IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 239 ACR 57/20

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

Hearing:	6 September 2022
Heard at:	Auckland/Tāmaki Makaurau
Appearances:	M Darke for the appellant J Sumner for the respondent
Judgment:	8 December 2022

RESERVED JUDGMENT OF JUDGE DL HENARE
[Suspension of Entitlements; s 117 Accident Compensation Act 2001]

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[1] The appellant, Rocky Hill, challenges a decision of the Corporation suspending his entitlements on his covered injuries.

[2] The suspension decision dated 9 May 2019 relevantly provided:

> After carefully assessing all medical information available, we're unable to continue with your entitlement. We've now suspended your entitlement to all entitlements, including treatment and weekly compensation.
>
> We're unable to continue providing you with this support as this medical information shows that your current condition is no longer the result of your personal injury of 10/05/2016. The medical report from Dr Brendon Coleman advised that your current diagnosis is of underlying arthritis in your acromioclavicular joint, made symptomatic from your accident in 2016.

> Dr Coleman's report also indicates that your covered injuries have resolved and are no longer the reason for your incapacity…

[3] This decision was upheld at review.

Agreed facts

[4] Mr Hill, previously employed as a truck driver, has cover for three separate accidents (separate claims), each leading to symptoms in his neck, lumbar spine and shoulders. In 2016, three claims were lodged for Mr Hill as follows:

- Accident on 26/04/2016, for left shoulder and upper arm sprain, neck sprain;
- Accident on 10/05/2016, for neck and lumbar sprain; and
- Accident on 16//07/2016, for right shoulder/upper arm sprain.

First Accident (April 2016)

[5] On 26 April 2016, Mr Hill fell while climbing down from his truck (the April accident). Three days later, he was assessed by Dr Ranchhod, General Practitioner who diagnosed a left shoulder/upper arm sprain and left neck sprain. The Corporation accepted cover.

Second Accident (May 2016)

[6] On 10 May 2016, Mr Hill was struck from behind by another vehicle while driving, and the impact jarred his lower back and neck (the May accident). The next day, he consulted Dr Ranchhod who diagnosed a left neck and left lumbar sprain, and lodged a claim with the Corporation. He also certified Mr Hill as unfit to work for seven days. The Corporation accepted cover.

[7] On 3 June 2016, an x-ray of the cervical spine showed multilevel disc and facet joint degeneration with foraminal narrowing (the June 2016 x-ray).

[8] On 8 July 2016, an ultrasound scan was taken of the left shoulder. Dr Allen, Radiologist, reported:

> Marked reduction in glenohumeral joint ROM following a capsular pattern. This may suggest adhesive capsulitis, plus sub deltoid bursitis with symptomatic impingement.
>
> No cuff tear found.

[9] An ultrasound guided injection was administered to Mr Hill's left shoulder on 21 July 2016 by Dr Allen.

[10] On 14 July 2016, the Corporation approved a funding request for acupuncture treatment.

Third Accident (July 2016)

[11] On 16 July 2016, Mr Hill injured his right shoulder lifting a bag of wood (the July accident). The Corporation approved cover for a right shoulder/upper arm sprain the following day.

[12] On 8 August 2016, an ultrasound was taken of the right shoulder. The scan showed moderate subdeltoid bursitis with symptomatic impingement and no cuff tear.

Request for additional diagnosis of shoulder pain from May 2016 accident

[13] On 22 July 2016, Dr Ranchhod lodged an ACC18 in respect of the May accident, which provided additional diagnoses of sprain of shoulder and upper arm (the side was not specified). On the same date, the Corporation advised it needed more time to consider this claim for additional diagnoses (left shoulder sprain).

[14] On 11 August 2016, an updated Return to Work report was completed by Ms Johnson who noted:

> Rocky sustained a second injury to his right shoulder affecting his ability to manage light duties and driving trucks. His left shoulder and back have made good progress. However he is unable to drive due to a subdeltoid bursitis in his right shoulder. His left shoulder remains weak and is progressing with strengthening.

