IN THE DISTRICT COURT
AT WELLINGTON

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

[2021] NZACC 31 **ACR 341/18**

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

Hearing: 23 November 2020
Heard at: Dunedin/Ōtepoti

Appearances: Mr P Sara for the appellant
Mr C Light for the respondent

Judgment: 5 February 2021

RESERVED JUDGMENT OF JUDGE C J McGUIRE
[Causation s 26 Accident Compensation Act 2001]

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[1] The issue in this appeal is the correctness of the Corporation's decision of 9 April 2018 declining to fund Ms Reynolds' lumbar spine surgery for a recurrent protrusion at L4/5, spinal stenosis and an L3/4 disc protrusion with central spinal stenosis.

Background

[2] On 2 October 2017, Ms Reynolds suffered a lumbar sprain (left in the course of "luxing"). However, the injury was more fully described in her statement of evidence at the review on 16 October 2018 as follows:

…

3. On 2 October 2017, my husband and I were in the process of moving houses.

4. I was in the process of packing cardboard boxes in order to shift to our new residence.

5. This process had taken several days.

6. I was packing a cardboard box about 600 mm squared and 800 mm high. I was packing linen into the box.

7. I lifted the box up and was in the process of carrying it to the garage.

8. As I lifted the box, I twisted around, intending to reverse direction and as I twisted, I tripped on something and I fell backwards, landing on my back.

9. The carton I was carrying landed on top of me.

10. When I landed on the ground, I experienced pain in the lower part of my back.

11. The pain was 10 out of 10 on a scale where 0 is no pain and 10 is the worst pain in my life. The pain was so bad I had to yell out to my husband, Allan, to help me get up.

12. Allan came and helped me get to my feet and then assisted me to get to a bed where I lay down. The pain remained excruciating.

13. I lay flat on my back on the bed for about an hour.

14. After that Allan managed to get me to my feet and with assistance, I got to the lounge where I sat in a chair while he rang the doctor.

15. From memory, I saw the doctor the same day.

[3] Ms Reynolds has something of a history of back pain and issues:

[a] On 14 August 2000, Mr Russell Fowler, an orthopaedic surgeon, reported on Mrs Reynolds' lower back pain. He said that she was cleaning her crib at Riverton approximately five months previously, and she then developed pain in her back. It later radiated into her right buttock around into her groin and down the lateral aspect of her thigh as far as her ankle. Mr Fowler noted a past history of low back pain intermittently over the previous 30 years. Mr Fowler said that the back pain was contributed to by the facet arthropathy although she could have a disc prolapse that was causing her sciatica.

[b] On 7 April 2003, Dr Neil Morrison, radiologist, reported on a DEXA scan, with the reason given for the scan as "chronic back pain".

[c] On 1 September 2003, Dr Murius Hill, Mrs Reynolds' GP, recorded a diagnosis of back sprain, possibly disc prolapse.

[d] Dr Josie Parker, radiologist, reported on 2 September 2003 on an x-ray of the lumbar spine with the clinical indications being a back strain. Dr Parker said that there were degenerative changes present in the lumbar spine with small marginal osteophytes present at all levels.

Accident in 2015

[4] In a claim form dated 16 June 2015, Mrs Reynolds claimed cover for a coccyx sprain suffered in an accident on 18 February 2015 when she was lifting furniture, lost her balance and hurt her back. ACC accepted cover for this injury. Dr Ajit Johri, a general practitioner with special interest in orthopaedics, commented on the history of the back pain. He referred to an accident in 1979, when Mrs Reynolds injured her lower back while shifting wool bales, leather bales and sheepskin bales. She did not apply for ACC cover. Dr Johri referred her for an MRI.

[5] Dr Gabes Lau, Radiologist, reported on an MRI on 1 September 2015. He noted there was spinal canal narrowing and disc bulges at the L3/4, L4/5 and L5/S1 levels.

[6] In October 2015, Mr Bruce Hodgson, Orthopaedic Surgeon, sought ACC funding for an L4/5 decompression and discectomy.

[7] Mr Peter Hunter, Orthopaedic Surgeon and Medical Advisor, commented on 11 November 2015 that while the history was atypical, in that a lifting injury was highly unlikely to damage the coccyx, he did suggest that disc damage could have been caused, and there appeared to be a sufficient contribution from the covered injury for ACC to fund decompression surgery.

[8] On 11 November 2015, ACC agreed to pay for spinal stenosis decompression at L4/5. ACC also added an additional injury of lumbar disc prolapse at L4/5 with radiculopathy.

[9] Surgery took place on 4 December 2015. In a follow-up report on 19 January 2016, Mr Hodgson recorded Mrs Reynolds' advice that her back and her legs were comfortable, although she found that walking was uncomfortable at the end of the day. Mr Hodgson suggested alternative exercises and advised Mrs Reynolds to keep active and busy.

