IN THE DISTRICT COURT
AT WELLINGTON

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

[2023] NZACC 147 ACR 222/20

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPEAL UNDER SECTION 149 OF THE ACCIDENT COMPENSATION ACT
BETWEEN	ROBERTA PAUL (as administrator of the Estate of ANANIA TE AONUI, deceased) Appellant
AND	ACCIDENT COMPENSATION CORPORATION First Respondent
AND	SILVERFERN FARMS Second Respondent

Hearing:	19 July 2023
Heard at:	Dunedin/Otepoti
Appearances:	Mr P Sara for the Appellant Mr I Hunt for the First Respondent
Judgment:	14 September 2023

RESERVED JUDGMENT OF JUDGE C J MCGUIRE
[Personal Injury s 26 Accident Compensation Act 2001]

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[1] This appeal concerns a decision of WorkAon (as third party administrator for Silverfern Farms Limited) dated 24 September 2019 in relation to cover and entitlements (including weekly compensation) for the late Mr Te Aonui.

[2] The second respondent was not represented on this appeal.

[3] The primary issue is whether Silverfern Farms was correct to decline cover for bilateral L4/5 stenosis on the basis that it was not a personal injury arising from an accident occurring on 12 October 2018.

[4] Suspension of the associated weekly compensation entitlements is also in issue, flowing from the decision on cover.

Background

[5] Mr Te Aonui, who died on 7 September 2021, was an employee of Silverfern Farms at its Waitane meat processing plant. The appellant brings this appeal as administrator of his estate.

[6] Mr Te Aonui suffered an accident on 12 October 2018 when he slipped on a wet floor, landing on his back and hitting the back of his head on the floor.

[7] In his statement at the review hearing, Mr Te Aonui said:

> 1. I am the applicant for review in respect of decisions made by Aon regarding cover and entitlements.
>
> 2. I am currently not working. I have not worked since April 2019.
>
> 3. I was employed by Silverfern Farms at its Waitane plant. I am still employed by Silverfern Farms, but am unable to work.
>
> 4. My position at Waitane was as a labourer.
>
> 5. I first started work for Silverfern Farms in about 2006.
>
> 6. I am a seasonal worker and not employed during the off season.
>
> 7. I had an accident at work on 12 October 2018. I had descended the stairs at work, intending to go into the changing room prior to smoko.
>
> 8. The floor was wet, which I didn't see. My foot slipped out from under me and I landed flat on my back. As well as that, I hit the back of my head on the floor.
>
> 9. I do not have a clear memory of the accident event, afterward. I believe I was knocked out momentarily.
>
> 10. I can't remember much of what happened after I fell. I have some memory of some of the ladies at work helping me to my feet and getting some towels to mop the wet floor.

11. I remember sitting on a bench in the changing room.

12. I was more dazed and confused than I was sore, that I can remember. I did not know quite what had happened to me.

13. As far as I know, there was no report of what happened to me. In the smoko room, the clean-up boss, who I know as Lou, came and asked me if I was alright. I said, "yes".

14. I think others may have reported what happened by that stage and I have a vague memory of going to the office to report the accident event.

15. I returned to work and managed to finish my work for the day.

16. I knew where I was and was able to do my normal work tasks. I was not aware of anything, at that time, wrong with my body.

17. I was not seen by any medical person or nurse on that occasion.

[8] Mr Te Aonui went on to say that he took the following day off work, hoping that over that day and the weekend he would recover. However, following this, his tailbone and legs were still sore and on the Monday, being too sore to go back to work, he saw one of the doctors at the Mataura Medical Centre. He said the doctor thought that he had bruised his tailbone and he was given a week off work to recover. After that week, he went back to work, but his legs remained sore with pain down the back of his legs into his calves.

[9] He said initially the pain was significant, but still bearable, and that even though he was sore, he had to be at work as he had just bought a house and had big mortgage payments to maintain.

[10] He said he had no idea that what was wrong with him was to do with his back. He said:

> I thought I had hurt my legs because that is where I was sore.

[11] He said he started taking more time off, at least once a week and sometimes more and that every time he had a day off, he had to get a medical certificate from his doctor.