[15] On 12 August 2016, Dr Lonergan, Branch Medical Advisor noted the lack of medical evidence on file, and that Mr Hill had presented to his GP multiple times following the May accident, but did not report a shoulder injury. The first mention of the shoulder problem was on 5 July 2016, two months after the first accident.

Dr Lonergan opined that there was evidence of degenerative changes in Mr Hill's neck, and these could not have been caused by the first accident. Dr Lonergan recommended a medical case review with an orthopaedic surgeon, to assess ongoing incapacity.

[16] On 22 August 2016, Dr Allen administered an ultrasound guided injection in the right shoulder. Dr Allen noted that Mr Hill had immediate improvement in symptoms, confirming the diagnosis of clinical bursitis and impingement. Dr Allen noted there were no clinical features of frozen shoulder or AC joint sprain.

[17] On 22 August 2016, the Corporation declined to cover a left shoulder and upper arm sprain claimed in relation to the May accident on the basis of insufficient medical information to support these injuries were caused by accident.

[18] On the same date, Dr Ranchhod certified Mr Hill as fit to return to normal duties and normal work hours. In response, the Corporation advised Mr Hill by letter of 22 August 2016 that it was unable to continue paying weekly compensation on the May accident claim, and that payments had been stopped.

[19] On 25 August 2016, an x-ray was taken of Mr Hill's left shoulder which showed "normal appearances at the glenohumeral joint with no osteoarthritis or subacromial spur".

[20] On 7 September 2016, Mr Hill was assessed by Ms Diskin, Physiotherapist who concluded it was possible Mr Hill had developed bilateral frozen shoulder.

[21] On 10 October 2016, Mr Ball, Orthopaedic Surgeon, assessed Mr Hill, and reported:

> ... Then on 10th May he was involved in a motor vehicle accident. I understand he was in a stationary vehicle which was struck from behind in a queue of traffic and this jarred primarily his neck and lower back and that was what the initial claim was for. **He tells me that the first injury that he had had to the left shoulder was gone by that point but he certainly injured the left shoulder again at the time of that motor vehicle accident and he feels that is when the primary problem in the left shoulder that he currently has started.**
>
> [Emphasis added]

[22] Mr Ball discussed the cervical spine and advised:

> A note from the plain x-rays from his cervical spine says he does have some altered level disc and facet joint degeneration with some foraminal narrowing but there didn't appear to be any objective neurologic symptom or deficit to suggest a radicular pattern and as mentioned his neck symptoms have all but resolved and probably aren't relevant in terms of his ongoing left shoulder issues and may well just be consistent with his age.

[23] In relation to the shoulder, Mr Ball noted:

> The examination today was certainly very difficult because the pain in his left shoulder seemed to be out of proportion to what one might expect.
>
> ... I am happy and convinced myself that he does not have adhesive capsulitis or frozen shoulder.
>
> …
>
> I am happy clinically, although it was difficult to examine him, that there is no frozen shoulder so at this stage the only working diagnosis is bursitis and impingement. As we know in this age group that really is truly traumatic in aetiology and I certainly wouldn't expect it given that he felt the primary mechanism of injury was the rear end accident in his motor car. If that was the case I certainly would have expected a much better response to the subacromial injection as well which often helps diagnostically in such patients.
>
> …
>
> Clearly the client reports three separate accidents this year; two primarily involving the left shoulder and one on the right and he continues to complain of persistent left shoulder symptoms that have meant he has been unable to return to his normal work. As outlined above it is not entirely clear to me what specific injury or condition is caused by this event because to date he has had basically normal plain x-rays and ultrasound that simply showed some mild bursitis and impingement. This did not improve to any significant extent following a subacromial injection and certainly the signs and symptoms on talking to him today are significantly out of proportion to what I would normally expect with an impingement problem. In fact his symptoms and signs don't really fit with any specific shoulder pathology.
>
> Certainly the only relationship I can determine with the original accident event is a temporal one in that he had onset of symptoms around that time but apart from symptom onset to date I was unable to determine any specific pathology that had been caused by that original accident event.

