IN THE DISTRICT COURT
AT WELLINGTON

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

[2024] NZACC 046 **ACR 74/23**

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

Hearing: 18 December 2023

Heard at: Christchurch/Ōtautahi

Appearances: Ms M Watson, advocate for Appellant
Mr C Light for the Respondent

Judgment: 13 March 2024

RESERVED JUDGMENT OF JUDGE C J MCGUIRE
[Section 25 - Accident; Section 26 – Personal Injury
Accident Compensation Corporation 2001]

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[1] The appellant appeals against ACC's decision of 10 August 2022 declining cover for left knee osteoarthritis and funding for left partial knee replacement surgery.

Background

[2] The appellant injured himself on 26 April 2018 when he tripped on the lower rung of a ladder.

[3] The evidence given for the mechanism of injury was coming down a ladder and caught his foot in a rung of the ladder – fell down the ladder and twisted his knee and landed in a forced flexed position.

[4] The appellant gave evidence that he suffered immediate pain. Swelling occurred at the time. He had to leave work.

[5] The appellant also has deemed cover for a radial tear of the medial meniscus (left), deemed on 25 October 2020.

[6] On 28 June 2018, Dr Welsh, radiologist, reported that the x-ray of the left knee showed there was no fracture; there was joint effusion; the medial cartilage space was moderately narrowed and there was mild varus deformity.

[7] Dr Welsh also reported:

> Possible intra articular soft tissue injury or arthritic damage. Medial compartment arthritis with mild malalignment.

[8] On 25 July 2018, the appellant was referred to Dr Matthews, sport and exercise medicine specialist, for treatment of his knee. The description of the mechanism of injury was twisting of the knee followed by landing in a forced, flexed landing. Dr Matthews said:

> His x-ray shows reduced medial compartment joint space consistent with knee osteoarthritis. I agree that it is likely that he has had an acute injury to his medial meniscus on the background of osteoarthritis of his knee.

[9] On 16 August 2018, Dr Wells, radiologist, reported on an MRI of the left knee. The report included the following:

> **Menisci:**
>
> Medial: extensive horizontal tear in the body and posterior horn, with slight truncation, probably indicating a small radial tear at the posterior root. More diffuse intermediate signal through these parts of the meniscus. Marked adjacent synovitis with thickening of the meniscofemoral and meniscotibial ligments.
>
> Lateral: normal.

Osseous and chondral: Irregular full thickness chondral loss from the medial margin of the weight-bearing part of the medial compartment with surrounding bone marrow oedema and small osteophytes.

Small amount of chondromalacia in the mid lateral femoral condyle. Cartilage thickness is preserved. Patellofemoral cartilage preserved.

Other:

Large effusion

COMMENT:

Medial meniscal tear.

Full thickness chondral loss medial compartment with bone marrow oedema.

[10] On 23 August 2018, Dr Matthews commented on the MRI:

…

His MRI shows full thickness chondral loss of the medial compartment and medial meniscal tear of the posterior horn. He has marked synovitis and a large effusion.

We had a discussion about knee osteoarthritis and meniscal tears today. I have suggested a corticosteroid injection to settle down his synovitis and effusion and help him progress with his rehabilitation programme.

I have encouraged him to continue with his weight loss efforts. I will review Daryl for his injection at my next available appointment.

[11] On 22 September 2018, Charlotte Price, physiotherapist with Allied Health, wrote:

This was a relatively low energy injury mechanism issues of lower limb malalignment, it appears likely that the medial tear is part and parcel of a long standing medial meniscus degeneration and medial compartment OA current diagnosis is of left knee OA with meniscal tear.

[12] On 26 September 2018, ACC gave a decision suspending entitlements, saying:

We are unable to continue providing you with this support as this medical information shows that your current condition is no longer the result of your personal injury of 26/04/2018.

The medical information states that you have osteoarthritis and meniscal tears, which our clinical advisor has advised is not a direct result of your accident of 26/04/2018. It has been advised that the cause of your ongoing incapacity is a result of degeneration in your knee. ACC have covered you for a sprain of your knee, however this would have been spent via the normal tissue healing processes in the time since your accident.

