IN THE DISTRICT COURT
AT AUCKLAND

I TE KŌTI-Ā-ROHE
KI TĀMAKI MAKAURAU

[2021] NZACC 40 **ACR 308/18**

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPEAL UNDER SECTION 151 OF THE ACT
BETWEEN	ALAN O'BRIAN Appellant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Hearing: 24 June 2020
Final submissions were not received until 16 November and 20 November 2020

Appearances: B Hinchcliff for the Appellant
L Hawes-Gandar for the Respondent

Judgment: 25 February 2021

RESERVED JUDGMENT OF JUDGE NICOLA MATHERS

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[1] On 8 December 2017 the Accident Compensation Corporation ("ACC") declined Mr O'Brian's request for elective surgery to his right shoulder and also declined the payment of weekly compensation. Mr O'Brian reviewed those decisions and on 8 October 2018 the Reviewer upheld ACC's decisions. Mr O'Brian now appeals those decisions.

[2] The matter came before me on 24 June 2020. During the hearing a number of issues arose which needed further investigation. The first was in relation to what

documents/reports the Clinical Advisory Panel ("CAP") had before them when they were making their report. The second was what email or letter was Ms Noventa, physiotherapist, referring to in her report of 4 June 2018. Mr Hinchcliff provided the email that he sent to Ms Noventa. Thirdly, the report of Dr Song of 29 April 2018 is to be referred to CAP for their comments and then the comments from CAP are to be referred to Mr Wright, Mr O'Brian's orthopaedic surgeon. I have now received the further CAP report dated 4 August 2020 and Mr Wright's report of 3 October 2020, which I received on 4 November 2020. I held a teleconference with counsel on 6 November 2020 and directed that Mr Hinchcliff file any further submissions in relation to the two new reports by 16 November 2020 with ACC to file any submissions in reply by 23 November.

[3] I indicated to counsel and Mr O'Brian that my decision would necessarily be delayed as a result of the further information that was sought. I have now received the additional report from CAP which inter alia confirms the documentation that was before the panel when making their decision.

Background

[4] Mr O'Brian had two prior shoulder injury claims:

[i] on 8 April 2002 which was diagnosed as "dislocation or subluxation of shoulder – side right"; and

[ii] on 9 January 2006 which was diagnosed as "Sprain, shoulder joint – side right".

[5] On 10 October 2016 Mr O'Brian suffered another injury when he fell into the cockpit of a yacht under repair. He hurt his back, neck and shoulder. An ACC injury claim was filed for a neck and thoracic injury following a visit to a chiropractor. ACC accepted cover for the injury on 4 November 2016. Mr O'Brian then received treatment from his chiropractor. Mr O'Brian saw his GP on 20 May 2017 who made a further claim on 30 May 2017 for a rotor cuff sprain. He was referred for an ultrasound x-ray and to a specialist orthopaedic surgeon. The GP noted that

Mr O'Brian had a complicated right shoulder injury history 15 years ago, which had never healed 100% but which he had adapted around.

[6] Mr O'Brian saw Mr Mutch, orthopaedic specialist, who was of the view that Mr O'Brian had a frozen shoulder. He recommended a cortisone injection and conservative treatment. Mr O'Brian then requested a second opinion from Dr Wright, orthopaedic surgeon. He reported on 13 July that there was a significant reduction of right shoulder movement, flexion and abduction 30 degrees with pain and guarding. He recommended an MRI scan of the shoulder and cervical spine. The x-ray report of the right shoulder of 17 July 2017 showed:

> *Degenerative changes involve the discs between C4 and C7 and changes of osteoarthritis involve at least three of the cervical facet joints, most pronounced at C4-05 on the right. There is some bony encroachment on the foramen for the right C5 nerve. Increased sliding movement was observed on flexion of the neck of the C4-5 level.*

[7] The MRI of the right shoulder of 17 July 2017 showed:

> *Large, complex full-thickness and near full-thickness distal supraspinatus tendon insertional tear.*
>
> *Large suspected full-thickness distal subscapularis tendon tear and partial retraction. Associated marked reduction in subscapularis bulk with fatty, peripheral change.*
>
> *Possible bifid LHB versus longitudinal split tear with distal reconstitution.*

And the MRI of the cervical spine showed:

> *The cervical spine alignment is normal. The cervical discs are generally dehydrated with mild C3-4 and C4-5 and moderate C5-6 and C6-7 disc height loss. The right C4-5 and left C2-3 and C3-4 facet joints have focally severe osteoarthrosis with bony proliferation and spurring. There is no significant bone oedema, no complication of trauma is detected. The cervical cord signal is normal.*
>
> *…*
>
> *Impression: Multilevel cervical disc disease, more pronounced at C5-6 and C6-7. No central canal stenosis. Severe right C4-5 and left C2-3, C3-4 facet arthrosis.*

[8] On 24 July 2017 Mr Wright filed a request for surgery with ACC. The diagnosis was a supraspinatus tendon tear with extension into subscapularis right shoulder. He said the history of the current condition was:

> *Mr O'Brian gives a nine month history of currently more or less constant activity-related severe pain localised to the periachromial region with radiation to the deltoid insertion and distally. He is very uncomfortable at night. He cannot sleep. He is struggling with all daily activities including washing, dressing, reaching, lifting and carrying. He requires assistance for many of these. … Mr O'Brian relates onset of symptoms to an episode 10/10/16 when he fell in the cockpit of a boat, twisting and landing on his hand. … Mr O'Brian does recall an episode about 17 years ago when he similarly fell into a cockpit and his shoulder settled over some weeks or months.*

Mr Wright went on to say that there is a direct causal link between the fall in the cockpit, the supraspinatus tear and the indication for surgery.

