IN THE DISTRICT COURT
AT WELLINGTON

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

[2021] NZACC 52 **ACR 35/19**

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

Hearing: 10 February 2021
Heard at: Christchurch/Ōtautahi

Appearances: Ms P Tucker together with Mrs L Thompson (wife of the appellant) on behalf of the appellant
Mr J P Coates and Ms A N Lane for the respondent

Judgment: 17 March 2021

RESERVED JUDGMENT OF JUDGE C J McGUIRE
[Section 117(1) – Suspension of Weekly Compensation
Accident Compensation Act 2001]

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[1] The issue on appeal is whether the respondent's decision of 7 August 2018 to suspend Mr Thompson's weekly compensation payments was correct. In particular whether on 7 August 2018 the respondent had sufficient basis to be satisfied, on the basis of the information in its possession that Mr Thompson was no longer entitled to weekly compensation. A further issue is whether there remains sufficient basis for the respondent to be satisfied that Mr Thompson is no longer entitled to weekly compensation.

Background

[2] On 25 November 2009, while working as a travelling salesman for an eyewear company, the appellant jumped off the back of a truck and landed heavily on his right foot.

[3] On 26 November 2019, the appellant saw his GP, Dr Thomson, who recorded in a referral to an orthopaedic surgeon on 18 December 2019:

> He was seen on 26/11/09 but is a stoical character and declined investigation and tried NSAIDS (non steroidal anti inflammatory drugs instead for a week.

[4] ACC granted cover for a work-related ankle sprain.

[5] On 4 December 2009, the appellant again saw his GP and this time was referred for an x-ray and ultrasound which were performed later the same day. The x-ray showed a "subtle" calcaneal (heel bone) fracture, and the ultrasound demonstrated ligamentous injuries to Mr Thompson's ankle.

[6] On 11 December 2009, the appellant had a follow up appointment with his GP who reported that at the time he could walk with pain and was still working.

[7] On 1 June 2011, Mr Thompson was involved in a car accident. His GP noted that he suffered "patella-femoral injury sprain L wrist and R ankle and lower back". On 18 October 2011, Dr Thomson noted that the appellant's ankles and knees were still painful. On 17 November 2011, Dr Thomson recorded that "the accident on 1/6/11 exacerbated previous injury to his ankle that was sustained on 25/11/09". On 23 November 2011, Dr Thomson recorded that the appellant was no longer able to work. The patient medical history records:

> Right ankle still painful, unable to walk normally, difficulty in driving car because cannot put full pressure on brake when required, previous injury to R ankle Dec 2009, had continued working until recent injury but has now found pain increased and cannot continue.

[8] Dr Thomson provided a medical certificate for four weeks off work.

[9] Mr Thompson was referred to Mr Rod Maxwell, Orthopaedic Surgeon. On 20 December 2011, Mr Maxwell submitted an Assessment Report and Treatment Plan ("ARTP") to ACC requesting funding for an arthroscopic debridement and lateral ligament reconstruction for Mr Thompson's right ankle. Mr Maxwell noted that:

> Given that he works as a travelling salesman and this is his right ankle, he will have to have some time off work, and he will be able to drive when he can walk unaided without crutches.

[10] ACC approved surgery and on 6 March 2014 Mr Thompson underwent surgery. In his report of 11 March 2014, Mr Maxwell said:

> Because of the degree of damage to his ligament complex, rather than going into a moon boot and weight bearing at one week, he will stay in a non weight bearing plaster for a total of six weeks post op.

[11] On 15 May 2014, Mr Thompson saw Mr Maxwell for a post operative review. Mr Maxwell noted that Mr Thompson:

> Demonstrates an unusual post operative course following his quite straightforward arthroscopy and lateral ligament reconstruction right ankle performed on 6.3.14. Despite stable reconstruction he has had great difficulty putting his foot on the ground. Despite my reassurance that his ligament complex is quite stable, now at two months from surgery, he refuses to put any weight on the foot and at my last consultation on 14.4.14 when I put him in a moon boot, told him that he could now bear weight, he tells me that he has not been able to put his foot on the ground. Clearly and unusually he needs some supplementary help and I have referred him to his local physiotherapist to encourage him to bear weight, and work on a range of movement recovery. This doesn't seem to be a pain issue, he doesn't have any features of regional pain syndrome, he says that he fees nauseated at the thought of putting his foot on the ground.

[12] On 17 June 2014, Mr Maxwell reviewed the appellant again who said that his:

> Lateral ligament reconstruction is very stable now at four months since surgery, and he is aware of the improved stability. Hopefully he can get off the crutches over the next few weeks, and perhaps be able to return to work in about a month's time.

[13] On 9 October 2014, the appellant signed a new individual rehabilitation plan, stating that he would be assessed by an occupational physician with a view to identifying any outstanding treatment or rehabilitation required to help him regain his independence. He was referred to Dr Hilliard, Occupational Medicine Specialist.

[14] Over the next 11 months Mr Thompson did not attend numerous appointments made for him with the occupational medicine specialists and the providers declined to make further appointments because they could not be confident he would attend.

[15] By letter of 4 August 2015, Mr Thompson's weekly entitlements were briefly suspended because he was not meeting his statutory obligations.

[16] The same letter listed five occasions between 3 November 2014 and 24 April 2015 when the appellant failed to attend occupational medical assessment appointments.

[17] On 21 August 2015, Mr Maxwell reported to the appellant's GP that he now had "full blown chronic regional pain syndrome right ankle".

[18] On 30 September 2015, the appellant was assessed by Dr Turner, occupational medicine specialist. This was a comprehensive assessment and Dr Turner prepared a substantive report.

