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

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

**[2021] NZACC 50 ACR 18/19**

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

Hearing: 11 February 2021

Heard at: Christchurch/Otautahi

Appearances: Mr T Yates, advocate for the appellant via telephone
Mr H Evans for the respondent

Judgment: 17 March 2021

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**RESERVED JUDGMENT OF JUDGE C J McGUIRE**
**[Suspension of Entitlements section 117**
**Accident Compensation Act 2001]**

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[1] At issue on this appeal is the correctness of WellNZ Limited's decision of 19 December 2017 to suspend the appellant's entitlements for her covered back injury.

## Background

[2] The appellant has cover for a coccyx and neck sprain and hip/thigh contusion injuries suffered when she fell downstairs on 6 February 2017. She was certified unfit for her employment as a result of her injuries.

[3] The appellant has lodged nine claims with ACC for lumbar sprains between 1992 and 2017. ACC has information relating to the claims lodged in 2005, 2014 and 2017 but does not have any information about the other claims for lumbar sprains.

**25 August 2005 Injury**

[4] On 2 September 2005, the appellant reported to her general practitioner Dr Richards, that she had injured her back while lifting a bag into a motor vehicle. The clinical notes record:

> Lifted a bag of compost at The Warehouse last week. Has had back problems in the past but had been good leading up to this event. Felt pain when lifted and twisted.
>
> Pain is across L3/4 with pain felt in SI jts. Back seems to lock up and can't walk. Is protecting back.
>
> Hurts to walk and drive.

[5] On 7 November 2005, she again saw the doctor who recorded:

> Works as a tracker for CTFs. Is in a lot of pain with driving etc.
>
> Has had physio, no benefit; and has seen a chiropractor, again with no benefit.
>
> Is wondering re cessation of work.
>
> Is having trouble with housework dusting etc.
>
> … for x-ray of back and SI jts.

[6] On 8 November 2005, the appellant underwent an x-ray of her lumbar spine. Radiologist, Dr Welsh, reported:

> Findings:
>
> There is a moderate narrowing of the L3/4 and L4/5 disc spaces with marginal osteophytic lipping. Mild diffuse osteophytic lipping present elsewhere. Mild rotary mid lumbar left scoliosis.
>
> Normal sacroiliac joints. No focal bone lesion.
>
> IMPRESSION:
>
> Lumbar spondylosis.

[7] On 22 November 2005, the appellant saw orthopaedic surgeon Mr Jeremy Evison.

[8] In his report of the same day he noted a diagnosis of "lumbosacral disc failure. Exclude central disc prolapse". He also noted:

> Disability:
>
> Remains at work but has trouble with driving and sitting, walking for more than 1 hour. Sleep is disturbed.
>
> …
>
> X-rays:
>
> Current lumbar x-rays show narrowing of the lower 3 lumbar discs with corresponding facet changes.

[9] Mr Evison arranged for her to have an MRI of her lumbar spine.

[10] In his report of 3 December 2005, radiologist Dr Balasingam reported:

> Findings:
>
> Normal segmental anatomy.
>
> The intervertebral discs down to and including L2/3 are normal. There is loss of disc signal and mild loss of disc height from L3/4, L5/S1. …
>
> Conclusion:
>
> Mildly lower lumbar spondylosis but no evidence of neural compromise.

[11] Mr Evison reviewed the appellant on 20 December 2005, noting:

> … her current MRI which shows mild facet arthrosis at L4-5, L5-S1 and corresponding disc hydration changes, but no focal neural impingement or surgical remediable pathology.
>
> I have explained the findings to her and advised continued non operative approach. She is keen to explore pain management options and I have referred her to Ric Acland at the Pain Service with this in mind and have not arranged to see her again at this stage.

[12] ACC sought advice from the Christchurch branch medical advisor, Dr Harding, who reported on 1 March 2006 as follows:

> …

COMMENT:

> The medical information on file suggests that current symptoms still relate to the most recent accident even though there is a history of significant previous lumbar spine symptoms. At some point in the future it may be appropriate to ask the question if symptoms are still accident related given that there is underlying degenerative change. I recommend that CPA (Comprehensive Pain Assessment) referral appears appropriate and reasonable.

[13] A comprehensive pain assessment report was completed on 28 March 2006.

[14] Under the heading "diagnosis" is this:

> Mrs Astle has lumbar spinal pain of uncertain origin. Radiological imaging has not revealed any diagnostic features. There is evidence of mild degenerative disc disease, affecting the lowest 3 levels, but findings such as these are as common in patients who have no symptoms of back pain as they are in patients with back pain and the significance of these findings is doubtful. It is possible that her pain is zygapophysial joint origin and the right L3-4 zygapophysial joint in particular appeared on MRI scanning to be abnormal.
>
> She presents with symptoms consistent with a mild major depressive episode.

[15] The recommendations of the report were for a work site assessment; an activity-based programme with an exercise focus; and also, that consideration be given to provision of psychological services to review both pain and mood management. The recommendations also included Interventional Pain Management Services if progress with the other interventions proved unsatisfactory.

[16] A work site assessment was carried out and, in the report completed on 24 May 2006, the recommendations included:

> It is recommended that Mrs Astle continues to assess contracts before undertaking them based on specific demands required and the level of flexibility which will assist to continue to manage her pain symptoms.
>
> It is important that Mrs Astle regularly moves from sitting, standing and walking.
>
> It is recommended that Mrs Astle works within her pain. She is encouraged to avoid tasks which involve prolonged static positions including sitting and standing.

[17] The recommendations noted that a graduated return to work programme was not required and she was managing her contracts and hours with Child, Youth and Family.

