IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 237 **ACR 252/21**

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

Hearing:	30 November 2022
Held at:	Wellington/Te Whanganui-a-Tara by AVL
Appearances:	M Williams for the Appellant J Sumner for the Accident Compensation Corporation
Judgment:	7 December 2022

RESERVED JUDGMENT OF JUDGE P R SPILLER
[Claim for personal injury - s 26(2), Accident Compensation Act 2001]

Introduction

[1] This is an appeal from the decision of a Reviewer dated 14 July 2021. The Reviewer dismissed an application for review of the Corporation's decision dated 8 October 2020 declining cover and funding for surgery to treat Ms Dooney's L5/S1 disc prolapse.

Background

[2] Ms Dooney was born in 1953 and became a midwife and practice nurse.

[3] On 23 May 1996, Ms Dooney suffered an injury by way of a secondary sprain or strain of her lower back/spine, and was granted cover by the Corporation.

[4] On 5 July 2000, Ms Dooney again suffered an injury causing pain to her lower back/spine. An ACC Injury Claim Form was completed by Dr Richard Eastcott, GP, who described the incident as "slipped on wet concrete", and her diagnosis was low back pain, acute pain-lumbar, and lumbago.

[5] On 5 June 2001, Mr James Elliot, Orthopaedic Surgeon, reported that he had arranged further imaging after Ms Dooney presented with constant back pain attributed to the July 2000 event. The event was described as follows:

> She slipped on a patch of ice in the Botanical Gardens on 5.7.00 landing heavily on her buttocks and sustaining a significant jarring injury to her lumbar spine. There was substantial lumbar pain after that for which she had a period of physiotherapy. The pain settled somewhat but did not resolve completely.

[6] Mr Elliot noted that x-rays taken on 15 May 2001 were essentially normal apart from a minor traction spur at the L3-4 level. Mr Elliot was concerned at the severity of Ms Dooney's pain and recommended that an MRI scan be conducted.

[7] On 26 July 2001, Mr Elliot reported further. He noted that the new x-rays appeared normal and unremarkable, with no abnormality seen in the frontal film, but the radiologist suggested that there was a minor irregularity of the posterior cortex of S1. Mr Elliot decided to arrange a bone scan.

[8] On 28 August 2001, the bone scan was taken. Dr Heather Bowmer reported no abnormal uptake, and that, in particular, the region of the sacrum appeared normal.

[9] On 13 October 2005, Ms Dooney reported lumbar pain after lifting a heavy baby while working as a midwife.

[10] On 17 October 2005 Dr Richard Eastcott, GP, provided Ms Dooney's lumbar spine ACC claim for "pain lumbar spine" on 13 October 2005. Dr Eastcott recorded that Ms Dooney had lifted a baby with outstretched arms and had severe low back

pain radiating down both legs. Ms Dooney received cover for "right-sided pain in the lumbar spine – lower back/spine".

[11] On 19 October 2005, an x-ray was taken of Ms Dooney. Dr Bowmer noted normal disc spaces and alignment, with small osteophytes at L4. No vertebral collapse was seen and both SI joints were normal.

[12] On 28 October 2005, an MRI scan was taken. Dr Moe David noted that alignment was anatomic. Disc space height and signal were maintained throughout the lumbar spine, except at L5/S1 where there was mild disc desiccation with loss of abnormal hyperintense T2 signal. Dr David also noted a broad-based central disc bulge at L5/S1 which did not cause lateral recess, central spinal or neural foraminal stenosis.

[13] On 24 January 2006, Mr Sud Rao, Neurosurgeon and Spinal Surgeon, recorded Ms Dooney's history that, on 13 October 2005, she was bending down to pick up a four kilogram baby and twisting, when she felt pain in her low back and buttock area. She thought nothing of it initially and treated herself with Panadol and heat. Then, over the next three to four days, she had very significant pain and could hardly move. This had improved 70% with conservative treatment. On examination, there was a normal range of motion and mobilisation, and normal neurology. Mr Rao reviewed the imaging, noted the L5/S1 disc bulge without nerve or spinal compression and he was not concerned about cauda equina.