[9] On 25 July 2017 Mr Wright administered an ultrasound guided right subacromial bursa steroid injection.

[10] ACC referred the request for an elective surgery medical advisor opinion. Dr Fong gave that opinion on 28 August 2017:

> *The initial clinical record from the treating chiropractor is not available.*
>
> *The client first saw his GP on 30/05/2017 with a complicated long history of shoulder problems.*
>
> *Initial injury 15 years ago, dislocated and nerve damage. Took months to heal, never 100%. Then six months ago, fell. Back pain since then, reduced range of movement. Examination shows reduction of abduction to 90 degrees only. Biceps wasting.*
>
> *X-ray of 09/06/2017: History was chronic right shoulder pain since 15 years ago. Had a fall and developed frozen shoulder. X-ray shows minor bony irregularity at the humeral tuberosity. No other significant abnormality. No recent bony injury.*
>
> *Ultrasound of 09/06/2017 reported: Right shoulder full thickness supraspinatus tear. Thinning of superior portion of subscapularis represents a partial thickness or full thickness tear. No subacromial subdeltoid bursal thickening. Abduction limited to 45 degrees only.*
>
> *MRI of the right shoulder 17/07/2017: Large complex full thickness, full width supraspinatus tear with a 31 mm retraction associated with bony irregularity at the greater tuberosity. Suspected full thickness distal subscapularis tear with wavy retracted fibres. Rotor cuff in*

general demonstrates a marked reduction in bulk of the subscapularis. Surrounding fatty changes and minor reduction in bulk of supraspinatus and infraspinatus. Mild fatty marbling.

This clinical history, examination and imaging findings all indicate a longstanding problem dating back to some 15 years ago.

There was a previous claim of 2002. The accident was: Slipped getting into a boat. Fall on the right arm bending backwards. The diagnosis was (?) dislocation/subluxation of the shoulder.

ACC18 dated 08/04/20092, diagnosis was: (?) partial dislocation, (?) subluxation of the right shoulder. Right shoulder sprain.

The clinical record available was the handwritten radiology report of 08/04/2002. "Posterior right glenohumeral dislocation/Hill-Sachs deformity present in … with previous anterior dislocation …".

The condition requiring treatment is likely to predate the claimed accident of 10/10/2016.

We do not have enough information about the injury of 08/04/2002 for a direct causal link to be established to the 2002 claim.

[11] Dr Wright referred Mr O'Brian to Dr Frith, Auckland Neurophysiology, whose opinion was:

> *The pattern along with the clinical picture is typical for brachial neuritis.*

[12] Then on 5 September 2017 Mr O'Brian was assessed by Dr Nicholson, an occupational medicine specialist, who undertook a medical case review. He said in summary:

> *Alan sustained an injury following a fall on an outstretched right arm in October 2016. He also had thoracic pain and underwent chiropractic treatment plus spinal mobilisation for the first six to eight months. His thoracic pain settled however he has continued to have reduced range of right shoulder movement as well as upper limb pain.*
>
> *Currently, he complains of mainly right hand pain and swelling as well as reduced right shoulder movement. Radiological investigations have indicated rupture of his right supraspinatus and subscapularis tendons. He has been seen by orthopaedic specialist Mr Wright and surgery has been recommended followed by appropriate rehabilitation. Alan has not been able to continue his work as a boat-builder.*

He then responded to the particular questions that had been put to him by ACC as follows:

1. Considering Mr O'Brian's injury and likely functional limitations as well as specific job requirements as a boat-builder, do you consider that Mr O'Brian could work effectively in that role at the following dates:

a. 10 October 2016.

No.

b. 4 January 2017 (date of his last chiropractic treatment).

No.

c. 12 June 2017 (being the date that his ACC18 medical certificate commenced).

No.

d. Any other time in between?

No.

It appears as though Alan sustained rupture of his supraspinatus and subscapularis tendon on 10 October 2016. Initially, he had no pain in this region. He was initially treated with chiropractic treatment mainly to his thoracic spine, but this subsequently settled. He has however continued to have reduced range of movement of his right shoulder as well as initially upper limb pain which is now localised largely to his hand. It is likely that he sustained the tendon ruptures at the time of the accident and this has significantly affected his ability to operate his right shoulder. His work as a boat-builder is physically demanding requiring a range of activities including lifting, repetitive movement, reaching, stretching, and lifting above shoulder height all significantly affected by his injury. It is therefore unlikely that he could have worked as a boat-builder since 10 October 2016.

