IN THE DISTRICT COURT
AT WELLINGTON

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

[2021] NZACC 33 **ACR 167/19**
ACR 235/19

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

Hearing: 9 October 2020
Held at: Christchurch/Otautahi

Appearances: Mr McSherry in person
Mr I Hunt for the respondent

Judgment: 10 February 2021

RESERVED JUDGMENT OF JUDGE C J McGUIRE
[Causation; Deemed Decision s 48 Accident Compensation Act 2001]

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[1] At issue on appeal ACR 167/19 is the Corporation's decision of 19 February 2019 declining to cover the appellant's disc herniation due to his accident of 23 April 1999.

[2] At issue on appeal ACR 235/19 is whether a review decision of 5 September 2019 dismissing the appellant's claim that he is entitled to cover by way of a deemed decision for disc herniation was correct.

Background

[3] On 12 October 1995, the appellant injured his back at work.

[4] The GP notes of 23 October 1995 state:

> Back injured at work lying fibreoptic cable for powermark.
> Pain both SI joints and some radiation down the fronts of legs O/E good flexion
> No tenderness
> Imp lumbar sprain
> … Feels unable to work

[5] ACC granted cover to the appellant for a sprain or strain of the lower back/spine under this claim.

[6] The appellant injured his back at work again on 23 April 1999.

[7] The mechanism of injury was described by the appellant in a statutory declaration, dated 1 July 1999, as follows:

> …I was lifting a steel door approx. 3.5 m x 3.0 meters weighing about 50 kgs into its top track. Although I had two helpers the task was very awkward and I strained my back trying to stabilize the weight of the door that was over my head. I was standing at the edge of the door pushing it onto its roller track and trying to align the rollers at the same time holding the weight of the door off the ground…

[8] This is consistent with the GP notes of 28 April 1999 and the claim form submitted. The doctor's notes record:

> Hurt lower back lifting at work at work 23/4/99.
> Ok over W/E – worse at work again yesterday when bending.
> 0 radiation
> 0 paraesthesia
> 0 tenderness

[9] Good flexion was noted. The diagnosis was one of mechanical lower back pain. The treatment plan was Voltaren and "physio".

[10] The GP notes on 21 June 1999 showed that back pain was exacerbated when the appellant returned to work, which included "bending in tunnels." The diagnosis of mechanical back pain was confirmed, and treatment by a chiropractor was proposed.

[11] On 2 July 1999, it was noted that the appellant still had lower back pain, which improved with rest but was worse when bending.

[12] X-rays on 2 July 1999 showed marginal osteophytic lipping in the lower thoracic and upper lumber disc spaces indicating spondylitic change.

[13] On 9 July 1999, the x-rays were reviewed with the appellant, and it was noted that he had worked that week and "coped ok". He expressed concerns that the back pain was interfering with his work and was referred to Dr Franzmayr.

[14] An undated referral letter stated two x-rays showing spondylitic changes at L1/2.

[15] On 14 July 1999, the appellant saw Dr Franzmayr, who noted that the appellant had a great deal of pain in the lower back on the right and in the right pelvic area, difficulty bending over, and even more difficulty straightening up after. He struggled to do his up shoelaces and find a comfortable position at night.

[16] The appellant's back is not mentioned again in medical notes until 30 November 2001 when the appellant was sweeping a path. It was noted he had severe pain, that he had felt something snap, but there was no sciatica or paraesthesia. The treatment plan was Voltaren and physiotherapy.

[17] The appellant was reviewed on 3 December 2001. The medical notes record he was "much better".

[18] In his submissions at review in 2018, the appellant said:

> In December 2001 I again approached my doctor after protracted problems with my back since my accident in 1999. I had been trying to get a diagnosis but failed. I just had to soldier on but I was badly incapacitated and returned to

> express my frustration and wanting another look at diagnosis and getting something done about it. Again without success.

[19] The appellant underwent three treatments with physiotherapist, Lindsay Jago, and was given stabilising type exercises. After that, he did not attend any further physiotherapy appointments.

The 2005 Claim

[20] On 8 August 2005, the appellant injured his lower back when he was lifting a weight in the gym and felt pain in his back. He saw a medical provider who lodged a claim on 12 December 2005. ACC funded five physiotherapy treatments and granted cover for pain in the lumbar spine. There are no other documents in relation to this claim on the ACC file. It is unclear whether there was any recorded injury to which the cover related.

[21] On 9 October 2007, the appellant presented to Dr Sitjes who noted:

> … recurrent lower back pain since initial injury in 2001. Injured lifting a heavy door.
>
> Pains in lumbar spine occasionally radiating to thighs including occasional paraesthesia but no numbness.

[22] Dr Sitjes referred the appellant to orthopaedic surgeon, Mr Rietveld, who on 10 December 2007 took the following history:

> … has a history of injuring his back, this occurred some years ago when he was working in a tunnel and lifting a heavy door and felt immediate pain in his lower back radiating into his legs. This was treated conservatively and eventually this sort of settled but intermittently he had back pain and more recently he's had an exacerbation of his back pain. The pain is in the upper lower back on the right hand side, it is not worse if he coughs or sneezes, but is worse if he bends backwards. Walking tends to relieve it, standing or sitting is quite severe for him.

[23] Dr Rietveld diagnosed probable facet joint pain at L1/2 on the right-hand side.

[24] X-rays on 11 December 2007 showed prominent anterior marginal vertebral body osteophytes at the T11/12 and the L1/2 levels with slight disc space narrowing at L2/3 and L4/5.

[25] Dr Rietveld noted on 17 December 2007 that the flexion and extension x-rays showed abnormal movement at the L2/3 level and referred the appellant for an MRI scan.

[26] An MRI taken on 20 December 2007 showed an L1/2 and L2/3 anterior annular disc bulge without evidence of neural compromise, as well as a right foraminal L4/5 annulus tear.

[27] On 21 January 2008 Mr Rietveld referred the appellant for a provocative discogram to see if the L2/3 level is where his pain was coming from.

[28] The discogram and CT discogram taken on 28 January 2008 showed extensive changes at L2/3 and L4/5 but overall provided a negative result.

