**IN THE DISTRICT COURT**
**AT WELLINGTON**

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

**[2021] NZACC 16 ACR 40/17**

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| UNDER | THE ACCIDENT COMPENSATION ACT 2001 |
| IN THE MATTER OF | AN APPEAL UNDER SECTION 149 OF THE ACT |
| BETWEEN | MARGARET SCOTT<br>Appellant |
| AND | ACCIDENT COMPENSATION CORPORATION<br>Respondent |

Hearing: 27 November 2020
Heard at: Dunedin/Ōtepoti

Appearances: Mr P Sara for the appellant
Mr H Evans for the respondent

Judgment: 14 January 2021

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**RESERVED JUDGMENT OF JUDGE C J McGUIRE**
**[Causation – s 20 Accident Compensation Act 2001]**

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[1] At issue on this appeal is the Corporation's decision of 5 July 2016 declining to cover a lumbar disc protrusion and elective surgery funding sought to treat it. The reason given for the Corporation's decision was that the surgery required to treat lumbar disc protrusion at level L4/L5 was not caused by the covered accident on 13 December 2015.

## Background

[2] The appellant was born in November 1962 and on 13 December 2015, at age 53, was involved in a motor vehicle accident. The vehicle that she was in collided

with the car in front of her at an intersection. The appellant was wearing a seatbelt. She was flung forward in the collision and hurt her back, although she was able to get out of the car and walk around. On 13 January 2015, the appellant reported to her general practitioner ("GP") that she had suffered injuries as a result of the vehicle accident.

[3] The clinical notes record:

> MVA 13/12/15 – rear ended another car stopped at an intersection – pain R buttock and low back ever since – been a month now … her car was written off, had thought the back pain would improve but it has not analgesia has not been useful tramadol + ibuprofen + panadol.
>
> …
>
> Tender over R SI jt and L5/S1 midline – tender trigger points in R paralumbar ms.
>
> Increased pain with lumbar extension especially hyperextension, reasonable forward flexion, pain right lumbar area and right SI area on both right and left lateral flexion.
>
> A: right lumbar sprain and right SI joint sprain.

[4] An ACC45 form was submitted with diagnoses of sacroiliac ligament sprain – right and lumbar sprain – right.

[5] The Corporation granted cover to the appellant for sacroiliac sprain and lumbar sprain suffered as a result of an injury on 13 December 2015.

[6] Earlier medical records relating to the appellant's back are noted:

- On 8 December 2003 an x-ray and ultrasound of the appellant's lumbar spine and pelvis were undertaken with the following report:

  > The intervertebral disc space heights are normal. There is minor osteophyte formation on the anterosuperior lips of L2, L3 and L4.
  >
  > Pelvis – no significant abnormality seen in the hips.

- GP record, dated 22 February 2005, says:

  > Injured her back moving rubbish bags at work.
  >
  > Plan: physio pain relief.
  >
  > …

DX: lumbar sprain – right.

- Follow up GP note dated 7 June 2005 recorded:

  Ongoing hip/lower back pain.

  Physio not really helpful.

  Plan: x-rays L/S spine and right hip.

- A further GP note on 5 July 2005 stated:

  Ongoing problems with back/hip.

  X-rays: minor OA only (osteoarthritis).

[7] The appellant was treated by physiotherapist, Jarrod Scott, for her lower back pain on 12 occasions between 22 January 2016 and 16 March 2016.

[8] On 23 February 2016, the appellant underwent an x-ray and ultrasound of her right hip and x-ray of her lumbar spine. The report included the following:

> X-ray: lumbar spine.
>
> There is mild scoliosis convexed to the left. There is a grade 1 anterior spondylolisthesis of L4 on L5. There is a mild spondylosis of L1-2, L2-3 and L3-4. Facet joint osteoarthritis is seen at L4-5 and L5-S1.
>
> X-ray pelvis.
>
> Hip joint spaces are well preserved. The right hip appears satisfactory. The left hip shows some subchondral cystic change regard to the femoral head which could indicate osteoarthritis.