2. What are your recommendations for treatment of rehabilitation?

At this stage surgical treatment has been advised by orthopaedic specialist Dr M. Wright. This would be appropriate in terms of repairing the supraspinatus and subscapularis tendons. Following this, he will require appropriate rehabilitation including physiotherapy with mobilization and strengthening.

3. What are your expectations for Mr O'Brian's recovery including timeframes for returned work?

Following the surgery, it is anticipated that it could take 6 to 12 months in order for Alan to regain full mobility of his right shoulder as well as appropriate strength in order to return to the tasks required of him as a boat-builder. I note that Alan does work as a self-employed boat-builder on his own, so therefore he would need to make a good recovery with good use of his right shoulder before he could perform the tasks required of him as a self-employed boat-builder. It appears today that Alan is very keen to return to work as a boat-builder as he has been working for 47 years in this field and is very keen to be able to continue

to work. He states that since he has been off work, it is [sic] cost him significant amount of money with loss of income plus overheads and therefore he is highly motivated to return to work as soon as possible.

[13] Dr Paterson reviewed the file, noting that Mr O'Brian had not been fit for work from June 2017 and going on to say:

But it seems to me that this has been caused by the brachial neuritis rather than injury caused by this accident. Brachial neuritis would explain the sudden onset of symptom and loss of function while injury caused by an accident months before would not.

I suggest that you obtain the report(s) from Mr Wright, orthopaedic surgeon, after the NCS became available and refer back. I recommend that you ask Mr Wright to confirm that shoulder surgery is still to go ahead. I suggest that you include a copy of this comment so that Mr Wright can let us know if I have misunderstood anything.

[14] On 22 November 2017 Mr Wright responded saying:

Surgery is still requested even though the situation has been complicated by branchial [sic] neuritis which appears to be settling.

There were questions from Dr Ben Hinchcliff. In reply to those:

1. The fall into the cockpit of the boat may have contributed to the rotator cuff tear. It is unlikely to be the sole cause nearing [sic] in mind there have been previous injuries to the shoulder going back over many years, including a dislocation in 2002.

2. The indication for surgery is the rotator cuff tear.

3. It is hard to state whether the injury "accelerated a degenerative shoulder condition that would have eventually required this type of surgery?" It is because there may have been a pre-existing cuff injury related to the dislocation and clearly there would be age related changes as for any shoulder. The situation is not straightforward because of the history where obstetrician clearly fell into the cockpit of his boat but, at least in retrospect did not develop pain immediately. Further him [sic] imaging suggests that he has chronic changes to his subscapularis (the MR scan showed marked reduction in bulk and fatty change) but relatively little change in bulk and texture of supraspinatus and infraspinatus.

[15] Mr Wright's further report was forwarded to Dr Paterson for comment. She noted that Mr Wright had responded to questions from Mr Hinchcliff, counsel for Mr O'Brian, but had not responded to her questions. Dr Paterson went on to say:

I have discussed with a Technical Specialist who advises that

1) *You now issue a decision on the surgery request on this claim based on the CAP opinion about this claim. BUT also obtain clinical records re the 2002 accident and refer back to CAP WITH THE FULL CLINICAL RECORDS RE THE 2002 CLAIM to review the surgery request in relation to the 2002 claim.*

2) *Issue a decision about WC based on my opinion or refer to Technical Specialist (TS) for comment before doing so.*

   1) Above makes sense to me.

   In relation to 2) above, I would prefer that Mr Barnes comment on my comment as I requested and then Technical Specialist (TS) opinion be obtained.

Happy to discuss.

[16] On 8 December 2017 ACC declined Mr O'Brian's request for elective surgery to his right shoulder and any entitlement to weekly compensation. The letter said:

> *ACC has considered all of the medical and associated evidence in its possession. This evidence indicates that the cause of your ongoing incapacity and need for surgery is caused by the brachial neuritis that you have been diagnosed with.*

[17] Mr O'Brian saw Mr Wright post-surgery and Mr Wright noted his findings as follows:

> *Mr O'Brian has engaged an Advocate to assist with the ACC. Mr O'Brian relates onset of his shoulder to an episode 10/10/16 when he fell into the cockpit of a boat (ACC CK81646). He recalls significant loss of function at the time but very little pain. He subsequently was aware of pain some months later and developed findings typical of a Brachial Neuritis and had nerve conduction studies consistent with this.*
>
> *From an ACC appeal viewpoint the question arises is there a causal link between the fall in the cockpit and the rotator cuff tear and the subsequent need for surgery. The question may also arise is whether or not there is a causal link between the fall in the cockpit and the subsequent Brachial Neuritis.*
>
> *With respect to the first question it is hard to be dogmatic but the fall in the cockpit may be a significant if not the sole cause of the rotator cuff tear bearing in mind the previous fall in 2002. I am not really aware of Brachial Neuritis being a post-traumatic problem, my understanding is that it is non-specific and is likely post-viral but I have sent a copy of this note to Richard Frith. I would be happy to answer any questions that the Advocate has even though I would not be completely optimistic about the outcome of an appeal.*

