 1996 injury it was a disincentive to climbing and though I tried some light bouldering I stopped completely soon after.

[38] As to the 2015 accident, the appellant said:

> I lifted a large bucket of wet liquefaction from in front of me and twisted as I raised it above the height of the large red wheelie bin that was in front of me. I twisted because the bucket was too heavy for me to walk with. I felt an acute pain in my right buttock and heard/felt a popping/scrunching sensation. I thought I had torn a muscle. I stopped working and went inside to take some pain relief and sit down with a hot water bottle. As time went on pain radiated down through the top of my hip. I understand that most injuries settle down over the first few weeks so I did not go immediately to the doctor but hoped that the pain would reduce as I recovered, this was not the case. The pain persisted and I sought medical advice and treatment. I was prescribed painkillers and anti-inflammatories.

[39] The appellant's partner at the time, Robin Hood, in his statement of evidence, said this:

> I built a specialist wall on our farm for rock climbing. It was made from ply and old power poles. It was about 4.6-4.8 metres high at its highest point. We had hay bales below it to break falls.
>
> One day Racheal fell from near the top of the wall and missed the hay bales landing on the ground. This was in 1996. I don't recall exactly what happened but I remember she was in serious pain for some time afterwards. She would have fallen while holding herself at an angle of about 60 degrees from the vertical (i.e. with her back/bottom facing the ground and her face to the wall) as the wall is about 45 degrees at the top.
>
> I know it must have been bad because I had fallen in that way for a lesser height previously and busted my back and a ruptured disc which required surgery.
>
> She had another fall in 1998 in Methven. This was onto concrete covered by carpet in a gym. She didn't really climb again after that.

[40] Mr Bell submits that it was Mr Burn who explored the mechanism of the 1996 injury and noted, from the way the fall took place, the landing and the twisting element would more likely that caused injuries at the L4/5 and L5/S1 disc levels.

[41] Mr Bell submits that because there is no change in the presentation of symptoms for the years preceding 2015 and the rest of her spine was normal, it is likely that the 1996 and/or 1998 accidents led to the damage to the two disc levels at L4/5 and L5/S1.

[42] Mr Bell notes that Professor Shipton says that the disc bulges or prolapse are post traumatic.

[43] He notes that Dr Causer is an occupational and environmental medicine doctor who did not actually examine the appellant, nor did he review the radiology imaging.

[44] Mr Bell refers to the Panel's reports. He questions how the Panel are able to conclude that the 1996 and 1998 injuries must have been minor with no significant back injuries. He notes that the Panel points out that the lumbar spine problem represents multilevel degenerative disease, an age-related condition.

[45] In relation to the further report from the Panel of 1 September 2020, Mr Bell notes that the Panel confirms disc degeneration at two levels but with no signs of recent traumatic injury.

[46] He submits that Mr Burn alone specialises in back interfusion surgery and in his report of 31 October 2016 confirmed the back problems were consistent with the previous injury, he would say, more than 10 years ago. His opinion is the problem at the two disc levels is due to a previous injury as all the other discs in the back have normal signal.

[47] In his report of 8 March 2017 Mr Burn also notes that the lower two discs are typically injured when patients land heavily on their backside and often when twisting under load trying to extend their back.

[48] Mr Burn also notes that the appellant has a completely normal signal and grey line through the rest of her discs other than at the 4/5 and 5/1 levels which suggests a traumatic origin is the most likely cause of the injuries.

[49] Mr Bell refers to the further report of Mr Burn of 10 April 2017 where he says:

> Racheal does not have a genetic condition that causes disc degeneration. She has entirely normal signal to all the discs above the 4-5 level from the lumbar 3-4 all the way up. She has the black line through the middle of the disc which is very important and is the segmental line through the sclerotomes of the body. It is unusual to see such healthy looking discs in a 49 year old with these grey lines so clearly shown. This is of significance.

[50] Mr Bell refers further to Mr Burn's report where he says:

> The lower two discs do experience usually the greatest load where the flexible segment meets the more rigid segments of the pelvis. However, all the above discs are normal and therefore there is not a constitutional failure of discs and it is likely that this has been caused by trauma and indeed going back through the history there are several episodes of significant trauma likely to have caused this. A sudden axial compression is typical and the fall she described in 1996 can fit with this. It is not typically degenerative as a constitutional features mentioned because the other discs are all normal.
>
> We can only give an opinion, but because the other discs are normal and there are only two discs which are abnormal, trauma is more likely, but MR evidence would have been more useful if we had two or three MR scans over a period of time.

[51] Mr Bell submits that it was Mr Burn alone who questioned the appellant and looked at the mechanics of the injury and how the fall took place, where the appellant landed, and the twisting element that could have caused injuries to the two disc levels involved. He examined the appellant twice, considered her reports of the fall and its aftermath, including the deep massage treatment she received.

[52] He submits that Mr Burn maintains that the grey or black line seen through the spine is important and shows a good spine as well as the normal signal that the appellant has down to L4/5 level.

[53] Mr Bell acknowledges that there is little evidence relating to the 1996 and 1998 injuries. However, when it made its reports, the Panel did not have the evidence from the appellant and her then husband about injuries, pain, mobility issues and treatment plus Mr Burn's view of the mechanism of injury.

