PURSUANT TO S 160(1)(b) ACCIDENT COMPENSATION ACT 2001 THERE IS A SUPPRESSION ORDER FORBIDDING PUBLICATION OF THE APPELLANT'S NAME AND ANY DETAILS THAT MIGHT IDENTIFY THE APPELLANT

IN THE DISTRICT COURT
AT WELLINGTON

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

[2023] NZACC 199 ACR 144/18

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

Hearing: 30 November 2023

Held at: Wellington/Whanganui-a-tara by AVL

Appearances: F Becroft for the appellant (the Accident Compensation Corporation ("the Corporation"))
J Miller for the respondent

Judgment: 7 December 2023

RESERVED JUDGMENT OF JUDGE P R SPILLER
[Suspension of entitlements - s 117,
Accident Compensation Act 2001 ("the Act")]

Introduction

[1] This is an appeal from the decision of a Reviewer dated 10 April 2018. The Reviewer quashed the Corporation's decision dated 8 May 2017 suspending the respondent's ongoing entitlements, and directed that these be reinstated while the Corporation investigated further the question of cover for quadriparesis.

Background

[2] The respondent was born in 1961. She experienced significant adversity during her life. She had a difficult relationship with her parents. She was a victim of significant abuse, both as an adolescent and in her first marriage. One of her children acquired a significant disability following brain damage. The respondent suffered intense grief around the decision she made to leave that child when he was five years old, and she has not seen that child since. In 1993, the respondent overdosed on pain medication. Following that, there was a history of pseudo-seizures and a psychiatric admission. She had a significant history with alcohol dating back to her youth. Her second-born child had a brain haemorrhage and thereafter suffered seizures.

[3] On 25 March 2012, the respondent collapsed at her home, hitting her head on a coffee table and losing consciousness. She was brought by ambulance to a hospital's emergency department, where a C-spine x-ray was taken. This showed no fracture. At this point, the respondent was reportedly experiencing bilateral weakness in her arms and legs, but this was thought to be due to the fall and having been in bed for some time. As such, she was discharged home.

[4] The respondent continued to experience ongoing weakness, with decreased sensation in her hands and legs, and she was unable to bear weight. She was subsequently seen by her GP and re-admitted to hospital.

[5] On 4 April 2012, an MRI was conducted on the respondent's cervical spine. Dr Kunaal Rajpal, Radiologist, reported multilevel neural foraminal and spinal canal stenosis involving the mid-cervical spine which was moderate to severe at C4/5 and C5/6, with associated cord myelomalacia/oedema; and multilevel discopathy involving the lumbar spine.

[6] On 12 April 2012, an ACC injury claim form was lodged, with a diagnosis of cervical spinal stenosis, and an injury date of 25 March 2012. The respondent was granted cover for cervical spinal stenosis, and then received entitlements including weekly compensation and home assistance.

[7] On 13 April 2012, the respondent was treated with dexamethasone, and underwent a C4/5 anterior cervical discectomy and fusion, conducted by Mr Bryan Thorn, Orthopaedic Surgeon. She was discharged, but she was readmitted after deterioration. A repeat MRI showed severe cervical stenosis throughout C3/4/5.

[8] On 21 May 2012, Mr Thorn noted that the respondent concerned him "a lot". He noted that she presented with an obvious spinal cord injury, and had not progressed well since her surgery on 13 April 2012. Mr Thorn suggested some persisting, changed or worsening cord compression anteriorly, or progress in the degree of myelomalacia in the spinal cord.

[9] On 30 May 2012, an MRI was conducted on the respondent's cervical spine. Dr Guy Mason reported:

> Decrease in the extent of the intrinsic cord oedema at the C4 level, which is now over a superior to inferior extent of approximately 8mm. There is a moderately severe central canal stenosis at C4/5 secondary to the broad-based central and paracentral disc bar, and an intrinsically narrowed cervical canal. AP canal diameter is narrowed to approximately 6.5mm at this level, and there is slight compression of the cord anteriorly.

[10] On 18 June 2012, Mr David Ardern, Orthopaedic Surgeon, performed a laminoplasty C3-C6 on the respondent, with indications of progressive cervical myelopathy.

[11] On 20 June 2012, Mr Ardern wrote a referral to the Spinal Rehabilitation Unit:

> [The respondent] is a 51-year-old who had no neurological impairment until she fell over 25.03.12. There was a delay in her diagnosis, but an MRI subsequently showed cervical myelopathy at C4/5 as well as stenosis C3/4 and C5/6. She underwent a C4/5 anterior cervical discectomy and fusion by my colleague, Mr Bryan Thorn, 13.04.12. [The respondent] believes that her situation further deteriorated and apparently a referral to the Spinal Unit was made and she was not able to be accommodated.
>
> The situation has become quite dire and she has been at home essentially immobile requiring 24-hour care from her elderly mother. She has an indwelling catheter and has had problems with her bowels. She has had very limited use of her upper limbs and not being able to feed herself other than using a modified utensil in her right hand. She has had difficulty holding a cup and certainly unable to walk. Her husband who works long hours and elderly mother have become frustrated as has [the respondent].