Accident in 2017

[10] Following the accident of 2 October 2017, Mr Mike McKewen, Radiologist, reported on an x-ray of Mrs Reynolds' lumbar spine on 20 December 2017. He reported the degree of spondylosis was largely unchanged compared to the previous scan.

[11] Mrs Reynolds saw Mr Hodgson on 17 January 2018. He recorded the accident on 2 October 2017 occurred "while shifting house and lifting a heavy box". He suggested an MRI scan of the lumbar spine. Dr McKewen reported on an MRI of the lumbar spine on 23 February 2018 as follows:

> 1. Recurrent L4-5 disc, with severe bilateral foraminal narrowing, which has progressed with impingement of the existing L4 for nerve roots.
>
> 2. Stable impingement of the existing L5 nerve roots at the L5-S1 level.
>
> 3. Persistent moderate foraminal narrowing of the L3-4 disc with a small enhancing annulus fissure within the right paracentral position. Moderate central canal stenosis at this level.
>
> 4. Post surgical neuroma superficially within the left paraspinal muscles at the L4 level, not evident on the pre-operative examination.
>
> 5. Cholelithiasis.

[12] In terms of the required causal medical link between the proposed treatment and the covered injury Mr Hodgson wrote:

> A direct link between her original injury on 18/4/15 giving rise to the problem at L4/5 requiring a decompression here at L5/S1. She subsequently had a

> second injury in October 2017 which has led to the onset of her symptoms and the L3/4 disc protrusion as confirmed on MRI scanning. The reason for surgery is to rid her of her ongoing problems relating to the stenosis present at the L3/4 and L4/5.

[13] As for relevant pre-existing factors, Mr Hodgson noted:

> Previous problems at L4/5 and L5/S1 required associated decompressive surgery 2011.

[14] ACC sought clinical opinion from Mr Ray Fong, Orthopaedic Surgeon. On 23 March 2018, Mr Fong concluded, after considering the history since 2015, that Mrs Reynolds had:

> Multilevel degenerative disc disease causing multilevel spinal canal/lateral recess stenosis. This is a multilevel degenerative disease that is at best symptomatically aggravated by the claimed accident but not caused by it.

[15] The ACC case manager pointed out to Mr Fong that ACC had in fact funded previous surgery to Mrs Reynolds' spine following Dr Peter Hunter, another panel member's advice. Mr Fong on 11 November 2015 had said, in response to the request for the surgery at that stage:

> There appears to be a sufficient contribution from the covered injury for ACC to fund decompression surgery …

[16] The case manager subsequently asked Dr Fong if there was a contribution from the previous funded surgery to the recurrent L4/5 protrusion and the L3/4 disc protrusion that now required treatment. Mr Fong responded on 6 April 2018 noting amongst other things that:

> … at L4/5 there is marked canal narrowing due to marked broad based disc bulge ligamentum hypertrophy, narrowing of the lateral recess with impingement at the L5.
>
> So it was accepted that there was a contribution to the broad based bulge at the L4/5 discectomy that has been performed.
>
> It is obvious from the operation that there is a tight central canal with large facet joints and marked thickening of the ligamentum flavum. This facet joint enlargement and ligamentum flavum hypertrophy at the L3/4 level is a longer standing pre-existing condition.
>
> Similarly, there were L5/S1 facet hypertrophy causing tightness and partial fasciotomy was performed. This L3/L4 and L4/5 canal stenosis reported in the MRI scan of 23/02/2018. Again, this is on the basis of broad based disc bulge

> ligamentum hypertrophy. This is a pre-existing condition unrelated to the previous surgery. At L4/5 there is a moderate loss of disc height and persisting annular disc bulge, foraminal narrowing, also a degenerative condition. At L5/S1 there is a degenerative anterolisthesis, marked facet joint hypertrophy with impingement of both nerve roots i.e. this is multilevel degenerative disease unrelated to the previous and these changes cannot be attributed to the previous surgery.

[17] On 9 April 2018, ACC issued a decision saying that it was unable to cover the proposed surgery.

[18] Following a review application being lodged, in a letter dated 12 July 2018, Mr Hodgson, responding to a letter from Mr Sara, addressed the issue of causation. Amongst other things he said:

> … Mrs Reynolds has suffered from back pain from time to time over a number of years. She has had various bouts of discomfort that have required plain x-rays in the year 2000 and 2003. These are not available on digital copy but the radiology report suggests narrowing of the disc spaces at these levels and degenerative change.
>
> That said, she has managed very well and continued a very active life. She first developed problems with her back that led to significant sciatica and disability on 18 April 2015 following her incident on that date when moving house.

