IN THE DISTRICT COURT
AT WELLINGTON

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

[2023] NZACC 198 ACR 24/23

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

Hearing:	29 November 2023
Held at:	Wellington/Whanganui-a-tara by AVL
Appearances:	R Ambridge for the Appellant F Becroft for the Accident Compensation Corporation ("the Corporation")
Judgment:	6 December 2023

RESERVED JUDGMENT OF JUDGE P R SPILLER
[Claim for personal (physical) injury - s 26,
Accident Compensation Act 2001 ("the 2001 Act")]

Introduction

[1] This is an appeal from the decision of a Reviewer dated 29 August 2022. The Reviewer quashed the Corporation's decision dated 4 May 2022 declining Ms Ambridge's claim for cover for chronic pain and complex regional pain syndrome. The Reviewer directed the Corporation to issue a further formal decision granting Ms Ambridge deemed cover for chronic regional pain syndrome (CRPS).

Background

[2] Ms Ambridge (formerly Edwards) was born in 1960. She suffered poliomyelitis at 18 months old, primarily affecting her right leg. The condition subsequently led to surgical lengthening of the right leg in 1972.

[3] On 24 July 1987, Ms Ambridge suffered an accident affecting her right ankle. A medical certificate dated 27 July 1987 recorded that the accident resulted in a medial ligament strain of the ankle. The certificate noted that Ms Ambridge continued to have pain and immobility and that she was referred to an orthopaedic surgeon for treatment.

[4] On 29 July 1987, an x-ray of Ms Ambridge's right ankle was taken. The x-ray confirmed evidence of an old injury with pinning of the tibia and fibula (the surgical lengthening), and some significant alteration of the normal joint architecture with accelerated osteoarthritis, but noted that "no recent change" was seen.

[5] On 11 February 1991, a late claim was filed for Ms Ambridge's accident on 24 July 1987, and referred to ankle pain. On 22 February 1991, an x-ray was undertaken which showed a screw fixing of the tibia and fibula.

[6] On 6 March 1991, the Corporation sent a letter to Ms Ambridge accepting the claim for the injury on 24 July 1987, although not specifying the injury covered.

[7] On 16 April 1991, Mr Jeremy Hopkins, Orthopaedic Surgeon, issued a report for Ms Ambridge's GP, Dr Haydon Gray. Mr Hopkins noted the history of polio and the leg lengthening procedure in 1972. He advised that, symptomatically, Ms Ambridge was well until 1987, when she suffered a fall. Mr Hopkins reviewed the x-rays and noted that they showed significant degenerative changes that had been present for some time. He was interested to review x-rays closer to the 1987 accident. He advised:

> I have explained to [Ms Ambridge] that her major problem is related to the degenerative changes in the ankle which have been stirred up by her 1987 injury presumably, but certainly not produced by them.

[8] Mr Hopkins suggested some form of splintage or, alternatively, arthrodesis or fusion surgery. He added:

> I really do not think we can ascribe all her present symptoms to the injury of 1987 unless she had relatively normal x-rays at that time.

[9] On 21 May 1991, Dr Gray advised that a splint had not assisted. In July 1991, Mr Hopkins responded that he was not too surprised that a splint had not controlled symptoms from the degenerative ankle.

[10] The Corporation commenced making weekly compensation payments to Ms Ambridge, and these subsequently continued for short periods. She underwent a series of surgical procedures, namely, a fusion in 1992, a re-exploration in 1993, and a revision fusion in 1994. After that procedure, Ms Ambridge was able to return to the workforce.

[11] In March 1994, Mr Hopkins undertook an impairment assessment. He understood that Ms Ambridge had suffered a sprain in 1987, on a background of significant pre-existing degenerative osteoarthritic changes in the ankle, secondary to stresses as a result of the polio and partial paralysis. He advised:

> It seems clear that [Ms Ambridge's] pre-existing degenerative changes of some significance were severely strained and further injured by her sprain in 1987, causing an increase in symptoms ultimately accelerating these to the point where arthrodesis was advised and carried out. It should be remembered however that the degenerative changes present in 1987 would have in any event progressed over the course of time. Thus, her pathology of degenerative osteoarthrosis was not produced by the accident but the necessity for management and the increase in symptoms clearly significantly accelerated by it.

