IN THE DISTRICT COURT
AT WELLINGTON

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

[2021] NZACC 51 **ACR 228/17**

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

Hearing: 11 February 2021
Heard at: Christchurch/Ōtautahi

Appearances: The appellant in person
Mr H Evans and Ms S Tzoumis for the respondent

Judgment: 17 March 2021

RESERVED JUDGMENT OF JUDGE C J McGUIRE
[Treatment Injury – Section 32(1); Section 33
Accident Compensation Act 2001]

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[1] The issue in this appeal is whether the respondent's decision of 2 December 2016 to decline cover for a treatment injury was correct. The respondent's reason for declining cover was that the appellant's claim did not meet the criteria for a treatment injury.

The Claim

[2] On 1 July 2016, Dr Srimala Kumarapaapillai of Barrington Medical Centre completed a claim for cover for a treatment injury. Dr Kumarapaapillai noted the injury caused by treatment as being:

> Patient alleges that there was a delayed diagnosis of subtle neurological symptoms of upper limb, now found to be cervical spine tumour.

[3] In a follow up letter to ACC on 13 July 2016, Dr Kumarapaapillai clarified that the appellant stated she had informed her doctor of her symptoms in 1986, but that she was ignored, and therefore, she wanted Dr Kumarapaapillai to fill out the claim as "delay in treatment".

Background

[4] The appellant says she first presented to her GP with neurological symptoms in 1986. She says she first raised the issue with her former GP, Dr Rosemary Ford, on a number of occasions between 1986 and 2008.

[5] Unfortunately, the appellant's GP records only date back to 2008. On 11 March 2008, Ms Wylie presented to her GP complaining of numbness. Dr Ford's notes record:

> … is experiencing numbness of the hands – all the time especially the left finger. Also the front of her legs from the foot up to the thigh. This has been present for at least 2 years.
>
> She has paraesthesiae in the hands and feet. She has been attending an osteopath.
>
> She has problems with her neck and lower back.
>
> She previously did a lot of data entry while she had considerable symptoms.
>
> Lower limb reflexes all present.
>
> Upper limb reflexes – triceps and supinator on the left and right biceps present. Others not obtained.
>
> For x-ray initially. Also for nerve conduction studies if insurance will cover this.

[6] The x-ray did not provide any explanation for the numbness. There are no records of the appellant raising the issue again until 25 February 2013 where GP, Dr Sarah Howard, noted:

> Also asking re altered sensation over hands, face, upper thighs. Been there a wee while and has not got worse but not got better. Prob got used to it.
>
> Has it over face and hands and bilat thighs anteriorly.
>
> O/e nil specific to find on examination pin prick soft touch.
>
> Plan: await bloods.

[7] Dr Howard referred the appellant to Dr Parkin, Neurologist. He noted her symptoms, which had been present for the last decade or so, were a "slightly vaguely defined feeling of numbness, tingling in both hands, extending up the ulnar border of the forearm".

[8] In his report to Dr Howard of 19 September 2013, he also said, under the heading "impression":

> As I listened to her describe her sensory symptoms I initially gave passing thought to the possibility of carpal tunnel syndrome as an explanation for the night time intensification of sensory symptoms in the hands – but this clearly would not be an explanation for the wider distribution of her symptoms, so that I must admit that I was anticipating that the neurological examination would be normal. In any event, however, it is normal but for a rather subtle abnormality in the tendon reflexes. The pattern of reflexes that I have described above is one that raises the possibility of her having a mid cervical spinal cord lesion, although I should stress that the findings are relatively subtle, and that she has no motor symptoms of a spinal cord kind at all (and that, of course, a lesion in the spinal cord would not account for facial sensory symptoms, anyway). Nonetheless, spondylotic cord compression would be the most common cause of tendon reflex abnormalities of this kind and the question, in the circumstances, is the extent to which we should set out to establish whether she does or does not have a cord lesion. To go down that path, of course, would be to undertake an MRI scan through the cervical spinal cord – and I have put that proposition to her. Although she was not particularly keen to submit to the scan forthwith because of various commitments she has at present, she suggested that I should write out the request form for it and give it to her, with a view to her arranging an appointment at a time slightly more convenient for her and her life circumstances. Accordingly, I have written out a request form for an MRI scan of both the cervical spinal cord and the brain and have given it to her, with the agreement that she will present it to Hagley Radiology when the timing is right for her. I have of course, requested that a copy of the report obviously comes to you as well as to myself – whenever that might be.