[18] The next report available is from Mr Inglis, Orthopaedic Surgeon, dated 12 June 2013.

[19] Mr Inglis noted that the appellant had a long history of inconvenient back pain.

[20] Mr Inglis noted:

> X-rays:
>
> The last x-ray available of her lumbar spine dated 19/01/2012 reveals displaced narrowing and age related change throughout the lumbar spine with a slight degenerate scoliosis convex to the left. She has a minimal forward shift of L3/4, quite marked changes at the 4/5 level i.e. multilevel lumbar spine age related change.
>
> Opinion:
>
> I have had a good chat to Adele today regarding back pain. The non specific nature of her back pain. She does not have any symptoms suggested of either central or foraminal stenosis. I have reassured her about her future with back pain. There is nothing from the surgical point of view we would offer her at this point in time. If she should develop stenotic symptoms in the future, either central or foraminal, we would be happy to review her. Right now she is not a surgical candidate. I have discussed the various conservative options open to her, all these have failed in the past.

**Injury of 6 February 2017**

[21] On 8 February 2017, the appellant consulted her GP, Dr Richards, reporting that on 6 February she slipped on timber stairs while wearing socks and slid down six or seven stairs on her back. In the claim form dated 8 February, Dr Richards diagnosed probable coccyx sprain, contusion, hip and thigh, and neck sprain. ACC accepted cover later the same day.

[22] Management of the claim was transferred to WellNZ which administered ACC claims on behalf of the appellant's then employer, Child Youth and Family.

[23] On 17 April 2017, the appellant underwent an x-ray of her lumbar spine. The following were the findings:

> Comparison study August 2014
>
> Mid lumbar curvature convex to the left, unchanged.

> Grade 1 anterolisthesis at L3-4 secondary to facet joint arthropathy, unchanged.
>
> Mid L3-4 and moderate L4-5 disc space narrowing with anterior osteophytes, unchanged.
>
> Vertebral body heights and disc spaces are otherwise maintained with no fracture or destructive bony lesion identified.

[24] On 4 May 2017, Dr Richards referred the appellant for an MRI and specialist assessment. He noted:

> Hurts to walk – possibly 100 metres.
>
> Hurts to stand up straight. Hurts to bend if lies still in bed then back v sore.
>
> Pain undiminished.
>
> R lower leg painful …

[25] On 21 May 2017, the appellant underwent an MRI scan of her lumbar spine. The radiologist Dr Coates reported:

> Findings:
>
> No significant abnormality proximally in L3/4.
>
> Mild spondylolisthesis associated with marked hypertrophic facet joint arthropathy.
>
> Mild annular bulging.
>
> L4/5:
>
> Hypertrophic facet joint arthropathy. Generalised annular bulging which extends eccentrically to the right neural foramen mild bilateral subarticular recess stenoses.
>
> L5/S1:
>
> Mild reduction in disc height intensity. No focal abnormality. Mild facet joint arthropathy. Distal thoracic cord and conus are normal in appearance.
>
> Comment:
>
> Degenerative spondylolisthesis L3/4 and L4/5 with mild subarticular recess stenoses L4/5 although I suspect in the erect position this may be more significant.
>
> No significant abnormalities elsewhere.

[26] On 7 June 2007, the appellant underwent an x-ray of her lumbar spine. Radiologist Dr Omar, reported:

> Findings:
>
> There is leftward convex mild lumbar curvature. There is marked spondylitic change at the L4-5 level and to a lesser degree L3-4 and L5-S1, with normal SI joints. Mild/moderate facet arthrosis. Appearances similar to 21/5/17.

[27] Consultant orthopaedic surgeon Mr Dalzell saw the appellant on 10 June 2017. His report included the following:

> Investigations:
>
> I have reviewed her plain x-rays and MRI scan. The MRI scan demonstrates some changes in the mid part of the lower lumbar spine and some spondylosis involving the L3/4 and L4/5 joints. There is a mild anterolisthesis grade 1 at L3/4 and some significant disc space narrowing at L4/5. This is associated with some subarticular stenosis at L4/5.
>
> In summary:
>
> I think in the first instance Adele would benefit from some continued core strengthening exercises. We will trial some medial branch blocks and if this is successful we can progress onto requesting some nerve ablation type treatments for the anterior rami. The chances of this being successful I think are at least moderate and the more definitive type of management for this problem would involve an L3/4 and L4/5 anterior lumbar interbody fusion type procedure if her back pain was significant and disabling. We would obviously talk in more detail about this with her if this was to be considered.

[28] On 6 July 2017, radiologist Dr Tony Goh treated the appellant with CT guided medial branch block injection into the nerve branch supplying the L4/5 facet joints.

[29] Mr Dalzell reviewed the appellant on 17 August 2017 and reported that the medial branch block injections were very effective at alleviating her pain in the short term. However, ACC had declined to cover any further injections, and Mr Dalzell referred the appellant through to the public hospital system.

[30] On 1 September 2017, Dr Walker, Occupational Medicine Specialist, carried out a medical case review. He assessed the appellant in person for just under an hour. He had been provided with information from the injury of 25 August 2005, East Care Medical notes from various dates and a range of reports from 2017.