[12] Mr Hopkins suggested that Ms Ambridge's impairment should be reduced to take into account the fact that she had pre-existing degeneration. Ms Ambridge's GP then sought a second opinion.

[13] On 8 June 1994, Mr Geoffrey Horne, Professor of Surgery, reported that Ms Ambridge had pain that developed after the fall. He suggested further revision surgery to compensate for her severe forefoot deformity.

[14] On 2 March 1995, after revision fusion, Mr Horne provided a further report:

> Mrs Edwards' ankle fusion is in my opinion in an excellent position clinically, although the function of her foot is compromised by the combination of the ankle fusion and the relative paralysis of muscles crossing the ankle probably the result of her old polio. The muscle weakness tends to accentuate the disability caused by the ankle fusion. I also note that she has evidence of damage to the dorsal lateral cutaneous branch of the superficial perineal nerve, resulting in absent like touch sensation of her third, fourth, and fifth toes.
>
> In my opinion Mrs Edwards has a compensatable disability of 25%, reflecting the fusion of the ankle in a satisfactory position, and the loss of sensation of the third, fourth and fifth toes probably as a direct result of the surgical incision.

[15] On 7 April 1995, the Corporation made an award (under section 78 of the 1982 Act) to Ms Ambridge for a 25% disability, reflecting the fusion of the ankle and the loss of sensation of the third to fifth toes. Ms Ambridge was entitled to 17% of $17,000 ($4,250), of which $1,785 had been earlier paid and the balance of $2,465 was now due.

[16] In November 1995, a medical misadventure claim was filed by Ms Ambridge relating to the 1992 fusion surgery. On 12 December 1995, the Corporation accepted cover for "adverse consequence of treatment", on the original 1987 claim.

[17] Subsequent reporting from Dr Gray advised that Ms Ambridge continued to have ongoing symptoms, extending to the thigh and the development of scoliosis. Dr Gray noted that Ms Ambridge had some lower back pain which he thought was due to posture from abnormal gait (related to the shortening of the right limb).

[18] On 19 January 1996, Mr Horne recorded a diagnosis of fractured ankle.

[19] On 21 May 1997, Dr Gray wrote to Dr Graham Chiu, Rheumatologist, advising:

> In 1988 [Ms Ambridge] fractured her ankle, and this never really recovered, in spite of 3 or 4 operations and a final fusion procedure. She continues with pain.

[20] On 29 May 1997, Dr Chiu reported that Ms Ambridge's articular symptoms were likely as a result of osteoarthritis in the joints, affected by poliomyelitis. There was also possible scoliosis and fibromyalgia.

[21] Ms Ambridge underwent additional surgical procedures, namely, a screw removal in 1998 and the removal of a cyst from the dorsum of the foot in 2000. These procedures were not funded by the Corporation.

[22] On 16 August 2000, Dr Gray reported on Ms Ambridge's fracture, some years before, and a long series of troubles following it.

[23] On 18 December 2000, a bone scintigram was undertaken of Ms Ambridge. Dr Andrew Taylor reported that the indication was "past fracture and arthrodesis". The scan report queried degenerative change and trauma.

[24] On 13 November 2001, Mr Horne reported that Ms Ambridge's pain, which had recently changed somewhat, was disabling. On 20 November 2001, he suggested possible surgical solutions, including a below the knee amputation (which evidently Ms Ambridge considered).

[25] On 26 February 2002, Mr Horne undertook a metatarsal wedge osteotomy on Ms Ambridge's right foot, which the Corporation funded. She received post-surgical support, including home help and rehabilitation. Following the surgery, Ms Ambridge made an attempt to return to work, but this proved difficult, and she continued to receive weekly compensation support.

[26] On 23 July 2002, Ms Ambridge was referred to a physiotherapy centre for a Physiotherapy Care and Assessment Plan.

[27] On 24 July 2002, Ms Louise Sloman, Physiotherapist, provided the Corporation with a Physiotherapy Care and Assessment Plan. This advised treatment for chronic pain syndrome, and possible CRPS "post fractured right ankle".

[28] On 13 December 2002, Dr Gray wrote to the Corporation as follows:

> I would be grateful if you could approve the referral of Nyree to the Wellington Hospital Pain Management Clinic for further assessment and treatment.