[9] In December 2015, Dr Kumarapaapillai again referred the appellant to Dr Parkin. In his report of 15 December 2015, he said:

> I read back to her the description of the symptoms I had recorded in 2013, and she confirmed that they remain exactly the same now as they were then. The essence of this is that it is now a 12 year history of exclusively sensory symptoms.
>
> …
>
> As was the case when I examined her in 2013, however, her tendon reflexes were abnormal in a most subtle way. The biceps reflex on each side is only just present and the supinator reflex is absent and is accompanied by finger flexion. The triceps reflex on the right is probably reduced and that on the left marginally so. There is a positive finger jerk on the right that is not present on the left. By contrast, the knee reflexes are rather more brisk and the ankle reflexes are normal. The plantar reflex is normal on the left but somewhat more equivocal on the right.
>
> …
>
> It is the subtle abnormality in the tendon reflexes that I noted in 2013, that prompted consideration of the outside possibility that her sensory symptoms might reflect an abnormality at cervical spinal cord level. This was on the basis of the asymmetry of the finger reflexes and on what virtually amounts to an inverted radial reflex on the right and probably the left as well – clinical findings that just hint at the outside possibility of mid cervical cord pathology. While spondylotic cord compression would, statistically, speaking, be the most common explanation for reflex findings of this kind, her very lengthy history of exclusively sensory symptoms that have shown no alteration in well over a decade, would be somewhat unusual for that. Distantly on the list of alternative possibilities would be benignly behaving demyelination.
>
> I have therefore enrolled her in the system to undergo an MRI scan through the brain and cervical spinal cord.

[10] An MRI scan was carried out on 7 March 2016. Radiologist Dr Lim commented:

> Large tumour within the cervical cord. The presence of possible blood products is suspicious for ependymoma. Differentials include astrocytoma.

[11] Dr Parkin referred the appellant to the neurosurgery department of Christchurch Hospital following the MRI scan. He reported on his findings from 2013 and said:

> While, in any other context, sensory symptoms of that kind would not prompt strong thoughts about there being structural pathology underlying them, the only abnormal neurological finding I observed on clinical examination – an inverted radial reflex on both sides – was sufficiently suggestive that she might

have a mid cervical spinal cord lesion, that I recommended that she undergo an MRI scan through that region (based on the belief on my part that if she did have a cervical cord lesion this was most likely going to be spondylotic, as that is by far the most common pathology causing that particular tendon reflex abnormality, of course). At the time, Mrs Wylie was not particularly keen to submit to the scan because of various commitments she claimed to have, and she therefore suggested to me that I should write out the request form for it and give it to her, with the expectation that she would then arrange an appointment for it at a time slightly more convenient for her and her life circumstances. I therefore duly went ahead and provided her with the request form for the scan, with the agreement that she would present it to Hagley Radiology when the timing was right. In the event, however, she failed to follow through with that so that the scan was never done.

I next caught up with her two years later at a hospital outpatient clinic, for the review of exactly the same symptoms as those I'd seen her for in 2013. When I read out to her from my 2013 letter the description of her symptoms that she had provided me then, she acknowledged that her current symptoms remain exactly the same now as they were at that time.

…

Thus, my concern about this potentially reflecting mid-cervical cord pathology was the same as it had been when I first met her two years before, and this time I was more determined to not let her escape without undergoing the previously intended MRI. At the time of my dictating this, the first scan series has clearly suggested an intrinsic tumour adjacent to the C7 vertebral body and with signal change extending rostrally up the cervical cord, with associated swelling.

…

In summary, if the sensory symptoms in her upper limbs are truly reflective of this cord lesion, the inference must be that it has been there for at least 15 years and that it has behaved in an extremely indolent way, producing what remains a relatively subtle motor impairment abnormality on clinical examination and one which has shown only marginal change in what effectively amounts to have been a two year period of clinical "follow up".

[12] Neurosurgeon, Mr De Tommasi, reported on 4 April 2016. His report included the following:

In summary, Mrs Wylie is a previously healthy 57 year old lady presenting with a 15 year history of sensory symptoms consistent with the described lesion at C7. The lesion is most consistent within ependymoma or an astrocytoma.

I discussed the nature of the diagnosis and the possible differential diagnosis with Mrs Wylie and her family. My general recommendation in the presence of a tumour like this would be to consider a biopsy in order to get a tissue diagnosis and decompress the cyst. That said, surgery at the cervical level carries some morbidity and there is some risk of permanent sensory findings, balance impairment, quadriparesis of quadriplegia.

> In consideration of the indolent course of the tumour I think a conservative management is also a reasonable approach with the goal of repeating a scan in six months' time.