[9] The conclusions in respect of the ultrasound were as follows:

> Visualisation was limited, no abnormality was detected.

[10] On 16 March 2016, the appellant's physiotherapist, Mr Scott, referred her to orthopaedic surgeon, Mr Hodgson, saying in the referral letter:

> Margaret was in a motor vehicle accident which resulted in low back pain with gross muscle spasm. Based on the presentation x-ray and ultrasound investigation was used to define the underlying pathology. X-ray demonstrated a grade 1 anterolysthesis of L4 on L5. With this in mind treatment has been focused on avoiding gross arching or extension of the back as well as strengthening of the deep trunk stability muscles.
>
> Unfortunately Margaret's pain persists, and she reports a significant level of pain as well as difficulty completing both activities of daily living as well as her current work duties.

[11] Mr Hodgson reported on the consultation on 5 April 2016 and said:

> Margaret clearly has a significant problem with bilateral sciatic symptoms, this probably related to a disc protrusion in association with her spondylolisthesis quite possibly coming from a more proximal legion.
>
> I will arrange for an MRI scan on a reasonably urgent basis and see her when this is available.

[12] Later the same day, following her MRI scan, Mr Hodgson reported:

> This has shown a foraminal stenosis at L4/5 perhaps more on the right than the left. There is no obvious transverse process fractures that I can see. There is certainly nothing to suggest any pars defects here. There is certainly significant enlargement of the facet joints of L4/5. The lumbosacral level looks satisfactory as does the rest of the lumbar spine up to the level of around T10.
>
> Margaret's symptoms would suggest involvement of bilateral symptoms, but I think we can help her with a lumbar steroid epidural injection in the first instance …

[13] Under the heading 'findings', the MRI report of the same day included the following:

> On the sagittal scans, there is a grade 1 anterospondylolisthesis of L4 on L5. Vertebral body weights are well preserved. Disc heights are satisfactory. The canal is of satisfactory calibre and the conus returns normal signal. No significant abnormality is seen at the T11 or T12 vertebral body levels. Some small haemanglomata are seen in the lumbar spine and sacral region.
>
> On the axial scans;
>
> At the L2-3 disc level, there is some mild right and left lateral disc bulge but no nerve root compromise.
>
> At L3/4 disc level, there is some mild generalised disc bulge but no nerve root compromise.
>
> At the L4/5 disc level there is some mild generalised disc bulge. There is moderate bilateral facet joint hypertrophy. These changes are leading to some mild right and left exit foraminal narrowing but no mechanical nerve root compromise. At the L5/S1 disc level, there is some mild generalised disc bulge but no nerve root compromise.

[14] In a further report of 5 April 2016, Mr Hodgson commented on the MRI scan as follows:

> I saw Margaret again today following her MRI scan. This has shown foraminal stenosis at L4/5, perhaps more on the right than the left. There is no obvious transverse process fractures that I can see. There is certainly nothing to suggest any pars defects here. There is certainly significant enlargement of the facet joints at L4/5. The lumbosacral level looks satisfactory as does the rest of the lumbar spine up to the level of around T10.

[15] Mr Scott requested a SAW programme to assist the appellant with her functional capacity and ACC branch medical advisor, Dr Heydon, was asked to provide an opinion. Amongst other things he said:

> The MRI shows multiple disc bulges which in my opinion are likely to be degenerative in origin. The MRI also reports moderate bilateral facet joint hypertrophy at the L4/5 level. In my opinion such changes develop gradually and also appear likely to be degenerative in origin. The MRI also reports moderate bilateral facet joint hypertrophy at the L4/5 level. In my opinion such changes develop gradually and also appear likely to be degenerative in origin. The report also describes grade 1 anterospondylolisthesis of L4 on 5. The x-ray also reports the anterospondylolisthesis. In my opinion grade 1 anterospondylolisthesis of L4 and L5 is common and appears unlikely to be due to the accident and in this case may well be related to the facet joint arthritis.
>
> The x-ray also reported spondylosis at three levels and also facet joint arthritis at L4-5 and L5-S1. In my opinion these changes are likely to be degenerative in origin.