> As you know Nyree has continued to suffer considerable pain since her last operation earlier this year and so far has not been able to maintain a sustained position in her employment. …

[29] On 20 January 2003, Ms Ambridge was referred to the Wellington Hospital Pain Management Clinic, for completion of an Initial Pain Assessment report.

[30] On 23 January 2003, Dr John Speirs provided an initial pain assessment, concluding that Ms Ambridge had "mixed Chronic Pain problem, mechanical, neuropathic and an element of Chronic Regional Pain Syndrome".

[31] On 23 May 2003, the Corporation issued a decision advising that it approved in full the recommendations made in the initial pain assessment, including medication, hydrotherapy, counselling and physiotherapy, and approving a revision assessment report to see if Ms Ambridge's needs had changed since January 2003. The Corporation then funded a six-week pain management programme for Ms Ambridge.

[32] On 19 September 2005, Dr Michael Roberts, Specialist Anaesthetist, stated:

> Chronic Pain and disability affecting right lower leg and foot with a history of poliomyelitis as an infant followed by an injury to the right ankle and much remedial surgery. Pain is probably a result of mechanical factors, possibly with a neuropathic component and a partially resolved (stable) CRPS …

[33] On 6 October 2006, Mr Horne reported that Ms Ambridge suffered from chronic pain in both her feet, and advised:

> On the right leg I think that the pain is probably primarily injury related, although one cannot say with certainty that some of the pain may be related to the post-polio syndrome.

[34] On 5 March 2008, Dr David Waite provided an assessment of Ms Ambridge. He recorded that she had twisted her right ankle in 1987, with worsening pain over time since then, including back pain. He advised:

> We have a 48 year old woman who having suffered poliomyelitis as an infant was left with significant wasting of the entire right lower limb. A fall in 1987 resulted in a sprain to the right ankle. There was felt to be degenerative change occurring at this time and healing of the original sprain was extremely slow. With the development of major pain and instability of the joint an arthrodesis

> procedure was undertaken with at least 3 revisions. From the 1990's to 2003 Nyree's pain escalated to a level where she required morphine from which she has been subsequently weaned.

[35] Notwithstanding the problems identified, Dr Waite thought that Ms Ambridge would be fit to undertake a range of light to sedentary work, including clerical work. In the period that followed, Ms Ambridge relocated to the Bay of Plenty and commenced a part-time role as a whanau support worker.

[36] On 26 February 2009, Dr Waite provided a further report, confirming his view that Ms Ambridge was fit to undertake light to sedentary work.

[37] On 27 February 2009, the Corporation issued a decision suspending weekly compensation on the basis that Ms Ambridge was no longer incapacitated. It referenced her work as a funds administrator in Wellington. For the next period, Ms Ambridge's claim was not actively managed, but she continued to receive medical support, with various referrals for pain.

[38] On 25 March 2011, a discharge summary from M Lean, Senior Rheumatology at QE Health, provided a diagnosis for Ms Ambridge of post-polio syndrome.

[39] On 25 February 2013, Ms Megan Mansel, Physiotherapist at QE Health, referred to Ms Ambridge's left ankle sprain, a contusion lower leg and a lumbar sprain. Reference was also made to a more recent accident on 18 November 2012 which "flared" her "post-polio" and pain.

[40] On 18 November 2013, Dr Sharon Lovegrove, GP, asked the Corporation to reassess Ms Ambridge's ankle injury, noting a quite significant deterioration since 2008.

[41] The Corporation subsequently advised Dr Lovegrove that she could provide another medical certificate if Ms Ambridge was incapacitated, and the Corporation would investigate. Around the same time, Ms Ambridge made an application for assistance for transport for independence (the Corporation had previously funded a vehicle for her).

[42] On 30 May 2014, a medical certificate was completed for Ms Ambridge, which noted both ankle and back injuries.

[43] On 17 July 2014, a further x-ray was undertaken of Ms Ambridge's right ankle. Dr Francois DeBruin, Radiologist, reported past history of operative reduction and internal fixation of the right ankle.

[44] On 15 May 2015, Ms Ambridge applied for weekly compensation for her injury on 24 July 1987. Dr Sharon Lovegrove provided a medical certificate in support, noting that Ms Ambridge had been unable to drive and had significant pain in her ankle from 13 October 2014.

[45] On 18 May 2015, Ms Ambridge's application was declined on the basis that Ms Ambridge was not an earner at the date of her subsequent incapacity (identified as 13 October 2014).