[18] On 13 April 2018 Dr Fong provided a further opinion commenting on the MRI of 17 July 2017 and he noted in particular:

> *It is noted that the MRI scan was done about nine months post-claimed injury of October 2016.*
>
> *The bony changes at the greater tuberosity with irregularity at the greater tuberosity, scalloping and cyst formation is indicative of longstanding rotator cuff tendinopathy/tear (also reported of 9/6/2017). These bony changes at the greater tuberosity has a positive predictive value of pre-existing rotator cuff tendinopathy to the order of over 90%.*
>
> *The subscapularis tendon tear and muscle shows marked reduction in bulk and fatty changes. This marked reduction in muscle bulk and fatty changes in the subscapularis represents a change that would only occur after many years post tendon tear, over three years.*
>
> *These MRI findings would indicate that the rotator cuff tears are longstanding and likely to predate the accident of 10/10/2016.*

[19] On 4 June 2018 Ms Noventa prepared a report in response to a request to comment on causation for Mr O'Brian's claim. She noted that she had not met with or assessed Mr O'Brian and her information had been received from Mr Hinchcliff and the MRI report dated 17 July 2017. She concludes:

> *The medical evidence indicates 2 traumatic events for the right shoulder. There is x-ray evidence to support a dislocation having occurred in 2002 and recent MRI evidence is suggestive of a subscapularis tendon injury also occurring at this time. However, it would appear that the client was functioning and working without restriction up to the time of the 2016 event. The MRI findings are indicative of further tendon injury in 2016 and this is functionally when the client become unable to complete his work tasks due to symptoms. Based on all this information it would appear likely that the 10.10.2016 covered event is the cause of the need for surgery and work incapacity.*

[20] Ms Noventa's report was referred for further comment from Dr Fong. He responded on 10 July 2018. I set out the questions and responses from Dr Fong:

> *1. Do you agree with Catherine Noventa, that the subscapularis tendon injury is an old injury possibly related to the 2002 shoulder dislocation?*
>
> *If we go back to 2002 there is hardly any clinical record apart from a handwritten radiology record. The handwritten report stated posterior glenohumeral joint dislocation and Hill-Sachs deformity in a person who has a previous history of anterior dislocation. So there is conflicting information between an anterior or posterior dislocation, even just in this handwritten record for a proper diagnosis to be made.*

There is simply insufficient information at 2002 for a causal link to be established to the 2002 claim.

2. Do you agree with Ms Noventa that the supraspinatus and infraspinatus tears are more recent and likely related to the October 2016 event?

I do not agree with this statement. There is clear radiological evidence that the rotator cuff tear, especially the supraspinatus and infraspinatus, are likely to be longstanding. This was shown by the greater tuberosity irregularity, scalloping and cyst formation in the X-ray 09/06/2016. These bony changes would have a positive predictive of pre-existing rotator cuff tear of over 90% reference 1. This was further supported by the MRI scan of 10/10/2016 which reported a rotator cuff tear of the subscapularis with a marked reduction in bulk of subscapularis surrounded by fatty degeneration. This is an advanced degree of fatty infiltration that would take more than three years to produce.

There is mild reduction in bulk of supraspinatus and infraspinatus with mild fatty marbling. This is fatty infiltration and muscle atrophy grade one. This degree of muscle bulk reduction and fatty marbling represents a moderate degree of fatty infiltration i.e. Goutallier two changes. Again the average time for supraspinatus and infraspinatus to produce this intermediate fatty infiltration as described are respectively three years and two and a half years i.e. the changes of the muscles in the supraspinatus and infraspinatus of moderate/intermediate grade of fatty marbling represents chronic changes that take two and a half to three years to develop and that of the subscapularis also takes over three years to develop. These conditions are chronic and would likely pre-date the claimed personal injury by accident.

3. Do you think that the effects of the 2016 event should be considered accident related?

No. I think the condition requiring treatment represents rotator cuff tendinopathy, a gradual process condition.

4. Do you agree that the MRI findings are indicative of a tendon injury in 2016?

No. I feel that the MRI findings are indicative of an extensive multi tendon rotator cuff tear that is longstanding and likely to pre-date the accident of 2016.

5. Do you agree with Ms Noventa that based on all this information it would appear likely that the 2016 covered event is the cause of the need for surgery and work incapacity?

I do not agree with the arguments provided. As I have stated above the rotator cuff tear represents a longstanding chronic condition that is likely to pre-date the claimed injury of 2016.

[21] The review hearing commenced on 13 June 2018 and was concluded on 12 September 2018. During that period the further report of Dr Fong dated 10 July 2018 was provided.