[13] On 17 December 2018, the appellant's left knee was x-rayed. The findings of Dr Tiffen, radiologist, were as follows:

> Moderate to marked medial compartment joint space narrowing with subchondral sclerosis, small marginal osteophytes, a genu varus and lateral tibial translation.
>
> Preserved lateral and patellofemoral compartments.
>
> Joint effusion. No other bony findings.

[14] On the same day, orthopaedic surgeon, Mr Kempthorne, provided Ms Watson with an assessment report and treatment plan.

[15] Under the heading "Diagnosis" he said:

- Varus medial compartment osteoarthritis, previously symptomatic until fall on 26.04.18.
- MRI scan on 16.08.18 shows intact cruciate ligaments, extensive tearing of the medial meniscus, normal lateral compartment, irregular full thickness chondral loss medial compartment with subtle early change in the lateral compartment. Associated medial compartment bone marrow oedema.
- X-ray on 28.06.18 and 17.12.18, progressive reduction in the medial joint space with progressive loss and now bone on bone articulation.
- Early osteophyte formation and preserved lateral compartment. Overall varus alignment.

[16] Under the heading "Summary", Mr Kempthorne said:

> My opinion is that Daryl has currently got symptoms of varus medial compartment osteoarthritis. His symptoms are isolated to the anterior medial part of his knee and I think he would benefit from a medial unicompartment knee replacement. He was clearly asymptomatic prior to his fall. He said that Mr Friesen would benefit from a medial unicompartment knee replacement.

[17] A review hearing on 23 January 2019 on suspension of entitlement was quashed. The reviewer wrote:

> On balance, I do not consider there is enough evidence on file to make an informed decision whether the meniscal tear was pre-existing, or if it was more likely a new and distinct injury.

[18] The reviewer also noted:

> However, the mere presence of degeneration does not bar a claimant from cover or entitlements. The question is whether there was a new and distinct injury caused by accident which is now a material cause of the ongoing incapacity. Mr Friesen's case was not properly investigated at the outset and a significant contribution to his ongoing incapacity relates to the meniscal tear in his knee. Therefore, the central issue is one of causation.
>
> **Conclusion**
>
> I find that ACC suspended entitlements without adequately investigating a possible traumatic cause of the meniscal tear.

[19] On 22 February 2019, Mr Kempthorne completed an assessment report and treatment plan. He recorded the following:

> **History of the Current Condition**
>
> Daryl is a 57 year old gentleman who sustained an injury to his knee on 26.04.18. MRI scan on 16.08.18 showed extensive tearing in the medial meniscus and preserved normal lateral compartment. There was associated medial compartment bone marrow oedema consistent with injury, but also full thickness chondral loss seen.
>
> **Causal Medical Link Between Proposed Treatment and Covered Injury**
>
> Mr Friesen's knee was completely asymptomatic prior to the fall. He would benefit from medial unicompartmental knee replacement.

[20] On 12 March 2019, Mr Ray Fong, orthopaedic surgery principal clinical advisor, and Sally Gordon, physiotherapy clinical advisor, provided clinical comment to ACC.

[21] On the issue of causation, they said:

> Low force event would be unlikely to cause a meniscal tear, or osteoarthritis. The medial compartment osteoarthritis was well established, the client's x-rays showed grade 3 kellgren lawrence chondral changes.
>
> Given the x-ray was two months after the injury, the osteoarthritis is clearly pre-existing.
>
> The chondral loss of the medial compartment is associated with bone oedema and osteophytes, both indicating that the condition was relatively long-standing.
>
> The surgeon reported that the client was asymptomatic prior to this injury, this may be the case, but is insufficient reasoning to establish causation.

[22] ACC declined cover and surgery on 13 March 2019.

[23] In a letter to the ACC case manager dated 26 March 2019, Mr Kempthorne agreed that the osteoarthritis was clearly pre-existing at the time of the accident.

