IN THE DISTRICT COURT
AT WELLINGTON

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

[2024] NZACC 003 ACR 60/23

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

Hearing:	14 December 2023
Held at:	Wellington/Whanganui-a-Tara by AVL
Appearances:	P Schmidt for the Appellant F Becroft for the Accident Compensation Corporation ("the Corporation")
Judgment:	8 January 2024

RESERVED JUDGMENT OF JUDGE P R SPILLER
[Claim for cover and entitlement to surgery - ss 20, 25, 26, 67 Accident Compensation Act 2001 ("the Act")]

Introduction

[1] This is an appeal from the decision of a Reviewer dated 27 February 2023. The Reviewer dismissed an application for review of the Corporation's decision dated 27 April 2022 declining Ms Keightley cover and funding for surgery on the basis that it was not caused by her accident of 20 July 2021.

Background

[2] Ms Keightley worked as an ambulance paramedic.

[3] On 27 August 2020, Ms Keightley suffered a lumbar sprain and a sacroiliac ligament sprain sustained when lifting a very heavy patient. She was granted cover for her injuries.

[4] On 1 March 2021, Ms Keightley attended her GP, who recorded:

> Paramedic, on her feet the whole day, wearing big capped boots, developed symptoms of plantar fasciitis 6 months ago. Has soft inlayers shoes, does her stretches, uses NSAIDs, but not getting any better.
>
> 6 months ago rotated her pelvis when she lifted a patient, seeing the chiropractor for this, getting better, but not there yet. Not sure if her legs/pelvis/back have a normal alignment at the moment.

[5] On 20 July 2021, Ms Keightley sustained an injury which is the subject of this appeal. She was not initially certified as unfit for work.

[6] On 28 July 2021, Ms Anitomita Sikulu, Podiatrist, recorded the following on Ms Keightley's accident:

> … her R foot is sore after she lifting a patient last Tuesday. She slightly slipped placing her foot in a wrong position causing this pain on the heel and toward arch …
>
> pain is getting worst
>
> she went and see her GP and they told her it will come right but it hasn't, so she's looking for other options

[7] On 28 July 2021, an ACC injury claim form was filed by Ms Sikulu, for Ms Keightley, repeating the description of the injured right ankle. Ms Sikulu diagnosed "sprain ankle and foot right".

[8] On 9 August 2021, Ms Keightley's claim was automatically accepted for right ankle sprain.

[9] On 4 October 2021, Ms Keightley saw Dr Michael Kohlhagen, GP, who noted the following:

> here for pain in R ankle and under heel - working as paramedic
>
> problems started when she lifted heavy patients last year and she put her lower back out - attended chiropractor she subsequently developed pain in R ankle and heel - attends podiatrist now and got insoles for potential plantar fasciitis
>
> however, pain is getting worse and is now rad to lower leg and around R ankle
>
> part tender under medial aspect of heel
>
> sounds like plantar fasciitis?[1] and spur?...

[10] On 4 October 2021, Dr Nicholas Dodd, Radiologist, after an x-ray of Ms Keightley's right ankle, reported:

> Indication: Twisting injury with persisting pain in ankle and foot.
>
> Findings: There is no evidence of recent bone or joint injury.
>
> A small separate ossicle at the anterior aspect of the ankle joint is associated with minor deformity of the adjacent anterior aspect of distil tibia and is likely long-standing, related to previous injury.
>
> Changes in keeping with early osteoarthrosis are noted in the calcaneocuboid articulation and appear long-standing, possibly post-traumatic in origin.[2]
>
> No other abnormalities are identified.

[11] On 7 October 2021, Dr Kohlhagen arranged a specialist referral for Ms Keightley, noting that her walking was getting worse and more painful.

[12] On 20 October 2021, Ms Helen Rawlinson, Orthopaedic Surgeon, examined Ms Keightley and reported:

> She recalls having no problems with her right foot until after a hip injury about a year ago at work when she had hip and low back problems and saw a chiropractor who noted that she was limping and loading the right lower extremity less than the left. She developed some right foot pain since that time and in the plantar aspect of that heel which was thought to be plantar fasciitis. She attributed it to loading the foot differently following a hip injury. Then on 09.06.21 she fell down five steps at work carrying a heavy defibrillator … this injury gradually settled down and the pain went away. She recalls that she was back to near normal when the next incident occurred on 20.07.21. She fell carrying a patient and again was able to continue weightbearing and walking and did not necessarily work. She applied strapping tape and boots. She

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1 An inflammation of tissue that runs across the bottom of the foot.