[16] On 20 April 2016, the appellant underwent a lumbar steroid epidural injection.

[17] Mr Hodgson saw the appellant again on 7 June 2016. He reported:

> She is no better following her lumbar steroid epidural injection. This is very disappointing. She is still quite disabled and unable to work with her back pain and bilateral sciatic symptoms.
>
> We need to proceed to surgery now. This will be an L4/5 decompression and inter transverse fusion with instrumentation.

[18] On 8 June 2016, the appellant saw her GP, who reported:

> Presents wanting to be off work on ACC.
>
> Under Mr Hodgson.
>
> Foraminal stenosis.
>
> Failed steroid injection 20th April.
>
> Seen in clinic today. Allegedly planned for surgery and he applying to ACC for funding.
>
> Margaret is struggling to work, has pain sitting and standing. Works as a customer representative. Has been doing one hour at a time until recently. Now feels unable to continue.
>
> Explained that we can try for ACC 18, but may or may not be accepted …

[19] Mr Hodgson provided an Assessment Report and Treatment Plan (ARTP) dated 9 June, which included:

> Query link between her original injury, the onset of her symptoms, this giving rise to the disc bulge, the spondylolisthesis has probably pre-existed the original disc bulge however she has developed severe symptoms and will require surgery related to this. … the spondylolisthesis may well have pre-existed the current injury.

[20] ACC medical advisor, Dr Hunter, provided clinical comment on 4 July 2016:

> It appears gradual process disc and facet joint pathology causing some stenosis has become symptomatic, but these conditions are not caused by a single injury event.
>
> On the information available a causal link to find the proposed surgical trigger from a ACC covered injury has not been established.

[21] The appellant was advised by the Corporation by letter dated 5 July 2016 that it was unable to pay for surgery to treat a lumbar disc protrusion at level 4/5 because the condition was not caused by the 13 December 2015 accident.

[22] On 23 September 2016, the appellant applied to review this decision.

[23] On 4 November 2016, Mr Hodgson performed surgery on Ms Scott.

[24] On 8 November 2016, Mr Hodgson reported on the operation. The report included the following:

> In my opinion Mrs Scott had sustained an injury to the L4/5 disc as a result of her injury. Prior to her injury she was asymptomatic and managing all her life and activities. Following her injuries which I believe was significant (motor vehicle accident), she has developed significant pain, associated sciatica and is limited in what she can manage, both at work, daily activities and recreational activities. This is on the basis of the damage to the L4/5 disc, associated instability that has developed and functional compression of the nerve roots as seen on clinical examination.
>
> The reason for surgery relates directly to the accident that has occurred and the injury has been sustained at the time of her accident. …
>
> In my opinion the accident of 13 December 2015 has caused a new injury, namely the central bulge of the L4/5 disc, this occurring as a result of the violent thrusting forward when she was struck from behind suffering the flexion extension injury despite being held in a safety belt and associated twisting, this overcoming the natural integrity of the L4/5 disc.
>
> Mrs Scott did not have a predisposition to suffer a disc protrusion because of the underlying spondylolisthesis.

[25] Dr Medlicott provided clinical comment to the Corporation on 15 November 2016. Dr Medlicott referred to the MRI report of 5 April 2016 and noted that:

> The generalised disc bulge at L4/5 is a condition process known as degenerative spondylolisthesis and this has also been confirmed on plain x-ray.
>
> I note the findings from the operation note. I note enlarged facet joints with marked thickening of the ligamentum flavum on each side. This is a condition of gradual process. The facet joint thickening and enlargement in the ligamentum flavum and thickening and enlargement are absolutely typical for a degenerative spondylolisthesis; this is exactly what one would have found during an operation. There was some protrusion on the right side affecting the L4 root and this is part of the degenerative process. Otherwise, the operation was exactly that which would be described for a degenerative, symptomatic, spondylolisthesis at L4/5.