[24] In response to a question about the cause of the extensive tearing of the medial meniscus, Mr Kempthorne said:

> It is impossible to differentiate between the degenerative and acute tears on his medial meniscus as I am unaware of any relevant and reasonably recent prior MRI scans to help us see what was present before and after the date of injury.

[25] Mr Kempthorne also noted that the appellant had no pain prior to his injury and has only had pain in his knee since; and in answer to the question "To what extent does his current incapacity relate to non-injury issues", Mr Kempthorne said:

> Non-injury issues are that he had previous asymptomatic osteoarthritis of his knee and is now currently symptomatic due to the additional injury caused by his fall.

[26] On 6 June 2019, Dr Hugh Roberts, radiologist, reported on an x-ray of the left knee with comparison to the x-ray of 17 December 2018. The report also addressed the right knee.

> **Left knee:**
>
> Moderate to severe medial joint space narrowing predominantly anteriorly with associated subchondral sclerosis and marginal osteophyte. Lateral tibial subluxion and genu varus (bow leggedness).
>
> Lateral and patellofemoral compartments are well preserved.
>
> **Right knee:**
>
> Moderate medial compartment joint space narrow and genu varus on single frontal projection.
>
> IMPRESSION:
>
> 1. Moderate to severe left knee medial compartment osteoarthritis.

[27] On 26 July 2019, Rachel Jenner, ACC technical specialist, in a technical services opinion and recommendation noted:

> I have discussed the case with Dr Peter Stormer on 27/07/2019, and on the current information, it would be difficult to support a decision to decline an acute meniscal tear.

> He agrees it would be helpful obtaining further opinion from Mr Kempthorne about the material cause of current incapacity.

[28] She recommended obtaining further comment from Mr Kempthorne.

[29] On 5 November 2020, there was deemed cover for medial meniscus tear. The reasoning for the deemed cover was:

> Because we did not make a decision on your injury within the legally required timeframe, on 25/10/20 specific injury diagnosis was automatically accepted. We still need to assess whether or not it was correct to accept your injury. That means we will need to make a decision based on information relevant to your injury.

[30] On 22 January 2021, Dr David Kaiser, orthopaedic surgeon, assessed Mr Friesen and reported to ACC. The diagnosis was "left knee medial compartment osteoarthritis and a medial meniscal tear".

[31] Dr Kaiser described the original accident event and outcome as follows:

> This was a fall from a height, landing on his knee, twisting and loading the knee, developing medial sided knee pain and progressive swelling. This was likely both an exacerbation of his underlying degenerative change as well as a tear to his medial meniscus.

[32] He went on:

> By far the dominant cause of his pain currently is his medial compartment osteoarthritis which is causing constant pain and functional deficit. To a lesser degree are his mechanical symptoms from his meniscal tear, which are likely both degenerative and traumatic in origin. His underlying degenerative change was, in my opinion, pre-existing, but his mechanism of injury would be consistent with that of sustaining a medial meniscal tear even in a normal knee. However, his predominant concerns now relate to his degenerative pain as evidenced by his bone on bone pain, as he describes it, his improvement with anti-gravity and his response to a cortisone injection and the lack of mechanical symptoms but rather constant medial sided pain classic of medial compartment osteoarthritis rather than a meniscal tear.

[33] While acknowledging that the appellant did tear his medial meniscus during his fall, Dr Kaiser went on to say that this also exacerbated his underlying degenerative change and that his predominant concern now was his degenerative knee rather than his medial meniscal tear.

[34] As to whether on the balance of probabilities the medial meniscal tear was acute, Mr Kaiser said:

> His MRI scan findings reveal a complex medial meniscal tear, but with signal change through the meniscus. There is no doubt that he has a degree of degenerative meniscus here. However, considering his mechanism of injury and lack of preceding symptoms, it is likely that he did tear his medial meniscus during his fall as evidenced by his immediate pain and subsequent swelling over the course of a few days and mechanical symptoms that he describes post-injury.