2 The calcaneocuboid joint is the joint between the calcaneus (the heel bone) and the cuboid bone (in the back of the foot).

> reported this to the GP who felt that there was inflammation around the foot and saw a podiatrist who also noted inflammation around the foot.
>
> The plain X-rays show a mature ossicle in the anterior ankle joint with mature bone spurring on the anterior distal tibial plafond. No osteochondral lesion in the talar dome can be seen. Established arthritic change is noted at the calcaneocuboid joint.

[13] Ms Rawlinson requested an MRI and a SPECT CT scan.

[14] On 10 November 2021, Dr Kohlhagen filed a medical certificate certifying Ms Keightley as unfit for work from 12 October 2021 to 8 November 2021, because of pain. Dr Kohlhagen listed the diagnoses as contusion of foot and sprain of ankle on 20 July 2021.

[15] On 11 November 2021, Ms Keightley underwent a bone SPECT CT scan of her feet. The bone scan, reported on by Dr Sahan Wadasinghe, Radiologist, noted the following interpretation:

> No acute fractures.
>
> Intense tracer uptake at the medial calcaneal tuberosity right foot at the plantar fascia insertion …
>
> Bilateral Calcaneonavicular fibrous coalition.[3] Intense uptake at the right calcaneocuboid joint superiority. No uptake on the left side.
>
> Mild to moderate increase in tracer uptake at the dorsal articular margins of the first and second tarsometatarsal joints of the right foot.

[16] Also on 11 November 2021, Ms Keightley underwent an MRI scan of the right foot and ankle. The MRI scan, reported on by Dr Philip Clark, Radiologist, showed the following impression:

> Moderate joint space changes involving the dorsal aspect of the first TMT joint, the joint space between the medial and intermediate cuneiform bones and calcaneo-cuboid joint dorsally.
>
> Bone marrow oedema[4] involving the mid to distal aspects of the 2nd, 3rd and 4th metatarsals, effusions in the 1sr to 4th MTP joints and enhancement surrounding

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3 A congenital condition of the foot that describes an abnormal union between the calcaneus (the heel bone) and navicular (located at the top of the midfoot), restricting normal movement.

4 Oedema is a build-up of fluid in the body which causes the affected tissue to become swollen.

> the 2nd to 4th MTP joints. The appearances are suspicious of an inflammatory arthritis. No erosive changes are identified.
>
> Moderate tibiotalar joint effusion.
>
> Moderate plantar fasciitis and small split tear involving the central band of the plantar fascia.
>
> Fibrous calcaneo-navicular coalition and subchondral bone plate oedema in the anterior process of the calcaneus.

[17] On 12 November 2021, the Corporation granted Ms Keightley cover for right foot contusion. Weekly compensation entitlements were subsequently calculated, and payments commenced.

[18] On 16 November 2021, in light of the scans, Ms Rawlinson reported:

> I am suspicious that she has inflammatory arthropathy affecting the right midfoot. She also has arthritis of the knee right calcaneocuboid joint which is likely a sequelae of the fibrous calcaneonavicular coalition.

[19] On 21 December 2021, Ms Keightley was seen in the Rheumatology Clinic at Counties Manukau, by Dr Jonathan Wright, Rheumatology Registrar. His impression was:

> ? asymmetric ongoing inflammatory arthritis vs post-traumatic synovitis.[5]

[20] On 13 January 2022, after Ms Keightley's scans were discussed at a radiology conference, an additional note was added to Dr Wright's report, with the consensus being that changes were likely related to post-traumatic synovitis.