[19] Mr Hodgson said that Mrs Reynolds had made a satisfactory recovery from the spinal surgery in 2015. He said that Mrs Reynolds suffered a further injury on 2 October 2017 while she was moving and that she saw him again on 17 January 2018. The incident described was of lifting a rather heavy box, hurting her back and developing severe pain in the back; but also the onset of left buttock pain, anterior thigh pain and numbness over the left thigh, skin and calf. To a lesser extent there was also a problem on the right side.

[20] Mr Hodgson then said:

> On 23 February 2018, the MRI scan, in my opinion, revealed a recurrence of the central disc bulge at L4/5 extending behind the body of L4. I also noted a new bulge at L3/4 with central stenosis here as well.
>
> In my opinion the accident she had suffered on 2 October 2017, while lifting a rather heavy box, had led to the onset of her severe back pain and particularly her left sided sciatic symptoms, these notably L4 nerve root territory. The MRI scan findings of the recurrent disc protrusion with the extruded fragment up behind the body of L4 compressing the thecal sac and L4 nerve root at this level, was completely consistent with the symptoms she described. I did note

> that there was now a disc protrusion at L3/4 as well. The L3/4 disc bulge was also abutting the L4 nerve root as it tracked behind this, as such I consider she had what is known as a double crush syndrome, where the L4 nerve root is compressed in two places, this magnifying the extent of the discomfort and changes within the nerve root territory.
>
> …
>
> In my opinion Mrs Reynolds has sustained an injury on 2 October 2017 while shifting a rather heavy box. This led to the recurrent protrusion at L4/5 on the left as noted on MRI scan. This also led to the development of the L3/4 disc prolapse as also noted on the MRI scan.

[21] Mr Hodgson concluded that the surgery treatment that Mrs Reynolds required was directly related to the injury that she suffered on 2 October 2017.

[22] The matter proceeded to review on 16 October 2018.

[23] By decision dated 24 October 2018 the Reviewer dismissed both the review applications, finding that the L4/5 disc bulge was wholly or substantially caused by a gradual process without material contribution from the accident event.

[24] Following the review on 14 November 2018, Mr Hodgson carried out a partial inferior laminectomy of L3, posterior L3/4, L4/5 decompression and a discectomy on the left side of L4/5.

[25] Mr Sara sought further comment from Mr Hodgson following the review decision. Mr Hodgson commented on 15 November 2018. Referring to the 2015 accident, Mr Hodgson said that Mrs Reynolds was experiencing symptoms that can be described as claudication. Claudication occurs when the spinal canal is narrowed, and the nerves are compressed and, therefore, do not function properly. This condition is most commonly associated with spinal stenosis or narrowing of the spinal canal. This can occur either as a result of a congenitally narrow spinal canal or due to secondary causes such as degeneration occurring with enlargement of the facet joints or movement of the vertebra alignment (spondylolisthesis). This can also occur with acute disc prolapse that bulge from the disc into the spinal canal and obliterate the space.

[26] Mr Hodgson said that Mrs Reynolds had degenerative changes in her lumbar spine over a gradual period of time. However, the accident on 18 April 2015 led to an acute disc protrusion at L4/5; this caused the compression of the spinal nerve roots at that level. Mrs Reynolds made a good recovery from her surgery until the accident on 2 October 2017. Mr Hodgson's view was Mrs Reynolds' symptoms had been caused by a recurrence of the disc protrusion at L4/5 and exacerbated by the development of a central bulge of the disc at L3/4 and narrowing of the spinal canal at that level.

[27] Mr Hodgson said that the surgery that he carried out on 14 November 2018 addressed the L3/4 and L4/5 levels. He said that a disc protrusion was present at L3/4 but did not require removal. Mrs Reynolds had made a good recovery after the surgery.

[28] As to the accident event in 2017, Mr Hodgson said:

> In my opinion the mechanism of her injury lifting a heavy box out in front (which is awkward and heavy) falling over backwards onto her back with the box landing on top has led to a significant force which has focused itself though her low back and in particular through the previous operated disc, which has subsequently re-prolapsed and led to the onset of her symptoms.
>
> Unfortunately for Mrs Reynolds her natural wear and tear process of aging has led to problems at L3/4 and in my opinion the disc protrusion at L3/4 while not bad in itself has added to the problem that has occurred at L4/5 and has led to the "double crush syndrome" of a narrow canal at L3/4 that she was aware of (this process coming on slowly and insidiously, aging process) but on top of this has had the recurrent protrusion of L4/5 that has compromised the canal and led to the sudden onset of symptoms which she now suffered from.

