IN THE DISTRICT COURT
AT WELLINGTON

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

[2024] NZACC 030 **ACR 237/21**
ACR 49/23

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

Hearing:	21 November 2023
Heard at:	Wellington/Whanganui-A-Tara
Appearances:	Ms E Pointon and M MacKenzie for the Appellant Mr C Light for the Respondent
Judgment:	19 February 2024

RESERVED JUDGMENT OF JUDGE C J MCGUIRE
[Entitlement to surgery s 67 and Schedule 1, Accident Compensation Act 2001]

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[1] The appellant appeals against two decisions of the respondent, the first dated 5 March 2021 declining cover and surgery funding for the appellant's left shoulder acromioclavicular joint arthropathy and instability said to have been caused by an accident on 31 May 2016.

[2] The appellant also appeals against a decision dated 23 March 2022 declining cover and surgery funding for the appellant's left shoulder acromioclavicular joint damage said to have been caused by an accident on 18 August 2018.

[3] There is no issue as to the current diagnosis, or that the requested surgery is necessary and appropriate. The issue in this case relates squarely to cover. The respondent's position is that the acromioclavicular joint pathology and instability were caused by a gradual process and not by an accident.

Background

[4] The appellant has cover for the following injuries:

(a) 7 November 2014 – left shoulder rotator cuff sprain;

(b) 31 May 2016 – left shoulder rotator cuff sprain and glenoid labrum tear; and

(c) 10 August 2018 - left shoulder rotator cuff sprain.

[5] On 7 November 2014, the appellant injured her left shoulder when she picked up some suitcases at the airport and felt a sharp pain in her shoulder. A claim for a rotator cuff sprain was lodged on 26 November 2014 by the appellant's physiotherapist. The appellant attended physiotherapy until mid-December 2014.

[6] In 2015, it was noted in a neurology referral that the appellant had slight upper limb weakness and loss of range of motion.

[7] On 31 May 2016, the appellant injured her left shoulder when she leaned back to pick up a bag out of the passenger seat of a car. The bag got stuck and she felt a sharp pain in her shoulder as she tried to pull it. A claim for a rotator cuff sprain and neck sprain was lodged on 3 June 2016 by physiotherapist, Ms Hobcroft.

[8] The appellant attended physiotherapy following this accident until late 2019.

[9] In addition, the appellant's GP on 9 June 2015 requested an outpatient assessment because of multi joint pain, with hips and back especially painful.

[10] On 2 December 2015, rheumatology nurse, Ms Kirby, reported on an assessment of the appellant. A relevant diagnosis was ankylosing spondylitis, ie. a chronic inflammatory disease. Ms Kirby recorded that the appellant had had ongoing significant neck, jaw and shoulder pain for at least the last six years.

[11] On 22 December 2015, the appellant's GP requested a clinical assessment for upper limb weakness, ankylosing spondylitis and rheumatoid arthritis. He noted that the appellant had mentioned ongoing neck stiffness and loss of range of movement, which was becoming worse.

[12] On 18 January 2016, Dr McQueen, rheumatologist, reported. He noted the appellant's symptoms of worsening joint pain and back pain and numbness and tingling affecting the hands and feet. He said that on examination, there was little to find except for a stiff back consistent with her known ankylosing spondylitis.

[13] On 31 May 2016, the appellant injured her left shoulder when she leaned back to pick up a bag out of the passenger seat of a car, the bag got stuck and she felt a sharp pain in her shoulder when she tried to pull it. A claim for rotator cuff sprain and neck sprain was lodged on 3 June 2016 by Ms Hopcroft, physiotherapist.

[14] In her assessment on 3 June 2016, Ms Hopcroft noted ongoing shoulder pain and pins and needles in left hand.

[15] The appellant appears to have had eight consultations with her physiotherapist between 3 June 2016 and 21 October 2016.