[21] On 21 January 2022, Mr Matthew Tomlinson, Orthopaedic Foot and Ankle Surgeon, reported. He described Ms Keightley as a 48-year-old Ambulance Officer who had sustained an anterior process fracture of the os calcis,[6] stepping down out of an ambulance and twisting her ankle awkwardly. He noted that Ms Keightley had had pain since the accident in the same area. After reviewing the radiological reports, he concluded that Ms Keightley was suffering from an "old" anterior process fracture which had healed but in a malunited position. He also noted that there was also some irregularity of the joint. He recommended surgery.

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5 Synovitis is inflammation of the (synovial) membrane that lines joints possessing cavities.

6 The os calcis is the heel bone.

[22] On 27 February 2022, an assessment report and treatment plan ("ARTP") was completed by Mr Tomlinson, requesting surgery funding for Ms Keightley. The diagnosis provided on the form was a malunion anterior process fracture right os calcis. In terms of causation from the covered injury, Mr Tomlinson noted "anterior process fracture with malunion leading to irregularity of the calcaneocuboid joint and lateral foot pain".

[23] On 5 April 2022, Dr Patrick Medlicott, Orthopaedic Surgeon and Principal Clinical Advisor, commented on the surgery request:

> I note slipped while picking up a patient, twisting the foot and developed pain in the foot and possibly an anterior process fracture of the calcaneus (anterior process fracture of the calcaneus is a somewhat unusual injury, and the anterior process of the calcaneus is a variable structure and often is associated with the degree of congenital or developmental abnormality).
>
> There would appear to be changes in the plantar fascia which, of course, is not a condition affected by trauma. There would also appear from the triage comment to be bilateral calcaneo-navicular fibrous coalition.
>
> I have reviewed the surgeon's ARTP. I note also the imaging reports.
>
> It is noted there is a bilateral calcaneo-navicular fibrous coalition, this is not a condition that is caused by trauma. The plain x-ray report suggests this is of longstanding as there is earlier osteoarthrosis which, of course, takes years to develop.
>
> Unfortunately, I do not think there is any direct causal link here.

[24] Dr Medlicott suggested that the case be referred to the Corporation's Clinical Advisory Panel ("CAP"), so that the imaging could be reviewed before a final comment was made.

[25] On 21 April 2022, an x-ray of the sacroiliac joint, reported on by Dr Kurt Smoliner, Radiologist, showed:

> Normal bone alignment.
>
> No evidence of acute fracture.
>
> Very mild subchondral sclerosis of both SI joints.

[26] On 22 April 2022, after he had discussed the claim with the CAP, Dr Medlicott commented:

> This client's case was discussed 12/4/2022 at the CAP teleconference and the imaging was reviewed.
>
> The Panel agreed with my comments that the problem is not an anterior process calcaneal fracture but the demonstration of a fibrous coalition between the calcaneus and the navicular which is the commonest type of fibrous coalition in the foot. The fibrous coalition between the calcaneus and the navicular is a developmental problem which can be rendered symptomatic. This would appear to be the case here.

[27] On 27 April 2022, the Corporation issued a decision declining cover and surgery funding for malunion of the anterior process fracture of the right os calcis of Ms Keightley's right foot. This was on the basis that the need for surgery did not arise as a result of an injury suffered in the accident on 20 July 2021, and was related to a pre-existing health condition.

[28] On 10 May 2022, Ms Keightley underwent privately funded surgery of her right foot with Mr Tomlinson.

[29] On 19 May 2022, Mr Tomlinson reported:

> Debbie underwent surgery under my care on the 10th May 2022 for an old fracture of the anterior process of the os calcis. The injury had occurred when she fell out of an ambulance door at work twisting her ankle badly. She had had no symptoms prior to that in the foot whatsoever and after the injury there was considerable bruising and swelling over the lateral hind foot. She was seen by a doctor who suggested that it was not broken but x-rays were not done. X-rays were eventually done in October of 2021 which showed irregularity of the calcaneocuboid joint on the left side. This was confirmed on a SPECT-CT scan within increased uptake at the anterior process of the os calcis. Further imaging with an MRI also showed evidence of irregularity of the anterior process and cartilage loss in the calcaneocuboid joint.
>
> The findings at the time of surgery were complete cartilage loss over the dorsal part of the calcaneocuboid joint which articulates with the anterior process.
>
> These findings in my view are all in keeping with an anterior process injury with rapid cartilage degeneration following the injury. Unfortunately we do not have x-rays done at the time of the injury as the GP did not think the foot was broken but the findings from a clinical point of view would suggest to me that there was most likely an anterior process fracture. This is an intra-articular fracture and the irregularity seen on the CT and MRI in my view would be consistent with a malunion of such a fracture. I am not aware of any other situation in which this pattern of joint damage would occur specifically in relation to the area of injury and the absence of preoperative symptoms would make chronic arthritis unlikely. Please take this into account.