[24] Mr Ball considered it possible Mr Hill had developed a regional pain syndrome.

[25] On 1 November 2016, Mr Hill was reviewed by Mr Heiss-Dunlop, Orthopaedic Surgeon who diagnosed left shoulder post-traumatic adhesive capsulitis. Mr Heiss-Dunlop reported Mr Hill also had early calcifications in his left shoulder supraspinatus

and prominent AC joint arthrosis, and that he would obtain copies of the reports from Mr Ball.

[26] On 10 November 2016, Mr Ball provided further comment following receipt of a CT scan. Mr Ball noted the scan showed a small degree of degenerative change. He noted the radiologist suspected adhesive capsulitis, but in his view there was no significant frozen shoulder element.

[27] On 16 November 2016, Mr Hill's employer advised him that it had terminated his employment, because there were no appropriate light duty roles or alternative positions available.

[28] On 7 December 2016, Mr Hill received a fluoroscopic guided injection to his left glenohumeral joint. His pain score decreased from 9/10 to 0/10 within 20 minutes of the procedure.

First Suspension Decision

[29] On 13 December 2016, the Corporation suspended Mr Hill's entitlements on the May accident claim and issued similar decisions on the other two claims. The Corporation enclosed a copy of Mr Ball's report who opined that the evidence did not support a causal relationship between Mr Hill's current condition and the May accident, or any of the covered accident events. Mr Hill applied for a review of this decision.

[30] On 20 December 2016, Mr Heiss-Dunlop diagnosed left shoulder post traumatic stiffness and recommended Mr Hill obtain an opinion from a third orthopaedic specialist.

Suspension Decision Revoked

[31] The Corporation revoked the suspension decision against the May accident in Mr Hill's favour on 13 January 2017 and agreed to investigate the matter further.

[32] On 1 February 2017, Mr Hill was reviewed by Mr Caughey, Shoulder Surgeon who concluded the main pathology supported a frozen shoulder. However, he

considered Mr Hill's symptoms were not typical of this condition, and he raised the possibility of a regional pain syndrome. Mr Hill had mentioned he was "prediabetic". Mr Caughey noted that "diabetics" were five times more likely to suffer from frozen shoulder. Mr Caughey sought clarification from Mr Hill's GP regarding the pre-diabetic condition.

[33] On 14 February 2017, Mr Caughey responded to a letter from Dr Ranchhod that advised Mr Hill took Metformin hydrochloride which controlled his blood sugar. Mr Caughey commented it was a difficult question to determine what part trauma may have played in the cause of the frozen shoulder. He concluded on balance:

> [While] the traumatic episodes may have played some part in the initiation of his frozen shoulder his diabetes is likely to be a more important factor in the causation of his frozen shoulder.

[34] On 20 March 2017, Mr Insull, Orthopaedic Spine Surgeon, undertook a medical case review of Mr Hill's claim. In relation to Mr Hill's left shoulder, Mr Insull diagnosed:

> Probable bilateral subacromial bursitis with transient complete relief of left lateral acromial pain with ultrasound guided subacromial local/steroid injection 21/7/16;
>
> Range of passive motion not in keeping with frozen shoulder on either side currently; and
>
> Potential left C6 radiculopathy.