[16] In her clinical note of 18 October 2016, the physiotherapist noted under the heading "Subjective":

> Tightened up again, still same aggs lifting laptop case, grocery bags and anything away from body …

[17] The appellant had further physiotherapy following another injury on 21 February 2017 when she lifted a heavy laptop bag from the passenger seat of her car and strained her wrist.

[18] She had a further injury on 10 August 2018 when she lifted a suitcase from a carousel at the airport. The physiotherapist noted under the heading "Current symptoms":

> Pain with loss of movement. Loss of function. Loss movt shoulder. Pain over sternal costal joint and Pects mm.

[19] The physiotherapist's differential diagnosis on this occasion was "strained chest".

[20] An ACC claim form dated 6 September 2018 was filed by the Otautau Medical Centre, with the diagnosis of rotator cuff sprain. In his consultation note of 6 September 2018, the appellant's GP, Dr Cremasco, noted:

> Lifting suitcase at Palmerston North Airport. Felt sudden lt shoulder pain. Since then, restricted ROM due to pain.

[21] A left shoulder examination by the doctor was carried out. He noted:

> Supraspin ROM to 90 deg. Very sore! Subscap ROM sore on rotation provocation ++ … the diagnosis was left rotator cuff sprain.

[22] The doctor noted:

> Needs imaging under ACC to check for tear.

[23] An ultrasound was carried out on 16 October 2018. The radiology report noted:

> Bursa: thickened. Fluid present.

[24] The radiologists conclusion was:

> Thickened bursa with degree of impingement.

[25] The ACC case manager noted in a file note on 23 October 2018:

> … [the appellant] advised that she was still experiencing problems with her shoulder injury that dated back to June 2016. She was able to continue work but had developed an inflamed bursa in the shoulder. She had seen her GP at Otautau Medical Centre and Christine Gibb at Pro-health Physio. Both considered there was a link back to the 2016 injury and a need for ongoing physiotherapy treatment.

[26] Physiotherapy continued until 5 September 2019.

[27] On 27 June 2019 the appellant's GP next referred her to musculoskeletal physician, Dr Bentley for a clinical assessment on:

> LT thoracic pain tracking to LT pec following LT shoulder injury.

[28] Dr Bentley reported on 23 January 2020. His assessment included the following:

> Sue has suffered a cervico thoracic first rib sprain and likely left shoulder rotator cuff tear (supraspinatus) +/- labral tear left shoulder reaching back lifting her laptop on 31/5/2016. She has related myofascial pain left pectoral, left scalene muscles (shoulder arm pain) and she has brachial plexus compression at the upper thoracic aperture and tension under the tight pectoralis minor affecting C8, T1, 4th, 5th finger numbness tingling …

[29] Dr Bentley referred the appellant for an MRI left shoulder arthrogram, which yielded these findings:

> Rotator cuff:
> The tendons of the rotator cuff are intact. The long head of biceps tendon is intact and enlocated.
>
> Acromion/Bursar:
> There is no bursal abnormality. The acromion has a gentle concave undersurface and the AC joint is normal in appearance
>
> …
>
> Joint and Labrum:
> Minor chondrolabral separation anterosuperiorly with small contained pocket of liquid, suspicious for a tear, with irregularity of the superior labrum undermining the biceps anchor. The appearances are suspicious for a SLAP tear extending from the 11:30 position to 2 o'clock position. No para labral cyst formation seen.

[30] In a further report dated 14 February 2020 Dr Bentley commented on the MRI Arthrogram saying:

> The MRI Arthrogram shows a SLAP lesion superior labrum, chondrolabral separation and accounts for I suspect the glenohumeral injection pain at MRI arthrogram which has aggravated the SLAP lesion and biceps tendon . There is in some images a suggestion of supraspinatus tear but I have discussed the scan with Dr James Fulton Radiologist who does think this is due to injectate into the subacromial space, which shouldn't occur, does occur, with full thickness tear. Dr Fulton also agrees with my interpretation that there is mild left acromioclavicular arthropathy and a subacromial spur.
>
> …
>
> In summary Sue has 3 problems:
>
> …
>
> - Left shoulder SLAP tear and associated strain myofascial pain left pectoral muscles subclavius and biceps (reaching back lifting laptop 31/5/2016), persistent left shoulder pain, associated impaired scapula stability.