> A repeat MRI scan was performed 30.05.12 showing persisting severe stenosis through the cervical spine and she underwent cervical laminoplasty C3-C6 18.06.12. The surgery was uneventful and at this early stage she has seen pleasing gains.

[12] On 12 July 2012, the respondent was admitted to a Spinal Unit for a period of rehabilitation. On admission, an American Spinal Cord Injury Association (ASIA) impairment scale was completed, and the respondent was diagnosed with a C2 ASIA D spinal cord injury subsequent to cord oedema.

[13] On 16 August 2012, a Preliminary Care Report was completed for the respondent. Regarding her cognition, the following was noted:

> A MOCA cognitive screen was carried out with [the respondent] on the 16/07/2012. [The respondent] scored 22/30 which is below normal. The deficits were in delayed recall, attention and visuospatial. Due to the low score of the MOCA, a further, more in depth cognitive assessment (CAM) was completed with [the respondent]. This assessment showed that [the respondent] has severe problems with attention, mental flexibility and complex problem solving. Moderate issues are also highlighted in auditory and motor memory, math skills, simple problem solving and safety and judgement … It is advised that [the respondent] has further cognitive rehab on discharge and that she receive a neuropsychological assessment to isolate the issues she has and continue to rehab or compensate for deficits.

[14] On 9 October 2012, Dr Susan Shaw, Neuropsychologist, completed a neuropsychological assessment of the respondent. Dr Shaw noted no evidence of slowed processing speed in conversation, but recall and recognition memory were below average. Dr Shaw recorded:

> Qualitatively, she produced a very flattened learning curve over repeated trials of the list learning task. This pattern of performance is often seen in people with executive dysfunction or frontal lobe brain injuries. However, I would be very cautious about drawing any firm conclusions based on her performances on memory tests, given her rather marginal performances on tests of symptom validity. …
>
> I suspect that [the respondent] is right in that any cognitive changes she is currently experiencing are likely to be due to a combination of factors including adjustment, fatigue, pain and medication. Her concussion may also be contributing to some degree. I do not have access to medical records regarding her pre-injury neurological status, but it is possible that there are other contributing factors as well. …

[15] On 4 March 2013, Dr Rick Acland, Rehabilitation Medicine Consultant at a spinal unit, assessed the respondent. Dr Acland thought that her neurological deficit

was unusual and difficult to explain. He advised that "one cannot rule out some aspect of functional overlay". He recommended a full neurological review, as well as review of her medication.

[16] On 21 May 2013, Dr Andrew Chancellor, Neurologist, completed an assessment of the respondent. He diagnosed: somatoform disorder;[1] psychogenic speech disturbances and motor impairments; non-organic cognitive complaints; episodes of poorly explained abdominal pain; dissociative experience and abnormal illness responses/behaviour with functional motor impairments; post traumatic cervical myelopathy – resolved; and opiate misuse with dependency. Dr Chancellor said that "most, if not all", of what he saw "cannot be explained by the cervical myelopathy, that is, injury to spinal cord", and that the abnormalities were "bizarre" and non-organic. He noted that, while the respondent had suffered a cervical spinal cord injury, there were no unequivocal abnormalities on the physical examination, and the appearances of the cervical spinal cord had improved significantly. He recommended a psychiatric assessment.

[17] On 17 September 2013, the respondent was assessed again by Dr Shaw, who commented:

> [The respondent] reports very high levels of somatic symptoms, and as far as I can ascertain, there is as yet no neurological explanation for her symptoms. …
>
> As present, I think a DSM 5 diagnosis of 'Conversion Disorder' best fits [the respondent]'s neurological or somatic symptoms cluster. Dr Chancellor's letter is dated May 2013, so was written just before the new DSM 5 came out, but his descriptions suggest that he is also in agreement with this diagnosis.
>
> With regard to her cognitive difficulties, there is no evidence that she has suffered a brain injury of significant severity to produce symptoms of the nature and magnitude that she currently reports. The nature of the cognitive symptoms she reports is not consistent with what is expected in the context of a concussion or closed head injury. The gradual worsening of her memory reported by [the respondent] is not consistent with a traumatic brain injury. This type of problem is sometimes seen in a dementia, but [the respondent] is not showing any other signs of dementia. Therefore, I think we can rule dementia out.

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[1] A mental disorder diagnosis wherein physical symptoms and signs are detected which are not based in disease or damage to the tissues of the body from which they appear to be arising.

> In sum, the nature of the memory difficulties [the respondent] reports cannot be explained by the documented injury. The severity of the memory problems is also inconsistent with the documented injury. …
>
> In [the respondent]'s case, I think it best at this stage to assume a Conversion Disorder, which appears to have been problematic for [the respondent] at many times over the past 20 years or so.

[18] On 23 September 2013, Dr Erin Eggleston, Psychologist, advised that, while the present working formulation was not of substantive injury consequences, the Corporation should not stop providing service.