[14] On 20 September 2006, a further MRI was taken due to ongoing pain and concerns about possible cauda equine syndrome. Dr Kelly Paul noted that the scan revealed no significant change since the 28 October 2005, with no evidence of significant disc prolapse or neural compression. There was minor loss of hydration of the L5/S1 disc.

[15] In 2006, Ms Dooney suffered breast cancer and a stroke which left her with some residual weakness in her right hand and a tremor.

[16] On 19 January 2011, a whole spine MRI was taken due to clinical concerns about a possible viral meningitis infection. Dr Ries Thorsten noted that the scan showed no signs of infection and no abnormalities apart from minor degenerative changes in the cervical spine.

[17] On 7 December 2011, an x-ray was taken. Dr Abdul Al-Ansari, Consultant Radiologist, found no evidence of any collapsed vertebral bodies.

[18] On 6 August 2013 another x-ray was taken of Ms Dooney's lumbar spine due to ongoing low back pain. Dr Edward Carter found unremarkable mineralisation, no significant disc space narrowing, and minor facet joint arthropathy at L5/S1. There were no acute findings.

[19] On 3 June 2016, Ms Dooney received cover for a lumbar sprain after she experienced pain and spasm in her lower back upon getting out of a chair. She attended physiotherapy.

[20] On 9 June 2018, Ms Dooney lifted a new microwave into her kitchen unit and reported pain in her mid back. This was recorded in an ACC Injury Claim Form dated 11 June 2018 completed by Ms Hanna Brough, GP. Ms Dooney received cover for a lumbar sprain as a result of this event.

[21] In June 2018, an x-ray reported that Ms Dooney's bone density was low from osteoporosis, but no compression fracture of metatarsis was found. The lumbar spine had mild spurring on disc margins consistent with age, and mild degeneration in L3/4 and L4/5 discs and L5/S1 facet joints.

[22] On 5 September 2018, Dr Ian Taylor, GP, saw Ms Dooney and she reported ongoing pain and discomfort in her mid and lower back. Dr Taylor reported that Ms Dooney had Sjorgen's syndrome for which she was stabilised on methotrexate and prednisone. Dr Taylor noted the breast cancer and CVA Ms Dooney suffered in 2006, and also that x-rays have failed to reveal any obvious abnormalities. Dr Taylor further noted that:

> Although this may have just been a consequence of loading the spine in a certain moment of force, the microwave per se would not have been particularly heavy and Barb has ongoing significant symptoms now three months following the event. …

[23] On 9 June 2018, Dr Hanna Brough, GP, submitted an ACC Injury Claim Form for Ms Dooney, with an accident date of 9 June 2018 and a diagnosis of lumbar sprain.

[24] On 11 June 2018, an x-ray was performed on Ms Dooney. Dr Bruce Allen, Radiologist, reported that bone density was low from osteoporosis but no compression fracture or metastasis was found. The thoracic spine had mild spurring on disc margins as expected at this age, and the lumbar spine had mild degeneration in the L3-4 and 4-5 discs and the L5-S1 facet joints.

[25] On 1 October 2018, an MRI scan was performed on Ms Dooney. Dr Al Junaid, Radiologist, reported that the scan revealed:

> Superior endplate fracture of the T12 vertebral body with 30% loss of the vertebral body height. The fracture was evident on the previous radiographs, which demonstrated endplate scelerosis and loss of the vertebral body height. Vertebral body height appears to be slightly more pronounced on the MRI than on the radiographs, possibly due to positional reasons. Associated mild kyphosis at T11-12. No significant retropulsion of fragments and no significant canal or exit foraminal narrowing at this level.
>
> Degenerative changes in the thoracolumbar spine and in the visualized lower cervical spine with multilevel disc changes.
>
> No neural compromise.

[26] On 24 August 2019, Ms Dooney injured her back, hip and thigh while crawling on the floor vacuuming. The accident was described in the ACC Injury Claim Form dated 29 August 2019 as (*verbatim*):

> Crawling along vacuuming dust ater house wall sanded, leaning forward, twisted awkwardly and felt pain in my leg, groin, buttock and back ***Household or garden chore***Twisting or sudden movement.

[27] Cover was granted for a right lumbar sprain and left hip and thigh sprain.