[31] On 2 March 2020, ACC's clinical advisor, Launa Steel, recommended that ACC decline to cover the left shoulder labral tear and left shoulder closed fracture, scapular, glenoid under this claim. Ms Steel said:

> … The labral pathology cannot be attributed to the controlled lifting event covered under this claim. In addition, the effects of the covered rotator cuff sprain injury can reasonably be expected to have resolved within weeks of the injury event, given known natural tissue healing process timeframes.

[32] On 5 March 2020, ACC wrote to the appellant declining cover for closed fracture scapular/glenoid under the 2016 claim.

[33] On 8 June 2020, radiologist, Dr McKewen, reported on x-ray and ultrasound findings of that date. Under the heading "Conclusion" is this:

> Low grade partial thickness articular surface insertional tear of the anterior fibres of supraspinatus (rim rent) on the background of mild tendinosis.
>
> Subacromial bursitis with impingement.
>
> Asymptomatic AC joint arthropathy.

[34] On 16 September 2020, Dr David Kieser, orthopaedic surgeon, wrote a report for ACC for the appellant's case after viewing the medical records and examining her. He considered the SLAP (Superior Labrum Anterior to Posterior) tear to be traumatic in origin but could not identify a traumatic origin for her subacromial bursitis, AC joint arthropathy or supraspinatus tendinosis.

[35] On 23 November 2020, ACC wrote to the appellant approving cover for a glenoid labrum tear.

[36] On 21 January 2021, Mr Twaddle, orthopaedic surgeon, submitted a surgery request to ACC to fund an excise of the outer end of the appellant's clavicle and debride the joint under the 2016 injury. The causal link he identified was:

> The patient gives a clear history of an acute event on 31.5.2016 where a heavy bag got caught on a handbrake and tore or jarred her shoulder. She had intense pain and had to go to hospital to be reviewed at the time. The predominant symptoms she has had since have been related to the acromioclavicular joint and across the front of her clavicle and she has noticed increased mobility in this joint as things have got worse.

[37] On 5 March 2021, ACC wrote to the appellant declining surgery and cover for acromioclavicular joint arthropathy and instability. She sought review of this decision.

[38] On 14 April 2021, Mr Twaddle wrote to ACC expressing concerns about Dr Kaiser's report of 16 September 2020 and reiterating his clinical findings.

[39] On 15 May 2021, Dr Fong, ACC's principal clinical advisor, orthopaedic surgery, provided further clinical comment, saying that Mr Twaddle is describing "symptomatic aggravation of the shoulder joint arthropathy. This is not the cause of the client's acromioclavicular joint arthropathy".

[40] On 16 July 2021, Mr Twaddle provided an indepth report to the appellant's advocate, saying, amongst other things:

> The substantial and most probably (sic) cause of Suzanne's need for surgical procedure was post traumatic joint surface damage and degeneration of the left AC joint. This in particular is related to an original injury with some degree of instability in the joint leading to progressive changes on her x-rays as documented by her radiology.

[41] The review was heard on 16 August 2021 and was dismissed in a decision dated 1 September 2021. The appellant appealed to this court.

[42] On 19 January 2022, Mr Twaddle submitted a surgery request to ACC in respect of both the 2016 and 2018 injuries. On 9 March 2022, Dr Fong gave comment on behalf of the clinical advisory panel. He considered that the mechanism was not a likely cause for traumatic AC joint injury and the imaging did not show any traumatic AC joint pathology.

[43] On 23 March 2022, ACC wrote to the appellant declining cover and surgery to treat her left shoulder AC joint damage, as it was not primarily due to her injury on 10 August 2018. She sought review of this decision.