[19] On 3 October 2013, Dr James Aoina, Orthopaedic Registrar, saw the respondent in the hospital emergency department after a fall resulting in a distal radius fracture. She had surgery for this and was discharged on 15 October 2013.

[20] On 13 March 2014, Dr Darren Malone, Psychiatrist, provided a psychiatric assessment report for the respondent. Dr Malone diagnosed alcohol abuse disorder and possible major depressive disorder, and possible opiate abuse disorder, undifferentiated somatoform disorder or factitious disorder. Symptom validity concerns were also raised. Dr Malone advised that the respondent's physical injury was not a material (necessary) cause of her current medical condition:

> [The respondent]'s medically unexplained symptoms (either a Somatoform Disorder or Factitious Disorder) predates the 25/03/12 injury by many years. Although the injury has reactivated the symptoms it is my opinion that the most significant causal factor in her current symptoms is her pre-existing mental condition. It is noteworthy that in 1996, [the respondent] suffered with similar neurological, memory and speech complaints…

[21] Dr Malone recommended a second neurological opinion and a repeat MRI of neck/cervical spine.

[22] In May 2014, Dr Acland examined the respondent and reported that "inconsistent aspects to her presentation abound", she presented with marked rigidity in all four limbs, and there was "no evidence of overt spinal cord impairment".

[23] On 17 June 2014, Dr Acland advised that there was no merit in arranging a further MRI, as the respondent's neurological deficit remained inconsistent, and he

was not convinced that she presented as an incomplete tetraplegic as a result of spinal cord injury.

[24] Due to the respondent's continued reduced function in all four limbs and widespread pain, she was referred to Mr Ardern. On 11 August 2014, following assessment, Mr Ardern provided a report:

> One of the other issues is that [the respondent] has been diagnosed with a somatoform disorder complicating the assessment and ACC liability essentially for her clearly sustained cervical cord injury. [The respondent] has seen Dr Andrew Chancellor, Neurologist, and also Dr Rick Acland, who is a consultant in rehabilitation medicine with the Auckland Spinal Rehabilitation Unit. I am in receipt of reports from both of these specialists. …
>
> Management:
>
> [The respondent]'s situation is clearly complex in that she clearly has had two separate diagnoses made. From my point of view as an operating surgery (surgeon) I would like to make sure that she hasn't developed a further complication of her cervical cord injury, myelopathy and subsequent treatment. I am obtaining flexion and extension views as well as an erect lateral cervical spine x-ray to help ensure that she is not developing increasing kyphosis and a follow up MRI scan of her cervical spine to ensure there are no unexpected complications such as syrinx formation. I anticipate that these investigations will be satisfactory and ultimately the question of further cover for ACC will be difficult but the reports provided already by Dr Chancellor and Dr Acland are very in depth and it is likely that [the respondent] has both problems co-existent.

[25] On 14 August 2014, the Corporation approved a lump sum payment of $5,766.86, based on the respondent's assessed impairment of 15% from her cervical spinal stenosis of 25 March 2012.

[26] On 26 November 2014, an MRI of the respondent's cervical spine was taken. This reported:

> Tiny T2 cystic change within the cord at the level of the previous compression, consistent with small post-compressive syrinx. No current cervical central stenosis. Foraminal stenosis, as detailed similar to previous study.

[27] On 3 December 2014, Mr Ardern wrote to the respondent following the imaging results. He commented that he was very pleased with them, and there was no sign of instability or nerve compression. He noted that he could see the damage

that occurred to the spinal cord but noted that there was nothing that could be done to improve this.

[28] On 10 December 2014, Mr Ardern wrote to the Corporation:

> In summary, I saw [the respondent] after previously failed cervical spine surgery. She clearly had cervical myelopathy which was demonstrated clinically and radiologically. Her MRI scan shows that the spinal cord has not returned to normal, as is commonly the case in such situations. There is T2 cystic change within the cord and a small post compressive syrinx. There is no ongoing compression however…. [The respondent] has no doubt suffered a spinal cord injury with some ongoing effects but I accept the co-existent diagnosis of a somatoform disorder. My findings are also consistent with this. The proportion of disability related to each of these separate problems, obviously one being ACC covered and the other not, is not an area that I am best qualified to pass judgement on however, from my point of view [the respondent] did clearly have a significant spinal cord injury with neurological compromise both clinically and radiologically requiring intervention.

[29] On 12 May 2015, Dr Bridget Louie, GP, noted that the respondent's left-hand function was mostly limited to the spasticity related to the cervical myelopathy, and that she was finding her cervical spine injury and pain to be the most debilitating.