[35] On 12 July 2021, Dr Lynch, radiologist, reported on an MRI of the left knee. Under the heading "Comment" is this:

> Stable appearances to the previously documented medial compartment osteoarthritis.
>
> Stable appearances to the previously documented horizontal medial meniscal tear with a displaced flap into the inferior recess.
>
> Small inferior surface flap tear in the free margin of the body of lateral meniscus.

[36] On 8 August 2021, Mr Rietveld, orthopaedic and spinal surgeon, conducted a file review. Mr Rietveld said:

> At the time of his MRI just after his injury, it did show that there was as significant tear of the meniscus which is both partly degenerative in nature as well as having a probably acute component to it. That is to say there was a radial component to this tear.
>
> Subsequently an MRI done in 2021 shows that there has been a progression of degenerative changes, more cartilage loss over the medial femoral condyle, that is the area of cartilage loss which has significantly increased in size. The tear remained present in the meniscus.
>
> There is no doubt that degenerative changes in his knee has progressed since his original injury and treatment option offered to him was that of a hemi knee replacement is appropriate treatment for him.

[37] Mr Rietveld concluded with the following:

> There is no doubt both stated by Mr Kaiser and Mr Kempthorne, that the injury he sustained was partially traumatic, but made underlying asymptomatic condition symptomatic. Therefore to deal with this we need to deal with both components, both the acute and chronic component of his injury.

[38] Dr Kaiser reported again on 6 October 2021. He noted that a complex medial meniscal tear can certainly result in continued medial pain, as well as potential mechanical concerns which can limit the capacity to return to a trade, particularly one requiring climbing ladders, such as a painter or decorator. It is noted that in the ACC injury claim form, the appellant's occupation is listed as painter and paper hanger.

[39] In the further report of 20 May 2022, Mr Rietveld, orthopaedic and spine surgeon, said:

> No doubt Daryl had arthritis in his knee prior to his accident, but it was asymptomatic. The accident, which then caused a tear, caused a rapid deterioration of the arthritis. This now requires him to have a hemi knee replacement or an equivalent procedure.
>
> That is to say the accident precipitated a rapid deterioration of the arthritis in the knee as seen on the plane x-rays, from one taken at the time of the injury to the one taken less than six months later.
>
> Therefore, I believe due to the fact that he had stable osteoarthritis prior to this, it became unstable due to the accident in 2018.
>
> Note: Had he not had the accident, it is unlikely that he would have had the rapid deterioration of the arthritis. His arthritis was stable prior to that.

[40] Dr Fong, orthopaedic surgery principal clinical advisor, gave further clinical comment on 29 July 2022.

[41] He said:

> The information available does not support a causal link between the condition now requiring treatment and the accident of 26/04/2018. As indicated by Mr Rietveld in his report of 20/05/2022, there was established osteoarthritis on the very first x-ray of 28/06/18.

[42] On 10 August 2022, ACC declined cover and surgery funding, saying:

> Based on the information available to us, we have determined that this condition wasn't caused by your accident of 26/04/2018 and relates to a pre-existing or unrelated health condition. This means we are unable to cover this condition or other support for this injury.

[43] The appellant took ACC's decision on review but was unsuccessful.

[44] On 27 June 2023, Dr Rajapakse, consultant rheumatologist, conducted a file review at the request of the appellant's advocate. Under the heading "Comment on Dr Fong's Observations", Dr Rajapakse said:

> I disagree with this view (Dr Fong's view that the "low force event of the accident was unlikely to cause a meniscal tear or osteoarthritis") as did the three other orthopaedic surgeons involved, who all conceded that the extensive horizontal tear, or at least the radial part of the tear, was probably caused by the fall. In fact, one can never be sure that more, if not all, of the tear was a consequence of the fall.
>
> I also disagree with the characterisation of the fall as a "low force event". There was likely to have been substantial force, given that it was a fall from a height of 2.5 metres and there was a twisting and a forced flexion on landing on hard concrete followed immediately by severe pain, swelling not long after with the pain persisting since, while there was no pain at all before the fall.
>
> These argue for substantial contribution from the fall to the complex horizontal meniscal tear, especially the radial tear at the posterior root. However, I agree with Dr Fong that the chronic loss of medial compartment cartilage very likely pre-dated the fall.
>
> The clear shortfall on the part of Dr Fong in the assessment of the detailed features of forces at play during the fall may have led to his trivialisation of the consequences of the fall and their contribution to the need for surgery.