[44] ACC obtained a report from its clinical advisory panel on 14 July 2022. The clinical advisory panel included ACC's principal clinical advisor – orthopaedic surgery – Dr Fong. The clinical advisory panel concluded that the contemporary evidence did not support a traumatic cause of the appellant's left shoulder AC joint arthropathy and grade 1-2 instability because:

- The appellant had long-standing documented left shoulder pain since at least 2009.
- Some months before 31/05/2016, her medical notes recorded persistent neck, bilateral shoulder girdle and upper body pain.
- There is no evidence of an acute AC joint injury in the contemporary notes from her 31/05/2016 accident.
- The mechanism of reaching over to pick up her work bag from the passenger seat did not have sufficient force to cause internal disruption to the AC joint, which is designed to withstand large forces.
- The AC joint was non-tender on examination on 3/06/2016 when the claim form was lodged.

- The work accident report of 2 June 2016 and the initial physiotherapy and general practitioner records did not note any bruising, swelling or damage to the AC joint or surrounding structures.

- The AC joint is not mentioned as a cause of her left shoulder problems in the records in the four years after her 31/05/2016 accident.

- Ms Smith's left shoulder imaging, including her ultrasound scan on 16/10/18 and the MRI arthrogram on 30/01/2020, reported a normal AC joint.

[45] The panel concluded:

> In summary, Ms Smith's left shoulder AC joint arthropathy and associated instability became symptomatic and mildly unstable around the time that she was reviewed by Mr Twaddle. The proposed surgery … is appropriate … but is not causally related to the 31/05/2016 ACC covered accident or any other accident recorded in her ACC files …

[46] Mr Twaddle responded to the appellant's lawyer on 24 August 2022 and amongst other things, he said:

> It should be noted that at no time have the supposed experts from ACC examined her, although she has been seen by David Kaiser, orthopaedic surgeon, on 16 September 2020. From his note, there is no clear recognition of a formal examination of the acromioclavicular joint, although symptoms related to the joint were noted.
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> …
>
> Her history of injury, which is a resisted bracing load in both cases, is typical of the forces required to injury the acromioclavicular joint. The other common mechanism is a direct landing on the outside of the shoulder …
>
> At the time of my examination of the patient, she had increased mobility in her acromioclavicular joint, particularly in a transient anterior to posterior plane, and this aggravated her symptoms. This is in keeping with a grade 1 to 2 instability of the acromioclavicular joint, which is a clear clinical examination finding.
>
> …
>
> For me, based on her history and particularly her examination findings, there is a definite causal link between her instability in her joint and the history of injury. The mechanism of injury is as noted, with a highly resistant downward or bracing, loading force, pulling the humerus and scapular towards the

ground, with the clavicle remaining locked as part of the shoulder girdle. These features are confirmed on clinical examination.

…

I definitely disagree with the clinical advisory panel's advice that lifting a heavy suitcase, which may or may not be a controlled low energy event, is unlikely to be a cause of traumatic acromioclavicular joint injury. In my experience, this is a common cause with a resisted bracing loading event and is well described as a mechanism of injury to the acromioclavicular joint, particularly in weight lifters who load it in the gym.

I think it is unfortunate that lack of attention to detail of history and clinical examination by other practitioners, has led to this patient suffering when finally she has some resolution of the cause of her pain, with clear clinical signs showing subtle instability and pain associated with this in her acromioclavicular joint. I see no reason why ACC should not cover her ongoing care and treatment.

[47] In response to the comments of Dr Fong, Mr Twaddle reported again on 15 November 2022.

[48] Mr Twaddle said:

What I have suggested is that the proposed cause of Ms Smith's problem is an injury to the capsular stability of her left acromioclavicular joint at the time of her documented accident. This had led her to have subtle instability in the joint, which has led to increased motion, which has subsequently resulted in her developing acromioclavicular joint arthropathy.

This is supported by her history of injury, being a bracing event which can often affect ligamentous structures around the acromioclavicular joint as the whole weight of the arm and load that it is trying to pull against, is pulled against the acromioclavicular joint.