[46] In 2015, Ms Ambridge filed a late review application against the Corporation's decision to suspend weekly compensation on 27 February 2009. That late application was declined and the Corporation's decision to decline the late application was upheld at review on 15 September 2015. Ms Ambridge appealed to the District Court.

[47] On 1 September 2016, the Corporation issued a decision which revoked the 27 February 2009 suspension. The Corporation noted that it had not applied the statutory test for incapacity correctly, because it had measured Ms Ambridge's ability to return to work against work that she had been doing in 2001, rather than the work that she had been doing at the time the injury occurred. Weekly compensation was subsequently reinstated.

[48] On 26 September 2016, Dr Michael Causer, BMA, noted that the nature of Ms Ambridge's injury was not such that it would infer incapacity in a sedentary role. He also noted the absence of medical evidence of incapacity between 2009 and 2014. The Corporation acknowledged, though, that its 2009 decision was wrong and that, if

that decision had not been issued, Ms Ambridge's entitlements would have continued (at least until reconsidered), and therefore reinstatement was appropriate.

[49] In February 2017, Mr Arpad Konyves, Orthopaedic Surgeon, provided a medical case review for the Corporation. He noted that Ms Ambridge's problem started in 1987, when she sprained her ankle, but then advised:

> She tells me that later on, she had an x-ray which showed possibly there was a fracture, but by the time of the x-ray, she already showed signs of osteoarthritis. Subsequently, she underwent an ankle fusion first in 1992 by Mr Hopkins in Wellington, but she tells me that her pain got worse following the operation. She had a second operation in 1993 which consisted of removal of screws due to ongoing pain and functional disability. She had a second opinion from Professor Horne who thought that the fusion of her ankle was not at the right angle and recommended the revision of the fusion. This was performed in September 1994 by Mr Hopkins again. This healed but Nyree needed further operations.

[50] Mr Konyves then referenced the surgical procedures in 2000 and 2002. He noted that Ms Ambridge had post-traumatic and post-surgical foot deformities and pain issues. He advised that the current condition was, in his opinion, the direct consequence of the initial injury and the subsequent fusion which resulted in a nerve injury, chronic pain, and suboptimal positioning of the foot.

[51] In June 2017, Ms Ambridge's file was reviewed by Dr David Oyaka, Regional Clinical Advisor. He suggested, based on Dr Konyves' report, that it would be reasonable to add right foot deformity as a consequential injury to the covered injuries. However, Dr Oyaka advised that there was insufficient evidence to support a direct causal link between Ms Ambridge's pain issues and the covered injuries. He also noted that there was no evidence on file to support the diagnosis of nerve damage, and that there was no information excluding post-polio pain as the sole or main cause of Ms Ambridge's ongoing pain, rather than a consequence of the injury and surgeries. He recommended a pain specialist review.

[52] On 19 June 2018, Ms Ambridge wrote to the Corporation. She noted that various file references referred to the covered injuries as a fracture of the ankle and a strain and sprain of the ankle, but she argued that cover should also extend to nerve

damage, chronic pain and complex regional pain syndrome, foot deformities, corn/calluses and knee, hip, and back complaints.

[53] In July 2018, Ms Ambridge's file was reviewed by Dr Ngaire Ellis, BMA. She raised the issue of a lack of evidence around a fractured ankle in 1987:

> The client's reported back and bilateral hip pains are not causally linked to the accident in 1987 when the client fell down stairs and twisted her ankle. There is not only a lack of clinical information to support a back or hip injury there is also a considerable delay from the sate of accident to the reporting of symptoms. I note the client's lumbar Xrays have shown OA changes which better explain the development of low back pain.

[54] Dr Ellis also noted that there was no clinical information that supported the diagnosis of CRPS Type II (Budapest criteria).

[55] On 26 October 2018, the Corporation extended cover to a peroneal nerve injury of Ms Ambridge's ankle. The Corporation noted that that injury had been added to the injury already covered on the claim, namely, a fracture of the ankle.

[56] On 13 February 2019, Mr Konyves completed a further report, having reviewed some of the evidence from the early 1990's. His report did not mention an ankle fracture, but he linked various knee, hip, and lumbar problems to abnormal biomechanics due to ankle problems and stated:

> Given that the ankle problems are a result of the injury in 1987 I would consider that the knee, hip and lumbar spine problems are indirectly linked to this injury.