[19] Dr Turner noted at page 9 of his report:

> He initially requested that I did not touch his right leg during the examination as he described the minimal contact caused significant pain. He indicated that he was markedly hypersensitive over his right ankle and his right foot, the hypersensitivity extending all the way up to the knee. There was no hypersensitivity in the left leg. He was observed to make contact with the couch partway through the examination and there is no evidence of suddenly withdrawing of the right foot/ankle.

[20] Dr Turner diagnosed Mr Thompson with post traumatic regional pain syndrome.

[21] In his report, under the heading "diagnosis", Dr Turner said:

> In my opinion Russell suffers from a chronic pain syndrome effecting predominantly his right ankle and foot and to a lesser extent his lower leg from knee to the ankle. Clinically he has the symptoms and signs that confirm this diagnosis. He has persistent and constant pain with hypersensitivity and hyperalgesia and allodynia in a diffused distribution in his right lower leg and knee distally. As evident in my assessment there was a somewhat variable response to light touch or contact about the right lower leg, ankle and foot (varying from marked withdrawal to no response in the presence of masking)

> but generally there was reasonable evidence to conclude significant hypersensitivity with allodynia especially about the ankle which is typical of regional pain syndrome disorder.

[22] As a result of Dr Turner's report, the respondent referred Mr Thompson for psychological assessment.

[23] On 1 February 2016, the appellant was reviewed by Dr Fran Brynn, Psychologist. Dr Brynn noted that Mr Thompson did not attend his appointment scheduled for 14 December 2015.

[24] Dr Brynn noted:

> He now presents with a predominant somatic focus and fear avoidance resulting in social withdrawal, anxiety and depressed mood. These factors impact upon pain through up regulation of the sympathetic nervous system and resulting tension, poor nutrition and chronic sleep disruption.

[25] Dr Brynn also said:

> Psychological strategies will be important to gently challenge some of his beliefs regarding his condition, and to provide him with strategies to increase his self efficacy regarding pain through the use of strategies rather than medication or further surgery.

[26] Dr Brynn also set out four functional objectives to be achieved:

> 1. Establish rapport and trust within the therapeutic relationship – by 15/03/16.
>
> 2. Provide strategies to address pain and fatigue through autonomous nervous system balancing – 15/03/16.
>
> 3. Psychoeducation to increase engagement with multidisciplinary pain management approach – 15/04/16.
>
> 4. Behavioural reactivation strategies – 15/05/16.

[27] On 6 April 2017, a pain management plan, update and completion report was completed by assessor Julianne Grant.

[28] Amongst other things Ms Grant noted the following:

> Walking with limp – minimal weightbearing through right leg.

> Uses crutches for longer distances.
>
> … uses numbing gel on entire body.
>
> Rolls trouser legs up.
>
> …
>
> Client reports he has not worn shoes or socks since surgery in 2014.

[29] Ms Grant recorded that the appellant would like the following question/issues addressed:

> 1. His hearing is deteriorating is he entitled to any assistance regarding this?
> 2. His eyesight is diminished, is he entitled to any assistance regarding this?
> 3. He would like his wife to understand his condition and be more tolerant.
> 4. Is he getting all the financial help from ACC that he is entitled to?
> 5. He would like ACC and his case manager to be aware of the trauma and negative impact of his dealings with ACC and how this has effected him.

[30] In May 2017, ACC received information that the appellant may be working. ACC Integrity Services engaged a private investigator to undertake surveillance of the appellant under the authority of the Search and Surveillance Act 2012 and the Private Security Personnel and Private Investigator (Code of Conduct – Surveillance of Individuals) Regulations 2011. The private investigator carried out surveillance on the appellant, including obtaining video footage on 17, 18, 24 and 26 July 2017 and on 22 and 24 August 2017.

[31] The investigator concluded:

> For clarity, the surveillance did not establish that the client was working but did reveal client functional behaviour inconsistent with statements about the same made by him to health professionals. The appellant through his lawyer objected to the surveillance footage being obtained and questioned the legal basis on which ACC was permitted to investigate the appellant.

[32] On 1 August 2017, the appellant was referred for Psychological Services and was seen by Mark Ottley, Clinical Psychologist, on 22 August 2017. Mr Ottley noted:

> His main methods of management are completely shaving his body and using hot baths … he has a very high somatic focus and fear avoidance resulting in withdrawal from recreational, social and occupational activities. This results in up regulation of his sympathetic nervous system, chronic sleep disruption, poor nutrition and lack of effective active coping mechanisms. In addition to this he is not using medication at the present time except for his migraine, and he appears to have some conflict with previous prescribers not providing what he expected in a timely fashion and hence he refuses to use medication.

[33] Mr Ottley was later asked to comment on the video footage, particularly that on the day of Mr Thompson's appointment with him.

[34] In a report of 27 February 2018, Mr Ottley said:

> On 22.08.2017, Mr Thompson was observed wearing sneakers and moving without difficulty while de-icing a car. He was then transported by his father to Southern Rehab and a psychology appointment with me, and he did not wear shoes at the time and his trousers were rolled up. On leaving Southern Rehab his father drove to "Mag and Turbo" on Fitzgerald Avenue. Mr Thompson is observed leaving the car and entering the shop – now wearing shoes and with his trousers rolled down. On leaving the shop, Mr Thompson drives the car with his father as the passenger.
>
> As a treatment provider, I note there appears to be a significant discrepancy between
>
> (a) Mr Thompson's presentation and reported capacity while seeing myself, and
>
> (b) his apparent capacity observed in the video footage including within the same day on 22.08.2017.