The clinical comment from the CAP is that acromioclavicular joint arthropathy is something that is a gradual onset, with slow deterioration of the whole joint. This is not the case in this patient's history, examination and radiological findings. The patient gives a clear history of injury, where she had pain around her shoulder girdle, which several clinicians had difficulty localising. From my own history taking, her pain was related to the region at the top of shoulder and radiating, if anything, towards the front of her chest, which is not uncommon with acromioclavicular joint pathology. The fact that her rapid deterioration and the radiological findings of her joint occurred after and following her injury, goes against the comments that acromioclavicular joint arthropathy would be a gradual onset of slow deterioration. She had initial symptoms she was aware of, and the symptoms never dissipated and got rapidly worse more recently, leading to her presenting with enough symptoms to warrant surgery.

[49] Physiotherapist, Janine Hopcroft, provided a further report on 6 January 2023. She said:

> Suzanne presented to our practice in 2016 with her initial acute injury to her cervical spine and left shoulder. The initial presentation was C5-7 nerve irritation and shoulder impingement signs. Due to the amount of pain Suzanne was in, the focus was on pain relief and management strategies associated with it. She did respond to treatment, but the ongoing painful abduction arc never resolved fully. But was at a level that she could function with normal ADL's but not elevated levels of sports/throwing etc.

[50] ACC's principal clinical advisor – orthopaedic surgery, Dr Rutherford, reported again on 23 January 2023. He said:

> Typically, injuries to the acromioclavicular joint result from a fall onto the point of the shoulder, such as coming off a bike or after a tackle. The degree of damage varies from a simple sprain to a complete dislocation with the distal end of the clavicle riding high and obvious instability. The client has three claims relating to her left shoulder, one from 7/11/2014 in which the accident description is picking up suitcases with her left hand and feeling sharp pain in the shoulder. The second is from 31/05/2016, reaching over to pick up a work bag on the passenger seat and feeling pain in the left shoulder. The latest is on 10/08/2018; the mechanism of injury is lifting a suitcase at the airport. Again, this mechanism of injury is not one likely to have caused an acromioclavicular joint injury.
>
> I note that imaging of the shoulder on 16/10/2018 reported that the acromioclavicular joint was normal. I note the subsequent imaging on 08/06/2020 reported that the acromioclavicular joint was intact and that there was asymptomatic acromioclavicular joint arthropathy.
>
> In answer to your questions, instability of the acromioclavicular joint, particularly grade 1 or 2 can lead to post-traumatic degenerative osteoarthritis; however, that instability is the result of tearing of the ligaments which stabilise the acromioclavicular joint, and this results from a fall on the point of the shoulder. Lifting suitcases and the like is not a mechanism that would cause an instability episode of the acromioclavicular joint.

Appellant's Submissions

[51] Ms Pointon notes that for her client's claim to succeed, there is a causal link between her shoulder condition, which required surgery, and her covered injuries and that her need for surgery is not "wholly or substantially" caused by a gradual process disease or infection. She submits that the medical evidence shows, on the balance of probabilities, that the appellant suffered personal injuries caused by accidents for which he has cover and which ultimately caused her need for surgery.

[52] She refers to *Ambros*[1] and the requirement of a generous and unniggardly approach to causation. She also refers to *Harrild v Director of Proceedings*[2]. If medical science is prepared to find there is a possible connection, a Judge may, after examining all of the evidence, decide that causation is probable.

[53] She notes that in respect of the injury of 31 May 2016, when the appellant injured her left shoulder when she leaned back to pick up a bag out of the passenger seat of the car, a claim for a rotator cuff sprain and neck sprain was initially accepted by ACC.

[54] Mr Twaddle recorded that the appellant had intense pain and since the injury has had trouble relating to the AC joint region.

[55] Ms Pointon also notes that as confirmed by Ms Hopcroft, physiotherapist, the appellant was treated in 2016 for nerve root irritation arising out of this accident event. ACC provided cover for neck sprain. Ms Pointon submits that this supports the accident was not insignificant.