[35] In relation to each accident, Mr Insull noted:

> The mechanism of the April Accident suggested a shoulder sprain injury, rather than a more significant injury.
>
> The May Accident is likely to have caused an injury to the cervical spine, which could include a whiplash injury or even cervical disc herniation. An MRI would help evaluate this further. It was possible that the appellant sustained a left shoulder injury in this accident.
>
> It was possible that the July Accident caused a sprain injury to the appellant's right shoulder, and that this could have led to an "activation of a subacromial bursitis or a rapid thawing frozen shoulder. "

[36] In relation to Mr Hill's neck pain, Mr Insull concluded "a single jolt to the neck is unlikely to be responsible for the extensive multilevel degenerative changes seen on the MRI." Mr Insull concluded the May Accident seemed to be the cause of the

substantial portion of Mr Hill's symptoms. Mr Insull agreed with Mr Ball that the pathology did not demonstrate frozen shoulder.

[37] On 3 July 2017, Dr Callaghan, Regional Clinical Leader for the Corporation, reviewed Mr Hill's claims. She opined the clinical evidence in its entirety indicated "it was not more probable" that the bursitis was caused by the accident events. She agreed with Dr Caughey's advice that in order for frozen shoulder to be of traumatic cause, the pathology or physical damage needed to be substantial. She further noted that Mr Ball and Mr Insull had found there was movement with distraction, meaning the diagnostic requirements for frozen shoulder had not been fulfilled.

[38] On 20 July 2017, Dr Davis, Radiologist, provided interpretations on an MRI taken of the left shoulder:

> There are imaging features suspicious for adhesive capsulitis.
>
> Moderate to severe arthrosis of the acromioclavicular joint.
>
> Mild tendinosis of subscapularis, supraspinatus, infraspinatus and long head of biceps tendon and a tiny low-grade partial-thickness interstitial tear of infraspinatus. No high-grade rotator cuff tendon tear.
>
> Tiny paralabral cyst adjacent to anteroinferior labrum would imply the presence of a poorly resolved/nonvisualised undisplaced labral tear.

[39] On 8 August 2017, Mr Heiss-Dunlop reviewed Mr Hill again and reported:

> Rocky returned following the MRI scan of his left shoulder. This revealed signs consistent with left frozen shoulder which is also consistent with his clinical examination. Rocky has had a steroid injection last year and I think that he would probably benefit from a further injection. If that does not work then surgery in the form of an arthroscopic shoulder joint release may be indicated. The MRI scan otherwise reveals moderate to severe arthrosis of the AC joint which does not appear to be symptomatic and some tendinosis in most of his rotator cuff components but no rotator cuff tears.
>
> It is quite possible that Rocky may require surgical intervention if his symptoms do not settle. I am aware that ACC is looking at his entitlements and fear that an ARTP will be declined. For that reason, I think he should be referred to the public system at Middlemore Hospital.

Second Suspension Decision

[40] On 9 August 2017, the Corporation suspended Mr Hill's entitlements on the April accident. The Corporation considered the medical information showed that his

incapacity was due to an underlying medical condition; diabetes and widespread degenerative pathology.

[41] On 9 August 2017, the Corporation also suspended Mr Hill's entitlements on the May accident. The Corporation considered Mr Hill's current condition was no longer due to the covered injuries of 10 May 2016, rather that he had ongoing incapacity due to widespread degenerative pathology.

[42] On 13 September 2017, Mr Hill applied for a review of the 9 August 2017 decision.

[43] On 18 September 2017, Dr Callaghan provided further comment and noted the "issues" in her earlier advice still remained. She recommended that further comment be obtained from Mr Heiss-Dunlop.

[44] On 25 October 2017, Mr Heiss-Dunlops's assistant advised that he had no further comment.

First Review

[45] On 6 March 2018, the review was adjourned part heard by Rachael Knight, Reviewer, on the basis that Mr Hill was to file further information including diabetic test results.

[46] On 23 April 2019, the Reviewer issued a decision quashing both 9 August 2017 decisions. The Reviewer directed the Corporation to obtain a comprehensive assessment by an independent specialist, such as an orthopaedic surgeon.