[54] Mr Bell argues that if this were a gradual process disease it would not be the case that one of the two disc protrusions had resorbed.

[55] Mr Bell submits that on the basis of *Ambros v ACC*[2] the Court is entitled in this case to draw robust inferences of causation in this case, based on facts not supposition.

The Respondent's Submissions

[56] Mr Light acknowledges that in this case the only way in which ACC's suspension decision could be wrong is if the evidence establishes that the appellant's condition is due to an injury caused by an accident suffered in 1996 or 1998 because these are the only covered lower back injuries.

[57] He submits that the evidence in support of a causal link between these accidents and the appellant's lower back condition is tenuous.

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2 *Ambros v Accident Compensation Corporation* [2007] NZCA 304.

[58] He notes that there is near universal consensus that the 2015 accident could not have caused the lumbar spine changes because they were already present by then.

[59] Mr Light submits that simply pointing to previous accident events without any contemporaneous context as to the severity of the injury suffered at the time, does not constitute adequate reasoning to make a causal link between the accident events and the appellant's condition in 2017.

[60] He points out that Mr Burn did not have any medical records, imaging or other contemporaneous notes on which to base an opinion that one or both of the accident events could have been causative of her condition 20 years later.

[61] He submits on the other hand that Dr Causer explained that changes in the lumbar spine were typical of persons of the appellant's age group and Dr Causer explained that degeneration affected the lower two lumbar discs more than the upper lumbar discs and equally the lower lumbar facet joints.

[62] He noted that it would be different if an incident had resulted in significant back pain that had persisted, but that was not the case here.

[63] He noted that the Panel conducted a detailed review of the evidence and concluded that there was no causal link between the accidents of 1996 and 1998 and the appellant's lower back pain.

[64] Mr Light reminds the Court that there are a number of factors to be taken into account in the evaluation of expert evidence. These include the thoroughness of the opinion; the extent to which the opinion engages with contrary or supporting opinions; support for the opinion by reference to relevant research findings; the evaluation of the factual bases for the opinion, as opposed to the uncritical acceptance of a version of events; and the overall logical reasoning and cogency of the report.

[65] In conclusion Mr Light submits that the evidence falls well short of establishing that Ms Western's lower back condition is due to injuries suffered in an accident in 1996.

Decision

[66] This appeal has arisen initially from an accident on 27 June 2015 when the appellant injured her right hip as she leaned forward to tip a heavy bucket of liquefaction into a wheelie bin. Various comments have been made about the mechanism of that accident some of which I find somewhat downplay what actually occurred. The appellant's own description was:

> I lifted a large bucket of wet liquefaction lift from in front of me and twisted as I raised it above the height of the large red wheelie bin that was to the right of me. I twisted because the bucket was too heavy to walk with. I felt an acute pain in my right buttock and heard/felt a popping/scrunching sensation. I thought I had torn a muscle. I stopped working and went inside to take some pain relief and sit down with a hot water bottle. As time went on pain radiated down through the top of my hip. I understand that most injuries settle down over the first few weeks so I did not go immediately to the doctor but hoped that the pain would reduce as I recovered, but this was not the case.

[67] In 1996 the appellant also had an accident when she fell from near the top of a climbing wall constructed by her then husband.

[68] In respect of that accident her description was:

> I pushed too hard one day and was tired. I could not climb down but rather fell from the top. We had placed hay bales under the wall to lessen the impact but these did not extend further out. I fell from a considerable height at the top outer limit of the wall, my feet clipped the edge of the bales which threw me slightly off a straight landing and I fell on my bottom onto the ground. It was extremely painful and I thought at the time that I had broken my tailbone.
>
> I went to the doctor, and was advised that there was little to do but wait and see if the pain subsided as I healed myself. I was in severe pain for some weeks and hobbled about getting on with daily life. The pain did eventually subside but my mobility was slightly lessened and I could no longer climb over boulders as my feet would pop out from under me when I leant forwards. I did see a massage therapist for a couple of months this was a combined back treatment and relaxation therapy.

[69] At the time, 1996, she described herself as extremely fit. She was the daughter of a sawmiller and worked in the mill as a teenager. She said:

> I come from hardy farming stock with years of farming experience, you don't stop working just because you're in pain. You can't stop, the work must get done. Livestock need tending to come snow, rain or high water. In my family pain means you are putting in some effort or have done a hard day's work, which is applauded.

[70] In his statement her former husband also describes the fall from the top of the wall. He said:

> I don't recall exactly what happened but I remember she was in serious pain for some time afterwards. … I know it must have been bad because I had fallen in that way from a lesser height previously and busted my back and ruptured a disc which required surgery.

[71] I have set out the above because it is helpful background in understanding the appellant. There are immediate similarities between the accidents of 1996 and 2015 in terms of her own personal response. In both cases she "got on with it".

[72] Following the 2015 accident she says she was in constant pain and had to take breaks at work because of it and that she probably had 6-10 days off sick over a two month period.