[29] The report included the following:

> L2/3 disc:
>
> There is extensive disruption of the annulus anteriorly and extending to the right. There are significant osteophytes demonstrated anteriorly and there is minor disc bulge into the L2/3 intervertebral foramen on the right as a result of a further posterolateral radial annulus tear. No spinal stenosis or evidence of neural impingement …
>
> L4/5 disc:
>
> There is a right sided posterolateral radial annulus tear. There is disc bulge which narrows the right L4/5 intervertebral foramen and contacts the exiting L4 nerve root …

[30] Dr Rietveld recommended a facet joint block at L2/3, which was performed on 7 February 2008. Mr Rietveld reported on 4 March 2008 that the facet joint block at L2/3 gave the appellant a marked improvement of his symptoms "but he still had problems lower down".

[31] Mr Rietveld therefore referred the appellant to pain specialist, Dr John Macvicar, to see if he was a suitable candidate for a rhizotomy of the facet joints at his L2/3 and L4/5 levels.

[32] Dr Macvicar wrote a detailed Assessment Report and Treatment Plan on 19 May 2008. He felt that a rhizotomy was not indicated and made the following statement which touched on the cause of the appellant's symptoms:

> Mr McSherry's persisting symptoms are directed linked to the 1999 injury.

[33] An Initial Medical Assessment report by Dr Murray Smith dated 11 February 2009 described the appellant as having had continual problems with his back since his accident in 1999. He said that the appellant:

> …. has had continual problems with his back since the accident. At times, perhaps once to twice a year he will feel that his back "clicks out". He will have severe pain for 2 to 3 days at a time. He has bed rest at these times and the back will generally settle down.

[34] The appellant lodged a claim for entitlements, and this was referred to Dr Obele, Branch Medical Advisor, for comment. She reported on 6 March 2009. She noted that there was confusion about which claim the medical certificate related to, the 1999 claim or the 2001 claim and she commented on both:

> The appellant has back pain and consistently normal examination findings with no evidence of bony injury or any neural compromise.
>
> Investigations of x-ray and MRI show degenerative changes, namely osteophytes, disc desiccation and annular disc tear.

[35] She then referred to research that had led to a dramatic shift in the understanding of disc degeneration and its aetiology, mentioning that heredity has the dominant role in disc degeneration.

[36] She continued:

> It is plausible that Mr McSherry sustained lumbar sprains in both 1999 and 2001 injuries. These usually resolve in 6 to 8 weeks with no long term consequences. Current best practice is to mobilise early, and indeed most people with such injuries continue to work at least light duties. This applicant's ongoing pain and incapacity is due to underlying age related degenerative factors. His individual risk factors, rather than his past lumbar sprains, would have been the predominant contributor to his current incapacity. His injuries and activities may have aggravated, but did not cause or contribute to the cause of the underlying degenerative medical process.
>
> With respect to his chronic back pain, arbitrarily described as back pain persisting for more than three months, "there is considerable consensus that

> psychosocial factors are of considerable importance in the transition from acute to chronic problems, and that these variables are probably more strongly related than physical, ergonomic or medical variables. (Waddell 2000).

[37] Dr Obele suggested that Mr Rietveld be approached for comment.

[38] Mr Rietveld responded on 26 April 2009. He stated the appellant had had back pain ever since his accident event and based on the appellant's history he believed that the cause of his symptoms was accident related. Mr Rietveld referred to the injuries of 1999 and 2001. He noted that prior to that time the appellant had no back pain at all.

[39] On 28 July 2009, the appellant underwent a medical assessment with Dr Wright GP, who wrote, in part:

> **Discogram and CT discogram 28.1.08**
>
> L2/3 disc there is extensive disruption of the annulus anterior and extending to the right. There are significant osteophytes demonstrated anteriorly and there is minor disc bulge into the L2/3 intervertebral foramen on the right as a result of a further posterior lateral radial annular tear. Injection of contrast caused pain at 3/10 concordant with his usual pain. This is consistent with his main level of pain and radiation of pain to the ilioinguinal areas on both sides.
>
> …
>
> L4/5 disc. Right sided posterior lateral radial annulus tear. Disc bulge narrowing at the right L4/5 intervertebral foramen and contacting the exit L4 nerve root. This is likely to be the cause of his intermittent pain radiating further down the legs towards the ankles …
>
> …
>
> I believe the diagnosis above is confirmed due to the MRI scan findings being consistent with the findings of Dr Macvicar, Mr Rietveld and Mr Penny …
>
> …
>
> I do not believe there are any non injury related factors wholly or substantially contributing to his current incapacity … although there are degenerative changes in both the shoulder and lower back, there are also changes that are consistent with trauma as being the precipitating cause and continuing cause of his current condition. …

[40] The appellant underwent an impairment assessment with Dr Bell on 22 February 2010, who noted:

> Mr McSherry presents a non specific mechanical low back pain. The source of symptoms has not been established to date. He describes mechanical symptoms along with some lower limb radiation of pain on an intermittent basis.
>
> Examination findings at the time of this assessment, as well as by a number of assessors over the years, has failed to document objective evidence of radiculopathy lower limb symptoms are therefore best considered as non verifiable radicular complaints.

[41] Dr Bell assessed the appellant's whole person impairment due to his covered back injury as 5%.

[42] The appellant sent an email to Dr Bell on 23 March 2010, setting out his experience with radiculopathy following the 1999 accident. He wrote in part:

> ACC specialist Dr Wright had ample explanation of my radiculopathy on pages 3, 5, 26, 31, 32, 33, 73 of our transcript 21 September 2009. One of the most disturbing visits during months of suffering was to a back specialist in Beckenham who refused to treat me on arrival because ACC's paperwork was too much for such an old injury. There are probably more appointments that are forgotten but generally I have had little real relief and don't always seek treatment but sometimes it's so bad I'm willing to try anything or anyone new. I can however unquestionably remember many months of lower abdominal/rib and leg nerve pain consistently associated with my heavy work …

[43] Dr Bell responded by email on 31 March 2010 saying, amongst other things:

> I have read Mr McSherry's detailed and thoughtful email regarding the issue of radiculopathy.
>
> For the purposes of determining impairment, radiculopathy as defined in the AMA guidelines must be present at the time of assessment. Essentially, this required the presence of certain objectively verifiable clinical criteria such as weakness confined to a particular myotome, or absence of relevant deep tendon reflexes. If such criteria are not met, then according to the AMA guidelines, radiculopathy does not exist.
>
> This is the case with Mr McSherry. While he has symptoms that meet criteria for non verifiable radicular complaints, his symptoms and signs do not meet AMA criteria for radiculopathy, so WPI must be 5%.
>
> An MRI scan was done on 7 January 2013 and this showed that at the L3/L4 there was a shallow left extra foramen disc protrusion with associated annular fissure. At L4/5 there was a shallow right foraminal disc protrusion with associated annular fissure. At L5/S1 shallow central disc protrusion was associated with annular fissure. There was no neural compromise on all three levels that have been reported. In the comments the radiologist mentioned multi level shallow disc protrusion in the lower lumbar spine without evidence of neural compromise.