[30] On 9 March 2016, the Corporation's External Medical Multidisciplinary Panel reviewed the respondent's file documents to clarify her diagnosis and update her treatment and rehabilitation programme. The panel comprised an Occupational Medical Specialist/Pain Physician, a Neurologist, a Psychiatrist/Specialist Physician, a Radiologist, and an Orthopaedic Surgeon. The Panel noted the extraordinary range of medically unexplained symptoms, the primary diagnosis of factitious disorder, and the secondary proposed diagnoses of borderline personality traits and polysubstance dependence. The panel concluded that none of the current diagnoses related to the injury or accident of 25 March 2012:

> Similar patterns of symptoms and distress manifested before that incident and new symptom patterns (consistent with the above proposed diagnoses) have manifested since the accident (new onset episodes of weakness for instance). …
>
> The Panel does recognise that there clearly was a real injury on 25 March 2012 with impact on the cord which was effectively treated with surgical intervention for what appears to be an excellent result radiologically and clinically. The possible mild spasticity of the right arm noted by Dr Chancellor is not consistent with the degree of impairment and the pattern of symptoms reported by [the respondent]. In other words, the Panel would consider the injury to

> have been successful remediated and not responsible for her current impairment.

[31] On 30 May 2016, Dr Alan Farnell, Pain and Palliative Care Specialist, reported, after assessment, that the respondent had a pain profile where she was predisposed to have a magnified response to any painful stimuli. He stated that the respondent had suffered a dreadful accident where her cord was compressed. This had however resulted in very little deficit. He believed that the respondent was suffering from a chronic pain syndrome associated with very strong psychosocial factors. Dr Farnell added:

> I could not find signs of her having been fictitious today. I clearly accept that she has medically unexplainable symptoms in terms of anatomy and in terms of tissue injury. This is not the problem. The problem is [the respondent's] response to a severe accident and her subjective feelings of pain which do not follow any recognised pattern. It does not mean to say that she does not feel pain. The point is the treatment for it should be psychological and physical.

[32] On 2 November 2016, Dr Farnell commented that the respondent's primary problems were not accident related, she had "awful" problems before her accident and these had continued, she had a dreadful accident, but her accident-related pathology was "now absolutely minimal". He noted:

> Hence, this lady is profoundly disabled due to her response, not only to her accident, but also to life's stresses that predate the accident. These life stressors include all medical assessments for medically unexplained problems. …
>
> 1. [The respondent's] current pain problems are due to her response to life's events, not her accident related pathology. Her problems with life's events go back to childhood.
>
> 2. Yes, [the respondent's] problems are due to her psychosocial profile and psychological factors which are clearly recorded.
>
> 3. I do believe the causation is multifactorial. But primary problem is psychological and psychosocial. I am very pleased to see her recover fully from a nasty accident.

[33] On 30 March 2017, the respondent's continued entitlement was discussed by Mr Gavin Burgess, Technical Claims Manager, who considered that the ongoing issues experienced by the respondent were not related to her covered accident. He considered that the expert medical opinion was now overwhelmingly that "the covered injury was effectively spent".

[34] On 4 April 2017, Dr Kris Fernando confirmed that the Corporation's suspension decision had been carefully considered with a solid rationale.

[35] On 8 May 2017, the Corporation issued a decision suspending the respondent's entitlement to weekly compensation, attendant care and other rehabilitation supports. The reasoning provided was that the medical information showed that her current condition was no longer the result of her personal injury of 25 March 2012, the covered index injury (cervical disc prolapse with myelopathy) or any previously covered injury. The Corporation noted that the preponderance of medical evidence supported that her covered index injury was now spent, and her ongoing incapacity was no longer the result of the covered injury. The covered injury was effectively treated with surgical intervention and an excellent result was obtained both radiologically and clinically. The respondent lodged a review application against this decision.

[36] On 1 January 2018, Dr Peter Wright, Neurologist, reported on the causation of the respondent's ongoing symptoms. Dr Wright concluded that the respondent suffered from two diagnoses:

> a) a severe underlying undifferentiated somatoform disorder. Her medically unexplained symptoms predate the cervical injury of 2012, and the injury reactivated her symptoms. There are currently ongoing but mild-moderate severity examination findings which support this diagnosis, and it is contributing to her current presentation as identified on examination. This is non-injury related.
>
> b) a mild neurologic syndrome of quadriparesis has been caused by a simple fall in 2012, in which a C4/5 cervical disc caused central canal stenosis, leaving her with several signs consistent with this pathology and MRI imaging showing atrophy and scarring of the spinal cord at this level. The injury of 2012 did not further damage her somatoform disorder, as the disorder was already profoundly severe part of her health presentations intermittently over many years.

[37] On 14 February 2018, Dr Wright clarified what he meant by quadriparesis. He noted:

> Quadriparesis (otherwise (less correctly) called tetraplegia) is a neurologic disorder affecting all 4 limbs, usually attributable to a cervical (neck) spinal cord level or bilateral brain disorder. It often affects sensory, motor, coordination, and bowel/bladder aspects of neurology and can be supported by definite neurologic signs on examination as in [the respondent]'s case….

> Unfortunately I cannot be certain about [whether the diagnosis incapacitated the respondent for work]. The quadriparesis is mild, and is partly obscured by the non-organic findings.

[38] On 27 March 2018, review proceedings were held. At the hearing, the respondent's representative referred to a report by Dr Louie that, at the time of the accident, the respondent was reasonably well; following the accident, the respondent was unable to mobilise with weakness in both her upper and lower limbs and loss of sensation; and, since March 2012, the respondent had not had the smoothest recovery with ongoing stiffness and pain in her limbs, especially her legs and hands and ongoing neck pain.