[12] He said he endured this pattern until April 2019 when one day at work he could not bear it any longer. He said:

> I couldn't even stand, so, I told my boss about my difficulties.

[13] After that he saw Dr Munro at the Mataura Medical Centre, who referred him to his employer's doctor, who in turn referred him to Mr O'Malley, as well as arranging an MRI scan.

[14] He said he was put off work indefinitely by the Waitane Works Doctor at the Gore Medical Centre.

[15] He said he had not been able to work since and that he was taking tramadol and tramal and that he was on the public waiting list at Kew Hospital, Invercargill.

[16] Mr Te Aonui first saw Dr Aroha at the Mataura Medical Centre on 17 October 2018. Dr Aroha issued an ACC 45 certificate with the injury identified as "coccygodynia". He was certified unfit for work for eight days and referred to a physiotherapist.

[17] An xray was undertaken on 23 January 2019. The findings were as follows:

> Changes are seen at the thoraco suggestive of DISH.
>
> Mild osteoarthritic changes are seen in the lower facet joints.
>
> No other bony or joint abnormality is seen.

[18] The appellant saw his GP on 19 February 2019. The surgery note includes the following:

> … pain and disability in buttocks and lower limbs.
>
> HPC Anania had to leave work early 10 o'clock because he could not stand as it both legs were unbearable. He had continuous pain shooting down both legs, knees and buttocks. It is getting so that he has to lie down when not at work. … Feels 7/10 pain buttocks now 9/10 at work. Took pain killer before work. He has been restricted in movement.

[19] The GP's impression was:

> Coccygodynia? Sciatica.

[20] On 19 March 2019, GP, Dr Munro, requested an MRI scan noting:

> This gentleman had a back injury on 12/10/18 and has had ongoing problems since. Slipped on a wet floor, landed heavily on back and hit head. He came to see us the following week and the ACC claim was initiated. Since then he has had ongoing problems with back pain and more worrying pain down his legs.
>
> He has tried physiotherapy which didn't really help, has had anti inflammatories which haven't helped. He has symptoms suggesting a possible disc prolapse due to the injury back in October 2018. On examination, his back is a little stiff, bending causes pain down both legs. No obvious weakness.
>
> I think he needs an MRI scan to further investigate, leg pain post injury. Is someone able to approve this or advise if it will be funded.

[21] Mr Te Aonui stopped working in April 2019.

[22] An MRI scan was performed on 30 April 2019 with the radiologist, Dr McKewen, reporting:

> Multi level spondylosis. Changes moderate to severe most levels although most marked at the L4/5 level, with probable impingement of the traversing L5 nerve roots with the lateral recess. Moderate bilateral subarticular recess narrowing at the L5/S1 level, with contact but not obvious high grade impingement of the traversing S1 nerve roots bilaterally.

[23] On 8 May 2019, Dr Munro wrote to WorkAon again following the MRI report on 8 May 2019:

> I have reviewed Anania again today following his MRI scan. I feel he would benefit from some specialist input from the local spinal surgeon and would ask your approval for this referral to go ahead.
>
> MRI shows multi level spondylosis with most marked changes at L4/5 with probable impingement of both L5 nerve roots and some sub articular recess narrowing at L5/S1 level with possible contact with both S1 nerve roots.
>
> His symptoms would certain fit with the above MRI findings. He has been a patient of ours for several years and has never consulted with low back or leg pain, the symptoms started after the fall at work where he slipped on a wet floor.

> He is very stoic and non-complaining and his pain is probably more than he likes to let on. He is very keen to get back to work, but his symptoms are preventing him from doing this.
>
> Can you please contact us if WorkAon are happy to approve referral on to Mr Michael O'Malley.