[22] The Reviewer summarised Mr O'Brian's case saying:

> *It was submitted that the surgery and weekly compensation entitlements under this claim are injury related and that his shoulder injury (now requiring surgery) was caused by the covered accident. It was submitted that in the present case ACC declined surgery on the basis that the accident (the personal injury following the accident) did not cause the laberal tear. It was submitted that the issue is largely one of causal link and the courts have invariably been guided by the medical evidence available. In this case, reliance was placed on the opinion of Mr Wright, orthopaedic surgeon, in terms of the ARTP and his letters dated 22 November 2017 and 11 January 2018. Reliance was also placed on the opinion of Ms Noventa, physiotherapist, in terms of the diagnosis of brachial neuritis not generally considered to be related to trauma and the fact that the requested surgery is not to address this condition. It was submitted that the supraspinatus tears are more recent and likely related to the October 2016 event.*

[23] In relation to ACC's case the Reviewer summarised it as follows:

> *It was submitted that ACC's decision to decline to fund surgery was correct on the basis that the surgery was required to treat a condition not caused by the accident that occurred on 10 October 2016.*
>
> *It was submitted that the issue for review is whether on the balance of probabilities the accident is most likely cause of the condition in relation to which any entitlement rests. Dr Fong has confirmed that the condition reported is longstanding and may relate to the earlier accident in 2002. His opinion is that the clinical history, examination and imaging indicate longstanding right shoulder problems dating back to some 15 years ago. Mr Wright also confirms his opinion that this could be an underlying gradual process condition and most likely rendered the tears symptomatic and refers to the High Court decision in McDonald v ARCIC [2012] NZAR 970.*
>
> *Mr Wright also comments that the fall may have only contributed to the rotator cuff tears and that he is uncertain whether the tears have been accelerated by a degenerative condition as the imaging shows pre-existing changes. Mr Wright said he "would not be optimistic about the outcome of this review". It was submitted that this is consistent with Dr Fong's comments that the MRI findings indicate that the rotator cuff tears are longstanding and likely to pre-date the accident of October 2016. ACC submits that the subscapularis tendon tear and muscle shows marked reduction in bulk fatty changes which represents a change that would only occur after many years.*

> *ACC submits that Dr Fong explains the presence of the tears are consistent with the results of an underlying gradual process condition. That being the case, it is submitted that ACC's decision to decline to fund elective surgery was correct and that the Application for Review should be dismissed.*

[24] The Reviewer summarised ACC's position saying that:

> *ACC's position is that there is no cover and it is not required to fund the elective surgery requested on the basis that it is either due to brachial neuritis (which is not a covered personal injury) or cover is excluded as the surgery requested is due to tendinopathy, a longstanding pre-existing condition or gradual process condition.*

[25] ACC referred in particular to Dr Fong's reports and Mr Wright's reports and in particular where Dr Fong said the condition reported is longstanding and may relate to the earlier accident in 2002 and his explanation for the presence of the tears are consistent with the results of an underlying gradual process condition. ACC's submissions referred to Mr Wright confirming his opinion that this could be an underlying gradual process condition and that he is uncertain whether the tears have been accelerated by a degenerative condition as the imaging shows pre-existing changes.

[26] The Reviewer considered the relevant law and in particular referred to the decision of *McDonald v ARCIC* which stated that cover is unavailable under the Act if the gradual or ageing process is "the whole or substantial cause" of the injury.[1] She also referred to the decision of *Dobbs v ACC* which provides that ACC is required to perform a reasonable investigation although usually a decision will come down to the weighing of medical evidence. [2]

[27] The Reviewer also refers to the well known decision of *ACC v Ambros* where a court can draw robust inferences of causation in cases of uncertainty, can only draw a valid inference based on facts supported by the evidence and not based on supposition or conjecture, and the assessment of causation should be based on what constitutes the

[1] *McDonald v ARCIC* [2012] NZAR 970.
[2] *Dobbs v ACC* [2005] NZACC 46.

normal course of events, which should be based on the whole of the lay, medical and statistical evidence and not be limited to expert witness evidence.[3]

[28] The Reviewer carried out an analysis of the evidence and the law. She said:

> *In my view, after reviewing all the evidence, while the accident may have contributed to the condition now requiring surgery there is doubt as to whether on the balance of probabilities this is the most likely cause of the condition now requiring surgery. There is medical evidence from Mr Frith, Dr Paterson and Dr Fong that points to brachial neuritis or tendinosis. Then there is Mr Mutch's initial orthopaedic surgeon opinion that this is a "frozen shoulder" type of injury for which Mr Mutch said did not require surgery.*
>
> *As to Mr Wright's letter dated 22 November 2017 he also indicated that the fall may have contributed to the rotator cuff tear and that it is hard to state whether the injury accelerated a degenerative shoulder condition because there may have been a pre-existing cuff injury and there would be age related problems. He did say that this situation is not straight forward because of the history where Mr O'Brian fell but did not develop pain immediately. He also noted that further imaging suggests chronic subscapularis changes (the MRI scan showed a marked reduction in muscle bulk and fatty change). This tends to correlate with Dr Fong's view that this is a longstanding condition and that the MRI indicated that rotator cuff tears were likely to pre-date the 10 October 2016 accident. Mr Wright also had an opportunity to comment on the brachial neuritis but has not addressed this apart from to say that the situation was complicated by brachial neuritis and that was more of a post-surgery issue rather than a pre-surgery problem. That does not appear to match up with Dr Paterson's opinion and the Hands-on assessment report which says that while awaiting decision from ACC Mr Wright referred Mr O'Brian to hands on for hand swelling and brachial neuritis. That indicates to me that brachial neuritis was identified in advance of the surgery requested.*
>
> *Then Dr Fong's further opinion dated 10 July 2018 (referred to in the background above) is adamant in that the supraspinatus and infraspinatus tears are likely to be longstanding. Dr Fong's opinion was that the condition requiring surgery presents as rotator cuff tendinopathy, a gradual process condition.*
>
> *Cover is excluded if the condition requiring surgery is "wholly or substantially caused" by a pre-existing or a gradual process condition. In my view, on balance, the causal link with the onus being on the Applicant on the balance of probabilities has not been sufficiently established.*
>
> *On the balance of all the medical information available, in my view the burden of proof has not been established that the condition now*