[29] The clinical advisory panel (the Panel) commented on 13 February 2019.

[30] The Panel firstly referred to the various reports of lower back pain over the years which dated back to 1970. In this regard it referred to a report by Mr Fowler on 14 August 2000 that "Mrs Reynolds had lower back pain for the last 30 years (from the age of 22) and had two occasions off work with lower back pain".

[31] The Panel noted that lower back pain was a common presentation in the general population and was not usually related to trauma. Many persons develop low back pain and sciatica without any history of injuries, accidents or trauma. The L3/4,

L4/5 and L5/S1 levels of her lumbar spine may be pain generators for her intermittent low back pain and sciatica. The Panel's view was that the covered accidents in 2015 and 2017 may have drawn attention to her underlying weakened discs and other multifactorial pathologies in her lower lumbar spine, but the accident events did not cause these changes.

[32] The Panel commented that multiple age-related degenerative changes were reported on all the available imaging. Mr Hodgson had also reported that L3/4 and L4/5 changes were likely to have developed over a long time. The chronic changes seen on the lumbar spine imaging, before the 2017 event could contribute to lower back and sciatica symptoms. Lumbar spondylosis was a very common medical condition, which often occurred in persons with no symptoms. It was a gradual onset process that was not causally related to a single episode of trauma or combination of episodes. The features showing on imaging could not have developed in a short timeframe after the accident event.

[33] The Panel noted that the causes of the changes in Mrs Reynolds' spine occurred over a long time period. The prominent changes were at the two lower spinal levels, which are the levels frequently involved in progressive lumbar spondylosis, including osteoarthritic changes and degenerative disc disease. The Panel concluded:

> The CAP noted that anything is possible, and certainly the mechanisms described on 02/10/2017 ("luxing", as Ms Reynolds wrote in her ACC45 form lodged on 27/10/17, and/or the twisting and fall Ms Reynolds described during the review) can cause acute low back pain and a symptomatic aggravation of underlying spinal pathology. The claim was lodged as a lumbar sprain and the clinical records were not provided.
>
> As discussed above, each change visible on imaging of Ms Reynolds' lumbar spine is most likely not acute, but rather, part of a chronic progressive process which has become symptomatic.
>
> Considering Ms Reynolds' overall clinical presentation and health records, the CAP preferred Mr Fong's and other reports which noted that the event described in 2017 is most unlikely to have caused an acute, two level disc prolapse.
>
> RECOMMENDATION:
>
> The CAP concluded that the 25/03/2000, 08/01/2008, 18/04/2015 and 02/10/2017 ACC covered events are unlikely to have had more than a minor

> causal contribution to the chronic changes at the L3/4, L4/5 and L5/S1 levels of Ms Reynolds' lumbar spine. These changes are most likely to have developed over a long time.
>
> The reported events including the 18/04/2015 and 02/10/2017 claims are likely to have symptomatically aggravated the chronic pathology in Ms Reynolds' lumbar spine, including her lumbar disc prolapses. However, a causal relationship has not been established and seems unlikely.

[34] Mr Hodgson commented on 10 April 2019, in response to the Panel's report.

[35] Mr Hodgson agreed that it was not uncommon for persons of Mrs Reynolds' age to suffer from bouts of back pain, particularly when they had worked in manual tasks over a number of years. It was also well known that over 50% of persons that had bouts of back pain from time to time are over the age of 40. Mr Hodgson agreed that Mrs Reynolds had a number of issues relating to her back over the years. However, none of these episodes required any surgical intervention and settled on their own accord.

[36] As to the 2015 accident, Mr Hodgson said:

> The incident Ms Reynolds suffered on 18 April 2015 led to the onset of quite severe sciatica down the back of both legs. Her investigations, including MRI scanning, revealed not only the known spinal stenosis at L4/5 but also a new prominent disc protrusion at L4/5, further narrowing the spinal canal and compressing the nerve roots significantly. This was the driver of her back pain, leg, sciatic and claudicant symptoms.
>
> I explained this in my report of 15 November 2018 and it was for this reason that she required surgery to correct the situation.

[37] In respect of the 2017 accident, Mr Hodgson said that the MRI scan showed a bulge at L4/5 had reoccurred and disc fragments were extending up behind the body of L4. Further surgery was therefore required.

[38] ACC declined to pay for this surgery and Mrs Reynolds funded the surgery herself.