[24] Mr O'Malley saw Mr Te Aonui on 29 July 2019. His report included the following:

> **Review of Images**
>
> The MRI scan of his lumbar spine shows loss of disc height, particularly at L2/3, but also L3/4 and L4/5. This is hypertrophy of the facet joints and thickening of the ligamentum flavum and this occurs particularly at L4/5 which, in combination with loss of disc height and generalised disc bulge, is causing significant stenosis at this level particularly.
>
> **Opinion**
>
> Mr Te Aonui has no past history of back pain and past history of leg symptoms according to the GP and his partner today. He is keen to get back to work but the leg symptoms are stopping this from happening.
>
> I entirely agree that the degenerative changes particularly at the L4/5 level were present prior to the accident in October 2018. However, Mr Te Aonui was (a-)symptomatic at that point in time and I think the axial load that occurred at the point of when he slipped on the wet floor has caused a momentary overload of the disc at that level, which caused it to bulge and take an a-symptomatic tight spinal stenosis and make it a symptomatic even tighter spinal stenosis. At this point in time, when the impact occurs, there is often a compression of the nerve roots with associated swelling and the body is unable to recover from this due to the pre-existent tightness of the spinal canal.

[25] Mr O'Malley proposed to perform a bilateral L4/5 open decompression and sought funding for the procedure.

[26] On 16 August 2019, WorkAon's branch medical advisor said:

> The changes noted on his MRI are not of acute pathology and have developed over a prolonged period of time and affect multiple levels within the spine. This is considered an age related degenerative condition without any significant evidence to suggest an acute injury. As such, there is no place for covering the spinal condition here in terms of being related to the event noted on 12 October 2018 …

[27] On 14 September 2019, Mr Vasudeva Pai, orthopaedic specialist, provided a paper file review.

[28] In answer to the question – do you consider the current diagnosis as being caused by the accident? Mr Pai said:

> In my opinion, the diagnosis or the pathology as noted in the lumbar spine has not been caused by the accident and the injury event precipitated his symptoms with an aggravation in the context of pre-existing pathology. The Spine 6th Edition has suggested that spinal canal stenosis, even in its severe form on MRI, does not very often produce symptoms as each individual may have an innate ability to compensate for the accumulating pathological changes and they may present symptomatically either spontaneously or following a physiological activity. In my opinion, it is more than likely that he had extensive pre-existing pathology and the fall made him symptomatic. There is no doubt that he had extensive degenerative spinal pathology at the time of his injury event. What is also documented is that he had not complained of any physical discomfort in his back. This is not an uncommon situation that a patient may well have extensive degenerative changes without actually being symptomatic. It is however an injury event that can trigger the whole process, causing the patient to become symptomatic and it is at that stage that all the pathological changes in the spinal area suddenly become noticeable.

[29] Mr Pai also said:

> In my opinion, the injury event related aggravation is spent. Generally most of the symptoms from an aggravation in the context of lumbar spondylosis resolve in around three months and some chronic residual symptoms may persist.

[30] On 11 November 2019, Counsel, Mr Sara, wrote to Mr O'Malley, amongst other things, asking "what changed physically as a result of the accident event?".

[31] Mr O'Malley responded on 20 November 2019 as follows:

> Many thanks for your letter on Mr Te Aonui. To begin with, I would entirely agree and apologise for the fact that the word symptomatic in the second sentence in the paragraph you put forward in your letter, is meant to be a-symptomatic rather than symptomatic. This was an error on my part.
>
> As far as I can see, the physical change as a result of the accident event was that he had an axial load across his low back and the axial load across the L4/5 disc which was already degenerate caused a momentary increase in the degree of stenosis in the spinal canal which pinched the nerve roots causing them to swell up and at that point unfortunately the pre-existing tightness did not allow the now swollen nerves to calm down.
>
> It is for this reason that I would not altogether agree with the comments in paragraph 4 of Mr Pai's opinion that whatever physical injury was caused by the fall was spent as the continuation of the symptoms would be because the roots were not able to reduce in size as a consequence of the pre-existing stenosis as well as the swelling caused by the accident in question.

[32] Mr Pai was again asked to comment and he provided his supplementary report on 14 May 2020. He reiterated the opinion in his initial report.