[28] On 29 August 2019, an x-ray of Ms Dooney's lumbar spine was performed. Dr Holger Boehm, Radiologist, found multilevel spondylosis and facet joint

osteoarthritis, resulting in neural foraminal narrowing on the lower lumbar segments and at the lumbosacral junction.

[29] On 5 October 2019, a lumbar spine MRI was taken against a background of new onset left-sided tension, with clinical query of L4 involvement. Dr Claudia Weidekamm, Radiologist, reported:

> 1. L3/4 progressive broad-based posterior disc protrusion with mild left paracentral disc extrusion resulting in narrowing of the lateral recess without nerve root compression. Contact of the right L3 nerve root far lateral.
>
> 2. Progressive L5/S1 posterior disc extrusion with obliteration of the left lateral recess cause is posterior displacement of the left descending S1 nerve root.
>
> 3. Right-sided foraminal stenosis at L4/5 and L5/S1.

[30] On 15 October 2019, Dr Taylor referred Ms Dooney to an Orthopaedic Surgeon after noting that she was still facing discomfort.

[31] On 2 December 2019, Mr Austin Enright, Orthopaedic Surgeon, reviewed Ms Dooney and noted that her case was complex. He observed that the imaging available did not explain any of her bladder/bowel issues. The big question in his mind was her 2005 disc herniation, and queried whether a cauda equina syndrome could fit with her timeline and current issues. In regard to her lumbar back pain and radiculopathy, Mr Enright noted that Ms Dooney certainly had some age-related predictable degeneration as well as root compression of the lumbar segments.

[32] On 20 May 2020, a whole-body SPECT CT bone scan was completed.

[33] On 22 July 2020, Mr Enright submitted an Assessment Report and Treatment Plan ("ARTP") seeking funding for L5/S1 decompression surgery to treat Ms Dooney's L5/S1 disc herniation and stenosis. Mr Enright considered that her pathology was likely a manifestation of both her covered 2005 disc herniation at L5/S1 and her recurrence in 2019 while lifting the microwave. Mr Enright reported that Ms Dooney's MRI showed a small-moderate disc herniation with mild neurocompression. He also observed a recent CT-guided injection had given nearly 100% relief from low back pain and leg pain for about six days before returning to normal.

[34] On 30 September 2020, Dr Ray Fong, Orthopaedic Surgeon and principal clinical advisor, provided a report to the Corporation. He assessed that Ms Dooney's pathology was not caused by her 24 August 2019 accident and, instead, was due to a widespread multifactorial degenerative condition affecting the lumbar spine. Dr Fong found:

> This present claim accident 24/08/2019is described: The accident was crawling along vacuuming dust after house wall was sanded, leaning forward; not a likely mechanism for a traumatic disc lesion. …
>
> X-ray 29/08/2019: Superior endplate deformity, fracture of t12 longstanding, no acute bony injury, multilevel lumbar spondylosis, facet joint osteoarthritis resulting in neural foraminal narrowing in the lower lumbar segment at the lumbosacral junction.
>
> This multilevel lumbar spondylosis, facet joint osteoarthritis and bony neural foraminal narrowing on the basis of these bony changes represents a longstanding gradual process/degenerative condition of the lumbar spine.
>
> MRI 01/10/2018: Superior endplate fracture at T12. L3/4 circumferential disc bulging. bilateral facet joint arthropathy, foraminal narrowing. L4/5 circumferential disc bulging, annular fissure. moderate bilateral facet arthropathy, moderate bilateral foraminal stenosis. L5/S1 circumferential disc bulging, slight extension to the left paracentral lateral recess, moderate facet joint arthropathy. mild foraminal: narrowing indicating a multilevel multifactorial degenerative condition of the L3/4, L4/5 and L5/S 1 level. Note that this multilevel degenerative disc disease is pre-existing to the claim accident.
>
> MRI 05/10/2019: L 1/2. L2/3 disc desiccation. mild disc protrusion. L3/4 broad-based disc protrusion. Left paracentral disc extrusion. bilateral lateral recess narrowing. L4/5 posterior annular tear. broad-based disc protrusion, bilateral facet disc herniation. ligamentum flavum hypertrophy, osteophyte result from foraminal narrowing, progressive in comparison to previous examination. L5/S1 progressive posterior disc extrusion. obliteration of the lateral recess. mild posterior displacement of S1 nerve root. Foraminal stenosis secondary to ligamentum flavum hypertrophy and facet joint arthrosis.
>
> In the presence of known degenerative disc disease as reported in the MRI scan 2018 (this L4/5 progressive changes of disc protrusion extrusion represents a continuant of the degenerative disc disease as it pre-exists). This. together with facet Joint hypertrophy/osteoarthritis and ligamentum flavum: hypertrophy. has caused foram1nal stenosis.
>
> This represents a multifactorial degenerative condition at L5/S1. This is on the background of multilevel involvement of the lumbar spine involving L 1/2. L2/3. L3/4, L4/5 and L5/S1 levels. Indeed. a widespread multifactorial degenerative problem of the lumbar spine. This condition could be symptomatically aggravated by the claim accident but not caused by that.
>
> Direct causal link of her L5/S1 condition now requiring treatment/surgery to the claim accident of 24/08/2019 cannot be established.