[45] He concluded his report as follows:

> Considering the above, I would contend that it is wrong for ACC to disallow funding for the same surgery as was required immediately following the fall, and that has still not been carried out, while the patient continues to suffer some pain and disability.

Appellant's Submissions

[46] Ms Watson notes that prior to his fall, Mr Friesen was a paint and paper decorator and that at no time in that occupation was his left knee either uncomfortable or painful.

[47] Mr Rietveld was of the opinion that his pre-existing osteoarthritis was mild.

[48] She submits that Mr Fong's view that the arthritis and meniscal tear were long-standing are not supported by the evidence, as prior to the accident the appellant would have had difficulties climbing ladders, with discomfort and pain.

[49] She submits that ACC is incorrect that the mechanism of injury was a low force injury.

[50] She submits that Mr Kempthorne, orthopaedic surgeon, reported that the MRI scan showed extensive tearing of the medial meniscus and that there was associated medial compartment bone marrow oedema consistent with injury. Also full thickness chondral loss was seen.

[51] She notes that there was no evidence of this prior to the accident.

[52] She submits that the diagnosis of post traumatic arthritis must be accepted as part of the accident causing the complex meniscus tear.

[53] She submits that ACC did not adequately investigate a possible traumatic cause of the meniscus tear.

[54] She submits that because of not treating the meniscus tear along with the post traumatic osteoarthritis, Mr Friesen has ended up now with the osteoarthritis dominating his knee condition. She says that five years of limping around without treatment has contributed to his current need for surgery.

[55] She submits that the knee specialists have stated that without the meniscus tear injury, Mr Friesen would not have needed surgery, and that the osteoarthritis was deemed to be post-traumatic osteoarthritis, that is caused by injury.

[56] She compares this case to that of *Johnston v ACC*[1] where Justice France noted that it was common ground that but for the accident, there was no reason to consider Mr Johnston's underlying disc degeneration would have manifested itself, or at least not for many years.

[57] She submits that it is common ground amongst the specialists in this case that without this injury, there would have been no need for surgery.

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1 *Johnston v Accident Compensation Corporation*, HC Wellington CIV-2010-485-424, 23 September 2010 at [11].

[58] She refers to *Harrild v Director of Proceedings*[2] and the need for a generous and unniggardly approach to causation.

[59] She refers to what Judge Ongley said in *Wilson*[3], namely:

> The Court is not qualified to draw any independent medical conclusions. The question for the Court concerns the weight given to medical professionals' opinion for or against the appellant's claim. The inquiry must be guided by the persuasive reasoning of a particular opinion, the skill and experience of the practitioner, the recital of authoritative sources, the first hand examination of the patient and/or observation of the development and progress of symptoms and possibly by a level of agreement between a number of practitioners.

[60] She submits that that is the case with this claim and that in particular, Mr Rietveld and Mr Kempthorne have noted a short time between June 2018 and December 2018, that significant changes have occurred, such as reduction of the medial joint space and now evidence of "bone on bone".

[61] She says that Mr Rietveld and Mr Kempthorne are knee surgeons and Mr Rajapakse is a rheumatologist and expert in arthritis conditions. She says that all have agreed that without the fall and injury Mr Friesen would not have had the need for the surgery required.

[62] She emphasises that there is no evidence at all that the meniscal tear was of long standing. The appellant has been unable to work because of the meniscal tear and that the meniscal tear and the osteoarthritis have to be corrected together.