[33] Counsel, Mr Sara, complained that he did not think the issue had been put fairly to Mr Pai. As a result, Mr Pai responded with a supplementary report on 15 May 2020. He said:

> With regard to the specific questions, considering his clinical course, or his MRI findings, I cannot confirm an inflammation of the nerve as having occurred from the fall. In my opinion, his symptoms are diffuse, with multiple nerve root involvement occurring in both legs, which is consistent with spinal stenosis symptoms. In the presence of spinal canal stenosis, the symptoms can vary and usually the symptoms are bizarre and may present with either weakness or numbness or gait abnormality or a combination of symptoms.
>
> In my opinion, the fall is more than likely an association and I cannot confirm any injury event related acute structural changes to his lumbar spine or any inflammation of the nerve on his MRI and his symptoms are more than likely related to underlying extensive spinal stenosis and such symptoms may present following even a trivial event or even spontaneously. I cannot establish any new changes as having occurred on his MRI and such scenarios are quite common with degenerative spinal stenosis which is a common type of stenosis occurring in the spine of this age group.

[34] Because Mr O'Malley had left New Zealand permanently, a further opinion was obtained from Dr Iain Bell, musculo skeletal medicine physician.

[35] In his report of 30 July 2020, Dr Bell said this:

> Spinal stenosis arises as a result of narrowing of the channels through which the nerves travel, running adjacent to a variety of structures. These structures include the discs. Disc bulging is associated with narrowing of the various channels that the nerves run through. Mr Te Aonui had no pain prior to the accident. Despite the opinions of Dr Burgess and Mr Pai, the fact remains that it is conjecture only that the appearances of discs (specifically the degree of disc bulging) on the post injury MRI has arisen entirely as a result of age related change. Given the mechanism of injury as a recognised cause of damage to discs, which can include disc bulging, and the likelihood his back pain is arising from a disc, it is highly likely in my opinion that the accident has given rise to disc bulging which has advanced the degree of spinal stenosis to the point that it has become, and has remained symptomatic.
>
> Mr O'Malley, Mr Te Aonui's treating orthopaedic surgeon, has opined that the axial force (compression) through the lumbar spine at the time of the accident gave rise to momentary disc bulging, causing swelling of the spinal nerves that has failed to resolve, and that is responsible for ongoing symptoms. This explanation would certainly explain ongoing lower limb symptoms.

> The mechanism of injury, time course of symptoms development, and the fact that Mr Te Aonui is left with back pain, is all consistent with an injury to a disc, and from an anatomical perspective an increase in disc bulging as a result of the accident would not only cause back pain, but the rapid development of lower limb symptoms.
>
> As such, the accident on 12 October 2018 is more likely than not to have given rise to a physical injury involving a lumbar intravertebral disc, and that this continues to cause back pain. The injury is likely to have been associated with an increase in disc bulging and associated inflammation, giving rise to lower limb symptoms that persist currently.
>
> Mr Te Aonui's case is one where the issue of causation cannot be considered on the basis of examination of the MRI alone, as Dr Burgess and Mr Pai have done.
>
> Rather, the entire clinical picture needs to be considered, including importantly the mechanism of injury, lack of symptoms prior and the fact that Mr Te Aonui has gone on to develop low back pain (that needs to be considered separately) as well as lower limb symptoms (arising on the basis of spinal stenosis).

[36] Following an unsuccessful review of ACC's decision, the appellant lodged an appeal and a further opinion was obtained from Mr Dunbar, orthopaedic surgeon, on 27 July 2021. Mr Dunbar had been asked the question: Did Mr Te Aonui suffer a physical injury to his spine as a result of his fall, and is that physical injury responsible for his ongoing incapacity? Mr Dunbar's opinion is as follows:

> It is clear Mr Te Aonui suffered quite a heavy fall onto his back and his head, which was sufficient to leave him dazed for at least a day after the fall. From the time of the fall, he also had pain in his low back, with pain radiating down his legs. His inability to continue working due to this pain was suggestive of a mechanical back pain, with possible nerve root compromise, which is confirmed on his MRI scan which showed focal spinal stenosis at L4/5 in particular with more mild changes elsewhere.
>
> The fact that Mr Te Aonui had onset of symptoms at the time of his fall suggests he is likely to have suffered some change in his spine to precipitate the symptoms. In such a scenario, the likely possibilities would be further disc bulging at a compromised level or simply an increase in swelling at the compromised level.
>
> His lumbar spine xray was taken on the 23rd of January 2019 which was approximately five months after his fall. The xray showed mild narrowing at the L4/5 level with some marginal spurring. These changes will have pre-dated his fall and there were no new changes that could be directly attributed to his fall on the xray.
>
> The MRI scan was performed on the 30th of April 2019, which was approximately eight months following his fall.
>
> The MRI scan is similar to the xray in that there were no specific changes that could be directly attributable to his injury. It did show a fairly symmetrical

disc bulge at the L4/5 level but no specific changes to indicate that this was relatively acute.