[57] Mr Konyves also spoke to relative decompensation from post-polio syndrome, with a lifelong weakness of muscles of the right lower limb gradually becoming weaker and contributing to symptoms.

[58] On 24 July 2019, Mr Duthie Mills, Orthopaedic Surgeon, advised as follows on Ms Ambridge. The x-ray on 29 July 1987 did not report a fracture of the right ankle, but reported accelerated osteoarthritis of the right ankle. The original accident event comprised a sprain injury which led to an aggravation of the pre-existing degenerative arthritis of the right ankle joint. Ms Ambridge's degenerative changes in the right knee and hip joints could reasonably be accounted to result from the

musculoskeletal abnormalities associated with poliomyelitis in infancy. The origin of the degenerative changes in the lumbar spine is less certain although the X-ray of the lumbar spine dated 3 June 2009 did show a degenerative spondylolisthesis at L4/5.

[59] On 7 August 2019, an X-ray of Ms Ambridge's pelvis was undertaken. Dr Eileen McGlynn, Radiologist, reported mild osteoarthritis of the hips, and no evidence of acute osseous injury.

[60] On 23 August 2019, in a supplementary report, Mr Mills acknowledged that allodynia and coldness in Ms Ambridge's right foot might be on the basis of a CRPS Type II, secondary to a right superficial peroneal nerve lesion.

[61] On 29 August 2019, Dr Ngaire Schmidt, advised that Ms Ambridge did not sustain a fracture as a result of her accident in July 1987, and so cover for right ankle fracture should be revoked; it is likely that the treatment for her right ankle caused a peroneal nerve injury; the evidence is that her ankle functional problems are not the result of the accidental injury in 1987 but rather the post-polio syndrome which was already developing prior to the injury.

[62] On 9 September 2019, Dr Richard Bruno of the Post-Polio Institute provided a report for Ms Ambridge, questioning Mr Mills' conclusions.

[63] On 18 May 2020, the Corporation issued a decision revoking cover for a right ankle fracture, on the basis that there was no clinical information or imaging that confirmed that there was a fracture. Ms Ambridge applied for a review of that decision.

[64] On 1 September 2020, Mr Ambridge for Ms Ambridge emailed the Corporation seeking deemed cover for chronic pain and CRPS, and referred to various claim documents from around 2002/2003 that noted chronic pain. Mr Ambridge suggested that those references were sufficient to give rise to deemed cover.

[65] On 5 November 2020, following review proceedings, the Reviewer concluded that he did not have jurisdiction to deal with the Corporation's decision revoking cover for the right ankle fracture. This was because there was no evidence that the Corporation ever made a decision to approve cover for a fracture, and therefore there was no cover to revoke. Ms Ambridge filed a Notice of Appeal against the Reviewer's decision.

[66] On 8 December 2021, the District Court issued a judgment upholding the Corporation's decision but observing that there were a number of unresolved issues for Ms Ambridge.[1]

[67] In February 2022, Mr Ambridge for Ms Ambridge filed a review application, attaching the above District Court decision and again seeking deemed cover for chronic pain and CRPS.

[68] On 27 April 2022, Dr Sefton Moy, Medical Advisor, reviewed Ms Ambridge's file and concluded:

> The medical records do not support the diagnosis of CRPS because all 4 of the Budapest criteria were not met. Ms Ambridge does have chronic pain, pain lasting greater than 3 months. It is not an injury so does not attract cover. A causal link between persistent pain and the covered injuries is not established.

[69] On 4 May 2022, there was a case conference relating to the review application filed by Mr Ambridge. The Minute noted that there was a jurisdictional issue because the review application had not been lodged against any decision issued by the Corporation. Mr Ambridge confirmed at the case conference that he was seeking cover for CRPS as a physical and mental consequence of the covered injuries in July 1987 and 1991/1992. The Minute added:

> I noted that the issue of chronic pain is viewed differently by reviewers and that we objectively look at whether the covered physical injury itself is the causal factor of the claimant's chronic pain. Ms Crooks said that ACC considers Ms Ambridge's pre-existing condition of osteoarthritis and polio are the cause of her pain based on a medical case review by Duthie Mills, Orthopaedic Specialist. Mr Ambridge said they disagree with Mr Mills' views. I note that once the cover decision has been issued, Ms Ambridge can lodge a review of it and then the substantive issues relating to the matter can be properly argued at

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1 *Ambridge v Accident Compensation Corporation* [2021] NZACC 196.