[31] The review includes the following:

> Current situation and general functioning:
>
> Adele describes pain across her lower lumbar region without radiation. Pain is aggravated by sitting and driving. It is near constant, and varies between 4/10 and up to 10/10 in severity. Pain is aggravated by twisting and bending her back, and, less so, with bending forward. There has been no disturbance of her bowel or bladder.
>
> In terms of the impact of pain, she has been unable to carry her daughter's baby, and is socialising less as she cannot sit through a movie. She is not confident about going on holiday. Sleep is reduced to about 5 to 6 hours per night. Her doctor has recently started her on a combination of Celebrex and Paracetamol, which helps. She can get some relief when lying flat, and tends to pace herself. If she has a flareup, she may lie down. She indicated that it was a bit of a struggle, and that she is often tired, but she appeared to be coping reasonably without too much distress. She describes some frustration …
>
> In terms of her current activity tolerances, she denied any difficulties with activities of daily living. She can walk for perhaps 500 metres. She can stand for perhaps only 10 minutes. She has not tested herself on stairs. She can sit for perhaps 10 to 15 minutes. She has not tried any kneeling or squatting. She can only lift a washing basket. She can drive a car, but only for about 20 minutes.

[32] Dr Walker then answered questions posed by the appellant's case manager at WellNZ, as follows:

> 1. What is the client's current diagnosis, and reason for symptoms/incapacity?
>
> The diagnosis is most likely to be a left L4/5 lumbar facet joint pain problem, given that pain is worse with extension, and rotation to the right and given the positive response to medial branch blocks. This would be the likely reason for her incapacity. There is a history of intermittent and previously more persistent lower back pain, but this is not considered likely relevant, as Adele was coping well with minimal back pain for some years until the recent accident event.
>
> 2. In your opinion was this caused by the accident of 06/02/2017, or wholly and/or substantially related to an underlying condition?
>
> It is not possible to be certain on this matter. On the one hand Adele has a significant history of back pain, and there are degenerative changes on her MRI scan, and no test results that confirm injury, but, on the other hand there is a clear and very significant accident event, which could have injured a facet joint, and she has had persistent pain since that time, which has proven to be localised, likely to the left L4/5 facet joint. I appreciate that there was no initial incapacity, but Adele gave a very clear reason as to the delayed incapacity, which was a clear and reasonable explanation; she stuck it out but it then proved unsustainable. On balance, therefore, I believe that it is most likely that Adele's problem relates to a facet joint injury, most likely L4/5 sustained on 6 February 2017. Note that there is literature involving high force motor vehicle trauma

indicating that facet joints can be injured but no good literature to indicate whether or not more moderate forces can cause facet joint injury.

3. Would you please explain the previous "back problem" mentioned in Mr Dalzell's letter?

As Adele described, there is a history of longstanding intermittent lower back pain. This has previously been considered to be a lower facet joint or disc problem. That said, pre-existing degenerative change does not exclude the possibility of subsequent traumatic injury, and the circumstances here support likely trauma as indicated.

Adele could not be specific as to the details, although relevant clinical notes indicate a more specific and persistent pain problem several years ago, although the indications were that she responded well to treatment at the time. Adele does not present presently as someone with a non specific chronic and/or disabling lower back pain problem, and her disability is not excessive, and there are no associated features, such as a significant mood disturbance, significant sleep disturbance, or excessive anxiety.

4. Is there in your opinion, a medical causal link between the accident and ongoing symptoms?

Yes. As per my response to question 2.

5. Is there, in your opinion, a medical causal link between the accident and the need for further surgery, as suggested in Mr Dalzell's letter?

Yes. Such surgery would be a radio frequency ablation, and that is likely to prove helpful. Such treatment is not a cure, but, assuming the diagnosis of L4/5 facet joint pain is correct, ablation of the sensory nerve serving that joint would, on average provide 9 months of pain relief which would enable rehabilitation to occur. Such treatments can, at time, be warranted indefinitely but not necessarily as persisting debilitating L4/5 pain may not be enduring. In any case such treatment should hopefully allow for rehabilitation to occur such as strengthening, conditioning and a graduated return to work programme. Input from a pain management physiotherapist should follow any such treatment to support such rehabilitation.

Sometimes the treatment approach is to provide a range of medical branch blocks, with blinded tests consisting of local anaesthetics of variable duration effects in order to more securely attain the diagnosis. Whilst such an approach would be more robust, it would add to delays and incapacity and is not likely necessary here. Alternatively if a gold standard approach is required, then referral to a musculoskeletal physician would be an option but I would not firmly recommend that in Adele's case as the diagnosis and best treatment appears quite clear.

…

7. Is the claimant fully fit for their pre-accident position?

No. Adele has a range of limitations due to her pain. These are constant walking, constant standing, constant sitting, medium or heavy lifting, constant driving and frequent lumbar twisting. A key problem with her pre-injury job is

the core requirement of intermittent medium lifting and associated lumbar twisting which render her incapacitated at present. Such demands would not be tolerated and would aggravate her pain.

8. What is the claimant's current capacity for work?

She is fit for all facets of her job, except for the lifting of children, but, given this is an essential requirement of her job, and cannot be readily accommodated, she is currently effectively fully unfit for her job.

9. If fully unfit when is the claimant likely to be fit for selected or alternative work?

A radio frequency ablation is likely to be at least moderately effective, and, following that, she will require a conditioning programme, and pain management approach. Input from a pain management physiotherapist should follow any such treatment to support such rehabilitation. She should be able to gain full fitness over approximately 3 months following a radio frequency ablation.

…

[33] On 8 September 2017 radiologist, Dr Oram, undertook a CT guided left L4/L5 facet joint medial branch ablation. The appellant saw Mr Dalzell again on 9 November 2017 and he reported:

She has had some nerve root ablation treatment and unfortunately this has only had minimal effect and she has ongoing persistent back pain.

Almost certainly the source of her symptoms are the changes in the lower lumbar spine. She is adamant that this is injury related and that there is a clear relationship between the onset of her symptoms and the fall that she sustained falling down stairs.