[44] On 4 February 2013, Mr Rietveld requested that the appellant be referred for review to the Burwood Pain Clinic. He said that a recent MRI showed multi-levels discogenic changes in the lower back and that higher up he had anterior partial fusions. He said the appellant had severe pains and spasms but these did not go down his leg as much.

[45] On 17 August 2017, Dr Burt, Medical Advisor, provided comment:

> The clinical information from the start of the accident in 1999 indicates that the appellant recovered from this injury in late 1999. It is further noted that the applicant was assessed by the musculoskeletal doctor in July 1999 and symptoms had resolved. There do not appear to be notes available between 2000 and 2007.
>
> The applicant was seen by Mr Rietveld an orthopaedic surgeon in 2007 who described the applicant having ongoing symptoms since the accident in 1999. The applicant was subsequently assessed by the musculoskeletal physician Dr Macvicar in 2008. None of these assessment really discuss the pathologies responsible for the applicant's clinical presentation except the AMA impairment assessment by the musculoskeletal specialist Dr Bell in 2010. He states that the cause of the applicant's mechanical back pain has not been determined. It is difficult to get a clear understanding of the applicant's current back symptoms, and then to determine whether or not they are due directly to a physical injury caused by the accident of 1999. In addition to this it is difficult to comment on incapacity since this accident where there are no incapacity medical certificates or clinical notes supporting this.
>
> I recommend given the limited information that is available that an MCR be considered, ideally with Dr Bell as he has seen the applicant previously.

[46] ACC arranged for the appellant to undergo an independent medical assessment with pain and musculoskeletal specialist Dr Gajendra Singh. Dr Singh reported on 15 November 2017, and stated in part:

> … initially injury has been recorded as lifting a heavy steel door to a truck on 23/4/1999 which got worse with bending at work on 28/4/1999, consideration of mechanical lower back pain. In July 1999, increased back pain with working in a narrow tunnel. Subsequently, a few more episodes of flareup sudden onset of right sided back pain, after chopping wood (June 2000), with sweeping path (20/11/2001). Record of epigastric pain and investigation for indigestion since October 2000. Multiple times it has been documented in various health care providers' reports recurrent back pain since initial injury …
>
> … Steve has a quite complex problem and situation. He had an initial injury in 1999 and further episodes of reinjury to his back. The MRI scans were done in 2007 and 2013 which confirm multiple disc abnormalities at lumbar spine. As part of diagnosis is based on the MRI scan, therefore the scan report is part of diagnosis for precise level of disc and facet joint abnormalities. Multiple facet

> joint strain and possibly referred somatic pain into his lower limbs. He has suffered with chronic pain and has an element of central sensitisation.
>
> …
>
> At this moment it is not possible to say in isolation that the current incapacity is the result of the injury in 1999. First MRI scan report available is from 2007, which has confirmed the disc abnormalities. In absence of any MRI scan immediately after initial injury in 1999 we cannot compare what was initial injury event and what is the consequence of injury plus age related factors til 2007 when he had his first scan. It is quite a complex situation and the current condition has been compounded with other factors, some of them evolved from the original injury – chronic pain, central sensitisation and facet joint strain. …
>
> He has been investigated in quite detail in the past, in 2007 and 2008 and also in 2013 by various specialists and it has been documented that Steve's persisting symptoms are directly linked to the 1999 injury. It is difficult to deny the original injury when it has been documented and treated in the past.
>
> The only dilemma comes when the initial diagnosis was based on x-rays and clinical findings and has not been updated in ACC records after the MRI scan. Injury to the discs causes irreversible changes; therefore there can be further consequence in terms of progression to the next stage. There is a natural recovery with body healing power but also dynamic changes in the original injury with time. One of them is the abnormal loading onto the corresponding facet joints which can become symptomatic as a consequence. There is difficulty to isolate the degenerative findings related to injury or normal aging process, radiologically. You may wish to confirm with radiologist if they can identify the MRI findings are related to injury, as part of the diagnosis is based on the MRI report. However, multiple levels of disc and facet joint abnormalities on scans are more indicative of degenerative process, as it is less likely that one injury episode in 1999 can effect so many spinal segments with the type of injury Steve sustained. …
>
> His symptoms have been variable in terms of severity but that does not mean he was asymptomatic or recovered when he did not report or continue working.

[47] After considering the report from Dr Singh, on 15 December 2017, Dr Burt commented:

> Thank you for the medical case review by the musculoskeletal pain specialist Dr Singh. He considers, taking into account all the information available that the current and ongoing incapacity is due to the effects of the accident of 1999. Given this report and the rationale provided by Dr Singh I support this opinion.

[48] Dr Burt, asked to look at the matter again, gave a more comprehensive report on 9 February 2018, concluding that orthopaedic advice was required.

[49] Mr Ray Fong, Orthopaedic Surgeon and a member of the clinical advisory panel (the Panel), commented on 6 March 2018:

What was the injury sustained on 23 April 1999? Please explain your answer.

The condition in 1999 was lumbar sprain. At that time the history was of lifting a heavy steel door and sprained lumbar spine. The applicant presented to the GP with ongoing pain.

Examination of 14/07/1999:

Signs of dysfunction on mixed type of low back pain. Segmental examination reveals restriction of rotation in L1/2 on the right, T11/12 left, T1/8 right. This points to one point of triggering in the pelvis on the right side. Very tense paraspinal muscles. No abnormal neurology in the legs.