Further Investigation

[47] On 11 February 2019, Mr Hill was reviewed by Mr Coleman, Orthopaedic Surgeon, at the request of the Corporation. Mr Coleman diagnosed AC joint pain, ongoing from the original injury. He opined the frozen shoulder was clinically resolved, and Mr Hill had a "near full passive range of motion, limited only by pain". Mr Coleman commented:

> Mr Hill has had a fall from a truck, supporting his entire bodyweight through his left shoulder girdle and then landing heavily on the ground. This occurred almost 3 years ago. He has had severe pain since that time. There has been some debate regarding the diagnosis of frozen shoulder, as although his imaging has stated initially there did not appear to be any clinical findings supporting this, although 2 subsequent surgeons have stated that this is a primary cause of his pathology in their opinion. **Clinically today, he has some mild stiffness but passively does have quite a good range of motion and is only limited by pain. It is my opinion that the majority of his pain is likely to be coming from his AC joint.**
>
> …
>
> It is my opinion that he sustained an AC joint injury as a result of a wrenching injury to his left shoulder girdle. This has caused him significant pain and he is likely to have gone on to secondary frozen shoulder, due to the degree of pain in his shoulder and immobility that this caused. I do not have all the information pertaining to his diabetes situation but he tells me that he only has borderline diabetes and his blood test was normal and his blood sugars normally run at 4-6, despite him not taking his metformin, which would indicate that his diabetes, if present at all, is not severe.
>
> Mr Hill has underlying arthritis of his AC joint. As a result of supporting his entire bodyweight through his shoulder girdle as he fell, and wrenching his shoulder, he has caused an injury to his AC joint which is, in part, likely to represent a new sprain injury, given the force of his entire bodyweight, but is also likely to represent, in part, an aggravation of his underlying arthritis. Having your arm wrenched above you, causing compression over the AC joint, whilst supporting your bodyweight, would result in injury to both the AC joint ligaments, the fibrocartilaginous disc within the joint, and the joint surface all of which will contribute to his ongoing pain. His frozen shoulder is likely a secondary problem, due to the severe pain and immobility that he was experiencing, rather than as a direct result of the trauma.
>
> [Emphasis added]

[48] On 3 May 2019, Dr Austen, Clinical Advice Manager, reported on behalf of the Clinical Advisory Panel (CAP) following a meeting on 26 March 2019. Dr Austen reported:

> Dr Coleman [sic] has opined that the client sustained an injury to his AC joint from the original injury. The Panel noted that this conclusion is not supported by any contemporaneous clinical records nor by the intervening examinations by other clinicians for either of the 2016 injuries. In the Panel's view a causal link between the client's injuries in 2016, including the wrenching injury, and the painful irritable AC joint cannot be established and is very unlikely.
>
> Dr Coleman acknowledges that the client has pre-existing asymptomatic AC joint arthritis. There is no objective contemporaneous evidence of any significant injury to the AC joint and it is much more likely that the AC joint problem that is irritable and symptomatic is based on arthritis and not trauma.

[49] On 9 May 2019, the Corporation, having reviewed Mr Coleman and Dr Austen's reports, issued the suspension decision.

[50] On 11 May 2019, Mr Hill filed a review application.

Second review

[51] On 11 October 2019, the review was heard before Mr Munro, Reviewer who, by decision dated 8 November 2019, dismissed the application. In reaching his decision, Mr Munro preferred the evidence of the Panel over that of Mr Coleman.

Further comment of Mr Coleman

[52] On 9 September 2020, Mr Coleman provided further comment and opined:

[i] Mr Hill had pre-existing AC joint arthritis and the injury he sustained caused a sprain to the AC joint as well as aggravating his underlying arthritis.

[ii] Sprains of the AC joint typically resolve by three months but there are occasional patients who have ongoing pain.

[iii] AC joint arthritis and injuries do not directly cause frozen shoulder.

[iv] In Mr Hill’s case, the severe pain he experienced resulted in lack of use and the development of secondary frozen shoulder. He did not believe an AC joint injury directly causes frozen shoulder.