The only real potential solution would be a multi level anterior lumbar interbody fusion type procedure. We have discussed the risks and benefits of this type of procedure and she wishes me to approach ACC on her behalf for this to be undertaken. I have explained to her that the degenerative changes in the lumbar spine are long standing and that the fall almost certainly exacerbated these symptoms.

[34] Musculoskeletal pain specialist Dr John MacVicar, saw the appellant and reported on 5 December 2017. Amongst other things he said:

She has undergone radio frequency ablation and thinks it has reduced the intensity of the pain by 50%, though it was 6 weeks before she started to feel better. The main differences are that a feeling like there is a knife in her back when she first gets up in the morning, and sharp pain when she rolls over in bed, don't happen as much, but she still can't lift anything.

…

> Diagnosis:
>
> A diagnosis has not yet been established.
>
> Radiological imaging has demonstrated several changes, but changes that are known to occur commonly in asymptomatic subjects. There is zygapophysial joint arthropathy at the L3-4 and L4-5 levels and Adele's particular difficulty in tolerating any attempt to actively hyper extend her back would be consistent with a diagnosis of zygapophysial joint pain. Her response to medial branch blocks suggests that the pain may be of L4/5 zygapophysial joint origin but there is a discrepancy between her recollection of a couple of hours' relief and the 6-8 hours of relief reported by Dr Walker.
>
> …
>
> Recommendations:
>
> I recommend investigation of Adele's pain with repeat bilateral L3, 4 medial branch blocks (the L4-5 zygapophysial joints are innervated by the medial branches of the L3 and L4 dorsal rami).
>
> She has had a disappointing response to RF neurotomy and the reason for this could either be incorrect diagnosis or suboptimal treatment technique. Medial branch blocks have been performed, but only once. The risk of a false positive response to lumbar medial branch blocks is substantial, and a positive response to a confirmatory procedure would increase confidence in the diagnosis. If she has a positive response to repeat medial branch blocks, Adele would be a candidate for radio frequency neurotomy, which should be performed under fluoroscopic guidance.
>
> A negative response would indicate that further investigation is required.

[35] On 12 December 2017, Dr Walker updated his report of 1 September 2017.

[36] In answer to the question as to whether the surgery requested is causally related to the incident on 6 February 2017, Dr Walker said:

> When I assessed Adele her pain was quite localised which, amongst other factors as outlined in my earlier report supported a role of injury likely affecting the left L4/5 lumbar facet joint. However it is no longer clear that my diagnosis is correct as Adele did not respond to the ablation treatment as expected and Mr Dalzell considers the problem more generalised and affecting multiple levels in the lower lumbar and lumbosacral spine.

[37] Dr Walker then referred to reports from Dr MacVicar and noted that he had taken his own literature search which:

> … found little in the way of other studies to provide consensus on this matter. I think the utility of CT guidance would also depend on training, techniques

> and experience of the individual operator so that criticism by Dr MacVicar may be excessive.

[38] Dr Walker then said:

> If my diagnosis was wrong then that obviously calls into question my comments on causation. I am however satisfied with my opinion I gave at the time I saw Adele, based on what clinical history I then had, examination findings I then noted, and test results that were provided. Perhaps Adele's diagnosis has become clearer with the passage of time as can occur and on that basis. Notwithstanding the possible shortcomings advised by Dr MacVicar, Mr Dalzell's diagnosis should possibly be preferred. If Mr Dalzell is in fact correct as to the diagnosis, then a more generalised lower back pain problem cannot be readily attributed to the fall of 6 February 2017.

[39] Dr Walker then addressed the question of whether the surgery requested is more likely wholly and/or substantially to address pre-existing pathology in the appellant's back. He said:

> As stated, if Mr Dalzell is, in fact correct as to the diagnosis, then a more generalised lower back pain problem cannot be readily attributed to the fall of 6 February 2017. Mr Dalzell would appear to be correct as Adele did not respond to the ablation treatment as expected, although there is some doubt about this as outlined by Dr MacVicar. Nevertheless, Mr Dalzell seems clear that more than one spinal level has been affected and an injury at multiple levels would not be expected due to the fall on 6 February 2017.

[40] The next issue addressed by Dr Walker was whether the lumbar sprain injury had resolved or whether the ongoing incapacity was still related to that or to the pre-existing pathology. He said:

> As stated, if Mr Dalzell is in fact correct as to the diagnosis, then a more generalised lower back pain problem cannot be readily attributed to the fall of 6 February 2017. Mr Dalzell would appear to be correct as Adele did not respond to the ablation treatment as expected. As stated, there is some doubt about this as outlined by Dr MacVicar but nevertheless Mr Dalzell seems clear that more than one spinal level has been affected and an injury at multiple levels would not be expected due to the fall on 6 February 2017. It therefore follows that if an acute injury is not the likely cause of ongoing difficulties, then pre-existing factors are likely responsible. Consistent with that, Adele described to me a long history of intermittent back pain since a fall at age 18. She referred to minor episodes of back pain on multiple occasions, and denied any history of significant persistent pain in recent years. I pointed out to her that the notes indicate more persistent pain some years ago, but she reported little memory of that. When I gave the recent opinion on Adele I concluded that various factors supported a persistent acute injury to the left L4/5 lumbar facet joint but that appears less likely now and her prior history of pain is likely indicative of pre-existing pathology for which the current surgery has been proposed.

[41] By letter dated 19 December 2017, WellNZ notified Ms Astle that entitlements under the 6 February 2017 claim would be suspended from 7 January 2018.