[35] On 8 October 2020, the Corporation issued a decision declining cover and funding for surgery to treat Ms Dooney's L5/S1 disc prolapse.

[36] On 16 December 2020, Ms Dooney's advocate lodged a review application, arguing that Ms Dooney's pathology was post-traumatic degeneration caused by her 2005 accident and aggravated intermittently over time.

[37] On 7 January 2021, the Corporation sought further clinical advice from Dr Fong. He advised, in response to specific questions:

> This loss of disc height and signal with disc desiccation at L5/S1 is clear evidence of established degenerative disc disease at L5/S1 level. This is not a traumatic condition.
>
> This degenerative disc disease is a gradual process condition with evidence of degenerative disc disease, degenerative disc bulging/protrusion is part of this degenerative disc disease.
>
> Degenerative disc disease with degenerative disc bulging/protrusion/extrusion is highly prevalent in the asymptomatic adult population.
>
> The MRI changes reported on 28/10/2005, two weeks after the accident, shows an established L5/S1 degenerative disc disease with degenerative disc bulging. This is a gradual process condition. This cannot be attributed to the accident of 2005. …
>
> The accident description for the episode of 13/10/2005 was lifting a baby with an outstretched arm. This is an activity of daily living, not a likely cause for an acute traumatic disc protrusion.
>
> More importantly, there is no MRI evidence of any acute disc protrusion reported in this MRI of 28/10/2005.

[38] On 7 March 2021, Mr Reuben Johnson, Neurosurgeon, provided a report for Ms Dooney and advised:

> Based on my consultation with Mrs Dooney and review of the imaging, it is my opinion that she suffered an acute disc prolapse as a result of her injury 2005.
>
> Over the intervening years she had further injuries to her back and the disc prolapse has shown clear progression. It is not possible to say which if any of these injuries has led to specific worsening of her disc prolapse. However, the injury in October 2005 has led to a disc injury and this has accelerated the degeneration of her disc at that level.
>
> There is certainly worsening of the disc prolapse on the MRI from October 2019 compared to earlier imaging. It is possible, therefore, that the injury of 24.08.2019 has contributed to the exacerbation of the disc prolapse. As the

> L5/S1 disc was already damaged it would be susceptible to further injury from even a minor mechanism.
>
> There has been gradual degeneration of the L5/S1 disc over time. However, the injury of 2005 is a significant contributing factor. It is well recognised that once a disc has been injured it is more susceptible to degeneration and further prolapse even with minor back injuries.
>
> The history given to me today, the medical records available, and the radiology, all fit with an exacerbation of the disc herniation in 2019. It is possible there was a contributing injury to the disc in 2018 but neither the history given or the records are supportive of that. It would appear most likely that the October 2005 accident has injured the LS/S1 disc which has degenerated further over time with an exacerbation of the prolapse in 2019.

[39] On 12 May and 18 June 2021, review proceedings were held. On 14 July 2021, the Reviewer dismissed the review. This was on the basis that Ms Dooney's L5/S1 disc prolapse was not caused by her 24 August 2019 accident or by consequential degeneration arising from her 13 October 2005 accident (or any of her other prior covered injuries), and so she did not have cover or entitlements under the Act for this condition.

[40] On 5 November 2021, a Notice of Appeal was lodged.