[39] Mr Hodgson said further:

> I accept Mrs Reynolds had degenerative change at L3/4 and L5/S1 prior to her injuries in 2015 and again in 2017. However, the particular pathology that required surgery related directly to the L4/5 disc protrusion. There was a clear

> disc protrusion as confirmed on MRI scanning in 2015, and a recurrent disc protrusion at L4/5 in 2018, as noted on both MRI scanning and at surgery.
>
> This was the reason as to why she required surgery. It was not because she had degenerative disc disease at L3/4 or a spondylolisthesis at L5/S1. It was because she had suffered an acute accident that had led to the disc protrusion at L4/5 that had compromised the spinal canal and led to the onset of her sciatic symptoms. In 2015 she required surgery for her L4/5 disc prolapse. She recovered only to suffer a recurrent prolapse as a result of her second injury.
>
> I believe the CAP group have been dismissive to state the widespread degenerative changes found in Mrs Reynolds' back were the reason why she had problems that required surgery.
>
> This is not so. On the contrary, the need for her surgery was aimed specifically at the accident related L4/5 disc prolapse which was noted on MRI scanning then confirmed at surgery.

The Appellant's Submissions

[40] Mr Sara submits that Mr Hodgson's operation findings take centre stage. He says that the opinions of Dr Fong and the other members of the Panel do not have the benefit of them having been present at the time of the surgery. He submits:

> While it may be the case that the opinion of a treating specialist may not necessarily be preferred over non treating experts in relation to diagnosis, this cannot be the case once the treating specialist, in this case an orthopaedic surgeon, has actually performed surgery.

[41] He says that in this case Mr Hodgson occupies a unique forensic position and says that while his observations about what he found at surgery might be open to interpretation by commentators, the observations themselves stand.

[42] He says that significantly Mr Hodgson found there was a disc bulge at L4/5 disc with a small fragment of disc behind the body of L4.

[43] Mr Sara refers to the fact that there was clear disc protrusion confirmed on MRI scanning in 2015 and recurrent disc protrusion at L4/5 in 2018.

[44] He says that Mr Hodgson has made it clear that Mrs Reynolds did not need surgery because of a degenerative condition in her spine. He emphasises that the particular pathology that required surgery related directly to the L4/5 disc protrusion.

[45] He says that that disc bulge was surgically repaired in 2015 and that Mrs Reynolds suffered another disc protrusion at the same level in the accident event on 2 October 2017. He says that is why Mr Hodgson refers to it as a recurrent disc protrusion, meaning that the disc protrusion has happened again.

[46] He submits that the Panel's concession, that the accident events, as listed, had at least a minor causal contribution to the chronic changes in Mrs Reynolds' lumbar spine, is significant. He says that this is because ACC is only permitted to decline cover for a personal injury caused wholly or substantially by a traumatic process such as aging or disease. He submits that it is settled law that there does not need to be any particular contribution to a physical injury from accident and that even a minor causal contribution means that ACC cannot have recourse to the exclusion provided by s 26(2) of the Accident Compensation Act; that is, that it was not personal injury caused wholly or substantially by a gradual process.

[47] Mr Sara refers to the fact that the Panel says that the reported events including the 18 April 2015 and 2 January 2017 claims are likely to have symptomatically aggravated the chronic pathology in Mrs Reynolds' lumbar spine but does not explain what it means by "symptomatic aggravation".

[48] He says that the panel cannot say that Mrs Reynolds had an L4/5 disc prolapse before the accident event of 2 October 2017 as this would be entirely speculative.

[49] Conversely, he said the case for Mrs Reynolds is that she did not have a disc prolapse at least from the surgical intervention in 2015. Similarly, there is no evidence to show that she had any kind of pathology in her back, causing nerve compression prior to her accident event on 2 October 2017. He submits that on the proper interpretation of the medical evidence the panel is actually supporting Mr Hodgson's opinion that the accident event caused the nerve compression.

Review Costs

[50] Mr Sara submits that the Reviewer was wrong to only award one amount for appearance in accordance with the regulations. Having found that there were two discrete review applications, Fairway Resolutions having allocated separate numbers

for each application, s 148 of the Act provides that where an award of costs is made it must be in accordance with regulations.

[51] He says that as a matter of law there were two appearances at hearing, not just one. The items listed in the scale are a package per review and cannot be selectively included or excluded once the threshold for entitlement is established under s 148. The threshold for entitlement is either a successful outcome, or that the review was reasonably brought. He submits it follows that Mrs Reynolds was entitled to two separate allocations for appearance at hearing per review not just one. Accordingly, he says that Mrs Reynolds is entitled to a further allocation of $204.53.

The Respondent's Submissions

[52] Mr Light notes that there are two issues for determination, namely cover and surgery, and that the two issues are interrelated because Mrs Reynolds has to be entitled to cover for the conditions for which surgery was required, because entitlements cannot be provided for a non-covered condition. He refers to s 20(1) and 20(2)(a).