[35] The appellant through his lawyer, Ms Tucker, responded to the surveillance footage on 7 December 2017.

[36] Amongst other things Ms Tucker said:

> Mr Thompson finds the actions of investigating him in such a covert manner undermine trust and confidence. Mr Thompson has always complied with ACC requests with regard to rehabilitation as best he can in his circumstances and in his view has been transparent with regard to his limitations and abilities when asked.
>
> …
>
> When understanding chronic pain it is important to consider that there are periods where a client can be active and then periods that are debilitated by pain. It is not necessarily constant and it is usually related to activity.

[37] On 7 May 2018, the appellant was referred to Dr Andrew Hilliard for further occupational medicine assessment. On 6 June 2018, Dr Hilliard assessed Mr Thompson and on 18 June 2018 provided his medical case review to the respondent. Dr Hilliard commented:

> … he placed no weight through his right foot at any stage during assessment, both while sitting and standing, heel walking on his right foot. However, I noted that on a few occasions while he was distracted he managed to place his whole foot onto the ground, without any obvious response from him.

[38] Dr Hilliard was of the opinion that the appellant's pain behaviours were at times incongruent.

[39] Dr Hilliard stated:

> He presented to me with a high level of non injury issues, including anxiety, being entirely injury focused, with high levels of fear avoidance, together with a tendency to catastrophise, and like Dr Turner and his psychologists also found him to have developed some significant maladaptive behaviours and beliefs with respect to the way in which he is currently managing his reported pain.
>
> He presented to me very atypically for an individual with chronic pain syndrome in the lower limb following injury.
>
> Inconsistencies on examination tend to strongly suggest that non injury factors are likely to be significant contributors to the way in which he clinically presents. I also note that like me Dr Turner found variable response to light touch on examination.

[40] Dr Hilliard provided further comment on 19 July 2018 after seeing the video footage. He said:

> (When I first saw Mr Thompson) I felt that his incapacity could not be explainable on the grounds of injury but was not able to provide a view on his precise capabilities.
>
> I provided a clear view that non injury issues were driving his current reported symptomology and clinical presentation.
>
> Having now seen the footage, I am now in a very strong position to provide a view that non injury issues are entirely driving his clinical presentation.

[41] In relation to a connection between Mr Thompson's incapacity and the covered injury, Dr Hilliard said:

> Based on the information on file, my assessment and examination of Mr Thompson, together with the surveillance footage recently shown to me, I can confirm that he has no condition that is causally linked to any covered injury on this claim.

[42] On 7 August 2018, Dr Anna Riddiford, ACC medical advisor, reviewed the case and concluded:

> I agree with Dr Hilliard's conclusion that the evidence shows that the client has no condition that is causally linked to any covered injury on this claim.

[43] On the same day, ACC technical specialist, Mr Burgess, recorded in the ACC 850 decision rationale:

> The issue here is that of suspension under section 117(1) of the Accident Compensation Act 2001. It appears that this relates to weekly compensation and that no other entitlements appear to be received on an ongoing basis at this point in time.
>
> In order to establish a basis to suspend any entitlements under section 117(1) ACC must be able to be "not satisfied" that there remains an injury related basis to continue to receive the specified entitlements (the Elwood test).
>
> I agree with the most recent medical opinions that there is no discernible injury related basis for weekly compensation to continue to be paid.

[44] On 7 August 2018, ACC wrote to Mr Thompson to advise him that it was suspending his weekly compensation payments because "medical information shows that your current condition is not the result of your personal injury".

[45] On 22 August 2018, the appellant submitted an application for review of the decision. The appellant was unsuccessful at review.

[46] On 14 March 2019, the appellant was assessed by Dr Michael Anderson at the request of his lawyer.

[47] In his report of 14 March 2019, Dr Anderson said amongst other things:

> My clerical staff and I noticed a change in "pain behaviour", which became exaggerated when arriving at the clinic.
>
> This has been commented on in previous reports, and observed to be quite variable, when not aware of being watched.

> I watched the surveillance videos provided by the ACC investigators and there was definitely an exaggerated display of symptoms and quite abnormal pain behaviour.
>
> Russell is an unreliable historian with proven "exaggerated pain behaviour" that has been interpreted as "malingering" by some observers.
>
> His observed behaviour can be interpreted medically as a statement of his pain experience.
>
> Consequently, I do not consider Russell is malingering with particular regard to the video footage, recorded some 20 months ago.

[48] In terms of the patient's expectations, at page 5 of his report Dr Anderson noted that Mr Thompson's view was:

> His pain is getting worse. He is needing more medication to try and get some pain relief. He is concerned about suicidal ideation, that is occurring with not being able to cope with the pain.

[49] Dr Anderson also found muscle wasting of the appellant's right leg.

[50] Dr Anderson did not consider that he could return to his pre-injury employment and said:

> I do not consider exaggerating his condition for short periods of activity detract from this diagnosis.

[51] The appellant's solicitor also obtained a psychiatric assessment from Dr Lim, Consultant Psychiatrist, as to his ability to give evidence or be available for cross-examination at an interlocutory hearing.

[52] Dr Lim's report is extensive. It includes the following:

> Russell reported having extreme fear and worry in having to deal with ACC. He is mentally exhausted to fight to prove his authenticity. The file suggests extensive correspondence about attendance for appointments, dispute over the issue of income as a wage earner versus a contractor.
>
> …
>
> He is fearful about going out of his house and avoids answering telephone or the door or any general dealing with people. He does not tell people about his being on ACC wage subsidy; instead would tell people that he has retired. Since the compensation was stopped two years ago, he has experienced significant financial stress. Since the footage surveillance was made, he has become even more socially reclusive and avoidant.