[39] On 10 April 2018, the Reviewer concluded without reservation that, at the time of the Corporation suspending the respondent's entitlements, the Corporation had discharged the onus upon it to have sufficient evidence to suspend the entitlements. The Reviewer found that the respondent had not, prior to the Corporation's decision, provided any convincing alternative medical evidence that supported a causal connection between the covered spinal cord injury and her ongoing symptoms. However, the Reviewer found that Dr Wright's report was sufficiently compelling that it cast significant doubt on the correctness of the Corporation's decision. The Reviewer concluded that there was sufficient evidence to show that it was likely that the respondent's ongoing symptoms were caused (at least in reasonable part) by a neurological injury which was caused by the covered spinal cord injury from the accident in March 2012. The Reviewer therefore quashed the Corporation's decision suspending the respondent's ongoing entitlements, and directed that these be reinstated while the Corporation investigated further the question of cover for quadriparesis. The Reviewer suggested that the Corporation consider a further orthopaedic opinion and updated MRI imaging.

[40] On 3 May 2018, a Notice of Appeal was lodged by the Corporation. However, the Corporation reinstated the respondent's entitlements, including weekly compensation and 23 hours per week home help.

[41] On 16 July 2018, Dr Chris Kenedi, Liaison Psychiatrist and Internal Medicine Physician, in a file review, noted that the respondent had had an extraordinarily

difficult life and that a consistent manifestation of the resultant distress had been abnormal illness behaviour. Dr Kenedi considered that the respondent had factitious disorder rather than somatic symptom disorder as she had been demonstrated to consciously replicate symptoms rather than an unconscious manifestation of distress. Dr Kenedi considered that the respondent's alcohol abuse/dependence and factitious behaviour were not injury-related and were not conditions that the Corporation was able to treat effectively.

[42] On 8 August 2018, Dr Chancellor provided a report, which included a reply to Dr Wright's findings of a mild neurologic syndrome of quadriparesis due to residual stenosis and spinal cord atrophy and scarring from her 2012 injury. Dr Chancellor noted that the examination findings of Dr Wright differed somewhat from those when he (Dr Chancellor) saw the respondent, and that this argued "in favour of a non-injury cause because if signs really are fluctuating this is more in keeping with a somatoform/functional basis". Dr Chancellor noted that quadriparesis was not a diagnosis, and that this had many causes, including functional/somatoform causes. Dr Chancellor added:

> Dr Wright and I do not disagree. We differ slightly on the emphasis that is placed on the relative contributions to the respondent's disability. A more straightforward examination scenario with Dr Wright shows signs of her remote cord injury.
>
> I have not seen the respondent since 2013 (this report is based on a record review only). At that time I could not explain her presentation on the basis of cervical spinal cord injury. I was fully conversant with her injury and the radiological features. There were much more plausible diagnoses, which considered her entire neurological history, such as a diagnosis of pre-existing somatoform (aka 'functional' or 'conversion' disorder). …
>
> In conclusion, although changes in the respondent's overall condition has led the recent neurological examiner to identify a mild underlying quadriparesis, there remain signs which are inconsistent with injury effects and as such, as it stands at present – based on the information you have provided, I see no reason for changing my views, substantially supported as they are by the opinion of others.

[43] On 30 October 2018, Dr Chancellor added that it may be that mild residual signs of the respondent's cervical injury did persist, which were more easily recognised when there is less functional overlay complicating the variable inter-rater reliability of physical signs. Dr Chancellor noted that Dr Wright's examination

showed some signs of her remote cord injury, but these did not mean these signs were the cause of the respondent's disability.

[44] The Corporation then agreed to investigate whether the respondent's separate ACC sensitive claim was of relevance to her symptoms, in particular whether it had caused a somatoform disorder to emerge.

[45] On 20 July 2021, an MRI was conducted on the respondent's brain and cervical spine. Dr Damon Blair, Radiologist, noted "scattered punctuate foci of T2", and commented:

> Cervical myelopathy at C4/5, with evidence of previous C4/5 ACDF and central canal decompression, comparable to a previous MRI (Bat Radiology) 26/11/2014. No evidence of a central canal stenosis or cord compression. No intrinsic cord signal abnormality is seen elsewhere, in particular no evidence of a syrinx.