[42] The decision read:

> … from the medical information obtained it has been established your ongoing symptoms are not a result of the injury for which you have cover. The specialist has stated the diagnosis is subarticular stenosis in the lumbar region which is longstanding degenerative changes. The occupational physician has stated any sprain injury sustained on 6 February 2017 would have likely run its course within a matter of months and would not likely account for ongoing symptoms/difficulties to any degree.

[43] On 15 January 2018, Dr MacVicar recommended that the appellant's pain should be investigated with confirmatory medial branch blocks. He said:

> A positive response would refute the diagnosis of pain resulting from subarticular stenosis. A negative response would indicate that she had a false positive response to the initial blocks but would not preclude investigating the possibility that she has zygapophysial joint pain arising from an adjacent level.

[44] Dr MacVicar also said:

> I am surprised that WellNZ has come to a decision without this potentially important diagnostic information which would either confirm or refute a diagnosis of L4-5 zygapophysial joint pain. True positive responses are more likely than false positive responses and it is likely that Adele's pain is in the L4-5 joint origin though this has yet to be confirmed.

[45] Dr Walker added a further addendum report on 21 March 2018 and concluded:

> I agree with Dr MacVicar's approach that there is a persisting facet joint injury; multiple repeat remedial branch blocks to the medial branches supply the left L3/4, left L4/5, and left L5/S1 facet joints is advised. The left L4/5 face joint was previously targeted with an ablation but persisting pain from this joint should be revisited as the ablation may possibly have been ineffective and such a full work up would allow for re-evaluation of what has been a rather complex claim.

[46] On 4 May 2018, Dr MacVicar reported again as follows:

> …
>
> 03.05.18 – bilateral L3, 4 medial branch blocks. Probable positive response. No vascular uptake on the right, but venous blood in the hub of the needle at the left L3 level again. When the needle was repositioned, there was epidural flow of contrast medium and no anaesthetic was injected at that level. Left L4

medial branch block uncomplicated. Complete relief, again without aggravation when pain returned.

0.05.18 – I reviewed Adele today and had asked her to keep a diary after she was discharged yesterday. The intensity of her pain did not increase during the remainder of the day and she continued to be able to perform activities that would usually aggravate the pain until this morning. She felt that she had prolonged relief from her usual pain and that the pain she experienced was caused by the procedure.

[47] In a further addendum report of 18 June 2018, Dr Walker commented:

…

I note repeat bilateral L3 and L4 medial branch blocks performed by Dr MacVicar on 3 May 2018. There was indicated to have been a positive response, thus concordant with the local anaesthetic used. Dr MacVicar did not however raise the possibility of a false negative test which is also common.

The letter by Dr MacVicar dated 4 May 2018 is noted. Dr MacVicar has proposed a right L3, 5 medial branch radio frequency neurotomy. Dr MacVicar also acknowledged that Adele had complete relief from CT guided medial branch blocks performed on 6 July 2017 (those were at bilaterally L4/5).

[48] Dr Walker then responded to ACC's questions:

1. Following the treatment/tests can you please confirm the current diagnosis?

No. Dr MacVicar has indicated that pain appears to be arising from the L3/4 level but the recent L3/4 medial branch blocks have not provided good evidence of that given that both comparative nerve blocks did not illuminate pain for the expected duration. I agree with Dr MacVicar the nerve block performed on 26 April 2018 may have been falsely negative, but the additional difficulty is that the nerve block on 4 May 2018 may have been falsely positive. There is the option of Dr MacVicar doing a repeat L3/4 nerve block and that would increase confidence in the L3/4 diagnosis further and that might be something to Dr MacVicar to consider.

2. Can you please comment on the results and whether this result is more conclusive regarding a possible causal link to the accident versus a more generalised pain diagnosis?

I previously stated on 31 March 2018 that I then agreed with Dr MacVicar's approach in that if there is a persistent facet joint injury that multiple repeat remedial branch blocks to the medial branches supply the left L3/4, left L4/5, and left L5/S1 facet joints were advised. One difficulty here is that only one of the comparative L3/4 anaesthetic blocks was positive and hence the accepted high standard for a positive test has not been met. Another difficulty is that pain at L4/5 and L5/S1 has not been explored by Dr MacVicar, albeit I note Dr MacVicar advises that the local anaesthetics used at the time of the 6 July 2017 L4/5 ablation did relieve pain for a period. A third difficulty is that Adele's pain is seemingly over a broad area; I thought her problem was left sided

whereas I see Dr MacVicar now thinks the problem is more likely right sided. Hence as time progresses and further tests have been undertaken, there is no greater clarity on there being any persisting injury.

3. Also can you please advise if the further procedure requested will shed more light on the cause of the injury of if it is purely further treatment for the pain?

The proposed left L3/4 medial branch radio frequency neurotomy would likely shed more light on the diagnosis. If that treatment eliminates pain then the problem will likely be left L3/4 facet joint pain in which case localised pain would be more supportive of an injury as claimed. If the treatment does not eliminate pain then the problem would not likely be left L3/4 facet joint pain, yet pain may be arising from another level which may or may not be injury related. If the treatment definitely reduces pain, then some of her pain would likely be arising from the left L3/4 percent joint but in that case multiple sites of pain would not be consistent with an injury.

4. In conclusion – in your opinion is the current diagnosis directly causally related to the accident or is it wholly or substantially due to non injury pathology?