[13] Following receipt of the appellant's claim in July 2016, ACC sought advice from its clinical advisor Dr Neall Holland, asking Dr Holland the following question:

> Subsequent to Mrs Wylie's consultation with Mr Parkin in September 2013 (which was detailed in the letter to GP Dr Howard dated 19 September 2013) should the GP have initiated contact with Ms Wylie to determine if she had undergone an MRI scan, and/or to monitor her altered sensory symptoms?

[14] In response, Dr Holland stated:

> The Royal College of General Practitioners (RNZCGP), the standard setting body for general practice, has a clear policy statement on the management of test results ordered by a general practitioner. If the results are of critical importance or high risk, then the general practitioner is expected to have in place a reminder system to track unfulfilled results that they have ordered. However, this policy does not cover the unusual situation presented in this case.
>
> In this case the general practitioner had referred Mrs Wylie to Dr Parkin, a consultant neurologist, for assessment in his private practice. Once Mrs Wylie came under Dr Parkin's care for this problem the responsibility for ongoing management of the problem would ordinarily remain with the consultant until he formally return her to general practitioner care.
>
> Dr Parkin found certain changes that led him to believe that an MRI was indicated. The consultant's letter describes precise and clear instructions to the patient as to the reason for and nature of the investigation recommended and that a referral form was provided. It also describes the choice of the patient to defer this investigation to a time of her choosing. At this point the responsibility for this investigation shifted from the consultant to the patient, given that she was a competent person and this was her personal and informed choice. Ms Wylie has expressed belief that the general practitioner should have initiated contact with her to determine if she had undergone the MRI scan. The RNZCGP document cited above includes the following expression of concern:
>
> > Patients have some responsibility for following up their own test results, and for doctors to assume all of this responsibility is paternalistic and infantilising.
>
> The previous Health and Disability Commissioner, Dr Ron Patterson, became concerned about GPs failing to track and notify test results. He stated that "a doctor is responsible for having an efficient system for identifying and following up overdue test results".
>
> The former quote compared with the latter illustrates the tension of responsibility in dealing with a competent and autonomous person. This is advice expressed in the case of the general practitioner ordering tests which the patient neglects to take. In this case where the tests were not ordered by the general practitioner and the patient has clearly chosen her own timing for the

> investigation, it is well beyond the normal expectations on a general practitioner to monitor whether a competent patient has chosen to proceed with a test that was ordered by someone else. It is very likely also to be beyond the expectations of the consultant, given Ms Wylie's choice to take informed responsibility.
>
> The specialist letter to the general practitioner in 2013 advises the general practitioner of Ms Wylie's choice but does not include any instructions to the general practitioner to reassume her care for this condition. There is thus no formal handing back of care and it is clear that the neurologist expected Ms Wylie to take the next step and that his ongoing care was contingent on this.
>
> This advice might be different had Ms Wylie returned to the general practitioner with further concern about her symptoms or a specific request to proceed with investigations. But the records provide no evidence that this happened. Of note, in this case there are long intervals between the patient presenting herself to the general practitioner and symptoms relating to her tumour. There are records available for only two general practitioner contacts in the 10 years of symptoms. Thus there is no evidence from the records to suggest that any other intervention was warranted by the general practitioner than that which occurred.

[15] ACC also sought advice from Dr Wallis, Neurologist. He answered a number of questions posed to him in his report of 27 September 2016, including:

> Do you consider Mr Parkin's assessment of Ms Wylie in September 2013 was in keeping with a reasonable standard of medical practice?
>
> Yes. This report of 2013 is a comprehensive assessment of both the relevant neurological history and examination. Dr Parkin recognised that the inverted radial reflex was a significant neurological finding that may indicate both cervical radiculopathy and myelopathy pathology the C5/C6 level. This is why he arranged MR imaging of the cervical spine. He also ordered imaging of the brain, as one of the causes of a lesion involving the cervical spine at the level in question is multiple sclerosis; and if there are demyelinating lesions found on MR imaging of the cervical spine, it is important to know whether there are more widespread signs of demyelination involving the white matter of the brain, all of which would be strong evidence of multiple sclerosis. I can find nothing to criticise in Dr Parkin's assessment and consider it to be of a standard one would expect of an expert clinical neurologist.

[16] In August 2016, the appellant underwent surgery recommended by Mr De Tommasi in his report of 4 April 2016. She had a clinical follow up on 31 January 2017.

[17] In his report of 3 February 2017, Dr Nguyen, Neurological Registrar, noted:

> I have also reviewed her MRI scan of the cervical spine dated 02/12/2016. The scan shows essentially interval debulking of her ependymoma. As we knew more or less from the operation, there is a residual tumour roughly at the C7 level. Of note there is significantly improved swelling of the cervical spinal

cord and improved oedema. The thickness of the cord is significantly improved since her pre-operative scan.