However the fact remains that his symptoms of spinal stenosis commenced at the time of his fall and we have to conclude that some physical event must have occurred to create that change.

It is not possible to identify a physical cause from the investigations, but as mentioned previously in this report, there is a high likelihood that some compromise did occur to the nerve structures, either from swelling or from potential further disc bulge. Sometimes with trauma there is a sudden flexion or extension produced on the spine which can cause a pinching effect on the underlying neurological structures. Where there is already narrowing of either the spinal canal or foraminae, this pinching effect can precipitate symptoms. An example is a central cord injury following a hyperextension injury to the neck in someone who was previously a-symptomatic but who has some pre-existing narrowing of their cervical canal. Therefore, it seems reasonable to conclude that although Mr Te Aonui had pre-existing degenerate change to his lumbar spine with the narrowing of his canal and foraminae, the actual cause of his symptoms was his fall.

[37] ACC then obtained a report from its clinical advisory panel dated 18 October 2021. Under the heading "CAP Recommendation", the panel said:

The predominant cause of Mr Te Aonui's lumbar imaging changes is likely to be chronic progressive tissue weakening and bony changes which developed over a long time.

Discs can bulge, protrude and prolapse as part of a continuum of gradual onset degenerative disc disease without external forces.

In Mr Te Aonui's case, the various gradual onset features of his lumbar spine imaging were problem free prior to the 12/10/2018 fall and then became symptomatic after that fall.

Noone knows exactly what factors played a role in the genesis of Mr Te Aonui's low back pain and leg symptoms from his spinal stenosis, and why this happened after his 12/10/2018 fall.

The onset of pain does not prove a new physical injury and the theories about disc/nerve/damage/swelling/inflammation are speculative at best and not supported by available medical evidence.

A causal link between Mr Te Aonui's 12/10/2018 ACC covered accident and the features on the lumbar spine xray and MRI scan including at the L4/5 level was not established.

Although the L4/5 decompression surgery may have been appropriate for Mr Te Aonui's lower back and leg issues, a causal relationship with the ACC covered 12/10/2018 accident was also not established.

Appellant's Submissions

[38] Mr Sara submits there are two theories relating to Mr Te Aonui's back condition following his injury on 12 October 2018. The first is that his pain and disability was caused by the pre-existing stenosis and not related to the injury and fall which did not do anything to his back to turn it into an injured back.

[39] Mr Sara says the second theory from Dr O'Malley and Dr Dunbar is that in the course of the fall, there was injury to the stenotic spine nerve route at the L5 level.

[40] Unfortunately in this case, there is no pre-accident imaging of his spine to make before and after comparisons with. As the MRI and xray did not show any particular injury condition, Dr Burgess and Mr Pai said there is no evidence on MRI of an injury therefore he did not have an injury.

[41] Mr Sara says the appellant had no history at all of back pain, but following this accident there were symptoms consistent with nerve compression.

[42] Mr Sara says that the clinical advisory panel does not offer a credible explanation of the cause of the symptoms, but is of the view that the symptoms were not caused by the fall.

[43] Mr Sara says however that the symptoms began on the occasion of the fall.

[44] Mr Sara refers to the decision in *Manning*,[1] where Judge Ongley says:

> … In a given case, an underlying condition coinciding with degenerative signs may be relatively stable until a traumatic event causes some structural shift that may not be apparent on imaging. In most cases, there is no pre-accident imaging for comparison and the attribution of cause can only be considered on the basis of probability. The legal test allows for a distinction between cases in which a claimant has a pre-disposing degenerative condition followed by actual injury, in cases where a degenerative condition is aggravated by trauma. Spinal changes are difficult to detect. By way of contrast, if an elderly person with severe osteoporosis were to fall and suffer a fracture, the disease would be an important contributing cause, but would not be wholly or substantially the cause of the fracture. That analogy may apply to some degenerative spinal conditions, but the process can be visualised only to a very limited extent and

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1 *Manning v Accident Compensation Corporation* [2012] NZACC 166 at [35].