[53] Dr Lim further notes:

> Previously he has taken more opiates than he should when Leonie was away in order to "take away the pain".

[54] Under the heading "mental state examination", Dr Lim says this:

> When under pressure he becomes tearful, dysphoric and distressed. He comes across as genuine and honest and genuinely having difficulty recollection events in his life. He acknowledges that he has been blocking these difficult and unpleasant memories about his past for many years.
>
> Russell becomes distressed when he talks about being labelled as malingering. He says that others have misjudged him and they do not appreciate the fact that he has become so incapacitated over the years …
>
> He does come across as genuine in communicating his distress and inability to cope with ongoing chronic pain as well as the fear of having to attend the hearing. He does not come across as very psychological minded and remains quite symptom focused. There is barrier linking psychological distress to his symptomology.

[55] Under the heading "corroborative history", Dr Lim includes this:

> I spoke to Dr Brendon Smith, Russell's GP on 6.7.20. Dr Smith confirmed that he took over Russell's primary care from his retired colleague. He is aware of the situation Russell has with ACC and the issues surrounding the video surveillance footage.
>
> Dr Smith considers Russell as having a debilitating pain disorder and a "hugely institutionalised individual". When he first took over Russell's care, Russell was using a large cocktail of pain relief medications that did not make sense. They have worked hard to simplify the regime over the years.

[56] Under the heading "assessment and opinion", Dr Lim says:

> It is clear that Russell has a substantial somatoform pain disorder under the DSM 4 associated with both psychological factors and a general medical condition namely the right ankle injury. This would be broadly consistent with the diagnosis of regional complex pain disorder given by the occupational health physician.
>
> …
>
> Consequently he has developed quite an extreme avoidant way of coping with issues and perceived threats; with easy catastrophising, fear focused response and misattribution of physical and pain symptoms.
>
> …

> My findings would concur with those of Dr Anderson and Dr Smith, in that I do not think he intentionally malingers. He does have abnormal sickness behaviour and there may be subconscious maintaining factors and secondary gain which he does not easily recognise because he does not appear to be psychologically minded.
>
> …
>
> I note that while he has been able to attend my assessment and other assessment appointments, it is only with the support from his wife. He explains that he is able to do so only because he pushed himself along with the genuine hope that he can get a proper assessment which may help explain why he is reacting and behaving this way. If under scrutiny, he does not think he will be able to handle the situation.
>
> …
>
> I would add that my observation and conclusions concur with Dr Anderson's and Dr Smith's observation in terms of Russell's incapacity to work, pain symptoms/diagnosis; and abnormal sickness behaviour. I think it is extremely unrealistic to expect him to return to pre-injury employment level. Complex factors that maintain his pain symptoms and his anxiety/depressive disorder would be too huge a barrier for him to return to paid employment in any significant capacity. Therefore his appeal to have his wage compensation reinstated should be worthy of serious consideration.

The Appellant's Submissions

[57] Ms Tucker reminds the Court that in 2009 the appellant suffered a substantial injury when he jumped off the back of a truck and landed heavily on his right foot. An x-ray revealed that he sustained a calcaneal fracture.

[58] A further car accident on 1 June 2011 caused his right ankle to be injured again.

[59] He was under the care of Dr Maxwell, Orthopaedic Surgeon, and the ankle was described as grossly unstable. Surgery was recommended and took place. Mr Thompson has been certified by his doctor as fully unfit for work.

[60] Ms Tucker submits there is a clear chronology towards chronic pain developing. She lists these matters:

[a] Dr Maxwell reported on 20 May 2014 that there was an unusual post operative course.

[b] Dr Turner reported on 2 October 2015 with a clear diagnosis of chronic pain syndrome effecting predominantly his right ankle.

[c] Throughout the file regular medical certificates have been provided by Dr Thomson and Dr Smith.

[d] She refers to the Canterbury District Health Board Emergency Medicine assessment of 22 July 2015 which records his ankle as having "diffuse swelling with limited ROM". It also records problems with increased pain and increasing requirements for analgesia.

[e] Dr Fran Brynn on 8 February 2016 records chronic pain syndrome since 2009.

[f] Dr Hillard reported on 18 June 2018 supporting the diagnosis of chronic pain.

[g] Dr Anderson reported on 10 July 2019 supporting the diagnosis of chronic pain.

[h] Dr Lim reported on 7 July 2020.

[61] Ms Tucker's submission, therefore, is that there is clear documented chronology of the developing pain syndrome accompanied by ongoing symptoms of the physical injury. This includes attending at a hospital in an emergency situation. It includes detailed interviews with multiple specialists.

[62] Ms Tucker refers to the medication that is documented through the period from 2011 to 2017.

[63] A pharmacy record of medications obtained by the appellant since 2017 was submitted at the hearing. It is substantial and commented on by the appellant's GP, Dr Smith, in Dr Lim's report.

[64] On the issue of the surveillance footage Ms Tucker refers to the appellant's statement placed before the reviewer. In that evidence statement the appellant says:

> 5. At the time of the footage, I had taken medication very much under my own guidance, in a reactive manner. When I feel pain I took pills. Often if one is recommended, I might take four. I have medicated in this way for a substantial period of time. I literally have draw full of pills.