I spoke with Mrs Wylie at length about her current symptoms and condition, and the results of her recent MRI scan. Although I am pleased that she still continues to have objectively good strength in her extremities and a relatively reasonable level of functioning, I do understand that she is becoming quite frustrated with her burning and paraesthesia on her left side. I went over the results of her MRI scan with her today in clinic. We know that there is a residual tumour in her cord, but happy with the decreased swelling. As I explained to her the location of the tumour makes treatment and surgery difficult.

We previously discussed her case in our multi-disciplinary meeting. At this point in time we will plan on a repeat MRI scan of the entire spine in six months to keep an eye on things. If there are any questions or concerns before then please don't hesitate to contact us.

[18] On 22 May 2017, Mr De Tommasi provided a further report to the clinical advisor of the ACC treatment injury centre. Amongst other things, he said:

Her case was discussed in the multi-disciplinary meeting held on 18 January 2017 and a suggestion was made to repeat an MRI in 6 months including the whole spine to see whether or not there was any dissemination of the tumour in the rest of the spinal cord. As the disease has apparently been stable for a prolonged period, opinion was that adjuvant treatment could be withheld, although further clinical radiological progression would necessitate either further surgery and/or radiation treatment. I discussed all these findings with Ms Wylie and I scheduled a new MRI which she is currently awaiting.

…

When confronted with a tumour in the spinal cord, the first goal is to try and establish the nature of the tumour and in this case the working diagnoses were ependymoma vs astrocytoma. Generally, the mainstay of treatment is surgery with a goal of obtaining a tissue diagnosis and removing the tumour. The present case was unusual in that we had a detailed neurological assessment that had been done 3 years before by the same neurologist and there had been no change in the patient's neurological function. Therefore we considered conservative management as an alternative option. Surgery was uncomplicated and revealed the tumour to be consistent with an ependymoma. Only partial removal of the tumour was accomplished during the procedure. It was the opinion of the MDT team that, in consideration of the clinical course and the improved symptoms, conservative management with no further treatment was the best way to manage the tumour further.

With regards to further management, at the moment we have scheduled a new MRI of the whole spinal cord to assess for possible spreading of the tumour within the rest of the cord. Based on the next MRI finding, further management option will include redo surgery, attempting to remove all the tumour and then + or – radiation treatment. The next MRI will be discussed in the multidisciplinary meeting as well.

The Appellant's Submissions

[19] In a handwritten submission filed prior to the hearing, the appellant said:

> The criteria for a delay to diagnosis has been met on all levels.
>
> Has there been a delay: yes!! Everyone agrees that there has been.
>
> 1986 first presented to my GP.
>
> 2016 finally a diagnosis.
>
> Has this caused more injury? It has from the fact that the tumour has grown and impeded on my spinal cord.
>
> The 30 year delay in first telling my GP to an actual diagnosis, has made it impossible to completely remove.
>
> I have enclosed a report from the neurosurgeon stating how much of an improvement in my spinal cord and improved oedema.
>
> The thickness of the cord is significantly improved since my pre-operative scans. That basically says it all, just on that one statement, the declined ACC treatment injury should be reversed.
>
> ACC declined my request on the fact that I did not have an MRI in 2013, when requested from the neurologist, was pure and simply because I could not afford it, which I told Mr Parkin was the reason.
>
> I could not do it straight away, if Mr Parkin was so concerned about me having an MRI, he should have referred me through to the public system, but this was not offered and I did not know it was an option as I had been turned down a number of times. He stated in his notes that he thought it would be a spinal cord tumour, I only saw this report after I requested my medical notes from my GP. I was never sent a copy. I would certainly have found a way to get an MRI if he had told me what he thought it was.
>
> All these medical people are the experts and you expect them to direct you for the best outcome whether the patient can afford it or not.
>
> All I am saying is if there was an improvement after surgery 30 years after presenting to the doctor, then it could possibly have been able to be completely removed if the doctor had done her job in the first place – 30 years previous.

[20] In her oral submissions Mrs Wylie told the Court that she first had symptoms of hand numbness just after her first baby in 1986, and it was suggested to her it might be carpal tunnel syndrome. She said six months later the numbness disappeared, and it reappeared again two years later when her second son was born. It again disappeared until 1997, 1998 when her son was 11 years old, and she found her face going numb.

[21] She remembers going to the doctor who thought it might be multiple sclerosis.