[30] In June 2022, Ms Keightley's file was reviewed by Mr John Riddell, Clinical Advisor and Ms Catherine McLean, Technical Specialist. The recommendation was made to suspend entitlements on the basis that Ms Keightley's symptoms were no longer related to her covered injuries.

[31] On 1 July 2022, Ms Catherine McGrath of Southern Cross Health Society filed a review application against the 27 April 2022 decision.

[32] On 4 July 2022, the Corporation issued a letter suspending Ms Keightley's entitlement to weekly compensation, treatment and vocational rehabilitation. This was on the basis that medical information showed that her current condition was no longer the result of her personal injury of 20 July 2021. The Corporation noted that her current incapacity was due to surgery, which was not to treat a physical injury caused by the accident on 20 July 2021. Ms Keightley lodged a review application against this decision.

[33] On 7 July 2022, Dr Michael Sexton, Principal Clinical Advisor, confirmed that the previous clinical comments remained relevant, and that the presence of a calcaneonavicular coalition bilaterally and its likely contribution to the pathology found at surgery had not been addressed by the operating surgeon.

[34] On 9 November 2022, Mr Tomlinson provided another report. He explained his view that, notwithstanding a developmental condition relating to a fibrous tarsal coalition, Ms Keightley had suffered a small fracture of the bone adjacent to the tarsal coalition called an anterior process fracture. He placed weight on the fact that only one side of the ankle was symptomatic, something which he considered pointed towards a traumatic cause. He also referred to the surgery findings with localised loss of cartilage over the dorsal part of the calcaneocuboid joint. He added:

> A malunion is where there has been a fracture or other bone disruption which has healed in a slightly non-anatomical position. The thing that made me think this was likely the site of a malunion was the irregularity of the bone and loss of cartilage at the site where I assume the anterior process fracture had occurred.
>
> In my view it is significant that it was not full thickness cartilage loss throughout the joint but rather only on the dorsal part adjacent to where I thought the fracture had occurred.

> The likely cause of the cartilage loss is injury to that part of the joint which interpreted as being at the level of where the interior process had healed in a slight malunion. …
>
> Although I can see that the injury that Debbie has had may have rendered symptomatic a developmental problem there was in my view evidence enough of injury to the joint to consider that the problem was one related to more acute trauma.

[35] On 22 December 2022, Dr Alex Rutherford, Orthopaedic Surgeon and Principal Clinical Advisor, provided further comment:

> There is no evidence of an acute fracture or malunion and furthermore, the abnormality is bilateral. I believe that, had there been a fracture 16 weeks prior to the imaging in November, there would be some increased uptake on both the SPECT CT scan and signal change on the MRI scan and this is not the case.
>
> I think it is likely that the client's accident has rendered symptomatic a congenital abnormality, but it has not caused it.

[36] On 27 February 2023, the Reviewer dismissed the review applications in regard to Ms Keightley's cover and surgery funding, on the basis that the condition treated was not injury related. However, the Reviewer quashed the Corporation's decision suspending Mr Keightley's ongoing entitlements, on the basis that, as at 4 July 2022, her incapacity was the result of her covered injuries of 20 July 2021. On 24 March 2023, a Notice of Appeal was lodged in respect of the Reviewer's decision dismissing the review application in regard to Ms Keightley's cover and surgery funding.

[37] On 23 June 2023, the CAP, comprising six Orthopaedic Surgeons and a Physiotherapist, advised that there was no proper basis to conclude that a fracture had occurred, and attributed Ms Keightley's pathology and symptoms to the particular make-up of her foot and an arthritic process. The CAP added:

> In this case, the client's mechanism of injury is described by the Podiatrist who lodged the claim as "picked up a patient last week and slightly slipped placing of foot in the wrong way causing pain on right foot". There was no explicit report of a sudden twisting or rolling of the ankle consistent with a lateral ankle sprain. This is only implied at a later date.
>
> The client's clinical presentation was also inconsistent with a right lateral ankle sprain or fracture of the anterior process of the calcaneus. The client reported that the accident event had caused "this pain on the heel and towards arch". She did not report lateral ankle pain.