> cannot be reliably reconstructed. Adjudication of disputes requires drawing conclusions from available evidence.

[45] In that case, His Honour went on to refer to *Ambros*[2] and he said:[3]

> There is no certainty of accident trauma having caused a further injury to a weakened disc, but there is evidence to show that it was probable. Mr Hoffman described the injury as "disruption of the L4/5 posterior annulus and displacement of nuclear material into the canal causing displacement of the L5 nerve root. There was certainly an underlying degenerative condition, but there was also an accident precipitating change.

[46] Mr Sara says that the opposition taken by ACC and its medical advisors was that there was no evidence of change to the appellant's spine following his accident. Mr Sara says, however, that Mr Te Aonui's symptoms that kept him away from work for 14 months is evidence of change.

[47] Mr Sara refers to Mr Dunbar's view of the possibility of disc protrusion or compression within the stenotic spine.

[48] Mr Sara submits that ultimately it was the fall that caused the changes in Mr Te Aonui's back that necessitated the operation.

[49] He submits that the appropriate inferences to be drawn from the facts in this case are these:

(a) Mr Te Aonui had an a-symptomatic fully functional back and was able to perform all the tasks required of a labourer in a meat works prior to his fall on 12/10/2018.

(b) Secondly, there was no evidence that Mr Te Aonui had any injury of any kind prior to that fall.

(c) Thirdly, that Mr Te Aonui's back pain and leg symptoms were caused by the fall.

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2 *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.
3 See *Manning* n1 at [38].

(d) Fourthly, that there must have been some kind of physical injury caused by the fall to produce those symptoms.

(e) Fifthly, probably, the mechanism of injury was the actual compression forces caused by the fall caused a bulge in Mr Te Aonui's back, which then caused compression on nerves which became inflamed.

[50] He further submits that the clinical advisory panel has set the evidential proof bar too high.

[51] He comments that it should not be difficult and burdensome for a person like Mr Te Aonui to get cover and that the ACC scheme should not have its focus on looking for ways to exclude cover.

[52] He says simply that Mr Te Aonui, who is now deceased, had an accident at work. He could work before, but he could not work after.

Respondent's Submissions

[53] Mr Hunt, on behalf of the respondent, notes that this is the sort of case that frequently comes before the Court, but that the answer to the case does not involve filling in gaps in the evidence.

[54] He submits that the often quoted dictum from *Ambros* as to causation does not provide an answer in every case.

[55] He submits that like many cases following an accident injury, once the injury recedes the underlying degeneration is left and is the reason for the ongoing pain.

[56] He says that ACC is not looking for ways to avoid cover in this case, however it is up to the appellant to prove on the balance of probabilities that Mr Te Aonui was entitled to cover.

[57] He submits in this case there is no dispute that there was considerable degeneration in Mr Te Aonui's spine before the accident. He therefore submits that

this is a case of degeneration existing and once the accident had resolved, the degeneration remained.

[58] He submits that the clinical advisory panel provides the best analysis and concludes that it can be said that the symptoms Mr Te Aonui had were not the result of the accident.

[59] Mr Hunt reminds the Court that it cannot just look at the temporal connection between pain and injury, the cause of the pain must be linked to some injury, rather than degeneration.

[60] He refers to this Court's earlier decision in *Reynolds v ACC* where the surgeon in that case was in the unique position of knowing exactly the condition of the appellant's spine before her accident. However, that is not the case here.

[61] Mr Hunt also refers to Judge Onley's decision in *Manning*where His Honour said: [4]

> Of course there may be opinions by the same practitioners favouring claimants, but the Court sees opinions only where there are disputes. Other orthopaedic surgeons or rheumatologists advising appellants tend to take the view that a traumatic event is the likely cause of actual injury, thus exceeding a mere aggravation of an existing a-symptomatic degenerative state.