[53] He refers to *Accident Compensation Corporation v Ambros*, particularly the requirement that the plaintiff prove causation on the balance of probabilities, meaning that the plaintiff must show that the probability of causation is higher than 50%.[1]

[54] He notes that in *Johnston v Accident Compensation Corporation,* France J rejected an argument on behalf of the appellant that it was sufficient to link the incapacity to the accident.[2] Referring again to *Johnston* , he submits it is not enough that an accident caused incapacity because the issue is whether the accident caused a physical injury that is presently causing or contributing to the incapacity.

[55] He refers to *Hill v Accident Compensation Corporation,* cited with approval in the High Court decision of *McDonald v Accident Rehabilitation and Compensation Insurance Corporation,* that if medical evidence establishes that there are pre-

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1 *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340 (CA).
2 *Johnston v Accident Compensation Corporation* [2010] NZAR 673.

existing degenerative changes which are brought to light or which become symptomatic as a consequence of an event which constitutes an accident, it can only be the injury caused by the accident and not the injury that is the continuing effects of the pre-existing degenerative condition that can be covered.[3]

[56] He notes that Mrs Reynolds must establish on the evidence, that the accident event in October 2017 caused physical injuries to her spine at the L3/4 and L4/5 levels for which funding was sought for surgery.

[57] He notes that the difficulty facing Mrs Reynolds is that it is clear from the medical records that she has had lower back problems for many years, dating back to her 20s and that she was in her 70s when the accident occurred in 2017.

[58] He refers to the evidence of the Panel that disc degeneration can take place over time: that includes bulging, protrusions and prolapses. Furthermore, disc degeneration is common in the absence of trauma.

[59] The Panel also explained how changes to discs by way of degeneration take place and how prolapses occur without any trauma.

[60] He submits that the Panel's conclusion should be preferred over that of Mr Hodgson, that the changes visible on imaging of Mrs Reynolds' lumbar spine was most likely not acute but rather the part of a chronic process that had become symptomatic. He submits that the event in 2017 was most unlikely to have caused an acute two-level disc prolapse.

[61] He notes that the Panel is a body of predominantly orthopaedic surgeons with considerable experience between them, also with expertise in determining causation in the context of the accident compensation scheme. He concludes that it is more likely that the disc bulges at L3/4 and L4/5 were caused by a degenerative process rather than by accident in 2017.

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[3] *Hill v Accident Rehabilitation and Compensation Insurance Corporation* DC Huntly 189/98, 1 September 1998; and *McDonald v Accident Rehabilitation and Compensation Insurance Corporation* [2002] NZAR 970 at [26]–[28].

Costs

[62] Mr Light submits that there is no merit in Mrs Reynolds' argument that she should be awarded review costs for two appearances at review because there were two review applications.

[63] He submits that the fact there was only one review hearing, and therefore only one set of review costs, accords with the general principle that costs can only be awarded for actual steps taken by a party in any matter.

[64] He says the position would be different if there were two hearings.

[65] Mr Light refers to *Sutton v Accident Compensation Corporation* where Judge Ongley said:[4]

> [20] Nothing in the legislation suggests that hearing and deciding separate review questions can be regarded as separate reviews for the purposes of cost awards. The costs provisions appear to be intended for mechanical application subject to the discretion in s 148(1)(b) and (c) and the discretion to order less than the maximum amounts.

[66] Mr Light also refers to *Pearson v Accident Compensation Corporation* where Judge Christiansen held that "an applicant should not be awarded costs by applying a multiplier by the number of review applications lodged, irrespective of the amount of preparation required or the duration of the hearings.[5]

Decision

[67] On 2 October 2017, Mrs Reynolds had an accident. The claim form (not before the Court), recorded that she suffered a lumbar sprain (left), caused by "luxing and twisted back – felt pain in back". ACC accepted cover for a lumbar sprain.

[68] The mechanism of this accident was later described in detail by Mrs Reynolds at the review hearing on 16 October 2018, as follows:

> I was packing a cardboard box about 600 mm squared and 800 mm high. I was packing linen into the box.

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4 *Sutton v Accident Compensation Corporation* [2014] NZACC 344 at [20].
5 *Pearson v Accident Compensation Corporation* [2018] NZACC 132 at [14].

> I lifted the box up and was in the process of carrying it out to the garage.
>
> As I lifted the box, I twisted around intending to reverse direction and as I twisted I tripped on something and fell backwards, landing on my back.
>
> The carton I was carrying landed on top of me.
>
> When I landed on the ground, I experienced pain in the lower part of my back.
>
> The pain was 10 out of 10 on a scale where 0 is no pain and 10 is the worst pain in my life. The pain was so bad I had to yell out to my husband, Allan, to help me get up.
>
> Allan came and helped me to my feet and then assisted me to get to a bed where I lay down. The pain remained excruciating.
>
> I lay on my back on the bed for about an hour.
>
> After that Allan managed to get me to my feet and with assistance, I got to the lounge where I sat in a chair while he rang the doctor.
>
> From memory I saw my doctor the same day.