[26] Mr Hodgson provided a further opinion on 22 November 2016 saying:

> As I have stated her spondylolisthesis at L4/5 may well be pre-existed the injuries she sustained in her motor vehicle accident, however something changed at that time that led to the onset of her leg symptoms, her generalised debility and lack of improvement which she had managed to achieve with other strains that she had experienced.
>
> This change was in fact, in my opinion, the L4/5 disc protrusion that had led to a compromise of the spinal canal that was narrowed as a result of the spondylolisthesis and facet joint enlargement.

[27] In a decision dated 18 December 2016, the Reviewer dismissed the appellant's application.

[28] Following the review, the appellant's counsel sought a further report from Mr Hodgson. In a letter dated 1 May 2017, Mr Hodgson said:

> It is my opinion, that an acute L4/5 disc protrusion has occurred at the time of her accident that has precipitated the crisis in her back, the compression of the L5 nerve roots and indeed the onset of her severe back pain and the sciatic symptoms from which she has suffered. This has been the reason she has required surgery.
>
> …
>
> For this reason she has required surgery, not because she had a pre-existing spondylolisthesis at L4/5. Unfortunately the pre-existing spondylolisthesis has complicated the issue with the disc protrusion and this has led to the need for the wide decompression, undercutting facetectomies and also the fusion of the L4/5 level to prevent any further instability which is known to recur when a compression at this level is carried out.

[29] The Clinical Advisory Panel (the Panel) provided a further report dated 14 July 2017. It noted:

> We have reviewed the file as well as the recent reports from Mr Hodgson. In our view Mr Hodgson's opinion from November 2016 does not add anything new to what was already known and as such does not alter the previous CAP advice. The medical evidence does not support a likely causal relationship been the accident on 13/12/2015 and the client's L4/5 disc pathology for which surgery was performed.

[30] After reviewing the medical evidence, the Panel said:

> When considering the evidence outlined above in its entirety, it would appear that a causal link between the client's L4/5 disc bulge and her December 2015 accident has not been established. The information suggests that the client has a degenerative spondylolisthesis and disc bulge that were likely at best, aggravated but not caused by the accident of 13 December 2015.

[31] Mr Hodgson wrote again to the appellant's counsel on 20 September 2017. Amongst other things, he said:

> In my opinion the panel's conclusion and related explanations are not correct.
>
> In particular:
>
> 1. Mrs Scott did suffer an accident. The mechanism involved high force. …
>
>    Most often, patients try and treat their aches and pains themselves. Until, such time it impacts on their life, their family or daily activities then the present. As I have stated, in my opinion the fact that she presented one month following her accident is entirely consistent with the traumatic causation of her L4/5 disc protrusion.
>
> 2. It is accepted that she had mild degenerative changes in her lumbar spine as seen on x-rays. The disc spaces were reported as normal.
>
>    Mrs Scott is 54 years of age and is therefore middle aged. It is entirely expected that she will have middle aged changes in her lumbar spine (mild degeneration). This in no way represents anything to do with her traumatic event that she suffered. …
>
> 3. Mrs Scott developed radicular symptoms in her legs after a period of time following her initial accident …
>
>    This is entirely consistent with over a third of the patients I see.
>
>    …