[41] On 9 June 2022, the Corporation's Clinical Advisory Panel ("CAP") provided a report after reviewing Ms Dooney's history, physical examination findings, clinical progress, medical reports and imaging. The CAP made the following observations:

> Ms Dooney's current diagnosis is multi-level lumbar spondylosis and degenerative disc disease. …
>
> … the CAP concluded that Ms Dooney's 13/10/2005 ACC-covered accident was a significant experience for her which resulted in transient lower back pain and non-specific bilateral leg symptoms. The contemporary evidence has no objective evidence of acute lumbar disc or spinal damage or disruption. As discussed … below, there was no material contribution from the 13/10/2005 accident to the gradual onset minor disc bulging or bony changes on Ms Dooney's imaging. There was no material contribution from the 13/10/2005 to Ms Dooney's ongoing lower back problems which, according to the available information, were present for some years before and after this accident. The 13/10/2005 accident certainly triggered lower back pain and bilateral leg symptoms; however, a causal link with the L5/S1 gradual onset changes on Ms Dooney's imaging is not established. …
>
> Everyone has some degree of age-related wear and tear of their lumbar spine on imaging. Ms Dooney's accidents may have stirred up her lower back and bilateral leg pain and discomfort, and triggered her symptoms, but those

> accidents did not cause the pre-existing changes seen on her imaging, including her L5/S1 degenerated lumbar disc which slowly got worse over time.

Relevant law

[42] 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.

[43] In *Johnston*,[1] 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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1 *Johnston v Accident Compensation Corporation* [2010] NZAR 673.

[44] In *Ambros*,[2] 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 …

[45] In *Sparks*,[3] Judge Ongley 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.

[46] In *Stewart*,[4] Judge Barber 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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2 *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.

3 *Sparks v Accident Compensation Corporation* [2006] NZACC 45.

4 *Stewart v Accident Compensation Corporation* [2003] NZACC 109.

[47] In *Bloomfield*,[5] Judge Joyce 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.

[48] In *Dobbs*,[6] Judge Cadenhead noted:

> [26] The crux of this case is a causal issue: the appellant to have an entitlement for the costs of surgery has to satisfy the respondent on the balance of probabilities that the need for surgery arises from and is an effective consequence of the original injury or injuries, for which cover was granted. This issue will generally involve a consideration of the type of injury or injuries suffered, the x-rays, and medical reports evaluating the present symptoms against what has brought about the need for present surgery. I would have thought that on this type of issue the view of the general practitioner and the medical specialists, who have actually examined and seen the claimant would be important.

[49] 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.

[50] Clause 1 of Schedule 1 of the Act provides that the Corporation is liable to pay or contribute to the cost of a claimant's treatment "for personal injury for which the claimant has cover".

[51] In *Dobbs*,[7] Cadenhead DCJ stated:

> [26] The crux of this case is a causal issue: the appellant to have an entitlement for the costs of surgery has to satisfy the respondent on the balance of probabilities that the need for surgery arises from and is an effective consequence of the original injury or injuries, for which cover was granted. This issue will generally involve a consideration of the type of injury or injuries suffered, the x-rays, and medical reports evaluating the present symptoms against what has brought about the need for present surgery. I would have

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

6 *Dobbs v Accident Compensation Corporation* [2005] NZACC 46.

7 *Dobbs v Accident Compensation Corporation* [2005] NZACC 46. See also *Stevenson v Accident Compensation Corporation* [2014] NZACC 139.

> thought that on this type of issue the view of the general practitioner and the medical specialists, who have actually examined and seen the claimant would be important.
>
> [27] The appellant must demonstrate on a probability basis that the need for surgery arose from the accident or accidents and that the need for surgery was not 'wholly or substantially' caused by the ageing process'. The onus of proof of this step is upon the appellant upon a balance of probabilities.