[46] On 31 January 2022, Dr Amanda Faulkner, Psychiatrist, reported after an examination of the respondent and a review of all physical and mental investigations to date. Dr Faulkner noted two current psychiatric disorders:

> 1. Undifferentiated Somatoform Disorder: it is without doubt that this exists alongside any residual physical health issues that [the respondent] has that were secondary to her 2012 fall. Moreover, it is evident that a tendency to experience somatisation (or functional) symptoms pre-dated the fall with the most striking example being of her pseudoseizures from 1993. However, prior to this, in association with extreme stress around the illness of her first child, [the respondent] clearly recalled getting IBS symptoms at that time in her life. There are other likely somatisation symptoms in the files (out with the fall-related issues) which also include headaches, the stroke-like episode and "blindness" noted by Dr Wright's report. …
>
> 2. Alcohol Dependence Syndrome (in partial remission): if we are to take [the respondent] account of her past (and current) history of alcohol usage, then previous reports have grossly underestimated the severity of this disorder as noted elsewhere. This is highly relevant to many aspects of this claim as [the respondent's] heavy alcohol usage has caused her to fall at home (she disclosed to me) a number of times and one wonders if it was also a factor in the 2012 fall. A 30+ year history of heavy alcohol use is also relevant medically in terms of things like cognitive function, peripheral neuropathy, balance as well as a host of other potential issues. [The respondent] did not seem to fully understand the potential seriousness of her alcohol history when we discussed this.
>
> Beyond this, there are other likely diagnoses in terms of iatrogenic dependency on both opioids and benzodiazepines (F11.2 and 13.2). Many previous medical professionals have noted these concerns and the need to reduce or stop these drugs and yet they persist. …

[47] On 10 June 2022, Dr Chancellor advised that there was no relationship between the brain abnormalities recorded in the recent MRI and the respondent's fall in 2012. Dr Chancellor agreed with Dr Faulkner's assessment of undifferentiated somatoform disorder.

Relevant law

[48] Section 26(2) of the Act provides:

> 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 described in section 20(2)(e) to (h).

[49] Section 67 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] Section 117 of the Act provides:

> Corporation may suspend, cancel, or decline entitlements
>
> (1) The Corporation may suspend or cancel an entitlement if it is not satisfied, on the basis of the information in its possession, that a claimant is entitled to continue to receive the entitlement.

[51] In *Ellwood*,[2] Mallon J considered equivalent legislation under the 1982 Act, and stated:

> [64] … Before entitlements are suspended at ACC's initiative (or that suspension is upheld by a reviewer or the District Court) ACC should take steps to clarify the position one way or the other. …
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> [65] … s 116 combined with the requirement in s 62 on ACC to make reasonable decisions requires ACC to have a sufficient basis before terminating benefits. If the position is uncertain then there is not a sufficient basis. The "not satisfied" test is not met in these circumstances.

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[2] *Ellwood v Accident Compensation Corporation* [2007] NZAR 205.

[52] In *Furst*,[3] Barber DCJ stated:

> [13] … The "*not satisfied*" test requires a positive decision … equivalent to being satisfied that there is no right to entitlements. This test would not be met where the evidence was in the balance or unclear: *Milner v the Corporation* (187/2007).
>
> [14] Section 26 of the Act defines "personal injury" as physical injuries suffered by a person. Personal injury caused "wholly or substantially" by a non-work gradual process, disease, or by the ageing process is excluded. 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 injury caused by the accident and not the injury that is the continuing effects of the pre-existing degenerative condition that can be covered: *MacDonald v ARCIC* [2002] NZAR 970 at 26.
>
> [15] There must be a causal nexus between the covered injury and the condition of the claimant for which entitlements were sought at the time of ACC's decision to suspend or decline entitlements: *Milner*.
>
> [16] Causation cannot be established by showing that the injury triggered an underlying condition to which the Respondent was already vulnerable, or that the injury accelerated the condition which would have been suffered anyway: *Cochrane v ACC* [2005] NZAR 193.
>
> [17] The question is whether the evidence as a whole justifies a conclusion that there is a nexus between injury and incapacity: *Cochrane*.

[53] In *Hayes*,[4] Powell DCJ stated:

> [11] … before the medical evidence adduced by both parties after the Corporation's decision can be considered, this Court must first be satisfied that the Corporation had a sufficient basis to be not satisfied that Mrs Hayes had a right to continue to receive entitlements at the time the decision to suspend was made. Only if this can be established does the Court then consider whether there remains a sufficient basis to be not satisfied having regard to all the evidence now before the Court.

Discussion

[54] On 25 March 2012, the respondent suffered an injury by accident. On 13 April 2012, she was granted cover for cervical spinal stenosis and was then granted weekly compensation and home help assistance. On 13 April and 18 June 2012, she underwent surgery on her cervical spine. On 8 May 2017, the Corporation suspended the respondent's entitlements, on the basis that her ongoing symptoms

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[3] *Furst v Accident Compensation Corporation* [2011] NZACC 379. See also *Booker v Accident Compensation Corporation* [2000] NZACC 205.

[4] *Hayes Accident Compensation Corporation* [2015] NZACC 327.

were no longer causally related to her covered injuries. On 10 April 2018, a Reviewer quashed the Corporation's decision, and the respondent's entitlements were reinstated. The issue in this appeal is whether the Corporation's suspension of the respondent's entitlements is supported by sufficient evidence both at the time it was made and in the period since, or whether the evidential picture as it stands remains sufficiently unclear such that the suspension decision is not sustainable.