> The third category is a group of patients who develop symptoms over a period of time and they wax and wane in severity until such time that they can no longer cope and present to medical staff for help.
>
> In my opinion Mrs Scott falls into the third category and this is entirely consistent with her clinical scenario.
>
> …
>
> 4. It is accepted that the grade 1 spondylolisthesis at L4 on the L5 pre-existed her current injury. However, as I have noted in previous reports the nerve root compression at L4/5, in my opinion, related to the disc protrusion as noted at surgery on the right side.
>
> In particular this disc protrusion compressed the L5 nerve root as I have stated. The fact that it was in a position where it was noted to be a narrow spinal canal secondary to spondylolisthesis unfortunately exacerbated the entire problem. Hence the significant disability that required surgical intervention.
>
> 5. The MRI scan carried out on 5/4/16 has been reported to show disc bulges. However, the report by the radiologist does not indicate the significance of the L4/5 disc protrusion and in fact, this was not clearly seen on the MRI scan.
>
> MRI scans are 90% accurate when compared to clinical and surgical findings. In particular, it should be noted that at surgery a moderate L4/5 disc protrusion compressing the L5 nerve was noted.
>
> This is important. In my opinion, it is consistent with the injury by accident and the cause of her ongoing symptoms that led to the need for surgery.
>
> 6. My operative findings have been noted and as I have stated in the past, the L4/5 disc protrusion caused the L5 nerve root compression. This was caused by the accident and injuries she sustained. It is accepted the spondylolisthesis was present. However this was not the reason for the surgery. The reason for the surgery was the L4/5 disc protrusion.
>
> I believe the Clinical Advisory Panel are incorrect in their conclusion. They rely on the report of a radiologist and have not paid attention to the specific surgical findings …

[32] Mr Hodgson referred the appellant to Dr Bentley, musculoskeletal physician. He reported on 22 March 2018. Much of his report is directed towards rehabilitation. However, he says:

> Margaret clearly suffered acute low back pain and developed right lateral leg pain as a result of the MVA, in my opinion the L4/5 disc sprain, internal disc disruption and annulus tear occurred as a result of that accident and possible the grade 1 spondylolisthesis, there is no evidence of either of these pathologies present before the MVA…

[33] The Panel commented further on 31 October 2018. Amongst other things, it said:

> There has been previous clinical comment pertaining to generalised multi level disc bulges in the lumbar spine and those at L4/5 show no features suggesting that the cause of this is any different from the other levels, and in particular there is no feature suggesting acute structural disruption of the disc. It has also been previously noted that there is a very weak temporal association between the symptoms and the crash.
>
> In summary there are no new features in Dr Bentley's report to support a causal link between the L4/5 pathology and the motor vehicle accident. The previous CAP comment remains relevant.

**The Appellant's Submissions**

[34] Mr Sara took the Court through the clinical evidence. He submits that whatever findings can be made using imaging techniques are secondary to Mr Hodgson's findings during surgery, which Mr Sara says are "unassailable".

[35] Mr Sara acknowledges that the real question in this case is causation, namely "how did it happen?".

[36] He notes that the Corporation acknowledged that the appellant suffered a physical injury in the car accident and the ultimate question is the extent of that injury. Mr Sara says that, in essence, Mr Hodgson is saying that the surgery was not required to deal with the spondylolisthesis but as Mr Hodgson said in his report of 1 May 2017:

> You will see that she was flung forward when her car ran into the back of another car. I believe she has suffered a significant flexion, torsional force to her back. This has overcome the natural integrity of the L4/5 disc leading to the rupture and subsequent changing of the whole situation in her back. The spinal canal at L4/5 has become more narrowed due to the profusion. The nerves at this level at L4/5 have become jammed.
>
> She developed the onset of symptoms related to the jammed nerves. This was her back pain and bilateral sciatic symptoms.
>
> The protrusion was noted at the time of my surgery and this is significant. There was clear evidence that the L5 nerve root on the right hand side had been compressed by the disc protrusion and as a result of the length of time it was compressed (some 11 months between the onset of her symptoms and surgery) that there had been adhesions develop between the inflamed L5 nerve root and the back of the L4/5 disc.

[37] Mr Sara submits that what Mr Hodgson describes is not a gradual process.