In my initial opinion dated 1 September 2017 I concluded that various factors likely supported a persistent acute injury to the left L4/5 lumbar facet joint. That was an opinion given on the balance of probabilities. In my second opinion dated 12 December 2017 I changed my mind and considered it more likely that the diagnosis was pre-existing degeneration as the bilateral L4/5 ablations were unhelpful for pain, though I now acknowledge Dr MacVicar's advice about the potential limitations of that treatment Adele had by the radiologist. In my third opinion dated 21 March 2018 I acknowledged that Dr MacVicar's approach to re-explore the diagnosis with multiple repeat branch blocks to the medial branches supply the left L3/4, left L4/5 and left L5/S1 facet joints would be helpful. However, Dr MacVicar has only investigated that L3/4 level and that has not adequately confirmed the diagnosis.

There are persisting factors consistent with pre-existing degeneration in this case given the prior history of pain, bilateral pain, and pain possibly arising at both the L4/5 and L3/4 levels. Further to that, arguably the most objective information, that being the MRI scan dated 21 May 2017 indicates advanced bilateral facet joint disease at both L3/4 and L4/5 levels. In conclusion, the site of pain has not been well clarified but the seemingly broad area of pain (possibly both L3/4 and L4/5, potentially bilateral) and seemingly matching broad area of disease as per MRI is more consistent with pre-existing degenerative disease as an acute injury would not be expected to affect multiple facet joints given the moderate nature of the claimed accident. My initial opinion was swayed by Adele's description that she had had persisting pain since the time of a forceful accident and that her pain was seemingly well localised. However, with further evaluations, the indications are that her pain may not be well localised and therefore it is more likely that the accident aggravated pre-existing degenerative disease and which more likely accounts for ongoing symptoms. No doubt there was an accident on 6 February 2017 and a period of injury but persisting pain at a localised site (i.e. what could potentially be a persistent injury) has not been confirmed and any persisting injury is doubtful. As stated there is the opinion of Dr MacVicar doing a repeat L3/4 nerve block and that would increase confidence in the L3/4 diagnosis

further but even so there would still be ongoing doubt about an injury given the bilateral and multi-level disease and likely associated symptoms.

[49] On 3 August 2018, Dr Xiong, specialist for rehabilitation medicine, saw the appellant.

[50] In his report Dr Xiong noted:

> The injury was a very significant trauma and it has caused extensive bruising. She showed me the picture taken that showed considerable bruising and subcutaneous haemorrhage to the buttock natal cleft area. …
>
> Summary:
>
> Mrs Adele Astle is a 64 year old lady who was working part time or nearly full time for the Child Youth and Family Unit prior to her injury. She was fully functional even though she did have a history of intermittent back pain. She has suffered from a very significant fall dated 6 February 2017 causing soft tissue damage to the sacral, natal cleft area but at the same time she also suffered from an axial loading injury to her lumbar spine.
>
> Clinically she has developed a chronic low back pain syndrome which in my opinion is directly a consequence from her injury on 6 February 2017.

[51] Dr Xiong then answered specific questions as follows:

> **Do you consider the radioablation and medial branch blocks conducted provide a reasonable basis for concluding Adele's symptoms are not the result of a direct focal injury to the spine, as Dr Walker originally thought, whether at the facet joints or elsewhere?**
>
> I believe the result of the radioablation and medial branch blocks would not alter the decision regarding the ethology of the pain. Clinically and medically there was very little question that she has developed a significant back pain regardless of the structures involved in the lumbar spine. I would certainly favour that the original injury was due to physical damage to the facet joints particularly L4/5 causing her mechanical back pain.
>
> …
>
> **From the radiology and the history, do you consider there is any evidence to suggest the likely cause of Adele's symptoms is in pathology resulting from the accident? If so, what is that pathology?**
>
> From the history it is evident that she has sustained a direct force which is in the form of axial loading with a direct impact of the force going through the spine more likely going through either the disc or the facet joints of the lumbar spine. Due to her pre-existing/co-existing degenerative changes it is very difficult to differentiate the injury component from the degenerative component of the facet joints. The likely pathology of the injury was soft tissue injury to the facet joints aggravating arthropathy causing the chronic low back pain.

> **Adele has changes to her spine that will have predated the 2017 accident. If you are able to do so, please advise whether the multiple previous injuries for which she has cover are likely to have materially contributed to the current pathology. If you cannot do so, is there any further information or any further tests that would enable you to form such a view?**
>
> From the history you would appreciate Adele had a significant back injury when she was very young. She also had further multiple injuries throughout the year that could have contributed to the early degenerative change of the lumbar spine. Purely from a medical point of view however I cannot confidently assess that the previous injuries would have contributed to a materially significant degree to the pathology. In another word, even without the previous multiple injuries, she could still have similar degenerative lumbar spine conditions present. However, I believe the pre-existing degenerative changes have not really caused a great deal of disability to her and certainly not as a significant back pain as what she currently presents.
>
> Degeneration in itself therefore is not the ethology of her back pain while the injuries she has had from 6 February 2017 are the direct cause of her current presentations and incapacity.

## The Appellant's Submissions

[52] Mr Yates refers to *Ellwood*.[1] He submits that if the matter is unclear or in balance ACC does not have a sufficient basis and cannot suspend the claimant's entitlements.[2]

[53] He also refers to what Dobson J said in the second *Ellwood* High Court appeal:[3]

> [22] … The argument for Mr Ellwood makes more than is justified of the onus on ACC to establish definitively what the cause of on-going pain is. Mallon J's concern was that entitlements should not be suspended where the potential causes of pain were more or less equally likely hypotheses of qualifying and excluded causes. It is not inconsistent with that approach to focus in a negative sense on discounting the contribution of an injury as the cause of pain in a definitive sense, without necessarily solving every medical puzzle as to what other causes contributed to the symptoms complained of.