> her subsequent review hearing, but they cannot be addressed currently without a decision on cover.

[70] On 4 May 2022, the Corporation issued a decision declining cover for chronic pain and CRPS due to Ms Ambridge's injury on 24 July 1987. Ms Ambridge applied for a review of the decision.

[71] On 5 May 2022, the Reviewer issued a decision on the papers declining jurisdiction in regard to reviews lodged by Ms Ambridge prior to the Corporation's decision of 4 May 2022.

[72] On 23 August 2022, review proceedings were held in relation to the Corporation's decision of 4 May 2022. On 29 August 2022, the Reviewer quashed the Corporation's decision dated 4 May 2022 declining Ms Ambridge's claim for cover for chronic pain and CRPS. The Reviewer directed the Corporation to issue a further formal decision granting Ms Ambridge deemed cover for CRPS (but not chronic pain) with the effect from 19 August 2018, and to consider what entitlements if any might flow as a consequence.

[73] On 20 January 2023, the Corporation issued a decision revoking deemed cover for Ms Ambridge for CRPS (but not chronic pain). Ms Ambridge filed a review application against this decision.

[74] On 27 January 2023, a Notice of Appeal was lodged against the Reviewer's decision, seeking cover for CRPS backdated to 28 July 2002.

[75] On 16 August 2023, a Reviewer quashed the Corporation's decision of 20 January 2023, on the basis that the Corporation did not adequately investigate the question of cover. The Reviewer directed that the Corporation refer Ms Ambridge for assessment with a pain specialist to determine whether she has CRPS and, if so, whether there is a causal link to her covered injuries.

Relevant law

[76] Section 360 of the 2001 Act covers claims for cover under former Acts not lodged until on or after 1 April 2002. Section 360 provides that a claimant has cover under the 2001 Act only if:

(a) the claimant would have had cover under the 2001 Act, had the injury occurred on or after 1 April 2002; and

(b) the claimant would have had cover under the Act that was in force at the time that the person suffered the injury.

[77] Ms Ambridge's antecedent accident occurred on 24 July 1987 when the Accident Compensation Act 1982 ("the 1982 Act") was in force. Section 2 of the 1982 Act provided for cover for a personal injury by accident, including "the physical and mental consequences of any injury or of the accident".

[78] Section 20 of the 2001 Act provides cover for various personal injuries including personal injury caused by accident and personal injury caused by a gradual process, disease, or infection consequential on a covered personal injury. Section 26 of the 2001 Act provides that "personal injury" means, *inter alia*, physical injuries.

[79] In *Arnold*,[2] Beattie DCJ noted:

> [16] This Court has signalled by its decisions on many occasions that pain of itself is not evidence of physical injury. In certain circumstances, it can be a symptom of a physical injury, but just as a migraine headache produces pain, that same condition is not a physical injury and it is quite clear from a medical perspective that pain can exist without being associated with physical injury.

[80] In *Westpac Banking Corporation*,[3] Beattie DCJ stated:

> … it is incumbent upon the claimant to establish that she has in fact suffered a personal injury, as that phrase is described in the Act. That description requires that there be a physical injury, that is there must be evidence of a discrete injury which has caused physical harm to the body of the claimant. As has been held by this Court on many occasions the mere experiencing of pain is not of itself injury and is not necessarily evidence of injury.

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2 *Accident Compensation Corporation v Arnold* [2003] NZACC 157.

3 *Westpac Banking Corporation v Accident Rehabilitation and Compensation Insurance Corporation* [2000] NZACC 298 at Page 13.

[81] In *Mura*,[4] Cadenhead DCJ stated:

> [24] … the requirement in these type of cases for the need to prove a physical injury. This is in accord with the statutory framework providing a filter to liability being generally the requirement of a physical injury, which provides an objective reference so that the injury may readily be audited or monitored over the course of the years. Without some significant external signpost this process would be fraught with difficulty.