[62] Mr Hunt also refers to Judge Beattie's decision in *Adams,*[5] where he distinguishes that case on the facts from this one. In that case, Judge Beattie was able to conclude:

> I am quite satisfied from the evidence that has been presented that the appellant was suffering from nerve root compromise at L4/5 arising from the disc bulge which had been caused in the tortional injury suffered by her and that this injury continued untreated until Mr Hodgson's surgery in December 2005.

[63] Mr Hunt says that by comparison, in this case, the evidence of the consultant orthopaedic surgeon, Mr Dunbar, falls short. He submits that Mr Dunbar's conclusion

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4 See *Manning* n1 at [38].

5 *Adams v Accident Compensation Corporation* [2007] NZACC 268 at [24].

in his 27 July 2021 report is that in effect Mr Te Aonui's presentation derives from his pre-existing condition.

[64] Mr Hunt does not dispute that Mr Te Aonui has suffered an injury, but that injury resolved with no long-term consequences. He also refers to the clinical advisory panel report and the report of Mr Pai to the effect that in cases of spinal degeneration, symptoms can occur without the pre-requisite of an accident.

Decision

[65] The appellant was aged 60 on 12 October 2018 when the accident in question occurred. He worked as a seasonal freezing worker and on the day of the accident he had descended stairs, intending to go to the changing room prior to smoko. It appears that someone had removed the non-slip mat at the bottom of the stairs. The floor was wet, which the appellant did not see. He slipped and landed flat on his back and hit the back of his head on the floor. He believes he was knocked out momentarily. However, as it often seen in cases like this, he managed to finish his work for the day.

[66] He said that when he went home, he was told that his speech was slurred and he looked odd and that prompted his partner to ask what had happened.

[67] He took the next day off work, which was followed by the weekend, hoping that he would recover. However, his tailbone and legs were still sore.

[68] He was too sore to return to work after his three day break and saw a doctor at the Mataura Medical Centre. The doctor thought that he had bruised his tailbone and gave him a week off work to recover. He said, however, that when he returned to work his legs remained sore, with the pain experienced being the back of his legs into his calves. He said he had no idea what was wrong with him was to do with his back and he thought he had hurt his legs because they were sore. He said he started taking more time off, at least once a week and sometimes more, and that each time he got a medical certificate from his doctor. He said:

> I endured this pattern until April 2019, when one day at work I could not bear it any longer. I couldn't even stand, so, I told my boss about my difficulties.

[69] He had reported to his doctor on 19 February 2019 that he "feels 7/10 pain buttocks now and 9/10 at work". The report of that consultation on 19 February 2019 also noted "Is here as he is unable to stand for long, works on gut tray. Worst thing is standing". So, what is described, not only by the appellant but the medical reports, is a steadily worsening presentation over the months immediately following his accident. That does not sit well with a proposition that the injury caused by the accident resolved and that his accident had rendered symptomatic his underlying degenerative spine pathology.

[70] In cases of this kind, the task of determining whether the issue is a degenerative spine rendered symptomatic by the accident, or whether the appellant's presentation is caused or contributed to by the accident, is often resolved by reference to before and after images of the claimant's spine. We do not have that advantage in this case. Furthermore, the fact that the appellant has an age-related degenerative spine is clear.

[71] It is noteworthy that the clinical advisory panel is less than dogmatic in its conclusions. It says:

> The predominant cause of Mr Te Aonui's lumbar imaging changes is likely to be chronic progressive tissue weakening and bony changes which developed over a long time.
>
> Discs can bulge, protrude and prolapse as part of a continuum of gradual onset degenerative disc disease without external forces.
>
> In Mr Te Aonui's case, the various gradual onset features of his lumbar spine imaging were problem-free prior to the 12/10/2018 fall and then became symptomatic after that fall.
>
> No one knows exactly what features played a role in the genesis of Mr Te Aonui's low back pain and leg symptoms from his spinal stenosis, and why this happened after his 12/10/2018 fall.

[72] I note in the clinical advisory panel report under the heading "CAP Discussion" it says:

> It does not necessarily follow, however, that there was any physical damage or internal spinal derangement after the 12/10/2018 fall. The CAP explained that the development of low back pain and leg symptoms can happen without any history of trauma, injuries or accidents.