In other words the applicant is suffering from a mechanical type of back pain with the history of a lumbar sprain. There was no obvious neurological abnormality. No investigation was performed (no radiological reports of 1999 provided).

What was the current diagnosis? Is this directly or consequentially linked to any ACC covered claims? Please explain your answer.

Clinical details as per ARTP by Mr John Rietveld dated 10/12/2007 re-describe the injury of his back dating back many years with low back pain radiating into legs. Examination shows tenderness on right hand side of facet of L1/2. Neurological examination is entirely normal.

X-ray shows L1/2 and L2/3 down in height with anterior spurring, indicating degenerative L1/2 and L2/3 discs.

Formal x-ray reports of 11/12/2007:

Prominent bony osteophyte at T11/12, L1/2. Narrowing of L2/3, L4/5, indicating multilevel degenerative disc disease.

MRI of 20/12/2007:

Loss of disc signal at L2/3 and disc desiccation at L4/5. At T11/12, L1/2, L2/3 anterior disc bulges, anterior end plate osteophytes, no neural compromise. L4/5 annular disc bulge, end plate osteophyte, annulus tear.

Throughout the remainder of the lumbar spine no focal disc protrusion, no neural compromise. So this again represents a multilevel degenerative disease of the lumbar spine.

The applicant was recently examined by Dr Gajendra Singh on 15/11/2017. Dr Singh's conclusion was that he has mechanical low back pain. He has been examined and found to have no abnormal neurological involvement at that stage. No investigation was performed until 2007 at which stage he was found to have multilevel degenerative conditions of the thoracolumbar and lumbar spine.

With the information available, I am unable to establish a clear direct causal link of the present condition to the claimed personal injury by accident in 1999.

> MCR report recommends a radiological MCR, can CAP confirm whether this would be beneficial? Note that the investigation including x-ray, MRI, and CT were done in 2007/2008, eight years post claimed injury. At that stage there was established multilevel degenerative condition of the lumbar spine.
>
> I cannot see how an MCR on radiology is going to shed further light on causation.
>
> In summary, I agree with Dr Singh's conclusion that "it is not possible with the limited information provided to say in isolation that he recurring (sic) incapacity is a result of the injury of 1999".

[50] Mr Fong has misquoted, or perhaps intended to paraphrase, Dr Singh who actually said:

> At this moment it is not possible to say in isolation that the current incapacity is a result of the injury in 1999.

[51] Mr Fong wrote a further comment dated 9 May 2018 and stated:

> This "a functional element of myofascial pain, central sensation and chronic pain" refers to the symptoms of his back, there is no evidence that these symptoms are causally related to the PIBA (Personal Injury By Accident) of 23/4/1999 or any other covered claim.
>
> As I said in my previous comment dated 06/03/2018, the physical injury as demonstrated in the ARTP of 2007, examination shows pain on the facet of L1/2, no neurological deficit.
>
> X-ray shows multilevel degenerative disease of the lumbar spine involving the T11/12, L1/2, L2/3, and L4/5.
>
> MRI scan of 2007 shows degenerative disc disease at T11, T12, L1, L2, L3, L4, L5 with degenerative disc bulge and end plate osteophytes and annulus tears, fissures. All of these are part and parcel of the degenerative problem of the lumbar spine.
>
> This degenerative disc disease of the lumbar spine is highly prevalent in the asymptomatic population as part of the degenerative problem of the lumbar spine.
>
> As I have previously commented, in the absence of contemporaneous clinical records it is not possible to draw a direct causal link of the lumbar spinal condition to the claimed personal injury by accident of 24/04/1999.

[52] The appellant then saw Mr Rietveld on 25 February 2019, who referred him for an MRI scan which took place on 7 March 2019. The scan showed no evidence of neural compromise but moderate facet arthropathy with small effusion/synovitis L3/4 and L4/5:

L1/2: no disc prolapse, nor any canal or foraminal stenosis.

L2/3: mild disc bulging and facet arthropathy. Prominent disc osteophyte change anterolaterally on the left. No spinal canal stenosis or foraminal stenosis.

L3/4: minor disc bulging. No neural compromise. Moderate facet arthropathy with small effusion/synovitis.

L4/5: minor disc bulging. No neural compromise. Moderate facet arthropathy with small effusion synovitis.

L5/S1: minimal disc bulging. No neural compromise.

[53] On 22 March 2019, Mr Rietveld noted:

> He is still sore in his back. His MRI shows an effusion at 3/4 and 4/5 facets. Most of his pain is towards the left side. I've arranged for a cortisone injection into these. If this doesn't last then a radio frequency ablation could be looked at for him.

[54] The appellant underwent a CT guided lumbar facet joint injection on 5 April 2019 funded by ACC.

[55] Mr Rietveld reported on 16 May 2019 and stated:

> He had quite an improvement with the local anaesthetic in the facets, so I've asked for radiology to see if they can do a facet ablation or radio frequency ablation for him to get a longer lasting result.

[56] Following the Review Decision of 5 September 2019, ACC sought a further report from Mr Finnis, Neurosurgeon "with regards to the most likely cause of the appellant's pathology". Mr Finnis saw the appellant on 4 February 2020.

[57] In his report Mr Finnis notes that the appellant attributes the onset of his problems to the 1999 injury. Under the heading Specific Diagnosis, Mr Finnis says:

> Steven has had problems with back pain which is felt in the upper lumbar region and also to the right side. The underlying nature of this has been subject to evaluation and is not entirely clear. From the history it would appear that he had a primary injury, given the development of symptoms that have been sustained subsequent to this.
>
> The imaging tends to show changes which have developed around the L1/2 and L2/3 discs. This shows some anterior herniation here. More recently there have been significant changes in the signal at the L1/2disc. He may well have had the fall with the twisting injury and the twisting of the back may well have

> caused a primary disc injury. We do see the structural changes of this. This would correlate with the upper lumbar level symptoms with some radiation into the groins and legs.

[58] ACC posed further questions to Mr Finnis who reported again on 6 May 2020.