> It wasn't until October 2022, that Ms Rawlinson noted pain and subtle swelling at the lateral aspect of the hindfoot and over the calcaneocuboid joint.
>
> In addition, at claim lodgement, palpation of the right ankle and foot revealed no bony tenderness at the lateral hindfoot, but at the right heel and right medial arch. There was no visible bruising or swelling reported. The impression was of plantar fasciitis.
>
> The client did not seek any further treatment for a two month period, and she continued to work. This is inconsistent with a fracture of the anterior process of the calcaneus.
>
> X-ray, MRI, and SPECT revealed evidence of an old or partially healed fracture and the Radiologists who undertook the x-ray (Dr Dodds) and SPECT CT (Dr Wadasinghe) specifically reported that there was no fracture. Similarly, Dr Rawlinson also noted no fracture.
>
> MRI and SPECT CT four months post injury would realistically have identified a fracture, malunion and any associated soft tissue trauma had there been a fracture of the anterior process. In addition, there would be increased uptake on the SPECT CT scan. This is not the case and imaging provides no direct or indirect evidence of a malunion fracture of the anterior process.
>
> Mr Tomlinson did not identify the fracture during surgery or describe the malunion. However, he inferred that the complete cartilage loss over the dorsal part of the calcaneocuboid joint, was in keeping with "where I assume the anterior process fracture had occurred". This is specious, with the full thickness cartilage loss also seen on MRI within four months of the accident event and it is inconceivable that this could have developed following a non-visible malunion fracture.
>
> Mr Tomlinson has also emphasised that the client's left foot calcaneonavicular coalition is asymptomatic. However, no weight can be placed on the absence of symptoms, with it well known that there is a poor correlation between MRI findings and symptoms, and clear evidence of calcaneocuboid arthritis on the right side.
>
> Finally, Mr Tomlinson has largely ignored the other widespread changes secondary to the calcaneonavicular coalition, the absence of trauma immediately following injury, the opinions of Ms Rawlinson, Dr Dodds, and Dr Wadasinghe and that there is simply no evidence of a malunion fracture on imaging or at the time of surgery.
>
> In the absence of an identifiable fracture during surgery and with all clinical evidence available, Mr Tomlinson cannot be considered to be in a better position to comment on causation.

Relevant law

[38] Section 20(2)(a) of the Act provides that a person has cover for a personal injury which is caused by an accident. Section 26(2) states that "personal injury" does not include personal injury caused wholly or substantially by a gradual process,

disease, or infection (unless it is personal injury of a kind specifically described in section 20(2)(e) to (h)). Section 25(1)(a)(i) provides that "accident" means a specific event or a series of events, other than a gradual process, that involves the application of a force (including gravity), or resistance, external to the human body. Section 25(3) notes that the fact that a person has suffered a personal injury is not of itself to be construed as an indication or presumption that it was caused by an accident.

[39] Section 67 of the Act provides:

> A claimant who has suffered a personal injury is entitled to 1 or more entitlements if he or she—
>
> (a) has cover for the personal injury; and
>
> (b) is eligible under this Act for the entitlement or entitlements in respect of the personal injury.

[40] In *Johnston*,[7] France J stated:

> [11] It is common ground that, but for the accident, there is no reason to consider that Mr Johnston's underlying disc degeneration would have manifested itself. Or at least not for many years.
>
> [12] However, in a passage that has been cited and applied on numerous occasions, Panckhurst J in *McDonald v ARCIC* held:
>
> > "If medical evidence establishes there are pre-existing degenerative changes which are brought to light or which become symptomatic as a consequence of an event which constitutes an accident, it can only be the injury caused by the accident and not the injury that is the continuing effects of the pre-existing degenerative condition that can be covered. The fact that it is the event of an accident which renders symptomatic that which previously was asymptomatic does not alter that basic principle. The accident did not cause the degenerative changes, it just caused the effects of those changes to become apparent ..."
>
> [13] It is this passage which has governed the outcome of this case to date. Although properly other authorities have been referred to, the reality is that the preceding decision makers have concluded that Mr Johnston's incapacity through back pain is due to his pre-existing degeneration and not to any injury caused by the accident.
>
> [14] … I consider it important to note the careful wording in the *McDonald* passage. The issue is not whether an accident caused the incapacity. The issue is whether the accident caused a physical injury that is presently causing or contributing to the incapacity.