[38] He submits that prior to the accident the appellant had no nerve compression. He further submits that the Panel does not explain how the disc bulge compressed the nerves at L4/5.

[39] Mr Sara refers to *Dawes v ACC* where the Court reminded itself that where specialists adopt differing positions, the Court ultimately would look at the medical reasoning and what makes sense.[1]

[40] In essence, Mr Sara submits that the appellant's motor vehicle accident was a significant traumatic event which ultimately caused the disc bulge to press on the L5 nerve root. This trauma was a new pathophysiological situation that had not existed prior to the accident.

**The Respondent's Submissions**

[41] Mr Evans, on behalf of the Corporation, refers to *Lucas v ACC* in which Judge Powell reaffirms that it is for the Court to give such weight to the evidence as it thinks fit and the evidence of the operating surgeon is not automatically preferred.[2]

[42] Mr Evans notes that, in this case, the appellant has some history of back pain. He refers to the clinical records of December 2003, February 2005 and the continuation of back problems for a number of months following the injury that she sustained in February 2005, injuring her back moving rubbish bags.

[43] Mr Evans also notes that while the accident appeared to have involved reasonably high force, the appellant presented for initial treatment about a month after the incident. The month's gap tends to point away from traumatic causation of the appellant's L4/5 disc pathology. He notes that the MRI scan noted mild generalised disc bulging at other levels as well as the grade 1 anterospondylolisthesis of L4 on L5.

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1 *Dawes v Accident Compensation Corporation* [2018] NZACC 151.
2 *Lucas v Accident Compensation Corporation* [2015] NZACC 216.

[44] He submits that the appellant's "injury" should have resolved within weeks. It did not. Therefore, it is more likely that it was due to underlying pathology. He submits that Mr Hodgson is unable to identify any condition in the appellant's spine that is acute or injury related. He submits that the Panel's reports are entirely supportive of the Corporation's case that causation arising from the motor vehicle accident of 13 December 2015 has not been proven.

**Decision**

[45] On 13 December 2015, the appellant was involved in a motor vehicle accident in which her vehicle collided with the rear of another car stopped at an intersection. She was flung forward but was wearing a safety belt and although hurt was able to get out of the car and walk around.

[46] She did not see her GP until 13 January 2015 but reported pain in her right buttock and lower back ever since the accident.

[47] The GP notes record that she thought the back pain would improve but it has not. I find that her failure to seek immediate medical treatment is a neutral factor in this case. First, she is not at all alone in hoping and expecting that the back pain she suffered from the accident would resolve itself. Furthermore, given the time of year, mid December, it is not at all surprising that she should wait until the Christmas "rush" was over before she sought medical treatment.

[1] Some reference has been made to her earlier back issues in 2003 and 2005 for which she sought medical attention. The x-ray and ultrasound of her lumbar spine and pelvis in December 2003 showed nothing of significance. The brief report on the x-ray in 2005 showed minor osteoarthritis only.

[48] The last report in 2005 is in her health centre's notes of 5 July 2005 which recorded "ongoing problems with back/hip".

[49] There is no evidence before the Court of any further back issues until the present matter.

[50] When it comes to the present matter, medical opinion relating to causation is sharply divided between that of the Panel and that of Mr Hodgson, the orthopaedic surgeon who performed the remedial back surgery on the appellant.

[51] I agree with Mr Evans' submission that, as said in *Lucas v ACC*, the operating surgeon's opinion on causation is not necessarily pre-eminent, even though it may be asserted that the operating surgeon best knows the patient. Rather, it is a case of weighing the evidence and, in this regard, Mr Evans rightly mentions *ACC v Mehrtens* which lists a range of issues that the Court should take into account.[3]

[52] Furthermore, in this case, I am conscious of the fact that the Panel included three orthopaedic surgeons, a general surgeon and a physiotherapist.

[53] Essentially the Panel's reasoning takes account of the appellant's already degenerative back condition. For our purposes, her condition was initially documented in the MRI report of 5 April 2016, which reported the grade 1 anterospondylolisthesis of L4 on L5 together with disc bulges at other levels.