[54] Mr Yates submits that in any suspension decision the Tribunal must first consider whether ACC had a sufficient basis for making the decision at the time it

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1 *Ellwood v Accident Compensation Corporation* HC Wellington CIV 2005-485-536, 18 December 2006.
2 At [64].
3 *Ellwood v Accident Compensation Corporation* [2012] NZHC 2887 at [22].

was made. If it did so, the Tribunal must then consider whether the information now to hand supports the conclusion ACC reached. He refers to *Hereaka* and *Brennan.*[4]

[55] Mr Yates took the Court through all the evidence of the medical experts as set out in the background section of this judgment. Referring to Dr Walker's report of 1 September 2017, he notes that Dr Walker acknowledges there were degenerative changes shown in the appellant's MRI scan but that there was a clear and very significant accident event.

[56] He submits that at that stage although the source of the appellant's pain was in the facet joints, "nailing down" exactly where the pain was coming from was an ongoing enquiry.

[57] He refers to Dr Walker's report of 21 March 2018 where he said:

> In conclusion then I agree with Dr MacVicar's approach and that there is a persisting facet joint injury; multiple repeat medial branch blocks to the medial branches supply the left L3/4, left L4/5, and left L5/S1 facet joints is advised.

[58] He refers to Dr Walker's further report of 18 June 2018 where the doctor's opinion changed between 1 September 2017 and his third opinion of 21 March 2018.

[59] He also notes that Dr Walker's description of the accident is now that it was "moderate" in contrast to his earlier description of a clear and significant accident event.

[60] He submits that there is an unexplained downplaying of the accident's seriousness and that the role of pre-existing changes now appears to be more important to Dr Walker but with no adequate explanation.

[61] In contrast he notes that Dr Xiong, a rehabilitation and spinal specialist, describes the appellant as having had a very significant fall and that the injury is due to physical damage to the facet joints.

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[4] *Hereaka v Accident Compensation Corporation* [2010] NZACC 222; and *Brennan v Accident Compensation Corporation* [2015] NZACC 124.

[62] He submits that Dr Xiong's report is a balanced one and that his diagnosis of traumatic injury to the facet joints is clear and in effect rules out alternative causes.

[63] He submits that ACC must exclude injury deriving from the accident before it may suspend entitlements.

**The Respondent's Submissions**

[64] Mr Evans refers to s 117(1) which allows the Corporation to suspend entitlements if it is not satisfied, on the basis of the information in its possession, that the claimant is entitled to continue to receive the entitlement.

[65] Mr Evans goes through the history of the appellant's back problems and refers to the doctor's notes of 2005. He submits that in the appellant's case the degenerative element in her spine is real.

[66] He refers to the pain assessment of 14 March 2006 which records that the appellant reported she first injured her back in 1975 and has sustained so many back injuries since then that she cannot remember them all.

[67] In the same report there was evidence of mild degenerative disc disease affecting the lowest three levels.

[68] He submits that when the pain assessment was carried out in 2006, the diagnosis recorded that the right L3-4 zygapophysial joint appeared on MRI scanning to be abnormal and that that is one of the joints that is in focus in the present claim.

[69] Moving forward to the 2017 accident, Mr Evans submits that there is no discrete injury shown on the x-ray taken on 17 April 2017.

[70] The MRI scan report of 21 May 2017 notes degenerative spondylolisthesis at L3/4 and L4/5.

[71] He refers to the report of orthopaedic surgeon Mr Dalzell of 9 November 2017 in which Mr Dalzell said:

> I have explained to her that the degenerative changes in the lumbar spine are long standing and that the fall has almost certainly exacerbated those symptoms.

[72] Mr Evans notes in his addendum report of 12 December 2017 that Dr Walker appears to change his mind, saying:

> It therefore follows that if an acute injury is not the likely cause of ongoing difficulties, then pre-existing factors are likely responsible. Consistent with that Adele described to me a long history of intermittent back pain since a fall at aged 18.

[73] He submits, therefore, that ACC had ample reason for making the decision it did on 19 December 2017.

[74] Mr Evans is critical of Dr Xiong's report of 3 August 2018. He submits that Dr Xiong has not analysed the radiological evidence and does not give reasons why he finds that degeneration is not the cause of her back pain and that the injuries from 6 February 2017 are the direct cause.

[75] He submits that the Reviewer was correct in concluding that the appellant's symptoms were now due wholly or substantially to her underlying degenerative condition.

**Decision**

[76] At the time the appellant had her accident on 6 February 2017, she was a fit 60 year old who at various times over the preceding 30 years had suffered back injuries.

[77] The file contains a reasonable amount of information relating to a back injury in 2005. Back then an MRI scan showed mild facet arthrosis at L4-5 and 5 S1 and the comprehensive pain assessment initial interview report of 14 March 2006 confirmed the same noting:

> There is mild degenerative disc disease, affecting the lowest three levels but findings such as these are as common in patients who have no symptoms of back pain as they are in patients with back pain and the significance of these findings is doubtful. It is possible that her pain is of zygapophysial joint origin and the right L3-4 zygapophysial joint in particular appeared on MRI scanning to be abnormal.

[78] Also, among the documents before the Court is a report from orthopaedic surgeon Mr Inglis dated 12 June 2013 regarding a diagnosis of non specific back pain. Mr Inglis noted:

> She does not have any symptoms suggestive of either central or foraminal stenosis. I have reassured her about her future with back pain.