[3] *ACC v Ambros* [2007] NZCA 2004

requiring surgery was caused directly as a result of the accident on 10 October 2016.

Medical evidence received after the review hearing

[29] Mr O'Brian saw Dr Snell, a specialist anaesthetist and pain physician and in an undated report he notes his diagnosis and opinion as:

> *Mr O'Brian has large complex full thickness and near thickness distal supraspinatus tendon insertional tear … large suspected distal subscapularis tendon tear and partial retraction. He also has brachial neuritis. Given the temporal relationship of his symptoms to the fall on 8th of October 2016 and the mechanism of injury was of a sufficient force and the awkward nature of the fall to have caused the compete [sic] tendon rupture from this injury. It is also likely given Mr O'Brian's age and occupation and his history of previous trauma to the right shoulder that he was likely to have had underlying degeneration to the rotator cuff.*

[30] Dr Snell went on to answer the questions that had been put to him by Mr Hinchcliff as follows:

1. *Whether the subscapularis tendon injury is an old injury related to the 2002 shoulder dislocation?*

   Given some of the chronic changes seen in the subscapularis tendon the inference is that this injury is of longer standing and may well be from his 2002 injury. I note the dislocation was a posterior dislocation which make up only a small portion compared to the more common anterior, and usually require high force which would likely have damaged the rotator cuff. I am therefore of the opinion that at least some of the subscapularis injury is old, however given he was almost symptom free up until the October 2016 event he may well have extended or completed the tear in this event.

2. *The supraspinatus and infraspinatous tears are more recent and likely related to the October 2016 event?*

   I am of the opinion that the tears to the supraspinatus and infraspinatous are likely to have been the result of his fall of October 2016.

[31] The file was referred back to the CAP who provided a further report on 8 November 2019. A number of questions were posed to the CAP inter alia:

What was the pathology that required surgical treatment*?*

The operation notes from 23/11/2017 have not been provided. The CAP noted that right shoulder surgery was requested for right shoulder supraspinatus tendon tearing extending to the subscapularis tendon.

Is there any evidence that the pathology identified above was caused by an accident in 2016*?*

The CAP noted that the mechanism of injury reported on 10/10/2016, a fall in the cockpit, could have led to an acute right shoulder injury, including a sprain or a tendon tear.

There was some delay in establishing the cause of Mr O'Brian's problem as right shoulder pain. It was initially treated as a spinal problem. Mr O'Brian described mainly spinal pain with right shoulder symptoms occurring some weeks afterwards. He noted that the shoulder was "not massively painful", "a bit sore" "3/10 pain" and then later, he developed more right shoulder pain and was unable to lift his shoulder.

The clinical picture was complicated by coincidental brachial neuritis (see discussion below) which is unlikely to be related to trauma.

The initial imaging was done 8 months after the covered event. That time span is not helpful in establishing an acute cause. Early imaging, done within 4 weeks, can show bleeding between torn tendon ends, but that is not present at 8 months. The imaging does not help in determining the age or cause of Mr O'Brian's right shoulder rotator cuff tendon tears.

The CAP noted that opinions from Ms Noventa, Dr Snell and Mr Wright – that Mr O'Brian's tendon tearing was acute – were conjecture at best based on Mr O'Brian's history of pain with the fall on 10/10/2016. On balance, there is no convincing clinical evidence that the fall on 10/10/2016 caused Mr O'Brian's right shoulder rotator cuff tendon tearing.

…

What is the most likely cause of Mr O'Brien's symptoms?

The CAP reviewed all the available evidence including the clinical records of Mr O'Brian's history, physical examination findings, imaging, allied health and specialist reports.

Based on the evidence provided, the CAP consensus opinion was that the most likely explanation for Mr O'Brian's symptoms was a symptomatic aggravation of chronic pathological right shoulder impingement. Mr Wright noted the diagnosis of impingement in his 13/07/2017 report, complicated by the brachial neuritis:

The findings today would be to some extent consistent with Impingement Syndrome however the degree of pain and inflation is much more than would be expected given the size of the cuff tear.

…

Is there any evidence that any of the pathologies present were caused by the 2002 accident?