[54] In its report of 14 July 2017, after reviewing all relevant documents including Mr Hodgson's report of 4 April 2017, the Panel said:

> When considering the evidence outlined above in its entirety, it would appear that a causal link between the client's L4/5 disc bulge and her December 2015 accident has not been established.

[55] At that stage, the Panel did not have Mr Hodgson's report to Mr Sara of 1 May 2017. In that report, Mr Hodgson said:

> It is important to take all parts of the patient's evaluation into account. Mrs Scott has suffered a disc protrusion at L4/5 as a result of her accident in the motor vehicle of 13 December 2015. This leading to the rupture (prolapse) of the L4/5 disc compression of the L4/5 nerve roots, this giving rise to the onset of her back pain but particularly her sciatic symptoms in her legs.
>
> For this reason she has required surgery, not because she had a pre-existing spondylolisthesis at L4/5. Unfortunately, the pre-existing spondylolisthesis has complicated the issue with the disc protrusion and this has led to the need for the wide decompression, undercutting facetectomies and also the fusion of the

[3] *Accident Compensation Corporation v Mehrtens* [2012] NZACC 250.

> L4/5 level to prevent any further instability which is known to recur when a decompression at this level is carried out.

[56] Mr Hodgson provided a further report to Mr Sara dated 20 September 2017. In it he emphasised these matters:

[a] The mechanism involved high force;

[b] While she had mild degenerative changes in her lumbar spine, the disc spaces were reported as normal;

[c] It is not unusual for patients to develop symptoms in their legs some days, weeks, or even months after the original injury;

[d] In the appellant's case, the disc protrusion compressed the L5 nerve root and "the fact that it was in a position where there was noted to be a narrow spinal canal secondary to spondylolisthesis unfortunately exacerbated the entire problem"; and

[e] Mr Hodgson's operative findings noted the L4/5 disc protrusion caused L5 nerve root compression and that this was caused by the accident and injury she sustained. It is accepted that the spondylolisthesis was present. However, this was not the reason for the surgery.

[57] The Panel reported again on 31 October 2018. It appears that the Panel did not have the reports of Mr Hodgson of 1 May 2017 and 20 September 2017. However, it did have the report of Dr Bentley, musculoskeletal physician, dated 22 March 2018. The latter report, however, did not have a particular focus on causation and simply said:

> Margaret clearly suffered acute low back pain and developed right lateral leg pain as a result of the MVA, in my opinion the L4/5 disc sprain, internal disc disruption and annulus tear occurred as a result of that accident and possible the grade 1 spondylolisthesis, there is no evidence of either of these pathologies present before the MVA.

[58] The Panel report of 31 October 2018 was brief and concludes:

> There are no new features in Dr Bentley's report to support a causal link between the L4/5 pathology and the motor vehicle crash. The previous CAP comment remains relevant.

[59] It is regrettable that the Panel did not have the two most recent reports of Mr Hodgson referred to above. It is at least possible that, had this been so, the Panel might have been less sure of confirming its earlier conclusion.

[60] However, my role is to decide this appeal on the evidence before me. I find the best evidence I have in this case is that of Mr Hodgson and, in particular, the conclusions he reaches as to causation in his reports of 1 May 2017 and 20 September 2017. I find these reports are carefully reasoned and nuanced to allow him to draw a conclusion that might, in other cases, not follow where a person in the appellant's position has pre-existing degeneration in her spine.

[61] Accordingly, on the balance of probabilities, I find that the appellant has proven that the decision by the respondent of 5 July 2016 declining to fund the L4/5 decompression and intertransverse fusion surgery was wrong. That decision is therefore quashed and the appeal is allowed.

[62] 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: P Sara, Barrister and Solicitor, Dunedin for the appellant
Young Hunter, Christchurch for the respondent