[69] There has been some speculation over the use of the word "luxing" suggesting vacuum cleaning. That seems entirely improbable. It is more likely that the word was used to mean luxation.

[70] There is no evidence to contradict Mrs Reynolds' description of her accident, and I accept it.

[71] At the time of this accident, Mrs Reynolds was 70 years old.

[72] There is an unchallenged narrative that Mrs Reynolds has a history of back issues. The Panel report of 13 February 2019 notes an earlier report from 14 August 2000 that she had lower back pain for the last 30 years (from the age of 22) and had two occasions off work with lower back pain.

[73] The Panel report documents referenced in the appellant's medical history in 2001, 2003, 2008 outline further and ongoing issues with her back.

[74] In April 2015, she had an accident and was granted cover for a coccyx sprain. An MRI report of 1 September 2015 said there was spinal canal narrowing and disc bulges at the L3/4, L4/5 and L5/S1 levels.

[75] ACC agreed to pay for spinal stenosis decompression at L4/5 and surgery was performed on 4 December 2015. The surgery was successful.

[76] Following the October 2017 accident, an MRI report from Dr McKewen on 23 February 2018 included the following:

> 1. Recurrent L4-5 disc, with severe bilateral foraminal narrowing, which has progressed with impingement of the existing L4 nerve roots. …
>
> Persistent moderate foraminal narrowing of the L3-4 disc with a small enhancing annulus fissure within the right paracentral position. Moderate central canal stenosis at this level.

[77] In the Assessment Report and Treatment Plan of 27 February 2018 Mr Hodgson diagnosed a recurrent protrusion at L4/5, spinal stenosis and a L3/4 disc protrusion with central spinal stenosis. Mr Hodgson also said:

> She subsequently had a second injury in October 2017 which has led to the onset of her symptoms and the L3/4 disc protrusion as confirmed on MRI scanning. The reason for surgery is to rid her of her ongoing problems related to the stenosis present at L3/4 and L4/5.

[78] When ACC declined to pay for the surgery, Mrs Reynolds elected to proceed and funded the surgery herself.

[79] In his report of 10 April 2019, Mr Hodgson described the surgery as follows:

> I had to carry out decompression at the level above L3/4 and below at the L5/1 in order to work towards the prior operated (scarred) level at L4/5. This is a common used surgical technique. Surgery proceeds from an area where the anatomy was normal, to the operated area where the anatomy was abnormal and considerably scarred.
>
> …
>
> It was important to decompress from the normal L3/4 level above then work down towards the abnormal L4/5 level, where the offending recurrent L4/5 disc was found with the nerves of this level compromised and compressed.
>
> …
>
> I noted the recurrent disc protrusion at L4/5 was identified and then removed. The left L4 and L5 nerve roots were freed.
>
> In carrying out the extended exposure, the L3/4 levels were explored, the space enlarged such that there was adequate clearance here. I did not need to carry

> out a discectomy of L3/4. The reason for this is outlined in my report of 15 November 2018.
>
> I should state that, in my opinion, the particular pathology at L4/5 that has been dealt with relates directly to the L4/5 disc protrusion, its increased narrowing of the compromised canal (spinal stenosis) at the L4/5 along with the compression of the L4 and L5 nerve roots.
>
> I accept Mrs Reynolds had degenerative change at L3/4 and L5/S1 prior to her injuries in 2015 and again in 2017. However the particular pathology that required surgery related directly to the L4/5 disc protrusion. There was a clear disc protrusion as confirmed on MRI scanning in 2015, and a recurrent disc protrusion at L4/5 in 2018, as noted on bot MRI scanning and at surgery.
>
> This was the reason as to why she required surgery. It was not because she had degenerative disc disease at L3/4 or a spondylolisthesis at L5/S1. It was because she had suffered an acute accident that led to the disc protrusion at L4/5 that had compromised the spinal canal and led to the onset of her sciatic symptoms. In 2015 she required surgery for her L4/5 disc prolapse. She recovered only to suffer a recurrent prolapse as a result of her second surgery.
>
> I believe the CAP group have been dismissive to state the widespread degenerative changes found in Mrs Reynolds' back were the reason why she had problems that required surgery.
>
> That is not so. On the contrary, the need for her surgery was aimed specifically at the accident related L4/5 disc prolapse that was noted on MRI scanning then confirmed at surgery.