[v] As there was only a CT scan of the shoulder performed after his injury, a sprain injury to the AC joint cannot be confirmed or excluded as there was only imaging of the AC joint ligaments.

[vi] Mr Hill sprained his AC joint but his long term pain is due to AC joint arthritis. The arthritis is pre-existing and has been rendered symptomatic from the sprain injury.

[vii] Mr Hill's frozen shoulder is due to his significant pain and possibly his altered blood sugar metabolism.

[53] In a further email dated 15 September 2020, Mr Coleman opined:

[i] The sprain element of the injury should have resolved more than three years after the injury and the arthritis was pre-existing so it is not likely to still be causally linked.

[ii] If the AC joint injection was not effective, it would mean there is an element of functional overlay as all injections have been ineffective.

The 2021 Clinical Advisory Panel report

[54] On 20 January 2021, the CAP commented:

[i] At the time of the decision suspending entitlements in respect of his left shoulder and neck injuries, the CAP acknowledged that Mr Hill may have had a reduced range of left shoulder motion and left shoulder stiffness; however, there was no convincing medical evidence of a frozen left shoulder.

[ii] Whilst Mr Hill had a limited range of active left shoulder motion, the medical evidence did not support the impression of a frozen shoulder, despite some suggestive features on the imaging. It seems unlikely that Mr Hill's chronic and diffuse left shoulder pain can be explained by the frozen shoulder hypothesis.

[iii] Mr Hill's diabetes would have been a predominant contributor to his shoulder stiffness, even if it was mild, well-controlled and even with normal blood tests.

[iv] Mr Hill's neck and shoulder sprains have most certainly resolved.

[v] The theory that the Accident(s) caused an injury to the AC joint, including to the ligaments and the fibrocartilaginous disc was speculative at best. There is no evidence of any acute AC joint injury.

[vi] The April Accident and the May Accident may have transiently triggered pain symptoms, but a causal link between his currently reported chronic pain and any covered physical injury or diagnosis has not been established.

[vii] The proposed AC joint injection is not related to any covered injury but rather, it is related to Mr Hill's chronic degenerative AC joint arthrosis.

[viii] The non-physical pain features noted in the specialist reports are likely to be a significant factor in Mr Hill's presentation and ongoing symptoms. These are not related to any covered injury, but rather they are related to chronic degenerative problems.

[ix] The recommendations for a pain physician review and management are likely a good option but they are not related to any covered injury.

The parties' positions

[55] Mr Darke submits:

- The decision dated 9 May 2019 suspending Mr Hill's entitlements and the Review Decision are incorrect and should be quashed.

- There has been no clear agreement between the specialists as to the diagnosis or causation of the ongoing problems.

- The cases of (*Ratnam* (286/04), *Lye* (7/07) and *Hanmore* (145/09) support the proposition that a person is entitled to receive the entitlement if the effects of the injury are "causative, even contributorily causative" of the existing incapacitating condition.

- The Corporation has not established, on the balance of probabilities, Mr Hill no longer has a right to entitlements under the Act. It has not been

established there was no causal link between his ongoing problems and the 2016 accidents.

- The Corporation's decision ought to be quashed and Mr Hill's entitlements arising from the 2016 accidents restored.

[56] Mr Sumner submits:

- The decision dated 9 May 2019 suspending Mr Hill's entitlements and the review decision are correct and should be upheld on appeal.

- The focus of the enquiry under s 117 of the Accident Compensation Act 2001 is determining whether the evidence is sufficiently clear for the Corporation to be not satisfied Mr Hill is entitled to continue to receive entitlements in respect of his covered personal injuries.

- As of 9 May 2019, the evidence was sufficiently clear Mr Hill was no longer entitled to continue receiving weekly compensation and treatment for his covered sprains arising from the 2016 accidents.