[65] Ms Tucker submits that the *Ellwood* test has not been met and there is no basis for disentitling Mr Thompson in the way that that has occurred.[1]

[66] Ms Tucker submits that it is more likely than not that Mr Thompson has incapacity and that the incapacity is causally linked to his injury. She says it extends to a chronic pain issue and submits it is covered under s 26 of the Act.

[67] Accordingly, she seeks reinstatement of weekly compensation and arrears, including for the period he was suspended after his emergency hospital admission in 2015; and he seeks costs.

The Respondent's Submissions

[68] Mr Coates on behalf of the respondent submits there are five key reasons why as at 7 August 2018 the respondent had sufficient basis to be not satisfied that the appellant was entitled to receive weekly compensation and, therefore, suspend the same:

[a] The health practitioners who had previously treated Mr Thompson had described his reported symptoms and capacity as unusual for a patient with a chronic regional pain syndrome.

[b] Mr Thompson's reported symptoms and capacity were inconsistent with the objective evidence of the surveillance footage and clinical records which casts doubt on their accuracy.

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[1] *Ellwood v Accident Compensation Corporation* [2007] NZAR 205 (HC).

[c] Dr Hilliard's opinion is clear that Mr Thompson's incapacity is a result of non-injury factors and not the covered injury. Dr Hilliard's evidence is based on objective evidence.

[d] Mr Thompson has had ample opportunity to explain the discrepancy between his capacity in the surveillance footage and when being assessed by health practitioners, but he has chosen not to do so.

[e] ACC repeatedly tried to obtain input from Dr Smith but was unable to do so, and his comments are of limited value because he has not viewed the surveillance footage.

[69] Mr Coates submits that there was sufficient information in ACC's possession on 7 August 2018 to demonstrate, on the balance of probabilities, that any ongoing incapacity was not caused by the covered injury, and therefore, Mr Thompson was no longer entitled to weekly compensation.

[70] He refers to Dr Thomson's report of 21 August 2015, who notes that the appellant's initial progress was:

> Really quite satisfactory. During his stay in hospital he got up and about very quickly and went home without any particular concerns. However at his follow up visit at six weeks post op when he was due to start weightbearing in a moon boot he said he couldn't weight bear. At the time he didn't say it was because it was painful, it was because he felt nauseated when he put his foot on the ground. At the time he didn't have features of a regional pain syndrome per se, but he certainly had quite a strange response to surgery and I just couldn't get him to weight bear. … his lateral ligament complex reconstruction is entirely satisfactory and quite stable.
>
> Clearly he needs help managing his pain syndrome and to this end we have requested his case manager to refer him to the pain clinic. …

[71] Mr Coates refers to the report of Dr Turner, Occupational Medicine Specialist, of 2 October 2015. Dr Turner gave a diagnosis of post traumatic regional pain syndrome effecting his right ankle, right foot and lower leg with non-specific non-traumatic mechanical pain involving his left ankle, both knees and hips and his back. He also added: "Indeed it is my opinion that psychological issues rather than injury

issues are the predominant basis of his declared inability to undertake paid employment."

[72] Mr Coates points out that psychologist Mark Ottley records: "Interestingly he stated he can stand the long sensations associated with the sit ups and press ups but not from other stimuli."

[73] Mr Coates refers to the report of Dr Hilliard, specialist occupational physician, of 18 June 2018 in which he notes that the appellant's "pain behaviours were at times incongruent … pain behaviours, including visual and verbal behaviours increased significantly during the examination part of the assessment".

[74] Mr Coates refers further to Dr Hilliard's report where he says:

> He presented to me very atypical for an individual with a chronic pain syndrome in the lower limb following injury.
>
> Inconsistencies on examination tend to strongly suggest that non injury factors are likely to be significant contributors to the way in which he clinically presents.

[75] Mr Coates submits that the comments of the health practitioners assessing and treating the appellant show a level of uncertainty about the diagnosis of complex regional pain syndrome consequent on the covered injury.

[76] Mr Coates submits that the appellant's reported symptoms and capacity are inconsistent with the objective evidence in both the clinical records and the surveillance footage:

[a] He told Mr Ottley and Dr Hilliard that he could not wear shoes but was seen on surveillance footage wearing shoes.

[b] He told Dr Hilliard that he was only able to bend with his left knee and was only able to demonstrate limited crouching but is seen crouching for extended periods on the surveillance footage.

[c] He told Dr Hilliard he was unable to place any weight on his right lower limb and could only walk with a hobble for minimal periods of time but is seen walking normally on the surveillance footage, only hobbling immediately before his appointment with Mr Ottley.

[d] He told Dr Turner that he does not go shopping but is seen doing so on the footage.

[e] He told Dr Turner that he has a driver's licence but does not drive a car and that he "can't drive". However, he is seen driving on the surveillance footage.

[f] Mr Coates points out that Dr Hilliard was unable to get the appellant to actively move his ankle at all but is now observed on surveillance footage as having a full range of motion in his right ankle.

[77] Mr Coates, therefore, submits that what Mr Thompson tells health practitioners and the respondent is often contradictory and unable to be verified by independent or objective evidence.

[78] He refers to the conclusion of Dr Hilliard in his report of 19 July 2018: "Having now seen the footage, I am in a very strong position to provide a view that non injury issues are entirely driving his clinical presentation."

[79] Mr Coates submits, therefore, that at the time ACC issued its decision suspending Mr Thompson's weekly compensation it had the benefit of a substantial amount of evidence from health practitioners expressing uncertainty about his clinical presentation. In addition, ACC had the objective evidence of surveillance footage and Dr Hilliard's opinion that the discrepancy between the surveillance footage and Mr Thompson's clinical presentation and reported capacity was the result of non-injury factors.