Respondent's submissions

[63] After referring to s 26 of the Act and what is included and not included as personal injury and also the definition of those accidents in s 25 Mr Light refers to *McDonald*.[4] In *McDonald,* Justice Pankhurst cited with approval the comments of Judge Beattie in *Hill*[5]:

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2 *Harrild v Director of Proceedings* [2003] 3 NZLR 289.
3 *Wilson v Accident Compensation Corporation* [2009] NZACC 189 at [21].
4 *McDonald v Accident Rehabilitation and Compensation Insurance Corporation* [2002] NZAR 970.
5 *Hill v Accident Compensation Corporation* [1998] NZACC 189 at [26].

> If medical evidence establishes that 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 the accident that 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 effect of those changes to become apparent and of course in many cases for them to become the disabling feature.

[64] Mr Light notes that there is no issue about the relevant diagnosis, ie. that Mr Friesen has left the medial compartment osteoarthritis and there is no issue that the surgery (a partial knee replacement) is required to treat this condition.

[65] Mr Light refers to the orthopaedic assessment by Dr Kieser of 21 January 2021 where he says:

> By far the dominant cause of his pain currently is his medial compartment osteoarthritis which is causing constant pain and functional deficit. To a lesser degree are his mechanical symptoms from his meniscal tear which are likely both degenerative and traumatic in origin.

[66] He goes on to note that Dr Kieser:

> Would advise conservative management for his meniscal tear in preference to definitive treatment of his underlying degenerative change which would be knee arthroplasty.

[67] He also notes that Dr Rajapakse "is in a minority of one" with his view that partial knee replacement surgery is needed to deal with the miniscule tear.

Decision

[68] On 26 April 2018, at age 56, the appellant had an accident at his work. The accident was described in the ACC injury claim form as "tripped off lower rung of ladder".

[69] His occupation was that of painter and paper hanger and when the accident occurred he was working as a picture frame finisher, which involved standing, painting or staining frames.

[70] The fullest description of his injury is from Dr Eloise Matthews, sport and exercise medicine senior registrar.

[71] In a report of 25 July 2018, she says this:

> Many thanks for referring Daryl, a 56 year old fairly sedentary frame finisher with left knee pain.
>
> Daryl describes injuring his left knee when he stepped off a ladder 10 weeks ago while holding a 1.5 metre piece of moulding and caught his boot on the lower rung of the ladder. He twisted and landed on the ground in a forced flexion position of his knee. He had anterior inferior knee pain and had some slow swelling over the next couple of days. Six weeks later he attended a podiatrist and had inserts put into his shoes which seemed to aggravate his swelling. He now has been off work for the last month. There are no light duties available for him at work. He reports that he has not done any home exercise programme and has only received passive treatments.
>
> He works as a picture frame finisher which involves standing, painting and staining frames. He has to be able to get the pieces of frame from one machine to another. The frames vary in weight significantly and can be awkward due to the increased length.
>
> He does not report a previous injury to his left knee and does not have any other injuries.

[72] Dr Matthews noted that he was overweight; that he was mountain biking once a fortnight for about 30 minutes but did not have any other regular activity.

[73] She also noted that his x-ray showed reduced medial compartment joint space consistent with knee osteoarthritis.

[74] An MRI of his left knee on 16 August 2018 revealed the following findings:

> Menisci
>
> Medial: extensive horizontal tear in the body and posterior horn with slight truncation, probably indicating a small radial tear at the posterior route.
>
> …

[75] On 23 August 2018 Dr Matthews elaborated further. She said:

> His MRI shows full thickness chondral loss to the medial compartment and medial meniscal tearing of the posterior horn. He has marked synovitis and a large effusion.

> We had a discussion about knee osteroarthritis and meniscal tears today. I have suggested a corticosteroid injection to settle down his synovitis and effusion and help him progress with his rehabilitation programme.