[22] She said that her doctor tried to get her an appointment with a neurologist but that was turned down.

[23] She said that in 2011 she told her doctor that she would pay to go to a neurologist.

[24] She said that she saw Mr Parkin who said that everything was fine but suggested an MRI scan. She said that this was going to cost $2,500, so she put it off.

[25] She says that Mr Parkin never mentioned the possibility of a spinal cord tumour. Furthermore, she never saw Mr Parkin's report of 19 September 2013 to her GP.

[26] She says that when she finally got an MRI scan, Mr Parkin said:

> Sorry there's a rather large tumour on your spinal cord.

[27] She emphasises the delay in diagnosis. She says it should have been picked up many years earlier.

[28] She says that someone should have said along the way that this woman has neurological problems, and we should have done something.

The Respondent's Submissions

[29] Mr Evans refers to the Court of Appeal's decision in *Adlam v Accident Compensation Corporation* which says:[1]

> [62] … The injury said to be a treatment injury must be the consequence of a departure from appropriate treatment choices and treatment actions.

[30] He took the Court through the available medical records that date from 2008. He refers to the x-ray report of 19 March 2008 which he submits included "nothing untoward".

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1 *Adlam v Accident Compensation Corporation* [2017] NZCA 457, [2018] 2 NZLR 102 at [62].

[31] Mr Evans refers to Mr Parkin's report of 19 September 2013 where after describing the appellant's altered sensations and hand numbness, he says:

> Thus, there has been no disturbance in motor function over that whole period [the last decade] and, on questioning her repeatedly about the point, she said that there had been little overall change in her symptoms over this 10 year period. Then having raised the possibility of her having a mid cervical spinal cord lesion

[32] Dr Parkin says:

> Nonetheless spondylotic cord compression would be the most common cause of tendon reflex abnormalities of this kind and the question, in the circumstances, is the extent to which we should set out to establish whether she does, or does not, have a cord lesion. To go down that path, of course, would be to undertake an MRI scan through the cervical spinal cord – and I have put that proposition to her.

[33] Dr Parkin goes on to note that the appellant was not particularly keen to submit to the scan forthwith because of other commitments but with her agreement wrote out a request form for an MRI scan of both the cervical spinal cord and the brain, which he gave to her with the agreement that she would present it to Hadley Radiology when the timing was right for her.

[34] Mr Evans notes that when Dr Parkin next saw the appellant in December 2015:

> She confirmed that they (the symptoms) remain exactly the same as they were then (in 2013).

[35] On that occasion on 15 December 2015, Dr Parkin enrolled her to undergo an MRI scan through the brain and cervical spinal cord.

[36] Once the MRI scan was carried out on 7 March 2016, Dr Parkin again reported. Mr Evans refers to the fact that in Dr Parkin's report of 11 March 2016, he says:

> … the inference must be that it (the spinal cord lesion) has been there for at least 15 years and that it has behaved in an extremely indolent way, producing what remains a relatively subtle motor impairment abnormality on clinical examination and one that has shown only minimal change in what effectively amounts to have been a two year period of clinical "follow up".

[37] Next, Mr Evans draws attention to the treatment injury advice of Dr Holland dated 19 September 2016 where he says:

> The specialist letter to the general practitioner in 2013 advises the general practitioner of Mrs Wylie's choice but does not include any instructions to the general practitioner to reassume her care for this condition. There is thus no formal handing back of care and it is clear that the neurologist expected Ms Wylie to take the next step and that his ongoing care was contingent on this.

[38] In a further treatment injury advice report of Dr Wallis dated 27 September 2016, Dr Wallis focuses on the time period between 2013 and 2015 when the scan was done. Dr Wallis says:

> But there is no evidence that she deteriorated during this time or that the delay between 2013 and 2015 produced any worsening of her neurological symptoms or change in her prognosis.

[39] Dr Wallis concludes:

> There is no evidence of treatment injury. Her assessment by Dr Parkin in 2013 was to a standard one would expect from a consultant neurologist in New Zealand.

[40] Mr Evans submits that the requirements of s 33 of the Act are not met and that the evidence is that there was no deterioration in her condition in the two years between 2013 and 2015 and that subsequent to 2015 the decision has been to treat her conservatively in any event.

Decision

[41] This is a treatment injury claim. The Accident Compensation Act 2001 deals with treatment injury claims in ss 32 and 33.