[80] In its report the Panel noted that Mrs Reynolds had changes at L3/4 and L4/5 before her 2017 claim. It also noted that lumbar spondylosis is common and that chronic changes were noted on Mrs Reynolds' lumbar spine imaging well before her 2017 event.

[81] It noted that her lumbar spondylosis is a very common medical condition often noted in people with no symptoms whatsoever and that it is a gradual onset process which develops over years and is not known to be causally related to a single episode of trauma or combination of episodes. The Panel noted that disc degeneration is common, and it referred to research that age-related prevalence of degenerative disc disease was at 88% in individuals in Mrs Reynolds' age group.

[82] The Panel said:

> In summary the 02/10/2017 event is unlikely to have caused an acute, two level disc prolapse:

> The CAP noted that anything is possible, and certainly the mechanism described on 02/10/2017 ("luxing" as Mrs Reynolds wrote on her ACC45 form lodged on 27/10/2017, and/or the twist and fall Mrs Reynolds described during the review) can cause acute low back pain and a symptomatic aggravation of underlying spinal pathology. …

[83] The Panel concluded:

> The reported events, including the 18/04/2015 and 02/10/2017 claims are likely to have symptomatically aggravated the chronic pathology in Ms Reynolds' lumbar spine, including her lumbar disc prolapses. However, a causal relationship has not been established and seems unlikely.

[84] Those on the Panel included five orthopaedic surgeons. Plainly, the Panel carries great weight. However, its report is measured, and it fairly notes that "anything is possible". It also acknowledged that the accident of 2 October 2017 can cause a symptomatic aggravation of underlying pathology.

[85] Were it not for the fact that the surgeon, Mr Hodgson, has had longitudinal dealings with Mrs Reynolds, having carried out the surgery following both her 2015 and 2017 accidents, it would be a relatively straightforward application of logic to conclude that her presentation requiring surgery in 2017 was age related and a case of a chronic progressive process becoming symptomatic as the Panel suggests.

[86] In this case, however, Mr Hodgson is in that unique position of knowing precisely the condition of her spine prior to the 2017 accident. Ultimately, his statement as the operating surgeon, that her need for surgery was not because she had degenerative disc disease at L3/4 or spondylosis at L5/S1 but because she had suffered an acute accident that led to the disc protrusion at L4/5 that had compromised the spinal canal and led to the onset of her sciatic symptoms, is accepted.

[87] Accordingly, I find that causation is proved and therefore her appeal is allowed. The Corporation's decision of 9 April 2018 declining to fund lumbar spine surgery and cover for Mrs Reynolds' condition that required the surgery is reversed.

Costs

[88] Section 148 of the Act deals with costs on review. Section 148 allows the Reviewer to exercise wide discretion in respect of costs and expenses that differ from the accepted tradition of costs following the event. Plainly s 148 is in part aimed at reducing barriers to claimants taking matters to review in providing for example for costs and expenses to be awarded to the applicant even where the review application is unsuccessful.

[89] Costs are awarded in accordance with the Accident Compensation (Review Costs and Appeals) Regulations 2002. Neither s 148 nor the regulations specifically deal with occasions where two reviews are heard conjointly.

[90] Rule 4 provides:

> (1) A reviewer's award under section 148 of the Act to an applicant for review or another person must be –
>
> (a) only for the costs and expenses of an item described in column 1 of Schedule 1; and
> (b) the only award to the applicant for review or other person for those costs and expenses.
>
> (2) The amount of the reviewer's award for costs and expenses of an item described in column 1 of Schedule 1 must –
>
> (a) not exceed the amount specified (opposite the description) in column 2 of that schedule; and
> (b) be calculated in accordance with the rate (if any) specified opposite the description) in column 3 of that schedule.

[91] Mr Sara submits that as a matter of law there were two appearances at the hearing not just one and that therefore Mrs Reynolds was entitled to two separate applications for appearance at the review not just one.

[92] Standing in Mr Sara's way are two decisions of *Sutton v Accident Compensation Corporation* and *Pearson v Accident Compensation Corporation*.

[93] I agree with Judge Ongley when he says that: "Nothing in the legislation suggests that hearing and deciding separate review questions can be regarded as

separate reviews for the purposes of cost awards."[6] I conclude the intention of s 148 and the regulations on the one hand was to be generous to claimants on review if they acted reasonably but were unsuccessful.

[94] The regulations themselves likewise are prescriptive in using the words "reviewer's award … to an applicant for review … must be".[7] Accordingly, I see no scope for allowing two awards of costs for two matters heard at the same review hearing. Accordingly, the appellant's application for further costs is refused.

[95] Should there be any issue relating to costs on this appeal, 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

[6] *Sutton*, above n 4, at [20].
[7] Accident Compensation (Review Costs and Appeals) Regulations 2002, r 4(1).