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7 *Johnston v Accident Compensation Corporation* [2010] NZAR 673.

[41] In *Ambros*,[8] Glazebrook J, for the Court of Appeal, envisaged the Court taking, if necessary, a robust and generous view of the evidence as to causation:

> [65] The requirement for a plaintiff to prove causation on the balance of probabilities means that the plaintiff must show that the probability of causation is higher than 50 per cent. However, courts do not usually undertake accurate probabilistic calculations when evaluating whether causation has been proved. They proceed on their general impression of the sufficiency of the lay and scientific evidence to meet the required standard of proof ... The legal method looks to the presumptive inference which a sequence of events inspires in a person of common sense …
>
> …
>
> [67] The different methodology used under the legal method means that a court's assessment of causation can differ from the expert opinion and courts can infer causation in circumstances where the experts cannot. This has allowed the Court to draw robust inferences of causation in some cases of uncertainty -- see para [32] above. However, a court may only draw a valid inference based on facts supported by the evidence and not on the basis of supposition or conjecture … Judges should ground their assessment of causation on their view of what constitutes the normal course of events, which should be based on the whole of the lay, medical, and statistical evidence, and not be limited to expert witness evidence …

[42] In *Sparks*,[9] Ongley DCJ stated:

> [29] By s26(2) and (4) of the Injury Prevention, Rehabilitation, and Compensation Act 2001, personal injury does not include personal injury caused wholly or substantially by a gradual process, disease, or infection, or by the ageing process. The legal test for entitlements requires sufficient evidence to show that need for assistance arises as a consequence of the covered injury. Where there is an accompanying degenerative or gradual process condition, entitlements will not be available if the personal injury is caused wholly or substantially by that condition. In the present case therefore, the appellant has to be able to point to evidence demonstrating that the condition, as it was when the need for surgery was identified in August 2004, was substantially and effectively caused by the covered injury and not by a pre-existing process.

[43] In *Stewart*,[10] Barber DCJ stated:

> [33] The cases consistently highlight that the question of causation cannot be determined by a matter of supposition. There must be medical evidence to assist the respondent Corporation, and now the Court, to determine that question. A temporal connection, in itself, will be insufficient. There needs to be a medical explanation as to how the ongoing condition has been caused by the originally covered injury. In this case the evidence does not establish this.

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8 *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.
9 *Sparks v Accident Compensation Corporation* [2006] NZACC 45.
10 *Stewart v Accident Compensation Corporation* [2003] NZACC 109.

[44] In *Bloomfield*,[11] Joyce DCJ noted:

> [18] In this case, and when all is rendered down, the extension of cover claims pursued on appeal by Mr Bloomfield rest mainly on the foundation of a temporal connection argument. On occasion, a temporal connection may be of significance in the context of other, helpful to a claimant, evidence. But the mere presence of such a connection will usually do no more than raise the post hoc ergo propter hoc fallacy.

[45] In *Sarten*,[12] Barber DCJ stated:

> [26] I have referred above to the onus of proof on the appellant and the standard of proof. The appellant must establish, on the balance of probabilities, that his ongoing symptoms are the result of personal injury for which he has cover; he is not entitled to the benefit of any doubt; he cannot rely on possibilities; and he cannot call on the respondent to prove that it is not liable to provide cover. It is up to the appellant to prove his case.

[46] In *Yde*,[13] MacLean DCJ held that:

> [28] As between the contrasting views, I do not think that the specialist opinion of the treating clinician necessarily has to prevail over that of the CAP. At the end of the day, both are applying their medical expertise to make an analysis of the total picture based on the various reports and MRI information.