[59] In answer to the question: "Is it possible using all available evidence to state an opinion on what injury the accident of 12 April 1999 caused, or not?", Mr Finnis said:

> Mr McSherry has stated the injury involved lifting and placing a heavy steel door on its track. This involved obviously a lot of axial loading as well as twisting. It is this mechanism which is specifically well associated with disc injury. Although more commonly related to injury in the lower lumbar region as this takes more loading than the upper, it is however still possible to have injury to the upper lumbar spine.

[60] Regarding causation, Mr Finnis said:

> To determine the causation one has to extrapolate what might be possible or indeed probable from the history and subsequent changes on the MRI and other imaging. Considering a heavy lifting and twisting event which was the mechanism of injury back in 1999 it is possible that he could have disrupted the discs significantly to cause a primary disc injury. If indeed this was in the upper lumbar or lower thoracic area then one could correlate this to the L1/2 and L2/3 discs. We subsequently see changes within the L2/3 disc which could represent a primary injury here and is particularly represented by the discogram in 2008 which is clearly showing a complete disrupted disc.

[61] ACC then obtained a further opinion from Dr Rutherford, Principal Clinical Advisor - Orthopedic Surgery. He said:

> I have reviewed the report of Mr Finnis including his conclusions.
>
> I accept that it is most likely that the client's symptoms are coming from the L2/3 disc region on the basis of the increased bone turn over seen at this level on the CT PET scan.
>
> It does not follow, however, that there is necessarily a traumatic cause for the pain now at the L2/3 level; indeed, the imaging would suggest that this is not the case. There has been evidence of fusion of the spine secondary to DISH at the levels above and longstanding degenerative changes at the L2/3 level, which are not traumatic in nature.
>
> A mobile segment adjacent to a fused segment is subject to increased stress and may degenerate as a result. It is more likely the increased uptake at the L2/3 level is a result of the degeneration at this level and associated stresses rather than secondary to trauma

Appellant's submissions

[62] Referring to the 1999 injury, the appellant says that the doctor's records show that 11 weeks after the injury of 23 April 1999 it was clear that there was still something wrong. He says he has no confidence in Dr Obele's opinion and that she did not have all the evidence.

[63] Regarding Dr Wright's assessment, he says he agreed to undertake the assessment with the express conditions of obtaining:

> An informed cover decision and
>
> To confirm appropriate rehabilitation and ongoing responsibility.

[64] He noted that Dr Wright did not believe that there were any non-injury related factors wholly or substantially contributing to his then current incapacity and that Dr Wright said:

> Although there are degenerative changes in both the shoulder and lower back, there are also changes that are consistent with trauma as being the precipitating cause and continuing cause of his current restriction.

[65] He refers to the other medical assessments that were relied on in Dr Wright's report.

[66] He refers to the retraining that he had to do for the purpose of achieving vocational independence.

[67] He refers to two illegal spying investigations on him during his case management and mentions "ACC's disgusting deceitful case management".

[68] Nevertheless, he says he worked exceptionally hard with retraining and was found vocationally independent; and additionally, he was found vocationally independent in his old work.

[69] He says:

> We should never redo this 2009 assessment in 2020, the accepted level of radiology assessment has changed which makes it impossible to make an objective analysis of what was acceptable in 2009.

[70] He refers to *Martin v Accident Compensation Corporation*, relating to what is required when assessing vocational independence.[1]

[71] He submits that before dismissing the assessment of Dr Wright, ACC would have to do more than have a new medical opinion some ten years later.

[72] He noted that three months after the 1999 accident he returned to his employment to do different work, not because he had recovered.

[73] He emphasises that multilevel degeneration in the back does not mean there was no injury cause.

[74] He submits that prior to the 1999 injury he was very active, fit and healthy.

[75] He refers to the mechanism of the 1999 injury and the fact that the door fell on him with "huge force".

[76] He also says he believed that the front of his spinal discs became deformed through being crouched in the steam tunnel immediately before he tried to support the steel door.

[77] The appellant is critical that Dr Franzmayr was a back surgeon from Germany and not New Zealand and that he had suggested he go home and have a hot bath. He says he remained in pain and greatly incapacitated in his work.

[78] He submits that the cover decision of ACC was wrong and that ACC now has the onus of establishing that it was correct. He refers to *Ellwood v Accident*

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[1] *Martin v Accident Compensation Corporation* [2009] 3 NZLR 701 (HC).

Compensation Corporation case in this regard.[2] He submits that ACC never had sufficient evidence to say that he was not entitled to cover.

[79] He says that people who did not meet him assumed they have all the evidence when they did not.

The Respondent's Submissions

[80] Mr Hunt deals first with the decision of the Corporation of 21 August 2019, namely whether there is deemed cover for disc herniation.

[81] Mr Hunt refers to Dr Wright's medical assessment of 28 July 2009. He notes that Dr Wright concludes that there are degenerative changes in the thoracolumbar junction; that there is disc herniation; and that there is an annular disc tear at the L4/5 levels. He says:

> These changes have been confirmed by the MRI scans and disc investigations.

[82] Mr Hunt notes however, that Dr Wright did not address causation.

[83] As to the issue of deemed cover which the appellant seeks in this case, Mr Hunt refers to the High Court decision in *Sinclair v Accident Compensation Corporation* where Dobson J says:[3]

> [42] … Claims lodged with the Corporation must specify which of the options in s 48 are claimed, and must conform with the manner specified by the Corporation for the lodging of claims under s 52 of the Act. However, the Corporation must not unreasonably refuse to process a claim for want of form, provided that the claimant specifies the nature and essential features of the claim so that they can be reliably discerned, notwithstanding that a claim is lodged other than in a manner specified by the Corporation.

[84] Mr Hunt says the issue here is markedly narrower than what the appellant has argued, namely it is whether there is deemed cover for disc herniation from 2009.

[85] He notes that this deemed cover was raised for the first time in August 2019.

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2 *Ellwood v Accident Compensation Corporation* [2007] NZAR 205 (HC).
3 *Sinclair v Accident Compensation Corporation* [2012] NZHC 406, [2012] NZAR 313 at [42].

[86] He says there was never a claim made with ACC for disc herniation. He submits that neither is it implicit or explicit that there was a claim for such cover.