[56] She refers to the 10 August 2018 injury when the appellant injured her left shoulder when lifting a suitcase at the airport and she felt sudden pain in her left shoulder, followed by a restricted range of motion. A claim for rotator cuff sprain was accepted by ACC.

[57] She reminds the court that Mr Twaddle states that the 2018 event also involved a resisted bracing type load mechanism for the acromioclavicular joint, which is typical of the forces required for an AC joint injury.

[58] She notes that Mr Twaddle says:

> There is a definite causal link between this instability in her joint and the history of injury. The mechanism of injury is as noted with a highly resisted downward or bracing, loading force, pulling the humerus and scapular towards the ground, with the clavicle remaining locked in part of the shoulder girdle. These features are confirmed on clinical examination.

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1 *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340 at [70].
2 *Harrild v Director of Proceedings* [2003] 3 NZLR 289 at [19].

[59] Ms Pointon adds that in respect of both the 2016 and 2018 claims there was a temporal link with the event and the injury in both cases.

[60] Ms Pointon refers to Mr Twaddle's report of 15 November 2022 where, as mentioned earlier, the appellant gives a clear history of pain around her shoulder girdle, which several clinicians had difficulty localising. Mr Twaddle then says:

> From my own history taking, her pain was related to the region at the top of her shoulder and radiating, if anything, towards the front of her chest, which is not uncommon with acromioclavicular joint pathology.

[61] Ms Pointon acknowledges that this case comes down to a clear difference in medical opinion, however the evidence of Mr Twaddle should be preferred as it was he who provided a very clear explanation of how the covered 2016 and 2018 injuries and their specific mechanisms have led to the AC joint injury.

[62] Ms Pointon also referred to the decision in *Cornwall*[3] where Judge MacLean found the reasoning process of Mr Love, who had actually done the surgery and seen for himself, to be coherent and plausible, and that having had the advantage of actually doing the surgery and seeing for himself, had lent weight to his contrasting opinion from that of the clinical advisory panel. Ms Pointon submits that in this case, too, based on the evidence of Mr Twaddle, the appellant should have cover for her AC joint injury and instability as being caused by the accidents of 31 May 2016 and 10 August 2018. Accordingly, she seeks orders providing cover for the appellant's left shoulder AC joint injury and an order that ACC fund surgery and treatment costs.

Respondent's Submissions

[63] Mr Light reminds the Court that the focus in this case is only on the appellant's acromioclavicular joint.

[64] He notes that unusually in this case we have accidents in both 2016 and 2018 which are claimed to be causative of the injury that required surgery.

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3 *Cornwall v Accident Compensation Corporation* [2016] NZACC 295.

[65] He submits that there is no evidence of an acute acromioclavicular joint injury in the contemporary notes from her 31 May 2016 accident. Further, that the accident mechanism did not have sufficient force to cause internal disruption to the acromioclavicular joint, which is designed to withstand large forces.

[66] He notes that the appellant has a history of "poly joint pain", as shown for example in a rheumatology referral to the Southland Hospital Rheumatology Department dated 9 June 2015.

[67] He submits that the appellant's imaging, including her ultrasound scan and x-ray on 16 October 2018 and the MRI arthrogram on 30 January 2020 reported a normal acromioclavicular joint.

[68] It is only in 2020 that the AC joint arthropathy is picked up.

[69] Mr Light refers to the left shoulder ultrasound and x-ray report of 16 October 2018 where, on ultrasound, the AC joint was found to be normal.

[70] He notes that likewise, an MRI scan on 30 January 2020 noted that the AC joint was "normal in appearance".

[71] When an x-ray and ultrasound of left shoulder was taken on 8 June 2020, the report says:

> AC joint: Capsular hypertrophy with bony irregularity, non-tender.

[72] The radiologist on that occasion, Dr McKewen, noted in his conclusion:

> Asymptomatic AC joint arthropathy.

[73] Mr Light says this is not injury related, but rather a disease of the shoulder.

[74] He says that unusually in this case we have "before" and "after" scans.