[42] So far as it is relevant s 32(1) provides:

> Treatment injury means personal injury that is suffered by a person –
>
> (i) Seeking treatment from one or more registered health professionals … and
>
> (b) Caused by treatment; and
> (c) Not … an ordinary consequence of the treatment, taking into account all the circumstances of the treatment, including –
>
> …
>
> (ii) The clinical knowledge at the time of the treatment.
>
> …

(iii) The fact that the treatment did not achieve a desired result does not, of itself, constitute treatment injury.

[43] Section 33 of the Act defines treatment as follows:

> (1) For the purposes of determining whether a treatment injury has occurred or when that injury occurred, treatment includes –
>
> …
>
> (b) A diagnosis of a person's medical condition:
>
> …
>
> (d) A failure to provide treatment, or to provide treatment in a timely manner.

[44] In this case the medical records that we have date back only as far as 2008.

[45] Mr De Tommasi in his report of 4 April 2016 notes:

> Mrs Wylie has been experiencing symptoms for at least 15 or 20 years. She does also report an episode of numbness in both of her hands after she gave birth at the age of 27. This episode lasted only six months and was diagnosed as a possible transient carpal tunnel syndrome. It is very difficult to say whether or not this was an early manifestation of the tumour.

[46] In her submission/statement to the Court, Mrs Wylie said that she first presented to her GP with the problem in 1986. At that time she would have been 27 or 28 years old. There is no further evidence of what occurred back then but as the episode of numbness lasted only six months, it may be inferred that both the appellant and her doctor concluded that the episode was over.

[47] The next way point is in 2008 when she went to her GP on 11 March of that year. The GP notes record:

> She is experiencing numbness of the hands – all the time especially the left fifth finger. Also the front of her legs from foot up to the thigh. This has been present for at least two years.
>
> She has parasthaesiae in the hands and feet. She has been attending an osteopath.
>
> She has problems with her neck and lower back.
>
> She previously did a lot of data entry when she had considerable symptoms.

> Lower limb reflexes all present.
>
> Upper limb reflexes – triceps and supinator on the left and right biceps present. Others not obtained.
>
> For x-ray initially. Also for nerve conduction studies if insurance will cover this.

[48] The x-ray was duly carried out on 19 March 2008 and in essence revealed nothing of particular significance.

[49] Likewise, there is no evidence that nerve conduction studies were carried out.

[50] As at 2008, therefore, the fact that nothing of significance was revealed by the x-ray appears to have ended clinical enquiries at that stage. I infer that, because of the somewhat "elusive" presentation of the appellant's symptoms, there was no obvious next step towards a firm diagnosis. It is noted that the appellant had been attending an osteopath. Also, it seems that her work doing data entry was a possible contributor to symptoms. There was no evidence at the hearing as to whether nerve conduction studies were undertaken. The GP's note appears to make this contingent on whether the appellant's medical insurance would provide cover for this treatment.

[51] The GP's note next records a series of consultations in September and October 2011 regarding a lump on her back. The entry of 12 September 2011 records:

> Here regarding lump on back. Has been there a few years but recently increased in size.

[52] The lump was removed, with the last of 8 consultations regarding this issue being on 18 October 2011.

[53] The next entry is on 25 February 2013. The note records:

> Also asking re altered sensation over hands, face, upper thighs. Been there a wee while and has not got worse but not got better. Prob got used to it.
>
> Has it over face and hands and bilat thighs anteriorly.
>
> O/E nil specific to find an examination pin prick soft touch.
>
> Plan: await bloods.

[54] There is no further medical record until Dr Parkin's report of 19 September 2013.

[55] In his report of 19 September 2013, Dr Parkin says:

> Her symptoms have been present for the last decade or so, as a slightly vaguely feeling of numbness/tingling in both hands, extending up the ulnar border of the forearm. She makes the point that the altered sensation over the forearm is particularly intense and unpleasant if she should happen to rest her forearm on a glass table top, when it results in a most unusual and unpleasant sensory experience there. In addition, she often awakes at night with an intensification of the hand numbness, prompting her to shake and move them about in a quest for relief. In addition there has been some sort of vaguely altered sensation over the anterior thighs and lateral calves, and she also referred to altered sensation on both sides of the face. Her symptoms are exclusively sensory in nature. Thus, there has been no disturbance in motor function of any kind over that whole period and, on questioning her repeatedly about the point, she said that there had been little overall change in her symptoms over this 10 year period.