[52] In *Medwed,*[8] Judge Ongley stated:

> [14] The scheme of the Act also requires a claimant to make an application for cover. The obligation rests on the claimant. A case manager could well have a responsibility to advise a claimant who needed to make a separate cover claim. The Corporation could invite a claimant to lodge a claim, but there is no obligation on the Corporation, in the absence of a claim, to carry out investigations in case of a possible entitlement available to a claimant. It is, the claimant who has to explain, by way of an application for cover, the kind of injury that the claimant suffered and the facts supporting the accident cause of the injury. If there was a case in which the circumstances were so clear that the Corporation gave cover, without receiving a formal claim, then there would be no problem. But if the Corporation unilaterally considered and declined cover, without receiving a claim, it would be acting outside its authority under the Act.

[53] In *Hetaraka*,[9] Judge Henare stated:

> [50] … It is well established that a claimant cannot rely on a noncovered injury to support a claim for entitlements, and in the absence of cover, no entitlements can flow.

[54] In *Civil*,[10] Judge Henare stated:

> [28] It is clear Ms Civil has cover for the lifting accident but not a falling accident on 13 April 2017. Further, she does not have cover for the accident on 18 April 2017. The sprain injuries for which Ms Civil has cover relate to the lifting accident on 13 April and the accident in the pantry on 30 April 2017. The reason only these accidents are able to be considered, arises from injury claim forms having been filed for them, leading to the grant of cover for the sprain injuries. This is important because surgery is an entitlement, and a claimant is not entitled to entitlements other than in respect of a covered injury.

Discussion

[55] The issue in this case is whether there is sufficient evidence to establish that Ms Dooney's L5/S1 disc prolapse was caused by her accident on 13 October 2005

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8 *Medwed v Accident Compensation Corporation* [2009] NZACC 86.

9 *Hetaraka v Accident Compensation Corporation* [2018] NZACC 163.

10 *Civil v Accident Compensation Corporation* [2021] NZACC 88.

(or any other personal injury), or whether her L5/S1 disc prolapse was caused by degeneration as part of a widespread pre-existing condition.

[56] Ms Williams, for Ms Dooney, submits as follows. The decision of the Corporation is flawed because Ms Dooney sustained a disc prolapse of the L5/S1 in 2005 which has become progressively worse since. There is sufficient evidence from Mr Enright, Orthopaedic Surgeon, and Mr Johnson, Neurosurgeon, that proves more likely than not that the need for surgery was due to the covered injuries she had sustained. There is no evidence of degenerative changes more than a normal person of Ms Dooney's age prior to the 2005 injury. The medical evidence from the Corporation's medical advisors has been general rather than specific, focusing on soft tissue injuries rather than the L5/S1 disc prolapse that occurred.

[57] This Court noted the above submissions. In particular, the Court acknowledges the reports of Mr Enright and Mr Johnson. However, the Court refers to the following considerations.

[58] First, preceding the 2005 injury, Ms Dooney had symptoms of lumber pain, caused by accidents:

(a) -- In May 1996, Ms Dooney received cover for "sprain or strain of her lower back/spine" after an accident.

(b) -- In July 2000, Ms Dooney received cover for "pain in lumbar spine; lower back/spine" after an accident. In June 2001, Mr Elliot, Orthopaedic Surgeon, reported that, after slipping on ice in July 2000, Ms Dooney had substantial lumbar pain requiring physiotherapy, and that the pain settled somewhat but did not resolve completely.

[59] Second, the claim form lodged on 17 October 2005 by Dr Eastcott, on behalf of Ms Dooney, described the accident on 13 October 2005 as lifting a baby with outstretched arm, and Dr Eastcott diagnosed pain in the lumbar spine. She received cover for "pain in the lumbar spine – lower back/spine". There was no indication in the covered claim of a likely or even possible disc prolapse.

[60] Third, the imaging taken of Ms Dooney's back shortly after her accident on 17 October 2005 showed no sign of a disc prolapse of the L5/S1, and indicated some signs of degeneration:

(a) The x-ray performed on 19 October 2005 showed normal disc spaces and alignment, no vertebral collapse, normal SI joints, but small osteophytes at L4.

(b) The MRI taken on 28 October 2005 showed that alignment was anatomic, but at L5/S1 there was mild disc desiccation with loss of abnormal hyperintense T2 signal, and a broad-based central disc bulge.