[55] Mr Miller, for the respondent, submits as follows. Although the Reviewer considered that the first limb of the *Ellwood* test was considered satisfied when the 7 August 2017 suspension decision was made, the evidential landscape had changed by the review hearing date, particularly following the reports by Dr Wright and the respondent's GP, Dr Louie. Dr Wright's 2018 opinion of several ongoing clinical signs consistent with atrophy and scarring of the spinal cord was confirmed by Mr Ardern's similar 2014 orthopaedic confirmation that there were radiological findings consistent with a spinal cord that had not returned to normal. Dr Louie's GP evidence included regular observations of the marked difference in function for the respondent since the 2012 accident compared to her good pre-injury levels of employment and management of stress. Dr Louie also explained how ongoing issues with pain and loss of function in the limbs were not mentioned in the notes, as the Corporation had asked her to remove tetraplegia from the ACC medical certificates. The latest MRI report continued to indicate the presence of T2 damage. The post-review reports of Dr Chancellor reviewing Dr Wright's report, Dr Faulkner's report, and the July 2021 MRI, simply re-confirm the earlier evidence without disturbing the unclear evidential picture.

[56] This Court acknowledges the above submissions, and in particular the evidence of Dr Wright. The Court now turns to consider the medical evidence at the time of the Corporation's decision, and then the medical evidence that was subsequently presented.

Evidence at the time of the Corporation's decision

[57] By the time of the Corporation's decision of 8 May 2017, the Corporation had received the following reports regarding the respondent's condition:

(a) On 4 March 2013, Dr Acland, Rehabilitation Medicine Consultant at a spinal unit, having assessed the respondent, thought that her neurological deficit was unusual and difficult to explain, and that "one cannot rule out some aspect of functional overlay".

(b) On 21 May 2013, Dr Chancellor, Neurologist, having assessed the respondent, diagnosed a range of conditions (including somatoform disorder), and advised that "most if not all" of these conditions were not explained by the cervical myelopathy (injury to the spinal cord). Dr Chancellor advised that there were no unequivocal abnormalities on the physical examination, and the appearances of the cervical spinal cord had improved significantly.

(c) On 17 September 2013, Dr Shaw, Neuropsychologist, having assessed the respondent, diagnosed very high levels of somatic symptoms, and advised that there was no evidence that she had suffered a brain injury of significant severity to produce symptoms of the nature and magnitude that she currently reported. Dr Shaw assessed that the respondent had a Conversion Disorder, which appeared to have been problematic for the respondent at many times over the past 20 years or so.

(d) On 23 September 2013, Dr Eggleston, Psychologist, advised that the present working formulation of the respondent was not of substantive injury consequences.

(e) On 13 March 2014, Dr Malone, Psychiatrist, advised that the respondent's symptoms (of either a Somatoform Disorder or a Factitious Disorder) predated the 2012 injury by many years. Dr Malone assessed that, although the injury had reactivated the symptoms, the most significant causal factor in the respondent's current symptoms was her pre-existing mental condition. Dr Malone noted that in 1996, the respondent suffered with similar neurological, memory and speech complaints.

(f) In May 2014, Dr Acland, having re-examined the respondent, reported that "inconsistent aspects to her presentation abound", and there was "no evidence of overt spinal cord impairment". On 17 June 2014, Dr Acland advised that he was not convinced that the respondent presented as an incomplete tetraplegic as a result of spinal cord injury.

(g) On 10 December 2014, Dr Ardern, Orthopaedic Surgeon, advised that the respondent had no doubt suffered a spinal cord injury with some ongoing effects, but he accepted the co-existent diagnosis of a somatoform disorder.

(h) On 9 March 2016, the Corporation's External Medical Multidisciplinary Panel (comprising an Occupational Medical Specialist/Pain Physician, a Neurologist, a Psychiatrist/Specialist Physician, a Radiologist, and an Orthopaedic Surgeon) noted that the respondent's 2012 injury was effectively treated with surgical intervention for what appeared to be an excellent result radiologically and clinically. The Panel considered that the respondent's injury had been successful remediated and was not responsible for her current impairment. The Panel concluded that none of the current diagnoses related to the injury or accident of 2012.

(i) On 30 May 2016, Dr Farnell, Pain and Palliative Care Specialist, assessed that the respondent had recovered fully from her accident, her accident-related pathology was "now absolutely minimal", her primary problems were not accident related, and they were due to her psychosocial profile and psychological factors.

(j) On 4 April 2017, Dr Kris Fernando confirmed that the Corporation's proposed suspension decision had been carefully considered with a solid rationale.

[58] In assessing the above evidence, this Court acknowledges Mr Ardern's observation (in December 2014) that the respondent's spinal cord had not returned to normal, and that there were T2 cystic changes within the cord and a small post

compressive syrinx. However, Mr Ardern also noted that there was no ongoing compression, that there was also a diagnosis of a somatoform disorder, and that he was not best qualified to judge the proportion of disability related to these separate problems. This Court also notes that Mr Ardern did not clearly explain the causal relationship between the spinal cord not returning to normal and the respondent's ongoing condition.