[80] He, therefore, submits that ACC had sufficient information to be satisfied on the balance of probabilities that Mr Thompson was no longer entitled to weekly compensation.

[81] Furthermore, Mr Coates submits that there continues to be sufficient basis for the respondent to be not satisfied that Mr Thompson is entitled to weekly compensation and lists these matters:

[a] Mr Thompson's explanation for the discrepancy between his presentation when being assessed by health practitioners and in the surveillance footage is not supported by the evidence and should not be afforded any weight.

[b] It is open to the Court to draw an inference from Mr Thompson's demonstrated reluctance to be assessed except by his own practitioners, and the Court should consider carefully what weight is to be given to Dr Anderson and Dr Lim's opinions.

[c] Dr Anderson's apparent findings of physical evidence of a pain syndrome are consistent with the historic medical evidence and are not new evidence or are based on Mr Thompson's reporting. In both cases, they do not assist the Court.

[d] Dr Lim has not expressly assessed Mr Thompson for the purposes of making a diagnosis of complex regional pain syndrome.

[e] Dr Hilliard's report is robust and should be preferred to Dr Anderson's and Dr Lim's evidence.

[82] Mr Coates further submits that Mr Thompson's explanation of his apparent capacity in the surveillance footage is that he was heavily medicated at the time. However, Mr Coates says that this is not supported by the evidence.

[83] Mr Coates refers to the inconsistency in Mr Thompson's explanation that at the time of the video surveillance footage he had taken substantial medication but then

went on to say that when he attends appointments, he considers it important that the health practitioners see him in his unmedicated state.

[84] Mr Coates refers to the fact that the surveillance footage shows Mr Thompson de-icing the car before attending the appointment; going shopping immediately after the appointment and driving a car home from the shop.

[85] He also points out that Mr Thompson's statement to the Reviewer was that he was able to wear shoes and socks only because of his medication regime instituted by Dr Smith. However, on 22 August 2017 the surveillance footage shows Mr Thompson wearing sneakers while de-icing the car. He then attended his appointment with Mr Ottley bare footed and with his right trouser leg rolled up. Immediately after the appointment he is seen going into a shop wearing shoes with his trousers rolled down.

[86] Accordingly, Mr Coates submits that Mr Thompson's actions before and after his appointment with Mr Ottley on 22 August 2017 cast serious doubt on the veracity of both his reported incapacity and his explanation for his current capacity in the surveillance footage.

[87] Mr Coates says:

> It cannot sensibly be suggested that he was able to medicate himself to the extent he says is necessary for him to wear shoes and undertake a task such as de-icing a car but have the effects of the medication diminish to allow him to present to his appointment with Mr Ottley a short time later in his "unmedicated state".

[88] Furthermore, he says:

> It cannot sensibly be said that the appellant was able to medicate himself sufficiently following the appointment to immediately be capable of wearing shoes and going shopping and then drive himself home.

[89] Mr Coates also submits that in the broader context of the case the Court is entitled to draw an inference from Mr Thompson's willingness to be assessed by his own experts (Dr Anderson and Dr Lim) while consistently refusing to be assessed by

a mutually agreeable health practitioner. Accordingly, Mr Coates says that Dr Anderson and Dr Lim's report should be treated with caution.

[90] Mr Coates reminds the Court that under the ACC jurisdiction a client must undergo assessment by a medical professional specified by the Corporation if reasonably requested to do so while they are receiving an entitlement.[2]

[91] Mr Coates then lists a number of appointments Mr Thompson failed to attend.

[92] Following Dr Anderson's report, ACC requested Mr Thompson to undergo an assessment by an independent occupational medicine physician to try to resolve the dispute between Dr Hilliard and Dr Anderson's interpretations of Mr Thompson's observed versus reported capacity. He says that ACC offered Mr Thompson a choice of practitioner to ensure independence. However, on 29 November 2019, Mr Thompson's lawyer advised that Mr Thompson would not agree to any further assessment because he finds them too difficult to cope with.

[93] Mr Coates points out that in spite of this, Mr Thompson was able to attend an assessment with Dr Lim on 24 June 2020.

[94] Mr Coates also submits that the criticism of Dr Hilliard's report on the basis that he did not adequately consider the role of medication in Mr Thompson's capacity is unfounded.

[95] He submits that there is no new evidence put forward to establish that Mr Thompson's current incapacity is the result of the covered injury. In turn he submits that there is no basis on which to find he is entitled to weekly compensation.

Decision

[96] Section 117(1) of the Accident Compensation Act 2001 provides:

> The Corporation may suspend or cancel an entitlement if it is not satisfied on the basis of the information in its possession, that a claimant is entitled to continue to receive the entitlement.

[2] Accident Compensation Act 2001, s 72(1)(d).

[97] Justice Mallon in *Ellwood v Accident Compensation Corporation* said:[3]

> [64] In contrast, if the test required the ACC/the Reviewer/the District Court "to be satisfied that there is no right to entitlements" then that test would not be met where the evidence was in balance or unclear. They could not be satisfied because the evidence would have left the position unclear. That said, the ACC must make reasonable decisions. In a situation where the evidence is unclear or in balance, is it reasonable to suspend entitlements? In many cases it may not be. Before entitlements are suspended at ACC's initiative (or that suspension is upheld by a reviewer or the District Court) ACC should take steps to clarify the position one way or the other. The claimant is not present at the first stage so the obligation must be on ACC at this stage to obtain sufficient evidence. Mr Beck's proposed test of asking whether there is a sufficient basis on which entitlements should be suspended (in effect, terminated) is a reasonable one. If there is an insufficient basis then the test of "is not satisfied" is not met. If there is a sufficient basis then ACC can be "not satisfied" of the right to entitlements. As the reviewer and the District Court apply the same test the same approach should be taken at each stage.
>
> [65] I therefore consider that s 116, combined with the requirements in s 62 on ACC to make reasonable decisions, requires ACC to have a sufficient basis before terminating benefits. If the position is uncertain then there is not a sufficient basis. The "not satisfied" test is not met in these circumstances.