[76] Mr Kempthorne, orthopaedic surgeon, saw the appellant and reported on 17 December 2018. His summary diagnosis included the following:

> - Varus medial compartment osteoarthritis, previously asymptomatic until fall on 26.04.18.
>
> - MRI scan on 16.08.18 shows intact cruciate ligaments, extensive tearing of the medial meniscus, normal lateral compartment, irregular full thickness chondral loss, medial compartment with subtle early change in the lateral compartment. Associated medial compartment bone marrow oedema.

[77] Mr Kempthorne's summary in the same report included the following:

> My opinion is that Daryl has currently got symptoms of varus medial compartment osteoarthritis. His symptoms are isolated to the interior medial part of his knee and I think he would benefit from a medial uni compartment knee replacement.

[78] In his assessment report and treatment plan, Mr Kempthorne said this under the heading "history of the current condition":

> Daryl is a 57 year old gentleman who sustained an injury to his knee on 26.04.18. MRI scan on 16.08.18 showed extensive tearing of the medial meniscus and preserved normal lateral compartment. There was associated medial compartment bone marrow oedema consistent with injury but also full thickness chondral loss seen.

[79] ACC took clinical opinion from its physiotherapy clinical adviser, Sally Gordon, and its orthopaedic surgery principal clinical adviser, Dr Fong. They were of the opinion that the medical evidence did not support a causal link between the appellant's accident and the condition requiring surgery.

[80] ACC then issued a written decision on 13 March 2019 declining cover "for surgery to treat your left knee osteoarthritis".

[81] Dr Kieser provided ACC with an orthopaedic assessment dated 22 January 2021 in which he said:

> By far the dominant cause of his pain currently is his medical compartment osteoarthritis which is causing constant pain and functional deficit. To a lesser degree are his mechanical symptoms from his meniscal tear which are likely both degenerative and traumatic in origin.

[82] The appellant's advocate sought advice from Mr Rietveld, orthopaedic and spine surgeon, following the reports of Mr Kieser and Mr Kempthorne.

[83] Mr Rietveld acknowledged that the MRI scan just after the injury showed there was a significant tear of the meniscus "which is both partly degenerative in nature as well as having a probably acute component to it".

[84] He also noted that:

> No doubt … degenerative changes in his knee have progressed since his original injury.

[85] It is fair to say that the relative positions of ACC and its advisers and those medical professionals from whom the appellant obtained opinions, remain unchanged.

[86] The appellant obtained a further opinion from Mr Rajapakse, consultant rheumatologist, in June 2023.

[87] Dr Rajapakse was of the view that the appellant's fall from the ladder was not a low force event and that the pain and swelling that followed "argue for substantial contribution from the fall to the complex horizontal meniscal tear, especially the radial tear at the posterior root".

[88] However, he agreed with Dr Fong that the chronic loss of medial compartment cartilage very likely pre-dated the fall.

[89] In his submissions, Mr Light referred to the High Court decision in *McDonald* [6] where Panckhurst J cited with approval the comments of Judge Beattie in *Hill v ACC*:

> The provisions of s 10 make it clear that personal injury caused wholly or substantially by the aging process is not covered by the Act.

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6 *McDonald*, See n4 above at [26].

> … if medical evidence establishes that 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 effect of the pre-existing degenerative condition that can be covered. The fact that it is the event of the 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 effect of those changes to become apparent and of course in many cases for them to become the disabling feature.

[90] Counsel has helpfully also referred to *Mehrtens*[7] where Judge Ongley referred to a number of factors as useful in determining whether there had been a new injury to which the claimant had a predisposition or the exacerbation of an underlying condition:

- The nature of the injury as initially identified;
- Any further or revised diagnosis of the injury;
- The significance and seriousness of the accident;
- The development of symptoms following the accident;
- The existence of any pre-existing condition;
- Whether any change in the presentation of symptoms is consistent with the natural course of the identified injury;
- The objective signs or indicia of injury;
- The nature and quality of the evidence, both medical and factual.