[59] Beyond Mr Ardern's observation, this Court finds that there is a considerable body of medical evidence that clearly indicated that, by the time of the Corporation's decision to suspend the respondent's entitlements, her covered index injury was spent, and her ongoing incapacity was no longer the result of the covered injury. In light of this medical evidence, this Court concurs with the finding of the Reviewer, who concluded, without reservation, that, at the time of the Corporation suspending the respondent's entitlements, the Corporation had discharged the onus upon it to have sufficient evidence to suspend the respondent's entitlements on the basis that it was not satisfied that she had the right to continue to receive the entitlements.

Subsequent evidence to date

[60] Subsequent to the Corporation's suspension decision of 8 May 2017, the following medical evidence was provided:

(a) On 1 January 2018, Dr Wright, Neurologist, assessed that the respondent's ongoing symptoms stemmed from two diagnoses. First (and in line with the above evidence), Dr Wright diagnosed that the respondent had a severe underlying undifferentiated somatoform disorder which predated the cervical injury of 2012, and was non-injury related. Second, Dr Wright diagnosed a mild neurologic syndrome of quadriparesis caused by a fall in 2012, causing central canal stenosis and scarring of the spinal cord. Dr Wright added that the injury of 2012 did not further damage her somatoform disorder, as the disorder was an already profoundly severe part of her health presentations intermittently over many years.

(b) At the review hearing on 27 March 2018, Dr Louie, GP, was reported as commenting that, following the respondent's accident in March 2012, she was unable to mobilise with weakness in both her upper and lower limbs and loss of sensation, and she had not had the smoothest recovery with ongoing stiffness and pain in her limbs, especially her legs and hands and ongoing neck pain.

(c) On 16 July 2018, Dr Kenedi, Liaison Psychiatrist and Internal Medicine Physician, in a file review, advised that the respondent had had an extraordinarily difficult life and that a consistent manifestation of the resultant distress had been abnormal illness behaviour. Dr Kenedi assessed that the respondent's alcohol abuse/dependence and factitious behaviour were not injury-related.

(d) On 8 August 2018, Dr Chancellor noted that the examination findings of Dr Wright argued in favour of a non-injury cause of the respondent's ongoing condition, because, if signs really were fluctuating, this was more in keeping with a somatoform/functional basis. Dr Chancellor advised that there remained signs which were inconsistent with injury effects and he saw no reason for changing his views. On 30 October 2018, Dr Chancellor added that signs of the respondent's remote cord injury did not mean that these signs were the cause of her disability.

(e) On 20 July 2021, Dr Blair, Radiologist, reported on an MRI conducted on the respondent's brain and cervical spine. Dr Blair observed scattered punctuate foci of T2, but noted no evidence of a central canal stenosis or cord compression, no intrinsic cord signal abnormality elsewhere, and, in particular, no evidence of a syrinx.

(f) On 31 January 2022, Dr Faulkner, Psychiatrist, reported, after an examination of the respondent, that she had two main current psychiatric disorders. First, there was undifferentiated Somatoform Disorder of which there were symptoms pre-dating the 2012 accident, as seen in her pseudoseizures from 1993, headaches, the stroke-like episode and

"blindness". Second, there was Alcohol Dependence Syndrome, the severity of which had been grossly underestimated by previous reports.

(g) On 10 June 2022, Dr Chancellor advised that there was no relationship between the brain abnormalities recorded in the recent MRI and the respondent's fall in 2012.

[61] In assessing the above evidence, this Court acknowledges the view of Dr Wright that the diagnosed neurologic syndrome of quadriparesis was caused by a fall in 2012. However, the Court notes that Dr Wright's report is couched in qualifying terms that the diagnosed quadriparesis was only mild, whereas the respondent's underlying somatoform disorder, which predated the cervical injury of 2012 and was non-injury related, was profoundly severe. Further, Dr Chancellor has noted that quadriparesis has many causes, including functional or somatoform conditions. This Court also acknowledges the report of Dr Louie, GP, who described the effects of the respondent's injury and the difficulties of her recovery. However, this Court notes that Dr Louie, as a GP, does not address the diagnostic nature and cause/s of the respondent's ongoing condition. This Court further acknowledges the ongoing evidence of scattered T2, but finds insufficient evidence of the causal link between this evidence and the respondent's ongoing conditions.

[62] Overall, this Court finds that the preponderant body of medical evidence continues to show, on a balance of probabilities, that the respondent's ongoing condition is not causally related to the injury for which she had received cover. This Court concludes that the Corporation's suspension of the respondent's entitlements is supported by sufficient evidence both at the time it was made and in the period since.

Conclusion

[63] For the above reasons, the appeal is allowed, and the review decision of 10 April 2018 is set aside.

[64] I make no order as to costs.

Suppression

[65] I consider it is necessary and appropriate to protect the privacy of the appellant. This order, made under s 160(1) of the Accident Compensation Act 2001, forbids publication of the name, address, occupation, or particulars likely to lead to the identification of the appellant. As a result, this proceeding shall henceforth be known as *FN v Accident Compensation Corporation*.

P R Spiller
District Court Judge

Solicitors for the Respondent: Medico Law Ltd.
Solicitors for the Respondent: John Miller Law.