[82] In *Monk*,[5] Miller J of the Court of Appeal held:

> [18] … the legislation does not define 'physical injury'. However, the term has been defined judicially as bodily harm or damage having some appreciable and not wholly transitory impact on the person…

[83] In *Studman*,[6] Ellis J stated:

> [26] … this requirement for "bodily harm" means that neither "pain" nor "stiffness" by and of itself constitutes a physical injury. Although both pain and stiffness may well be symptomatic of an underlying (and potentially qualifying) physical injury, that is not necessarily so. Most obviously, I suppose, pain could just as easily be caused by disease, for which (in general terms) coverage is not extended. It is for that reason that it is, in my view, necessary separately to identify the underlying physical injury with some precision.

[84] Section 57 provides:

> (1) This section applies to a claim for cover: …
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> (c) for personal injury caused by treatment ….
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> (2) The Corporation must take the following steps as soon as practicable, and no later than 2 months, after the claim is lodged:
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> (a) investigate the claim—
>
> (i) at its own expense; and
>
> (ii) to the extent reasonably necessary to enable it to take the following steps in this subsection; and
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> (b) either—
>
> (i) make its decision on the claim and give notice of it under section 64; or
>
> (ii) decide that it cannot make its decision on the claim, or any other decision, without additional information, extend the time for making its decision, and tell the person making the claim about the extension.

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4 *Mura v Accident Compensation Corporation* [2003] NZACC 133.
5 *Accident Compensation Corporation v Monk* [2012] NZCA 615.
6 *Accident Compensation Corporation v Studman* [2013] NZHC 2598.

[85] Section 58(1) provides:

> When the Corporation fails to comply with a time limit under section 56 or section 57, whichever applies, the claimant is to be regarded as having a decision by the Corporation that he or she has cover for the personal injury in respect of which the claim was made.

[86] In *Sinclair*,[7] Dobson J stated:

> [25] The statutory requirements for initiating a claim specify that it must be lodged with the Corporation, and that it has to constitute a claim either for cover, for cover plus a specified entitlement, or for a specified entitlement subsequent to acceptance of a claim for cover. It ought to be clear, from the terms of what is lodged, which of those alternatives it constitutes. The provisions also define when a claim is lodged and received, provide for the manner in which claims may be made and the time limits in which they are to be made.
>
> [26] I am not satisfied that the adoption of a generous approach to what might constitute the lodging of a claim for cover can focus upon the nature of the Corporation's responses to an initiative by a claimant. Conceptionally, the adequacy of what is submitted as a claim may, in some circumstances, be influenced by the nature of the Corporation's response to it, however, that does not justify an approach which uses a misconceived or inappropriate response on behalf of the Corporation to transform what is patently something other than a claim for cover under the Act into such a claim.

Discussion

[87] At issue in this appeal is a review decision of 29 August 2022 modifying the Corporation's decision declining cover for chronic pain and CRPS, and determining that Ms Ambridge was entitled to deemed cover for CRPS (not chronic pain) effective from 19 August 2018.

[88] Ms Ambridge submits that the Reviewer was wrong simply to determine that deemed cover arose, and that the Reviewer ought to have found that she was entitled to substantive cover for chronic pain and CRPS, and deemed cover from at least 2002. The Corporation has since revoked deemed cover in a new decision dated 20 January 2023. The Court should direct the Corporation to add chronic pain and CRPS as covered injuries, and the Corporation should be instructed to pay Ms Ambridge the treatment costs incurred to date. The report of Mr Moy is substandard and complete, and there is competing evidence that Ms Ambridge

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7 *Sinclair v Accident Compensation Corporation* [2012] NZHC 406.

should have cover for CRPS. The behaviour of the Corporation regarding Ms Ambridge's CRPS injury between 2002 and 2022 should be classified as being a Serious Service Failure, and the Corporation's inaction and delays over many years have fallen well below a reasonable service standard and failed to comply with the legislative requirements.

[89] This Court acknowledges the submissions made on behalf of Ms Ambridge. The Court confines itself to the correctness or otherwise of the Reviewer's decision of 29 August 2022, and does not address broader allegations of serious service failure, which can be addressed in the ACC complaints process. The Court now points to the following further considerations.