[98] Eligibility for weekly compensation is dependent on incapacity for employment (s 100). The test of which is set out in s 103(2):

> The question that the Corporation must determine is whether the claimant is unable, because of his or her personal injury, to engage in employment in which he or she was employed when he or she suffered the personal injury.

[99] On 25 November 2009, while working as a travelling salesperson, the appellant jumped off the back of a truck and landed heavily on his right foot.

[100] An x-ray on 4 December 2009 showed a "subtle" calcaneal (heel bone) fracture and ultrasound demonstrated ligamentous injuries to his ankle.

[101] On 1 June 2011, the appellant was involved in a car accident which exacerbated the 2009 injury.

[102] His then GP Dr Thomson provided a medical certificate for five weeks off work.

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3 *Ellwood v Accident Compensation Corporation*, above n 1, at [64]–[65].

[103] He was then appraised by Mr Maxwell, who noted:

> Given that he works as a travelling salesman and this is his right ankle, he will have to have some time off work, and he will then be able to drive and then can walk unaided without crutches.

[104] On 6 March 2014, the appellant underwent surgery and on 15 May Mr Maxwell noted that Mr Thompson demonstrated an "unusual post operative course following his quite straightforward surgery". He described the appellant as needing supplementary help although he noted "he doesn't have any features of a regional pain syndrome".

[105] On 9 October 2014, the appellant signed a new individual rehabilitation plan and was referred to Dr Hilliard, occupational medicine specialist.

[106] Over the next 11 months the appellant failed to attend a number of appointments made for him with occupational medicine specialists. However, on 21 August 2015, Mr Maxwell reported to the appellant's GP that he had "full blown chronic regional pain syndrome right ankle". On 30 September 2015, the appellant was assessed by Dr Turner, Occupational Medicine Specialist, who diagnosed the appellant with post traumatic regional pain syndrome. He was then referred to Dr Bryn, Psychologist, who recommended psychological pain management. On 6 April 2017, a pain management plan, update and completion report was completed by Julianne Grant from AMP Work Care. The appellant reported to her that he had not worn socks or shoes since surgery in 2014. She noted that he walked with a limb with minimal weight bearing through his right leg and that he uses crutches for long distances and that he rolls his trouser legs up.

[107] In May 2017, the respondent received information that Mr Thompson may be working and in July and August 2017 surveillance of him was undertaken.

[108] On 17 July, he is seen unloading his car outside a property and taking items onto the property. He also puts empty petrol cans into the boot of the car. He is wearing sneakers. He takes quick steps between the car and the property. He turns quickly both into the property and out and he is seen going into a shop.

[109] On 26 July 2017, he is seen backing a car out of a garage. He is then on his knees for several minutes cleaning the car exhaust. He is seen swivelling on his knees and sitting on his haunches for an excess of a minute. He is also seen stooping over the open boot for several minutes.

[110] On 22 August 2017, at approximately 7.00 am, the appellant is seen with a hot water jug "de-icing" a car. He is wearing shoes and long trousers. The de-icing activity continues for a considerable period of time with the appellant pouring hot water onto different parts of the car and wiping that area. He is wearing long trousers. At 8.36 am he is no longer wearing shoes and his right trouser leg is rolled up almost to his knee. He is next seen at 8.55 am the same day emerging from the passenger side of his car outside the Southern Rehab premises in Christchurch. He is again bare footed with trouser leg rolled up to the knee on his right leg and is using crutches.

[111] Psychologist Mark Ottley, who assessed the appellant that day said under the heading "current physical symptoms":

> Mr Thompson experiences diffuse pain mainly in the lower half of his body from his ankle, legs and up into his groin area. However, he complains of wide spread sensitivity all over his body. He states that this pain averages 8/10 (with 10 being worst imaginable pain).

[112] Following that appointment, he is next seen alongside his car outside Mag and Turbo at 10.55am. His trousers are down, and he is wearing shoes. There is no evidence of the limp seen outside Southern Rehab. As he walks, he is seen to have a full range of movement and drives the car away.

[113] Finally, on 24 August 2017, he is seen bare footed using a motor mower with a catcher at the entrance to a residential property. A person arrives who interacts with him and the appellant is seen walking around on the footpath bare footed.

[114] Suffice it to say that the footage outside Southern Rehab excepted, one would be forgiven for concluding that the surveillance footage simply shows a fully functional physically fit adult carrying out a range of tasks including bending,

kneeling, lifting, twisting and stooping with complete ease. There is a naturalness and a nonchalance seen in these activities.

[115] The explanation provided by Mr Thompson in his statement tendered to the Reviewer is this: "At the time of the footage, I had taken medication very much under my own guidance, in a reactive manner."

[116] It does not appear to be challenged that the ACC investigator requested comment from the appellant's GP, Dr Smith, and offered to show him the surveillance footage but received no response. I agree with the Reviewer that for Dr Smith's comments to be persuasive he would need to view the surveillance footage.

[117] Dr Lim assessed the appellant following an interlocutory application by ACC that the appellant be available for cross examination.