[87] He submits that Dr Wright's report was not directed to the issue of cover, it was to inform ACC as to entitlements, whether by way of treatment, compensation or rehabilitation.

[88] He submits that ACC has the obligation to rehabilitate a person who has cover, as best as possible.

[89] In order to do this, there needs to be a diagnosis and there needs to be, in cases like this, an enquiry as to the mechanism of injury.

[90] He submits therefore that in this case there was no reason for ACC to give disc herniation cover because it was not asked to.

[91] Mr Hunt then addresses the issue on appeal, 167/19, namely the Corporation's decision of 19 February 2019, that there was insufficient evidence to show injury caused by the accident on 24 April 1999.

[92] Mr Hunt referred to the injuries of 12 October 1995 and 23 April 1999 as described in the background section of this judgment.

[93] He refers to the x-rays of 2 July 1999 showing marginal osteophytic lipping in the lower thoracic and upper lumbar disc spaces indicating a little spondylitic change. His GP indicated that L1/2 was involved.

[94] He submits that the evidence of the appellant and other sources show that he has continued to have back pain since that event, albeit with different levels of intensity. He notes that the appellant felt it was pointless going back to his GPs as they could not offer him a diagnosis or treatment that made a difference and that he had to work to make a living. He acknowledges that the appellant has been found to be a reliable and truthful witness by the District Court, and the Court accepted it is

not disputed that the 1999 back injury has caused him to be incapacitated at various times – see *McSherry v Accident Compensation Corporation.*[4]

[95] Mr Hunt notes that the appellant saw his GP after the 2001 accident event. It was noted that he has severe pain, that he felt something snap, but that there was no sciatica or paraesthesia. The diagnosis was one of non-specific back pain. A claim was lodged for "twisting back sweeping floor" and cover was afforded for a lumber sprain.

[96] He also notes that the appellant has cover for pain in the lumbar spine after a weightlifting accident in 2005.

[97] As to the pathology that is causing the pain, Mr Hunt says that after the 1999 accident the initial theme of the medical evidence was that the pain came mainly from the appellant's L1/2 facet joints, and he refers to the notes by Mr Rietveld of 10 December 2007.

[98] He submits that the radiological and medical evidence shows that there was spondylosis at that level which indicated it was likely due to pre-existing degenerative changes.

[99] He says the focus later shifted to the L2/3 and the L4/5 levels as is evident from the report of Dr Wright dated 28 July 2009. He next refers to the orthopaedic comment from Mr Fong, that changes at these levels were degenerative and not caused by any accident event.

[100] Mr Hunt submits that as time wore on the changes to the appellant's lumbar spine became more widespread but without intervening accident events to account for it.

[101] Mr Hunt submits that there is no medical evidence to show that the appellant suffered a disc herniation caused by the 1999 accident event. He submits the

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4 *McSherry v Accident Compensation Corporation* [2010] NZACC 96.

evidence shows that the 1999 accident likely caused the pre-existing changes at L1/2 to become symptomatic.

[102] He notes that since the review decision in this case on 11 July 2019 there has been a report from Mr Finnis dated 6 May 2020. Dr Finnis' report was subsequently referred to Dr Rutherford who reported on 3 July 2020.

[103] He submits that Dr Rutherford's report is comprehensive in that it begins by analysing an injury said to have occurred on 25 November 1993, that being a karate injury. Dr Rutherford analyses the event of 12 April 1999.

[104] He notes that Dr Rutherford concludes that most of the appellant's symptoms were coming from the L2/3 disc region. He notes that Dr Rutherford did not consider that it necessarily followed there was a traumatic cause for the pain reported by the appellant at that level and that imaging results suggested otherwise.

[105] Mr Hunt submits that the evidence, including that of Dr Rutherford, is cogent and compelling and that the respondent's decision of 19 February 2019 is correct.

Decision

[106] The injuries, giving rise to the two appeals that the appellant has brought, date from 1993 and onwards, including accidents on 10 October 1995 and 23April 1999. There is also consideration of accidents on 30 November 2001 and 8 August 2005.

[107] Naturally, medical assessments made immediately following the injury play an important part in all later assessments.

[108] The earliest report is GP notes of 23 October 1995, reporting "back strain at work laying fibreoptic cable". The doctor noted on that occasion "good flexion no tenderness".

[109] The doctor's recommendation was physiotherapy. He was certified unable to work for a few days. A later report the same month noted that rest had been most beneficial.

[110] Next there is the accident on 23 April 1999.

[111] It would appear that he first saw his GP five days later on 28 April 1999. The description recorded is:

> Hurt lower back lifting at work 23/4/99. Ok over W/E – worse at work again yesterday when bending.
>
> 0 radiation
>
> 0 paraesthesia
>
> 0 tenderness.
>
> Good flexion

[112] In his report of 3 July 2020, Dr Rutherford, Orthopaedic Surgery Principle Clinical Advisor, describes the mechanism of injury from the appellant's statutory declaration dated 1 July 1999:

> That he was lifting a steel door approximately 3.5 metres by 3 metres weighing about 50 kg into a stop track, although he had two helpers the task was very awkward and he strained his back trying to stabilise the weight of the door that was over his head. He was standing at the edge of the door pushing it into its roller tracks and trying to align the rollers at the same time holding the weight of the door off the ground.

[113] On 28 April 1999, the appellant was referred for physiotherapy and given Voltaren.

[114] The appellant next consulted his GP on 21 June 1999, and the doctor recorded: "Exacerbation of LBP (lower back pain) when returned to work bending in tunnels (engineer)."

[115] The doctor noted: "0 neurology and on examination good flexion and 0 tenderness."

[116] As with the consultation on 28 April 1999, the diagnosis was mechanical lower back pain. On this occasion, the appellant was referred to a chiropractor.

[117] He visited his GP again on 2 July 1999 for the same issue. The doctor noted the pain was improving at rest and that it was worse with bending. He was referred for an x-ray. This occurred the same day and the report said:

> There is marginal osteophytic lipping in the lower thoracic and upper lumbar disc spaces indicating a little spondylitic change. There is no focal bone lesion. The spine tilts a little to the left. The sacroiliac joints are normal. No focal bone lesion.