[75] Mr Light refers to principal clinical advisor, Dr Rutherford's, summary of 23 January 2023, where he concludes:

> Instability of the acromioclavicular joint, particularly grade 1 or 2 can lead on to post-traumatic degenerative osteoarthritis; however, that instability is the result of tearing of the ligaments which stabilise the acromioclavicular joint, and this results from a fall on the point of the shoulder. Lifting suitcases and the like is not a mechanism that would cause an instability episode of the acromioclavicular joint. There is no clear evidence that I can find that Mrs Smith has suffered an injury causing capsular instability of her left acromioclavicular joint in any of the accidents that she has sustained involving her left shoulder.

[76] Mr Light notes that the clinical advisory panel supports this view.

Appellant's Reply

[77] Ms Pointon responds, noting that Mr Twaddle, in his report of 15 November 2022 says that:

> The clinical comment from the CAP is that acromioclavicular joint arthropathy is something that is a gradual onset, with slow deterioration of the whole joint. This is not the case in this patient's history, examination and radiological findings. The patient gives a clear history of injury where she had pain around her shoulder girdle, which several clinicians had difficulty localising. From my own history taking, her pain was related to the region at the top of shoulder and radiating, if anything, towards the front of her chest, which is not common with acromioclavicular pathology.
>
> The fact that her rapid deterioration and the radiological findings of her joint occurred after and following her injury, goes against the comments that acromioclavicular joint arthropathy would be a gradual onset of slow deterioration.

[78] She also notes that some of the medical professionals who examined the appellant had difficulty in locating where her pain was.

Decision

[79] The ultimate issue to be decided in this case, as both counsel acknowledge, is whether the appellant's need for surgery was wholly or substantially caused by her covered injuries.[4]

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4 *McDonald v Accident Rehabilitation and Compensation Insurance Corporation* [2002] NZAR 970.

[80] In this case, the appellant has cover for a left shoulder rotator cuff sprain caused when she was picking up suitcases at Christchurch Airport using her left hand and felt a sharp pain in her shoulder.

[81] She was assessed by physiotherapist, Ms Gibb, on 26 November 2014, who diagnosed a sprain rotator cuff left side. The physiotherapist noted the following:

> Severity: High.
> Irritability: High.
> Nature: Mechanical.
> Stage: Acute.

[82] The differential diagnosis was that of sprain rotator cuff left side.

[83] The appellant attended the physiotherapist on five occasions until 18 December 2014.

[84] The appellant's next relevant injury occurred on 31 May 2016.

[85] At her review hearing on 31 January 2023, the appellant described the 31 May 2016 accident as follows:

> So I'd parked up … reached over as I was turned that way to open the car door, so quickly was jumping out of the car, one leg out of the car, grabbed my bag, normal motion and it caught on something. Umm, and it was heavy. I had my laptop, had a lot of gear in it, so it was probably a wee bit over over heavy but you know, its umm, as I grabbed it with a twisting motion I had my neck and I was looking right over that way umm, I felt something pull, like sharp and sort of give way, … right inside my shoulder and went down my shoulder and up my neck … I tried to do some things, I unpacked my bag, I thought no I've really done something here. So I just kept thinking right if I just rest it'll be fine, it'll be alright. It umm immediately started noticing umm, the tingling, like in, in my fingers and numbness and that so I went home …

[86] The appellant was assessed by her physiotherapist on 3 June 2016 with symptoms of ongoing anterior shoulder pain and pins and needles in the left hand. The physiotherapist recorded:

> Overreaching injury pain, decreased sensation and reflexes down left arm …

[87] The appellant continued with physiotherapy until October 2016, the physiotherapist noting on 18 October 2016:

> Tightened up again, still same aggs lifting laptop case, grocery bags and anything away from body. Difficulty sleeping on side again ++ up to 7/10 pain at times.

[88] The appellant was injured again on 10 August 2018. The claim form notes:

> Lifting suitcase at airport. Felt sudden LT shoulder pain. Since then, restricted ROM due to pain.