[61] Fourth, on 24 January 2006, Mr Rao, Neurosurgeon and Spinal Surgeon, noted that Ms Dooney advised that, on 13 October 2005, she was bending down to pick up a four-kilogramme baby and twisting, when she felt pain in her low back and buttock area; she thought nothing of it initially and treated herself with Panadol and heat; and then, over the next three to four days, she had very significant pain. Mr Rao recorded that he examined Ms Dooney and found a normal range of motion and mobilisation, and normal neurology. Having reviewed the imaging, Mr Rao noted the L5/S1 disc bulge without nerve or spinal compression, and he was not concerned about cauda equina problems.

[62] Fifth, the MRI taken on 20 September 2006, revealed no significant change since the previous MRI, as there was no evidence of significant disc prolapse or neural compression, but with minor loss of hydration of the L5/S1 disc. Further imaging in ensuing years revealed similar findings.

[63] Sixth, the report of Mr Enright, seeking funding for L5/S1 decompression surgery to treat Ms Dooney's L5/S1 disc herniation and stenosis, was submitted on 22 July 2020, nearly 15 years after Ms Dooney's 2005 injury. During this period, Ms Dooney received cover for lumbar sprains arising out of accidents, in June 2016, June 2018 and August 2019. Mr Enright's observation in his report seeking funding, that Ms Dooney's condition was "likely a manifestation of both her covered 2005

disc herniation and her recurrence in 2019 while lifting the microwave", was not backed by objective, contemporaneous medical evidence.

[64] Seventh, the report of Mr Fong, Orthopaedic Surgeon, dated 7 January 2021, noted that the accident description for the episode of 13 October 2005 was lifting a baby with an outstretched arm, and observed that this was an activity of daily living, not a likely cause for an acute traumatic disc protrusion. Mr Fong pointed out that the MRI two weeks after the accident found no evidence of any acute disc protrusion, and instead showed an established L5/S1 degenerative disc disease with degenerative disc bulging. Citing literature, Mr Fong noted that degenerative disc bulging is part of degenerative disc disease, and that this is highly prevalent in the asymptomatic adult population. Dr Fong observed that this is a gradual process condition, and advised that this could not be attributed to the accident of 2005.

[65] Eighth, the report of Dr Johnson, dated 7 March 2021, assessing that Ms Dooney suffered an acute disc prolapse as a result of her October 2005 injury, was provided 15-and-a-half years after the injury. Dr Johnson acknowledged that spinal imaging showed deterioration and progression over the years, and that there had been a gradual degeneration of the L5/S1 disc over time. The Court finds that Dr Johnson's assessment of causation, of an acute disc prolapse as a result of her October 2005 injury, does not appear to have been backed by objective, contemporaneous medical evidence.

[66] Ninth, the report of the Corporation's Clinical Advisory Panel (comprising six Orthopaedic Surgeons, a Sports Medicine Specialist, an Occupational and Environmental Medicine Specialist, and a General Surgeon), dated 9 June 2022, commented that:

(a) -- The contemporary medical evidence did not support the impression of an acute L5/S1 disc prolapse, from a controlled movement which she "thought nothing of" and with no dermatomal motor or sensory deficits.

(b) -- There was no contemporaneous evidence of acute lumbar disc or spinal damage or disruption resulting from Ms Dooney's covered injury of October 2005.

(c) -- Ms Dooney's 2005 lumbar spinal imaging was consistent with naturally progressive, genetically based deterioration of her lumbar spine over a long time, with no acute features and no evidence of acute disc damage here.

(d) -- Ms Dooney's 2005 accident, and later accidents, may have stirred up her lower back and bilateral leg pain and discomfort, and triggered her symptoms. However, these accidents did not cause the pre-existing changes seen on her imaging, including her L5/S1 degenerated lumbar disc.

(e) -- Ms Dooney's current diagnosis was multi-level lumbar spondylosis and degenerative disc disease.

Conclusion

[67] In light of the above considerations, the Court finds that there is insufficient evidence to establish that Ms Dooney's L5/S1 disc prolapse was caused by her accident on 13 October 2005 (or any other personal injury), rather, her L5/S1 disc prolapse was caused by degeneration as part of a widespread pre-existing condition.

[68] The decision of the Reviewer dated 14 July 2021 is therefore upheld. This appeal is dismissed.

[69] I make no order as to costs.

P R Spiller
District Court Judge

Solicitors for the Respondent: Ford Sumner.