[73] In this case ACC has quite properly and humanely put forward no objection to the injuries of the 1990s as well as the injury of 2015 being considered in order to find an answer to the question of whether it was correct to suspend the appellant's entitlements to treatment and weekly compensation.

[74] I have found in my time in this jurisdiction that there are a cast of claimants whose instinctive response to accidents causing injury is to simply "get on with it". I find the appellant is one such. Given this predisposition, one has then to exercise care to ensure that that attitude does not unconsciously influence conclusions reached regarding the origins of her diagnostic presentation when assessment for entitlements to due to injury are being considered.

[75] In the appellant's case there are no records available regarding her 1996 injury nor the injury she sustained in 1998 when she again fell from a climbing wall at a gym in Methven hurting her back as she fell onto concrete covered by a carpet.

[76] Her ex husband says that after the latter accident "she didn't really climb again after that".

[77] As mentioned, no records survive regarding her 1996 and 1998 injuries although she plainly did her best to find the same. She got as far as ascertaining that any records held by the medical centre in Christchurch were destroyed in the Christchurch earthquake.

[78] In terms of hard medical evidence therefore, the best that is available is the MRI report from 8 October 2015. That MRI scan showed that at L4/5 level there was reduced signal. Shallow focal central protrusion without foraminal or spinal canal narrowing. At the L5/S1 level there was severe loss of disc height and signal. Shallow disc bulge. No foraminal or spinal canal narrowing.

[79] The information that was available therefore fell to be interpreted by suitably qualified medical professionals.

[80] The ACC Clinical Advisory Panel, comprising of six orthopaedic surgeons, who reported most recently on 16 September 2020, commented:

> Imaging confirms signs of disc degenerative disease at L4/5 and L5/S1. There is no nerve root compromise or signs of recent traumatic injury.

[81] On behalf of the appellant, Mr Bell has not seriously argued that the appellant's injury in 2015 is the cause of her problems at the L4/5 and L5/S1 discs.

[82] In its earlier report of 24 September 2018, the Panel says:

> It is of note that there were two ACC covered episodes of 11/11/1996 and 25/10/1998, but there are no contemporaneous clinical records from the time available. It appears that the injuries were relatively minor and that the client did not appear to have sustained any significant injury in either of the events. There is no further input from those two injuries until 2015.

> These two accident events do not support a direct causal link of the current condition.

[83] The Panel report went on to say:

> The lumbar spinal problem of L4/5 and L5/S1 represents multilevel degenerative lumbar disc disease with degenerative disc narrowing, loss of signal/desiccation, and degenerative disc bulge/protrusion, a common age related gradual process condition.
>
> The view of the CAP is that the disease of the hip and lumbar spine is the whole or substantial cause of the client's condition.

[84] Looking at the mechanisms of the two accidents in 1996 and 1998 I conclude that on the basis of the available evidence of the mechanisms of both of those accidents, for the Panel to say "it appears that the injuries were relatively minor", is not supported by the available evidence. In fairness to the Panel, the members did not have the full description of how the injuries had occurred, in particular the injury that occurred in 1996. I take from the Panel's reasoning that the lumbar spinal problem of L4/L5 and L5/S1 is found to be multilevel degenerative lumbar disc disease, not only because it is a common age related gradual process condition but also because the 1990s injuries were "relatively minor".

[85] The appellant's orthopaedic surgeon, Mr Burn is of a different view. He says in his report of 10 April 2017:

> Racheal does not have a genetic condition which causes disc degeneration. She has entirely normal signal at all of the discs above the 4-5 level from the lumbar 3-4 all the way up, she has the black line through the middle of the disc which is very important and is the segmental line through the sclerotomes of the body. It is unusual to see such healthy looking discs in a 49 year old with these grey lines so clearly shown. This is of significance.

[86] What I understand Mr Burn to be saying in that report and also in his earlier report of 8 March 2017 is that if her presentation was due to multilevel degenerative lumbar disc disease the black line through the rest of her discs would not be as he has described it.

[87] Ultimately in this case we have the disadvantage of there being no hard evidence of the state of her lumbar discs following her accidents of 1996 and 1998. And, the GP medical records that the appellant tried to locate, that may have assisted,

appear to have been lost in the Christchurch earthquake. Hence, less evidence is available to conclusively resolve the trauma versus degeneration debate. That state of affairs is not to be weighed against the appellant's claim.

[88] What in my view tips the balance in the appellant's favour is Mr Burn's conclusion that a traumatic origin is the most likely cause of her presentation because of the state of the rest of her discs.

[89] *Ambros*[3] allows me to draw robust inferences of causation in some cases of uncertainty where, as here, such an inference is based on facts not supposition.

[90] Accordingly, I conclude that the appellant has proven on the balance of probabilities that her back injury was caused by her accidents in 1996 and 1998.

[91] Accordingly, the appeal is allowed and the respondent's decision of 11 December 2015 suspending her entitlements to treatment and weekly compensation is overturned.

[92] Should there be any issue as to costs, counsel have leave to file memoranda in respect thereof.

Judge C J McGuire
District Court Judge

Solicitors: Corcoran French, Christchurch for the appellant
Young Hunter, Christchurch for the respondent

3 Ibid n2.