[91] The nature of the injury was that while holding a 1.5 metre piece of moulding the appellant caught his foot on the lower rung of the ladder. He twisted and landed on the ground in a forced flexed position on his knee. He had anterior knee pain and some slow swelling over the next couple of days. The reports indicate that the immediate effects of his injury were still present six weeks later when he attended a podiatrist to have inserts put into his shoes. This was a significant injury for someone who is overweight.

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[7] *Accident Compensation Corporation v Mehrtens* [2012] NZACC 250 at [48].

[92] Further precise diagnosis was forthcoming after the MRI scan on 16 August 2018. This revealed an extensive horizontal tear in the body and posterior horn of the medial meniscus.

[93] In this case, it is common ground that the appellant had knee joint osteoarthritis. According to the respondent's orthopaedic surgery clinical advisor, Dr Fong:

> At the time of the accident, there was established osteoarthritis shown on the x-ray on 28 June 2018 and confirmed by the MRI on 16 August 2018.

[94] According to Dr Fong, therefore, the requested knee surgery replacement is to treat the osteoarthritis of the knee joint, which he describes as a "common age related gradual process pre-existing condition".

[95] However, the preponderance of the clinical opinion is that the significant meniscal tear was all or substantially caused by the fall from the ladder on 26 April 2018.

[96] The report from the MRI carried out on 16 August 2018 said:

> Menisci:
>
> Medial: Extensive horizontal tear in the body and posterior horn with slight truncation…

[97] Dr Kaiser had said in his report of 6 October2021:

> A complex meniscal tear can certainly result in continued pain as well as potential mechanical concerns which can limit the capacity to return to a trade, particularly one requiring climbing ladders.

[98] Dr Rietveld said in his report of 20 May 2022:

> The accident, which then caused a tear, caused the rapid deterioration of the arthritis…

[99] Dr Rajapakse says in his report of 20 July 2023:

> The appropriate treatment for this (meniscal) tear now is none other than total knee replacement.

[100] I find in this case therefore that on the balance of probabilities the consequences of the meniscal tear caused by this accident went beyond rendering his underlying osteoarthritis symptomatic.

[101] If the Respondent's position were accepted in its entirety, it would mean the appellant would be denied cover and treatment for an injury by accident, namely the torn meniscus. Such an approach would not be consistent with the generous and unniggardly approach to causation that *Harrild*[8] requires in this jurisdiction.

[102] It is acknowledged that ACC's decision of 10 August 2022 that is being appealed from, namely the declining of cover for left knee osteoarthritis and funding for left partial knee replacement surgery is also a decision that would see the appellant's non-covered left knee osteoarthritis also remedied by the same surgery.

[103] Given my finding that on the balance of probabilities the appellant's meniscal tears were caused by his accident of 26 April 2018, the fact that the knee surgery will also remediate his non-injury related osteoarthritis, is not of itself a reason to deny him that surgery. Sometimes, remediation of covered accident related injuries necessarily involves remediation of connected or adjacent non injury conditions. This not infrequently occurs with shoulder injuries.

[104] ACC's decision of 10 August 2022 declines the appellant's request for elective surgery for left knee osteoarthritis. Given the decision in *McDonald's* case that decision is correct as, on the evidence as it stands, the osteoarthritis caused the degenerative changes, rather than the accident.

[105] And Mr Light, correctly notes that there is presently no request for treatment of the meniscus tear. This needs to be remedied by the appellant.

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8 *Harrild v Director of Proceedings* [2003] 3 NZLR 289 at [19].

[106] The way forward therefore appears to be that in reliance upon the evidence of Dr Rajapaske of 20 July 2023, and in the absence of evidence to the contrary, total knee replacement surgery is required to treat the appellant's meniscal tear arising from the covered injury of 26 April 2018. The appellant should lodge his request for knee replacement surgery to treat that injury, and on the basis of the evidence as it stands, that request should be granted by ACC.

[107] However, because *McDonald* stands in the way of granting this appeal against ACC's refusal to fund surgery for left knee osteoarthritis, this appeal must be dismissed.

[108] Costs are reserved.

CJ McGuire
District Court Judge

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