The information provided indicates that the ACC-covered 2002 fall caused a right shoulder dislocation when Mr O'Brian was 48 years old. From the 08/04/2002 radiology report, this appears to have been a posterior dislocation, with evidence on the imaging of a previous right shoulder anterior dislocation too (the Hill Sach's lesion): …

Mr O'Brian's right shoulder dislocations are most likely to have been traumatic in nature. At that young age, the CAP consensus opinion was that Mr O'Brian may have also torn rotator cuff tendons, but we cannot prove that, in the absence of an ultrasound or MRI scan at the time.

There was simply not enough information to clearly establish whether there was rotator cuff tendon tearing with the 2002 event. However, the mechanism described in April 2002 – slipped over with right arm caught behind him when he was getting into a boat – could have led to rotator cuff tendon tearing.

CAP recommendations

On balance, the CAP agreed that the most likely cause of Mr O'Brian's tendon tearing was not the fall on 10/10/2016 but rather a slow deterioration of his rotator cuff tendons which is common in his demographic, perhaps with a contribution from the 2002 ACC-covered accident.

[32] As I have already said, after the appeal hearing CAP was asked to provide clarification in respect of a comment in a report of 3 July 2020. They were asked as follows:

Answers to your questions.

1. Can CAP please cast their minds back to this and provide clarification on their comments dated 3 July 2020?

"CAP do not appear to have answered question 2 (copied below) which was specific to a clinic note dated 16 December 2002 (this is not referenced in their report) where it is recorded the claimant was unable to internally rotate. Could CAP please review this note and indicate its relevance and whether it would lead CAP to conclude that it is more likely than not that the subscapularis (or any other) pathology) present and requiring surgery in 2017 is causally related to the 2002 accident."

The CAP acknowledges that we did not list every single item in the 26y0 pages that we reviewed in the preparation of our 08/11/2019 comment.

We can assure the Court that we did consider all the information available in the 2002 claim, including the history noted below and the inability to internally rotate the shoulder in December 2002, around pages 88-89 of the Bulk Print.

This led to their comments which I have previously referred to at paragraph [31]. The CAP concluded the following:

> *The CAP have reviewed this file and we have nothing further to add to our comments.*

[33] On 3 October 2020 Mr Wright provided a further report. He noted that he reviewed his notes from when he originally saw Mr O'Brian in 2017. He noted at that stage that his impression was:

> *The findings today will be to some extent consistent with Impingement Syndrome, however the degree of pain and limitation is much more than would be expected given the size of the cuff tear. Furthermore there is a hyperaesthetic pain radiating through the radial aspect of the forearm with marked numbness in this region again not consistent with simple rotator cuff problems.*
>
> *The later findings would suggest a radiculopathy although the neck examination was relatively unremarkable. There is generalised weakness about both upper limbs, however in no specific distribution and reflexes are very brisk.*

[34] Mr Wright also noted that:

> *Nerve conduction studies and an MR scan of the shoulder and neck were carried out. Following that, the subsequent working diagnosis was Impingement Syndrome reflecting the underlying supraspinatus and subscapularis tears. The nerve conduction studies were consistent with a brachial neuritis and there was generalised cervical spondylosis, that is age related changes in the neck. … The implication would be that the subscapularis damage predated the supraspinatus damage. This accepts that both muscle tears are likely to have an age-related component. That is a fall and even a dislocation of the shoulder is unlikely to result in a rotator cuff tear in an individual say in their 4th decade but much more likely to result in a cuff tear in an individual in their 5th decade or older. It also accepts that some rotator cuff tears are attritional.*

[35] Mr Wright was asked the question "was the subscapularis tendon torn in 2002?" After referring to the Shorecare Medical Services notes and a radiology report and the x-ray reports, he is of the view that it is unlikely given the mechanism of injury that there was a posterior dislocation. He continues by saying:

> *On the other hand the description of loss of control of elevation and weakness would be consistent with a significant rotator cuff injury and therefore a subscapularis tear is a possibility. In my view it is likely, if not certain, that the subscapularis was torn when Mr O'Brian fell in his*

boat in 2002. Unfortunately I could not find any soft tissue imaging from that time to confirm this view.

[36] Mr Wright defines Impingement Syndrome as follows:

> *Mr O'Brian has a history and findings consistent with Impingement Syndrome, i.e. that combination of symptom and signs generally characterised by activity related ache localised to the lateral aspect of the arm with radiation to the forearm and occasionally to the neck. These symptoms are increased with movements of elevation and protraction e.g. putting on a shirt or hanging out washing and are classically present at night.*
>
> *In general the aetiology or cause of these symptoms is multifactorial, and could reflect a number of underlying problems including an acute rotator cuff tear, an acute or chronic cuff tear or a chronic rotator cuff tear. It could also reflect rotator cuff irritation, rotator cuff imbalance (e.g. associated with a suprascapular nerve palsy or instability) or labral or biceps problems. It may also reflect the aging process. It may reflect a fracture of the greater tuberosity. In most individuals there are a combination of factors. The use of the term "Impingement syndrome" does not define cause and the ACC is obliged to provide benefits for many individuals with Impingement syndrome.*

[37] At the conclusion of the hearing on 24 June 2020 I directed that further information was to be obtained as set out in paragraph [2] above. Furthermore I gave leave for further submissions from ACC and Mr Hinchcliff to be filed if necessary. I have carefully considered all of that additional information and in particular the further submissions of counsel. I have found those submissions to be of assistance.