[89] The appellant again attended the physiotherapist who on 1 October 2018 noted current symptoms as:

> Pain with loss of movement. Loss of function, loss movt shoulder. Pain over sternal costal joint and pects.

[90] On 17 October 2018, her physiotherapist set goals of lifting 10 kgs in a safe lift and lifting 5 kgs to shoulder height.

[91] The physiotherapy continued until September 2019. Although other issues intruded in 2019, including a cardiac issue, it is clear that the appellant's presenting symptoms following the injury of 10 August 2018 did not resolve.

[92] In his report of 24 August 2022, Mr Twaddle said:

> Her history of injury, which is a resisted bracing load in both cases, is typical of the forces required to injury the acromioclavicular joint. The other common mechanism is a direct landing on the outside of the shoulder. This often results in vertical instability of the acromioclavicular joint as well.
>
> At the time of my examination of the patient, she had increased mobility in her acromioclavicular joint, particularly in a transient anterior to posterior plane, and this aggravated her symptoms. This is in keeping with a grade 1 to 2 instability of the acromioclavicular joint, which is a clear clinical examination finding.
>
> Unfortunately ACC's paper experts are not able to reproduce this from the end of their pens, but in the statement they acknowledge and accept the findings of the expert who is examining the patient at the time.

[93] Mr Twaddle went on to say:

> I definitely disagree with the clinical advisory panel's advice that lifting a heavy suitcase which may or may not be a controlled low energy event, is unlikely to be a cause for traumatic acromioclavicular joint injury. In my experience, this is a common cause with a resisted bracing, loading event, as is well described as a mechanism of injury to the acromioclavicular joint, particular in weight lifters who load it in the gym.

[94] Mr Light, understandably, points to the ultrasound taken on 16 October 2018 showing the appellants AC joint as normal. This find is confirmed in the MRI taken on 30 January 2020.

[95] However, in concluding his report of 24 August 2022, Mr Twaddle says:

> I think it is unfortunate that lack of attention to detail of history and clinical examination by other practitioners, has led to this patient suffering when finally she has some resolution of the cause of her pain, with clear clinical signs showing subtle instability and pain associated with this in her acromioclavicular joint. I see no reason why ACC should not cover her ongoing care and treatment.

[96] In a further report of 15 November 2022, Mr Twaddle again states his conclusions:

> As stated, the medical evidence suggests a condition of acromioclavicular joint pathology is a gradual process. I have provided adequate evidence that the accident has led to instability in the joint, supported by the fact that there was no radiological deterioration or damage in the joint when first seen and subsequently reviewed. This rapidly deteriorated as the patient's symptoms and her ongoing pain related to this instability and motion of the joint, led to deterioration of her symptoms.

[97] I find that there is otherwise support for this thesis in the fact that the best efforts of her physiotherapist in 2018 and 2019 did not resolve the appellant's "strained chest" that was the physiotherapist's differential diagnosis from the time the appellant first presented on 1 October 2018 with loss of shoulder movement of her left shoulder and an area of pain depicted as extending horizontally down from her left shoulder "over sternal costal joint and pects".

[98] I conclude that this long term observation by the physiotherapist supports what Mr Twaddle says. Her injury plainly did not improve.

[99] Dr Bentley too in his report of 14 February 2020 linked the pain in her left pectoral muscles with her shoulder injury from 2016.

[100] While I have great respect for the views of the clinical advisory panel, there will always be unusual cases that do not resolve in the expected way, or cases where the mechanism of injury would ordinarily be insufficient to cause the injury in question but nevertheless cause or contribute to it. I find that this is one of those cases.

[101] I conclude therefore that the appellant's left shoulder acromioclavicular joint arthropathy and instability was wholly or substantially caused by her accidents in 2016 and 2018 and that therefore ACC's decisions of 5 March 2021 and 3 March 2022 declining cover and surgery were wrong and are reversed.

[102] Accordingly, the appeal is allowed.

[103] Costs are reserved.

CJ McGuire
District Court Judge

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