[56] Under the heading "impression" Dr Parkin says this:

> As I listened to her describe her sensory symptoms I initially gave passing thought to the possibility of carpal tunnel syndrome as an explanation for the night time intensification of sensory symptoms in the hands – but this clearly would not be an explanation for the wider distribution of her symptoms, so that I must admit that I was anticipating that the neurological examination would be normal. In any event, however, it is normal but for a rather subtle abnormality in tendon reflexes. The pattern of reflexes that I have described above is one that raises the possibility of her having a mid cervical spinal cord lesion, although I should stress that the findings are relatively subtle, and that she has no motor symptoms of a spinal cord kind at all (and that, of course, a lesion in the spinal cord would not account for facial sensory symptoms, anyway). Nonetheless, spondylotic cord compression would be the most common cause of tendon reflex abnormalities of this kind and the question, in the circumstances is the extent to which we should set out to establish whether she does or does not have a cord lesion. To go down that path, of course, would be to undertake an MRI scan through the spinal cord – and I have put that proposition to her. Although she was not particularly keen to submit to the scan forthwith, because of various commitments she has a present, she suggested that I should write out the request form for it and give it to her, with a view to her arranging an appointment at a time slightly more convenient for her and her life circumstances. Accordingly, I have written out a request form for an MRI scan of both the cervical spinal cord and the brain and have given it to her, with the agreement that she will present it to Hadley Radiology when the timing is right for her.
>
> The evidence available to us relating to her efforts to obtain a diagnosis and treatment up to 2013 lead to a conclusion that while her numbness in both hands and elsewhere had been ongoing for some 27 years the progression of this numbness and tingling appears to have been very slow indeed and for most of this period appeared to be something that she could live with. This appears to

> be borne out by the passage of years during which she sought no further help or investigation of these problems. As is shown in the medical notes there is little or no indication from her that the problems have been getting worse. Indeed they are not mentioned at all in the notes of her eight visits to the GP in 2011 when she had the lump on her back removed.

[57] Regarding the effort in March 2008 to identify the cause of the numbness, there was the clinical note of 11 March 2008 which stated: "also for nerve conduction studies if insurance will cover this". There is no evidence that anything in the way of nerve conduction studies were carried out, and it appears that from the records before the Court, the next occasion on which she saw her GP was on 12 September 2011 for the lump on her back.

[58] The x-ray carried out on 19 March 2008 appears to have been normal for someone of her age.

[59] As mentioned, the numbness and altered sensation is not mentioned in the medical notes for the 2011 GP visits.

[60] Plainly, however, this had changed by 2013 when this issue was the focus of her GP visit of 25 February 2013, leading to her consultation with Dr Parkin, neurologist, on 19 September 2013.

[61] Her evidence is that she was unaware of the possibility of a spinal cord lesion because she only saw Dr Parkin's report after she requested her medical notes from her GP.

[62] She said at the hearing that if she had seen Dr Parkin's report of 19 September 2013, "no one in their right mind would have done nothing".

[63] That said, it is clear from Dr Parkin's report of 19 September 2013 that there was substantial focus at that consultation on what to do next.

[64] Dr Parkin said:

> Nonetheless, spondylotic cord compression would be the most common cause of tendon reflex abnormalities of this kind and the question, in the circumstances, is the extent to which we should set out to establish whether she

> does, or does not have a cord lesion. To go down that path, of course, would be to undertake an MRI scan through the cervical spinal cord – and I have put that proposition to her. Although she was not particularly keen to submit to the scan forthwith, because of various commitments she has at present, she suggested that I should write out the request form for it and give it to her, with a view to her arranging an appointment at a time slightly more convenient to her and her life circumstances.

[65] Accordingly, I find that Dr Parkin did his best at this consultation to place the appellant on track for an MRI scan of her cervical spine and brain.

[66] Equally, however, it is not unusual for a lay person with the stress of a medical condition and in the unfamiliar surroundings of a specialist consultation, not to recall all details of what was discussed and agreed upon.

[67] It was just over two years later on 15 December 2015 that the appellant next saw Dr Parkin after a further referral from her GP.

[68] In his report of 15 December 2015, he says:

> I read back to her the description of the symptoms I had recorded in 2013, and she confirmed that they remain exactly the same now as they were then. The essence of this is that it is now a 12 year history of exclusively sensory symptoms.
>
> …
>
> While spondylotic cord compression would statistically speaking be the most common explanation for reflex findings of this kind, her very lengthy history of exclusively sensory symptoms that have shown no alteration well over a decade, would be somewhat unusual for that. Distantly on the list of alternative possibilities would be benignly behaving demyelination.
>
> I have therefore enrolled her in the system to undergo an MRI scan through the brain and cervical spine.

[69] Following this, after consultation with neurosurgeon Mr De Tommasi, she had the recommended biopsy in order to get a tissue diagnosis and to decompress the cyst.