[118] It would appear that to assess the appellant Dr Lim received the ACC surveillance report of August 2017 (which, save for the investigator's conclusion, is not before the Court), but it would appear that Dr Lim did not see the surveillance footage itself. Dr Lim says at paragraph 11 of his report:

> I will not go into details regarding Russell's injury history nor comment on the review findings from ACC; and the counter arguments from Russell around the ACC surveillance footage. The available documentation and the submission by various parties speak for themselves.

[119] Dr Lim's focus was on the issue of whether the appellant should be available for cross examination. Dr Lim suggested that the appellant prepare an affidavit or answer questions for which he had time to prepare written replies.

[120] Ultimately, therefore, both Dr Smith and Dr Lim provide no appraisal of the surveillance footage.

[121] However, Dr Anderson in an addendum to his report of 10 July 2019 said this:

> My clerical staff and I noticed a change in "pain behaviour", which became exaggerated when arriving at the clinic.

> This has been commented on in various reports, and observed to be quite variable, when not aware of being observed.
>
> I watched the surveillance videos provided by ACC investigators, and there is definitely an exaggerated display of symptoms, and quite abnormal pain behaviour.

[122] He also says:

> Russell is an unreliable historian, when proven "exaggerated pain behaviour", that has been interpreted as "malingering" by some observers.
>
> His observed behaviour can be interpreted medically as a statement of his pain experience.

[123] In his report of 7 December 2018, Dr Smith says:

> As I have indicated Mr Thompson has an enormously complex history of trauma and pain issues and it is difficult for me to be completely clear as to the nature and cause of all his issues.

[124] Dr Hilliard, Occupational Medicine Specialist, carried out a complex medical case review on 19 July 2018.

[125] In his report Dr Hilliard said:

> Based on information on file, my assessment and examination Mr Thompson, together with the surveillance footage recently shown to me, I can confirm that he has no condition that is causally linked to any covered injury on this claim.

[126] Elsewhere he answers this question:

> **Has your viewing of the video surveillance caused you to change any of your opinions expressed in the medical case review?**
>
> When I saw Mr Thompson, I provided a view that non injury issues were likely to be driving his clinical presentation.
>
> Specifically, I found the history on file and his clinical presentation to be somewhat odd for an individual with a post injury regional pain syndrome.
>
> I felt that his incapacity could not be explainable on the grounds of injury but was not able to provide a view on his precise capabilities.
>
> I provided a clear view that non injury issues were driving his current symptomology and clinical presentation.
>
> Having now seen the footage, I am now in a very strong position to provide a view that non injury issues are entirely driving his clinical presentation.

> When I saw Mr Thompson I wondered whether psychiatric issues, including a non injury conversion disorder may account for his reported symptomology.
>
> The footage on the day of his psychology appointment, including being able to initially walk normally with shoes when de-icing his car, then a short period of time later being able to walk normally without footwear, then limping and using a crutch immediately prior to his psychology appointment, then demonstrating an ability to again walk normally and wear shoes a short period of time after that appointment, clearly suggests conscious awareness and possibly a degree of intent. This is not an unconscious act. This is therefore not a picture of an individual with a psychiatric condition or unconscious conversion disorder. I therefore no longer believe that there is any role for psychiatric assessment of Mr Thompson's current condition. He most certainly does not have a psychiatric condition or conversion disorder based on the surveillance footage.

[127] In his report a year earlier on 18 June 2018, Dr Hilliard had said:

> He presented to me with a high level of non injury issues, including anxiety, being entirely injury focused, and with high levels of fear avoidance, together with a tendency to catastrophise, and like Dr Turner and his psychologists also found him to have developed some significant maladaptive behaviours and beliefs with respect to the way he is currently managing his reported pain.
>
> He presented to me very atypically for an individual with a chronic pain syndrome in the lower limb following injury.
>
> Inconsistencies on examination tend to strongly suggest that non injury factors are likely to be significant contributors to the way in which he clinically presents. I also note that like me Dr Turner found variable responses to light touch on examination.

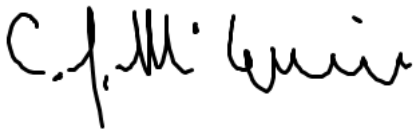
[128] Clinical psychologist Mark Ottley, in his report of 27 February 2018, said:

> As a treatment provider, I note there appears to be a significant discrepancy between (a) Mr Thompson's presentation and reported capacity when seeing myself, and (b) his apparent capacity observed in the video footage, including within the same day on 22.08.2017. Unfortunately, this discrepancy makes it difficult to establish an accurate understanding of his impairment, and what his treatment needs, if any, may be. In the first instance I think it would be helpful for a medical case review to help clarify such details and I imagine this will occur.

[129] Setting the reports of Dr Lim, Dr Anderson and Dr Smith alongside those of Dr Hilliard and Mark Ottley, the conclusions of the latter clinicians are plainly to be preferred. At best, there is substantial uncertainty on the part of Dr Anderson and Dr Smith as to the causes of the appellant's presentation.

[130] Accordingly, therefore, I must conclude that on 7 August 2018 ACC had sufficient basis to be satisfied that Mr Thompson was no longer entitled to weekly compensation. I find the *Ellwood* test met.

[131] Furthermore, given the evidence before me that has come into existence since that decision, I again conclude for the same reasons that there continues to be sufficient basis for ACC not to be satisfied that Mr Thompson is entitled to weekly compensation. Accordingly, I must dismiss the appeal. There is no issue as to costs.



Judge C J McGuire
District Court Judge

Solicitors: Joynt Andrews, Christchurch for the appellant
Claro, Solicitors, Wellington for the respondent