[118] He saw his GP again on 9 July 1999. The doctor noted "interfering in work", and he referred the appellant to Dr Franzmayr.

[119] He was seen by Dr Franzmayr on 14 July 1999. Dr Franzmayr noted that he had signs of dysfunction of a mixed type for the lower back and:

> Segmental examination reveals restriction in rotation at L1/2 on the right, T11/12 left and T7/8 right. He has one trigger point in the pelvis on the right. He has very tense paravertebral muscles.

[120] Dr Franzmayr then said under the heading "therapy": "I carried out mobilisation and the signs of dysfunction were no longer present. I will review him in a week."

[121] What is notable is that, in respect of this injury, the appellant saw his GP four times between April and July 1999 and regards this injury as being the onset of his back problems. It is noted also that Dr Franzmayr found "restriction in rotation at L1/2", the area that Mr Finnis, in 2020, opines could be the site of the primary injury.

[122] The next entry of relevance is that of his GP of 30 November 2001, some two years and four months later.

[123] His GP noted: "sudden onset R side of back when sweeping path – pulled brush towards him and felt something snap, pain ++".

[124] The doctor noted: "0 sciatica. 0 paraesthesia … tender to L upper paravertebral area – L1/2." He was referred to physiotherapy and prescribed Voltaren.

[125] The next consultation was on 3 December 2001. Although the doctor notes "back much better", he was referred to Lindsay Jago for physiotherapy. Mr Jago reported on 8 January 2002:

> I saw Steven three times. I gave him some stabilising type exercises which I think he understood but I am unsure if he's continuing with this approach as he failed to keep his next appointment.

[126] The next record is a consultation with a GP on 9 October 2007. The appellant reported recurrent lower back pain since "initial injury in 2001." and was referred to Dr Rietveld.

[127] On 20 December 2007, an MRI scan was undertaken. The findings were as follow:

> The distal thoracic spinal cord and conus appear normal in signal and morphology. There is straightening of the normal lumbar lordosis. There is normal bone marrow signal throughout the lumbar spine. There is slight loss of T2 signal within the L2/3 intervertebral disc and mild dislocation of the L4/5 intervertebral disc.
>
> At the T11/12 – L1-2 and L2-3 levels there is anterior annulus disc bulge with end plate osteophyte but no focal disc protrusion or evidence of neural compromise.
>
> At the L4/5 level there is annulus disc bulge with end plate osteophytes. There is a right foraminal annulus tear. No focal disc protrusion or evidence of neural compromise is seen. Throughout the remainder of the lumbar spine, no focal disc protrusion or evidence of neural compromise is seen.
>
> **Comment:**
>
> 1. L1/2 and L2/3 anterior annular disc bulge without evidence of neural compromise.
>
> 2. Right foraminal L4/5 annulus tear.

[128] Dr Wright, GP, examined the appellant and his medical records. In his report of 28 July 2009, he said:

> I do not believe there are any non injury related factors wholly or substantially contributing to his present incapacity in relation to his previous employment in heavy engineering. Although there are degenerative changes in both the shoulders and lower back, there are also changes that are consistent with trauma as being the precipitating cause and continuing cause of his current restriction.
>
> Until he has resolved his issues with ACC, my impression is that he will not be able to focus on moving on in terms of his rehabilitation. Once this is resolved he indicated he would have no problem in finding suitable work as he has always been very adaptable in terms of what he could do.

[129] There then followed an impairment assessment from Dr Bell dated 22 February 2010.

[130] He was assessed again by Dr Singh, Musculoskeletal and Pain Specialist, in 2017. This was by way of medical case review commissioned by ACC. The report is dated 15 November 2017.

[131] In answer to the question "Is there a causal link between current incapacity and the event on 24/4/1999 …?", Dr Singh said:

> At this moment it is not possible to say in isolation that the current incapacity is a result of the injury in 1999 … in the absence of any MRI scan immediate after the initial injury in 1999 we cannot compare what was the initial injury event and what was the consequence of injury plus age related factors til 2007 when he had his first scan. … there is difficulty to isolate the degenerative findings related to injury or normal aging process radiologically. You may wish to confirm with radiologist if they can identify the MRI findings are related to injury, as part of the diagnosis is based on the MRI report. However multiple levels of disc and facet joint abnormalities on scans are more indicative of degenerative process as it is less likely that one injury episode in 1999 can affect so many spinal segments and the type of injury Steve sustained.

[132] After the review hearing of July 2019, on referral from his GP, the appellant was examined by Mr Finnis, Neurosurgeon, who reported on 6 May 2020.

[133] Mr Finnis was asked the question "Is it possible using all available evidence to state an opinion on what injury the accident of 12 April 1999 caused or not?". Mr Finnis said:

> Mr McSherry has stated the injury involved lifting and placing a heavy steel door on its track. This involved obviously a lot of axial loading as well as twisting. It is this mechanism which is specifically associated with disc injury. Although more commonly related to injury in the lower lumbar region as this takes more loading than the upper, it is however still possible to have an injury to the upper lumbar spine.
>
> I note there is some comment by Dr Clemens Franzmayr on 4 July 1999 of a whole lot of back pain in the right lower lumbar and pelvic region. This is slightly different to the middle, upper lumbar area where he is complaining of currently and what he associated with the onset of injury and therefore I am unable to interpret Dr Franzmayr's comment here further.

[134] In answer to the question "What if any of the conditions shown by the radiological series mentioned above, are caused by any accident or event?", Mr Finnis said:

> The CT PET scan has not directly demonstrated any injuring event. What it has shown, is from the CT scan component, osteophyte development and anterior longitudinal ligament ossification which has secured the diagnosis of diffuse idiopathic skeletal hyperostosis for the latter. The PET scan component has also been helpful in localising more the origin of the pain that he is getting in his upper lumbar region and it is very likely from the L2/3 level. At the test itself it has therefore not shown any injury related factor but has demonstrated where the pain source may be coming from.