[47] In *Mehrtens*,[14] Ongley DCJ noted:

> [48] … In relation to the medical evidence, particularly in an area where an opinion is relied upon, the Court will be influenced by the extent to which the medical opinion proceeds logically from as clear or settled a basis of fact as is possible (including the possible need for caution when significant reliance is based on a claimant's self report); appropriate analysis of that material including, where necessary, the presentation of a differential diagnosis; an appropriate level of regard for and consideration of medical research and studies bearing on the issue at hand applied to the particular facts of the case; and a logically reasoned conclusion which takes account of any differing views or factors which might contra indicate the opinion being presented. In this respect, an opinion which is seen to absorb and respond to matters (whether matters of fact or opinion) which challenge the view offered will often be regarded as more persuasive.

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11 *Bloomfield v Accident Compensation Corporation* [2014] NZACC 1.

12 *Sarten v Accident Compensation Corporation* [2004] NZACC 2.

13 *Yde v Accident Compensation Corporation* [2015] NZACC 108. See also *Topping v Accident Compensation Corporation* [2018] NZACC 182, at [82].

14 *Accident Compensation Corporation v Mehrtens* [2012] NZACC 250.

[48] In *Stark*,[15] Powell DCJ commented that "the most appropriately qualified specialist with regard to interpretation of an ultrasound must be a radiologist rather than an orthopaedic surgeon". In *Shirkey*,[16] Powell DCJ stated:

> [37] … As has been noted in other cases the appropriately qualified specialist when it comes to interpreting imaging, whether MRI scans, CT Scans, ultrasounds or x-rays, are radiologists, and in the absence of good reason as to why in a particular case a particular radiologist's report should be treated with caution, the radiologist's interpretation will be preferred to the interpretation of imaging proferred by other specialists.

Discussion

[49] The issue in this case is whether the Corporation correctly declined Ms Keightley cover and surgery funding for a malunion of the anterior process fracture of the os calcis of her right foot, arising from her accident on 20 July 2021.

[50] Mr Schmidt, for Ms Keightley, submits as follows. Her condition and need for surgery are caused by an injury suffered in an accident on 20 July 2021. It is likely that she suffered an anterior process fracture and malunion in her right foot when she slipped off a step while removing a patient from an ambulance. The surgery corrected the malunion that was impinging on the calcaneocuboid joint. The ankle is a very complex structure, and there often is more than one plausible cause of pain in a patient's ankle. The more complex the assessment, the greater the reliance on clinical judgment. The opinion of Mr Tomlinson, the treating surgeon, should be preferred. He is in the best position to make the correct judgment, and his conclusion is consistent with the radiological evidence and the evidence provided by Ms Keightley.

[51] This Court acknowledges the above submissions and, in particular the views of the treating Orthopaedic Surgeon, Mr Tomlinson. However, the Court points to the following considerations.

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15 *Stark v Accident Compensation Corporation* [2015] NZACC 129, at [19].
16 *Shirkey v Accident Compensation Corporation* [2017] NZACC 106.

[52] First, this Court finds that the factual and medical information recorded within the first five months after Ms Keightley's injury on 20 July 2021 does not establish that she suffered a fracture in her accident:

(a) According to Ms Keightley's accounts, shortly after the accident, her GP thought that there was inflammation around her foot and told her that it would come right; and she was able to continue weightbearing and walking.

(b) On 28 July 2021, Ms Sikulu, Podiatrist, recorded that Ms Keightley slightly slipped, placing her foot in a wrong position causing pain on the heel and toward arch; and Ms Sikulu diagnosed sprain of the right ankle and foot, which was duly accepted by the Corporation.

(c) On 4 October 2021, Dr Kohlhagen, GP, suggested that Ms Keightley's condition sounded like plantar fasciitis and spur.

(d) Later on 4 October 2021, Dr Dodd, Radiologist, reported on an x-ray of Ms Keightley's right ankle that there was no evidence of recent bone or joint injury, but noted a minor deformity, likely long-standing, and in keeping with early osteoarthrosis.

(e) On 10 November 2021, Dr Kohlhagen diagnosed contusion of Ms Keightley's foot and sprain of her ankle.