[70] In the treatment injury advice report of Dr Neall Holland dated 19 September 2016, he says:

> In this case, where tests were not ordered by the general practitioner and the patient has clearly chosen her own timing for the investigation, it is well beyond the normal expectations on a general practitioner to monitor whether a competent patient has chosen to proceed with a test that was ordered by someone else. It is very likely also to be beyond the expectations on the consultant, given Mrs Wylie's choice to take informed responsibility.
>
> …
>
> This advice might be different had Mrs Wylie returned to the general practitioner with further concern about her symptoms or a specific request to proceed with investigations.

[71] In a further treatment injury advice report of neurologist Dr Wallis dated 27 September 2016, he says:

> In conclusion, Mrs Wylie did not have the MRI scan of the cervical spine as ordered by Dr Parkin in 2013. There is no contemporary documentation that she contacted Dr Parkin to explain why she did not carry out the scan. Accordingly, there was a delay in reaching a satisfactory explanation for her symptoms until late 2015, but there is no evidence that she deteriorated during this time or that the delay between 2013 and 2015 produced any worsening of her neurological symptoms or change to her prognosis. In fact, it appears that at least at present the decision has been to observe her rather than more aggressive surgical treatment, so that whatever delay has occurred in the diagnosis has so far not changed her management.

[72] For the purposes of s 33 the "treatment" that is under the spotlight in this case is:

> Section 33(1)(d) - a failure to provide treatment, or to provide treatment in a timely manner.

[73] The other requirement is that there be a treatment injury as described in s 32, that is to say a personal injury suffered by the appellant and caused by treatment, or more specifically in this case caused by the failure to treat.

[74] In this case on the evidence as it stands which is notably from the appellant herself, there was no difference in her presentation between 2013 and 2015. It is therefore not possible to conclude on the balance of probabilities that she suffered a treatment injury during this time.

[75] Plainly, however, between 1986 when she first felt initial symptoms of numbness and 2013, there was a worsening of symptoms and logically a progression of the lesion.

[76] However, as her history shows, none of that progression is shown to be as a result of a failure to treat by a medical professional.

[77] During this time, no doubt the appellant was busy with work and family. The x-ray she undertook in 2008 was regarded as normal and the appellant pursued nothing further until 2013.

[78] As the Court of Appeal in *Adlam v Accident Compensation Corporation* said:[2]

> [52] … In order for there to be a failure to provide treatment, we consider there must have been some indication at the time of the failure that the treatment not provided should have been provided. Unless that approach is taken it is difficult to see how there could be a relevant failure to provide treatment that caused the personal injury.

[79] It is also notable that even in 2013 Dr Parkin was somewhat perplexed saying:

> As I listened to her describe her sensory symptoms I initially gave a passing thought to the possibility of carpal tunnel syndrome as an explanation for the night time intensification of sensory symptoms in the hands – but this clearly would not be an explanation for the wider distribution of her symptoms, so that I must admit that I was anticipating that the neurological examination would be normal. In the event, however it is normal but for rather subtle abnormalities in tendon reflexes. The pattern of reflexes that I have described above is one that raises the possibility of her having a mid cervical spinal cord lesion, although I should stress that the findings are relatively subtle, and that she has no motor symptoms of a spinal cord kind at all (and that, of course, a lesion in the spinal cord would not account for facial sensory symptoms anyway).

[80] The Court of Appeal in *Adlam v Accident Compensation Corporation* also said:[3]

> [62] Taken as a whole the provisions indicate a legislative intent to limit cover for persons who suffer injury while undergoing treatment, rather than providing cover for all those who suffer. The injury said to be a treatment injury must be the consequence of a departure from appropriate treatment choices and treatment actions. The drafting could have simply provided for cover for all injuries suffered while a person undergoes treatment. But that course was not

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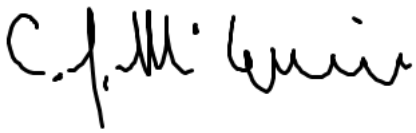
2 *Adlam v Accident Compensation Corporation*, above n 1, at [52].
3 At [62].

> taken. Rather, boundaries are set out that have the effect of limiting the availability of cover for injury during treatment. A failure in the sense of omitting to take a step required by an objective standard is necessary.

[81] Applying this test, I am driven to conclude that in the particular circumstances of her consultation with Dr Parkin in September 2013 resulting in his providing her with a request form for an MRI scan, I am unable to conclude that after applying an objective standard there was a failure by Dr Parkin and the appellant's GP to provide treatment. Accordingly, therefore, I must dismiss the appeal.



Judge C J McGuire
District Court Judge

Solicitors: Young Hunter, Christchurch for the respondent