Discussion and decision

[38] It is not in doubt that there was a covered injury as a result of an accident on 8 April 2002. It is acknowledged by Dr Fong that there was not sufficient information about the 2002 injury "for a direct causal link to be established". This is a reference to whether or not there was evidence at that time of right shoulder rotator cuff tendon tearing. However, the CAP did accept that the April 2002 injury "could have led to rotator cuff tendon tearing".

[39] What has emerged, however, as to the main issue in dispute in this case is whether or not the subsequent fall in 2016 caused the tendon tearing or whether there was a slow deterioration of Mr O'Brian's rotator cuff tendon. The CAP added that the

latter view is common in the appellant's demographic but perhaps with a contribution from the 2002 ACC covered accident.

[40] Therefore I must consider whether or not there is sufficient evidence of a causal connection between the fall in 2015 and the rotator cuff tendon, or whether it has been sufficiently established that the claim is excluded due to the subsequent tearing being the result of the ageing process.

[41] A further issue has arisen due to the fact that the review decision was given later than 28 days after the decision closing. The Act provides that any review decision must be given within 28 days of the decision closing.

[42] Dealing with the 28 day issue first. I have considered two decisions being, *ACC v O'Neill* and *Farrelly v ACC*[4]. I am satisfied that the Act provides for no penalty for such a delay. In this case the delay is not long and within the normal amount of time that courts often take to give reserve decisions. Given that there is no penalty and given that the delay is not excessive by any means, I am satisfied that this is a non-issue. Obviously there may be extreme cases where natural justice or Bill of Rights issues arise but this is clearly not one of them.

[43] I return to the central issue. In this case, as I have set out, there have been numerous reports and recommendations by various experts covering many years. I have not overlooked that Mr Wright, the treating orthopaedic surgeon, has made subtle revisions of his opinion. I do not find that to be disqualifying in any way. I have also noted that Dr Fong has given various opinions supporting the ACC view of an ageing process prior to the CAP review. The CAP view must also always be given weight as to its independence and expertise. However I note the CAP included Dr Fong as one of its members. Dr Fong has come to the independent review with a fixed and published view of his own and I have no idea as to how much weight his view carried. Clearly he became no longer independent.

[4] *ACC v O'Neill* [2012] NZAR 729. *Farrelly v ACC* [2016] NZHC 3153.

[44] I approach my decision in accordance with the principles set out by the Court of Appeal in *ACC v Ambros*[5]. This decision recognises that courts sitting on appeal can draw robust inferences of causation in some cases of uncertainty. I note the caution that valid inferences must be based on facts supported by the evidence and not on conjecture. A plaintiff must prove causation on the balance of probabilities. *Ambros* held that courts proceed 'on the general impression of the sufficiency of the lay and scientific evidence to meet the required standard of proof".

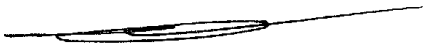
[45] Section 26(4)(a) excludes personal injury caused wholly or substantially by the ageing process. I say at once that I do not consider on all the evidence that anyone has established on the balance of probabilities that the rotator cuff tendon tearing was caused wholly or substantially by the ageing process. Even the report of 28 July 2020 and its conclusion referred to 'most likely' and then relied upon demographic statistics to support a slow deterioration of the rotator cuff tendon. There is a marked difference of opinion between the experts and principally Dr Fong as to causation, and the various experts including the treating surgeon Mr Wright as to the opposing view that the fall in 2016 caused or contributed to the rotator cuff tendon tearing.

[46] In all the circumstances and following the principles of *Ambros* I consider that there is enough evidence to support an inference that the fall in 2016 did cause or contribute to the tearing and that it was not caused wholly or substantially by the ageing process. In reaching this view I have taken into account that Mr Wright was the treating surgeon whose evidence is supported by two other experts. I have also taken into account that the CAP evidence of demographic statistics cannot always be relied upon to relate to the facts of a particular injury. The 2002 injury was covered by ACC and the 2016 incident was also covered by ACC. There is doubt as to whether there was any rotator cuff tendon injury in 2002 and there is acknowledged doubt by CAP as to the amount of contribution the 2002 injury may have contributed to their view. Then there is the fact that in 2002 MRI scans were not available. Then there is the use of demographic statistics. Then there is the strong evidence of the treating surgeon to whom I give weight. Taking a non-niggardly approach and upon the

[5] *ACC v Ambros* [2007]NZCA 304

principles in *Ambros* I am satisfied on the balance of probabilities that the appeal must be and is allowed.

[47] Mr O'Brian is entitled to costs and disbursements, which I hope counsel will be able to resolve between them. If not, then I will receive memoranda.



Nicola Mathers
District Court Judge