[79] The remaining evidence before the Court relates to her most recent accident of 6 February 2017. In his report of 10 June 2017, Mr Dalzell said:

> Her main problem is her lower back pain and she has had previous episodes of back pain but she had a severe exacerbation of her pain when she fell down some stairs. She slipped on a slippery stair in her socks and continued down the stairs on her buttocks and thighs landing heavily initially and then subsequently bouncing down the stairs. Her back pain has been quite significantly worse since this occurred and she has had to stop her work at Child Youth and Family because of the pain she gets.

[80] Mr Dalzell reviewed her x-rays and MRI scan and said:

> The MRI scan demonstrates some changes in the mid part of the lower lumbar spine and some spondylosis involving the L3/4 and L4/5 joints. There is a mild anterolisthesis grade 1 at L3/4 and some significant disc space narrowing at L4/5. This is associated with some subarticular stenosis at L4/5.

[81] Mr Yates notes that in terms of assessing the severity of the accident of 6 February 2017, Dr Walker initially described it as "a clear and significant accident event" but in a later report said that the accident was "moderate in nature".

[82] Dr Xiong said:

> The injury was a very significant trauma and it has caused extensive bruising. She showed me the picture taken that showed considerable bruising and subcutaneous haemorrhage to the buttock natal cleft area.

[83] I conclude from the evidence that the accident was a significant one.

[84] In order to more precisely identify the cause or causes of her back-pain, Dr Walker agreed with Dr MacVicar's approach that there be "multiple repeat medial branch blocks to the medial branches supplying the left L3/4, left L4/5 and left L5/S1 facet joints.

[85] Dr MacVicar carried out some of this treatment on 24 April 2018 and 3 May 2018 with a review on 4 May 2018.

[86] It appears that some success with this approach occurred at the consultation of 3 May 2018 when Dr MacVicar reported:

> Bilateral L3, 4 medial branch blocks. Probable positive response. No vascular uptake on the right, but venous blood in the hub of the needle at left L3 level again. When the needle was repositioned, there was epidural flow of contrast medium and no anaesthetic was injected at that level. Left L4 medial branch block uncomplicated. Complete relief, again without aggravation when pain returned.

[87] Dr Walker commented on 18 June 2018 as follows:

> I note repeat bilateral L3 and L4 medial branch blocks performed by Dr MacVicar on 3 May 2018. This was indicated to have been a positive response, thus concordant with the local anaesthetic used. Dr MacVicar did not however raise the possibility of a false negative test which is also common.

[88] While the analysis of Dr MacVicar's tests by Dr Walker is undoubtedly fair, we are prima facie left with the appellant obtaining complete relief from the branch blocks and as Mr Yates submits that evidence is supportive of injury rather than degeneration as being the basis for the appellant's pain.

[89] Dr Walker in his final addendum report of 18 May 2018 says that as Dr MacVicar has only investigated the L3/4 level, that has not adequately confirmed the diagnosis. He goes on to refer to persisting factors consistent with pre-existing degeneration.

[90] Dr Walker concludes the addendum with this:

> As stated, there is the option of Dr MacVicar doing a repeat L3/4 nerve block and that would increase confidence in the L3/4 diagnosis further but even so, there would still be ongoing doubt about an injury given bilateral and multi level disease and likely associated symptoms.

[91] In essence I conclude that Dr Walker does not rule out an injury cause and indeed he acknowledges that Dr MacVicar's L3/4 diagnosis supports an injury related cause.

[92] Finally, there is the report of Dr Xiong who says:

> I would certainly favour that the original injury was due to physical damage to the facet joints particularly L4/5 causing her mechanical back pain.

[93] His report goes on to acknowledge the pre-existing and co-existing degenerative changes that make it very difficult to differentiate the injury component from the degenerative component of the facet joints.

[94] Dr Xiong concludes:

> Degeneration in itself therefore is not the aetiology of her back pain while the injuries she has had from 6 February 2017 are the direct cause of her current presentations and incapacity.

[95] Dr Xiong's conclusions are challenged by Mr Evans as lacking supporting reasons.

[96] It is correct that Dr Xiong's declaration that injuries are the direct cause of her current presentations and incapacity is a short conclusion of the kind not often seen in medical reports. It is not immediately backed up with reasons. However, reading his report as a whole, I do not find that Dr Xiong has "jumped" to a conclusion. He says for example:

> I believe the pre-existing degenerative changes have not really caused a great deal of disability to her and certainly not as a significant back pain as what she currently presents.

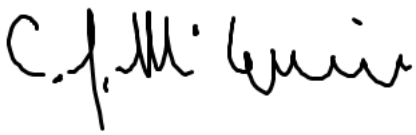
[97] He also notes:

> Her degeneration of the lumbar spine has not precluded her from working successfully and leading a normal life and working for Child Youth and Family as a resource worker for 14 years.

[98] I acknowledge Mr Yates' reference to the cases of *Hereaka* and *Brennan* that in a suspension decision the Tribunal must first consider whether ACC had a sufficient basis for making the decision at the time it was made and, if so, it must then consider whether the information now to hand supports a conclusion ACC reached.

[99] I find in this case that on the basis of the information that ACC had on 19 December 2017 it was justified in suspending the appellant's entitlement. However, on the basis of the information now at hand and in particular based on the evidence of Drs MacVicar and Xiong, I conclude that ACC no longer has sufficient basis for suspending the claimant's entitlements.

[100] Accordingly, the appeal is allowed and WellNZ's decision of 19 December 2017 to suspend the appellant's entitlements is quashed. Should there be any issue as to costs, leave is given for the parties to file memoranda in respect thereof.



Judge C J McGuire
District Court Judge

Solicitors: Young, Hunter, Christchurch for the respondent