[135] Regarding causation, Mr Finnis said:

> To determine the causation one has to extrapolate what might be possible or indeed probable from the history and subsequent changes on the MRI and other imaging. Considering a heavy lifting and twisting event which was the mechanism of injury back in 1999 it is possible that he could have disrupted the discs significantly to cause a primary disc injury. If indeed this was in the upper lumbar or lower thoracic area then one could correlate this to the L1/2 and L2/3 discs. We subsequently see changes within the L2/3 disc which could represent a primary injury here and is particularly represented by the discogram in 2008 which is clearly showing a complete disrupted disc.

[136] ACC then obtained clinical comment dated 3 July 2020 from Dr Rutherford, ACC's orthopaedic surgery principle clinical advisor.

[137] Dr Rutherford said:

> It is not possible to state an opinion on what injury the accident of (23/04/99) caused as there is no available imaging that would allow an anatomical diagnosis to be made.

[138] Concerning the MRI scan of 7 March 2019, Dr Rutherford said:

> The MRI scan of 7/03/2019 showed no abnormality at L1/2, at L2/3 there is mild disc bulging and facet arthropathy, along with prominent disc osteophyte changes anterolaterally on the left. There was no spinal canal stenosis or foraminal stenosis. L3/4 reports minor disc bulging and moderate facet arthropathy with small effusion and synovitis. At L4/5 there is minor disc bulging, again moderate facet arthropathy with small effusion and synovitis. At L5/S1 there is minimal disc bulging.
>
> The conditions shown by the MRI are those of degenerative changes within the facet joints along with minor disc bulging. An age related change in the lumbar spine is for discs to lose fluid volume or to become dislocated over time. This results in loss of disc height and bulging of the disc. This in turn would put

> abnormal pressures on the facet joints which become worn with loss of articular cartilage, increased fluid within the joints and causing small effusions and inflammation of the lining or synovitis. Most individuals will have some features of these degenerative changes in the lumbar spine over time and they may not cause symptoms, however degenerative disc disease can cause mild to severe pain, either acute or chronic, near the involved disc as well as neuropathic pain if an adjacent spinal nerve root is involved.

[139] Dr Rutherford went on to say that in his opinion none of the conditions showed by the radiological series from 2007 onwards were caused by any accident event.

[140] Further, he said:

> I accept that it is most likely that the client's symptoms are coming from the L2/3 disc region on the basis of the increased bone turnover seen at this level on the CT PET scan.
>
> It does not follow however that there is necessarily a traumatic cause for the pain now at the L2/3 level; indeed, the imaging would suggest that this is not the case. There has been evidence of fusion of the spine secondary to DISH (Diffuse Idiopathic Skeletal Hyperostosis) at the levels above and long standing degenerative changes at the L2/3 level which are not traumatic in nature.
>
> A mobile segment adjacent to a fused segment is subject to increased stress and may generate (pain) as a result. It is more likely the increased uptake at the L2/3 level is a result of the degeneration at this level and associated stressors rather than secondary to trauma.

[141] The evidence of the clinicians is equivocal in this case, and in a substantial way this derives from the absence of good imaging evidence relating to the appellant's back, particularly following the 1999 accident. However, I accepted the appellant's evidence that his back problems stemmed from that accident, a significant one, which involved a heavy lifting and twisting event. What we then know is that the injury had not settled four months later.

[142] I also note that in 2009, Dr Wright, who provided an assessment for ACC, was of the belief that there were no non-injury related factors "wholly or substantially contributing" to his then incapacity.

[143] Although the opinion of Dr Rutherford is entitled to respect, I am of the view that Mr Finnis' qualifications as a neurosurgeon carry more weight. He acknowledges that the 1999 injury was significant and that it could have disrupted the discs significantly to cause a primary disc injury. He also says:

> We see increased bone turnover at the L2/3 level on the CT/PET scan for which probably correlates well with the pain source. We therefore have the scenario where a primary injury may well have occurred at the upper lumbar discs maybe L1/2 and L2/3 for which have developed secondary changes influenced by the process if DISH.

[144] The history of the injury, and the views of Dr Wright and Mr Finnis in particular, allow me to draw robust inferences of causation in favour of the appellant. Therefore, I find on the balance of probabilities that the appellant's disc herniation was due to his accident of 23 April 1999. Accordingly, appeal ACR 167/19 is allowed, and the Corporation's decision of 2019 is reversed.

[145] As to the issue of deemed cover (appeal ACR 235/19), I respectfully adopt what Justice Dobson said in *Sinclair v ACC*:[5]

> [25] The statutory requirements for initiating a claim specify that it must be lodged with the Corporation, and that it has to constitute a claim either for cover, for cover plus a specific entitlement, or for a specified entitlement subsequent to acceptance of a claim for cover. It ought to be clear, from the terms of what is lodged, which of these alternatives it constitutes. The provisions also define when a claim is lodged and received, provide for the manner in which the claims may be made and the time limits in which they are to be made.
>
> …
>
> [42] … Claims lodged with the Corporation must specify which of the options in s 48 are claimed, and must conform with the manner specified by the Corporation for the lodging of claims under s 52 of the Act. However, the Corporation must not unreasonably refuse to process a claim for want of form, provided that the claimant specifies the nature and essential features of the claim so that they can be reliably discerned, notwithstanding that the claim is lodged other than in the manner specified by the Corporation.

[146] Here, claims to ACC, in respect of the appellant's various back injuries from 1995, 1999 and 2001 on, were lodged and accepted.

[147] Following the accident of 23 April 1999, cover was granted for a lower back strain. Likewise, following the injury of 30 November 2001, cover was again granted for a lumbar sprain.

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5 *Sinclair v Accident Compensation Corporation* [2012] NZHC 406, [2012] NZAR 313.

[148] Entitlements, including weekly compensation, treatments and rehabilitation followed. The focus throughout has been squarely on the appellant's back issues.

[149] Therefore, it is somewhat unreal for the appellant to now claim that he has deemed cover for disc herniation as a result of the 1999 accident or any other covered personal injury. Suffice it to say that in terms of *Sinclair*, the claims lodged in respect of the appellant were specific as to their nature and essential features. At the times they were lodged and afterwards, they have received appropriate attention from ACC. Accordingly, his claim for deemed cover (Appeal ACR 235/19) must be declined, and that appeal is therefore dismissed.

[150] There is no issue as to costs.

Judge C J McGuire
District Court Judge

Solicitors: Young Hunter, Christchurch for the respondent