> The CAP noted that cause of Mr Te Aonui's low back pain and bilateral leg symptoms is unknown and that there is no evidence of any new physical injury in any of the available medical records or reports.

[73] However, in the report of orthopaedic and spinal surgeon, Mr O'Malley, dated 29 July 2019, he says:

> I entirely agree that the degenerative changes particularly at the L4/5 level were present prior to the accident in October 2018. However, Mr Te Aonui was a-symptomatic at that point in time and I think the axial load that occurred at the point of when he slipped on the wet floor has caused a momentary overload of the disc at that level, which caused it to bulge and take an a-symptomatic tight spinal stenosis and make it a symptomatic even tighter spinal stenosis. At this point in time, when the impact occurs, there is often a compression of the nerve roots with associated swelling and the body is unable to recover from this due to the pre-existent tightness of the spinal canal.

[74] The clinical advisory panel reports notes that it considered the opinions of both Mr O'Malley and Mr Dunbar that the fall with axial compression forces caused momentarily increased disc bulge, which tightened the already narrowed spinal canal and pinched nerves, which remained inflamed and could not heal.

[75] The panel is somewhat dismissive of their reports, saying:

> Dr O'Malley's and Mr Dunbar's concepts may sound like a neat, tidy and simple explanation, but there is no evidence to support them and they are speculative at best.

[76] It goes without saying that there is no hard scientific evidence to support the opinions. There were no "before and after" scans and no scans done of the appellant's spine in the days following the accident.

[77] Musculo skeletal medical physician, Dr Bell, said:

> Mr O'Malley, Mr Te Aonui's treating orthopaedic surgeon, has opined that the axial force (compression) through the lumbar spine at the time of the accident gave rise to momentary disc bulging causing swelling of the spinal nerves which has failed to resolve, and that this is responsible for ongoing symptoms. This explanation would certainly explain ongoing lower limb symptoms.
>
> The mechanism of injury, time course of symptoms development, and the fact that Mr Te Aonui is left with back pain, is all consistent with an injury to a disc, and from an anatomical perspective an increase in disc bulging as a result of the accident would not only cause back pain, but the rapid development of lower limb symptoms.

> As such, the accident on 12 October 2018 is more likely than not to have given rise to a physical injury involving a lumbar intravertebral disc, and that this continues to cause back pain. The injury is likely to have been associated with an increase in disc bulging and associated inflammation, giving rise to lower limb symptoms that persist currently.

[78] I prefer the opinions of Mr O'Malley, Mr Dunbar and Dr Bell.

[79] I do so because they are supported by what we know actually happened.

[80] The accident that happened to Mr Te Aonui on 12 October 2018 was a significant one, not only because it may well have rendered him unconscious from an additional head knock, but because the record shows that his symptoms got steadily worse, to the point that by April 2019 he was on any basis no longer able to work. He impresses as a man who got on with life and did not make a fuss and he was a hard worker. It was only when his injury literally brought him to a standstill in April 2019 that there was any serious medical inquiry as to the effects of his accident of 12 October 2018.

[81] It is acknowledged that because of his degenerative spine, the competing view in this case that his fall simply rendered that degenerative spine symptomatic, has been put forward on behalf of ACC, such a stance is open, on the state of the evidence that we have in this case.

[82] However, applying *Ambros*, and in this regard I am satisfied of the truthfulness of Mr Te Aonui's evidence, that this was more than spinal degeneration being rendered symptomatic by the accident. On the totality of the evidence, therefore, I find it more likely than not that Mr Te Aonui, on 12 October 2018, suffered a spinal injury when he slipped on a wet floor at his work. Accordingly, I find that Silverfern Farms was not correct to decline cover for bilateral L4/5 stenosis on the basis that it was not a personal injury arising from an accident occurring on 12 October 2018 and that its consequential suspension of associated weekly compensation entitlements was wrong and is reversed.

[83] Accordingly, the appeal is allowed.

[84] Costs are reserved.

CJ McGuire
District Court Judge

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Peter Sara, Barrister & Solicitor, Dunedin