[90] First, this Court finds that Ms Ambridge's claim for cover for chronic pain, of itself, is not supported by legal authority. Section 20 of the 2001 Act provides cover for personal injury, and section 26(1)(b) provides that personal injury includes physical injuries such as a strain or a sprain. The Courts have repeatedly held that physical injury requires evidence of a discrete injury which has caused physical harm to the body of the claimant, and that the mere experiencing of pain is not of itself injury and is not necessarily evidence of injury.[8] It has been held that the requirement for physical injury to be bodily harm or damage, having some appreciable and not wholly transitory impact on the person, means that pain by and of itself does not constitute a physical injury.[9]

[91] Second, this Court finds that Ms Ambridge's claim for substantive (as opposed to deemed) cover for CRPS, as at the date of the Reviewer's decision, was not adequately supported by medical evidence then provided. This Court acknowledges the suggestions of CRPS in the reports from Ms Sloman (Pysiotherapist) in July 2002, Dr Speirs (Pain Specialist) in January 2003, Dr Roberts (Specialist Anaesthetist) in September 2005, and Mr Mills (Orthopaedic Surgeon) in August 2019. However, the Court also notes:

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8 *Westpac Banking Corporation*, above note 3.
9 *Studman*, above note 6, at [26].

(a) The absence of diagnosis of CRPS by specialists including Professor Horne (Professor of Surgery), Dr Chiu (Rheumatologist), Dr Waite (GP), QE health professionals, and Mr Konyves (Orthopaedic Surgeon).

(b) The advice of Dr Ellis, Medical Advisor, in July 2018, that there was no clinical information that supported the diagnosis of CRPS Type II (Budapest criteria).

(c) The advice of Dr Moy, Medical Advisor, in April 2022, that the medical records did not support the diagnosis of CRPS, because all four of the Budapest criteria were not met.

[92] Third, on 16 August 2023, a Reviewer issued a review decision finding that there was not sufficient investigation to determine whether or not Ms Ambridge suffered from CRPS. The Reviewer did not accept that the medical evidence before her diagnosed Ms Ambridge with CRPS, and the Reviewer noted that she could not approve cover because the evidence did not establish the injury and did not consider its cause. The Reviewer directed that the Corporation refer Ms Ambridge for assessment with a pain specialist, to apply the appropriate diagnostic criteria and determine whether Ms Ambridge has CRPS, if so, in what form, and if so, whether there is a causal link to Ms Ambridge's covered injuries, including the covered peroneal nerve lesion. This Court finds that it would be inappropriate for it to intervene in this process and make a concluded finding as to whether Ms Ambridge is entitled to cover for CRPS.

[93] Fourth, this Court finds that the Reviewer's decision that Ms Ambridge was entitled to deemed cover for CRPS (not chronic pain) effective from 19 August 2018, was well supported by the available evidence. On 19 June 2018, Ms Ambridge wrote to the Corporation submitting that her cover should extend to (among other things) CRPS. However, it was not until 4 May 2022 that the Corporation issued a formal decision on the request. The Corporation therefore failed to comply with the two-month limit, from 19 June 2018, to make a decision on the claim (section 57(2)), and so Ms Ambridge was to be regarded as having a decision by the Corporation from 19 August 2018 (section 58(1)). There is no evidence that Ms Ambridge made a clear claim for cover for CRPS before 19 June

2018. In particular, the letter from Dr Gray on 13 December 2002 was not a claim for cover for CRPS, but was a request for a referral of Ms Ambridge for further assessment and treatment, in light of her considerable pain since her last operation earlier that year. This Court has no power to transform what is patently something other than a claim for cover under the Act into such a claim.[10]

Conclusion

[94] In light of the above considerations, the Court finds that the Reviewer correctly determined that Ms Ambridge was entitled to deemed cover for CRPS (not chronic pain) effective from August 2018.

[95] The decision of the Reviewer dated 29 August 2022 is therefore upheld. This appeal is dismissed. I make no order as to costs.

[96] This Court registers its sympathy for Ms Ambridge in her pain condition and notes that interactions and proceedings with the Corporation have been ongoing for a number of years. In particular, this Court notes that the Reviewer, in her decision of 16 August 2023, directed that, within one month of the date of this decision, the Corporation was to refer Ms Ambridge for assessment with a pain specialist. Regrettably, it appeared that Ms Ambridge had, at the date of the hearing of this appeal, not been referred to a pain specialist. This Court expresses the expectation that the Reviewer's direction, that Ms Ambridge's assessment be completed, be complied with as soon as possible.

P R Spiller
District Court Judge

Solicitors for the Respondent: Medico Law Ltd.

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10 *Sinclair*, above note 7, at [26].