(f) On 11 November 2021, Dr Wadasinghe, Radiologist, reported on a bone SPECT CT scan of Ms Keightley's feet that there were no acute fractures, but there was a bilateral calcaneonavicular fibrous coalition.

(g) On 11 November 2021, Dr Clark, Radiologist, reported on an MRI scan of Ms Keightley's right foot and ankle that there was suspicious inflammatory arthritis and moderate plantar fasciitis.

(h) On 16 November 2021, Ms Rawlinson, Orthopaedic Surgeon, in light of the scans of Ms Keightley, assessed suspicious inflammatory arthropathy

affecting the right midfoot, and arthritis of the knee right calcaneocuboid joint, likely a sequelae of the fibrous calcaneonavicular coalition.

(i) On 21 December 2021, Dr Wright, Rheumatology Registrar, suggested asymmetric ongoing inflammatory arthritis vs post-traumatic synovitis of Ms Keightley.

[53] Second, this Court finds that further medical evidence supported the Corporation's decision, on 27 April 2022, to decline cover and surgery funding for a fracture of Ms Keightley's right foot in her accident on 20 July 2021:

(a) On 5 April 2022, Dr Medlicott, Orthopaedic Surgeon, noted Ms Keightley's changes in the plantar fascia and longstanding bilateral calcaneo-navicular fibrous coalition, which were not conditions caused by trauma.

(b) On 21 April 2022, Dr Smoliner, Radiologist, reported on an x-ray of Ms Keightley's sacroiliac joint, that there was normal bone alignment, no evidence of acute fracture, and very mild subchondral sclerosis of both SI joints.

(c) On 22 April 2022, Dr Medlicott assessed that Ms Keightley's problem was not a fracture, but appeared to be a fibrous coalition between the calcaneus and the navicular, which was a developmental problem rendered symptomatic.

[54] Third, this Court finds that subsequent medical evidence supported the Corporation's decision on 27 April 2022, to decline cover and surgery funding for a fracture of Ms Keightley's right foot in her accident on 20 July 2021:

(a) On 7 July 2022, Dr Sexton, Principal Clinical Advisor, confirmed that the previous clinical comments on of Ms Keightley remained relevant, in particular, the presence of a calcaneonavicular coalition bilaterally and its likely contribution to the pathology found at surgery.

(b) On 22 December 2022, Dr Rutherford, Orthopaedic Surgeon, advised that there was no evidence of an acute fracture or malunion of Ms Keightley's right foot, and her abnormality was bilateral. Dr Rutherford thought it likely that Ms Keightley's accident had rendered symptomatic a congenital abnormality, but had not caused it.

(c) On 23 June 2023, the CAP, comprising six Orthopaedic Surgeons and a Physiotherapist, advised that there was no proper basis to conclude that a fracture occurred in Ms Keightley's case, and attributed her pathology and symptoms to the particular make-up of her foot and an arthritic process.

[55] Fourth, this Court finds that the assessment of Mr Tomlinson, that Ms Keightley suffered an anterior process fracture from her accident, is not sustained by the relevant medical evidence. The weight of this evidence is Ms Keightley's foot pathology and symptoms are due, not to a fracture from her accident, but to the particular make-up of her foot and an arthritic process. Of particular significance, Mr Tomlinson's assessment is out of line with the early diagnoses of her condition, and with the x-ray taken 11 weeks after the accident. Here, the radiologist reported no evidence of recent bone or joint injury and noted long-standing changes in keeping with early osteoarthritis. This radiological report was confirmed by radiological reports from later imaging. In the absence of good reason as to why the radiologists' interpretation should be treated with caution, their interpretation is preferred to that offered by Mr Tomlinson.

Conclusion

[56] In light of the above considerations, the Court finds that the Corporation correctly declined Ms Keightley cover and surgery funding for a malunion of the anterior process fracture of the os calcis of her right foot, arising from her accident on 20 July 2021. The decision of the Reviewer dated 27 February 2023 is therefore upheld. This appeal is dismissed.

[57] I make no order as to costs.

P R Spiller
District Court Judge

Solicitors for the Appellant: Schmidt and Peart Law.
Solicitors for the Respondent: Medico Law Ltd.