- There is insufficient evidence before the Court to establish a causal relationship between Mr Hill's ongoing symptoms and the covered personal injuries arising from the 2016 accidents. There is clear evidence and no uncertainty that as at the date of the decision, Mr Hill's ongoing incapacity and symptoms were caused by his left shoulder joint arthrosis which developed gradually over time and became symptomatic following the 2016 accidents.

The Corporation's power to suspend entitlements

[57] In *Collins*,[1] Judge Walker addressed the key issue of causation, citing the High Court that:

> [106] The central element which these proceedings relate to is a question of causation. There requires be a nexus between the personal injury by accident and the claimant's entitlement to cover.

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[1] *Collins v Accident Compensation Corporation* [2016] NZACC 93.

This is stated succinctly in the decision of Priestley J in *Wakenshaw v ACC* [2003] NZAR 590 (HC) where he states:

> It is trite law that there must be a nexus between personal injury by accident and a claimant's condition or situation before there is an entitlement to cover. That elementary requirement is central to the scheme of the Act and importantly is the underlying principle of the Act.

[58] In *Popoalii*,[2] the Court discussed *Ellwood*,[3] stating:

> [24] As a result, 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 Mr Popoalii 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.
>
> [25] With regard to what is required for the Corporation to be satisfied as to whether a claimant remains entitled to an entitlement, the starting point is clearly s 67 of the Act...
>
> [26] As a result, the correct approach in determining whether a claimant is no longer entitled to an entitlement or entitlements is to consider whether the two components of s 67 continue to be satisfied. In other words, entitlements can only be suspended under s 117(l) if either of the two requirements in s 67 are not, or are no longer, met.
>
> [27] With regard to the requirement under s 67(a) this is most often manifested when the covered injury is recorded as a sprain or a strain and the entitlement sought is for a more specific injury such as a rotator cuff tear or lumbar disc prolapse. In such situations, a causal inquiry is necessary to determine whether the tear or prolapse was indeed related to the injury for which cover was granted or whether the injury for which the entitlement is required occurred independently of the covered injury. Likewise, it is well established that a claimant cannot rely upon a non-covered injury to support a claim for entitlements, and in the absence of cover no entitlements can therefore flow.
>
> [281 In contrast where there is no dispute over the extent of cover the question becomes whether the claimant is still eligible for a particular entitlement or entitlements pursuant to s 67(b). If the covered injury has resolved the claimant will for example no longer be eligible for weekly compensation as he or she is “no longer unable, because of his or her personal injury, to engage in employment in which he or she was employed when he or she suffered the personal injury” pursuant to s 103(2) of the Act.

Agreed Issues

[59] The issues for determination are:

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2 *Popoalii v Accident Compensation Corporation* [2018] NZACC 123.

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

[i] Whether the Corporation had a sufficient basis to suspend entitlements as at the date the decision was made; and

[ii] Whether the Corporation had a sufficient basis to suspend entitlements on the basis of all the evidence before the Court.

Issue One: Whether the Corporation had a sufficient basis to suspend entitlements at the date the decision was made

Discussion

[60] The Court acknowledges that Mr Hill has experienced ongoing symptoms since his accidents. The issue is squarely causation whether the current symptoms are causally linked to the covered sprains. The question is whether Mr Hill's ongoing symptoms are causally linked to his covered sprains.

[61] As the agreed statement of facts in this judgment shows, specialists have grappled both with diagnosis and causation. At the date of suspension, the Corporation had a welter of medical opinion, imaging reports, Mr Coleman's medical case review and a CAP report prepared by Dr Austen. A relevant consideration is the conclusion reached by Reviewer Knight and her direction for an independent orthopaedic opinion which led to Mr Coleman's report. It is therefore reasonable for this report to be relied on by the Corporation.

[62] I agree with Reviewer Munro that the opinion of CAP is well reasoned and thorough, finding the covered sprain injuries resolved and addressing all points raised by Mr Coleman including his opinion that AC joint arthritis was pre-existing. CAP explained why there was no injury to the AC joint having regard to the contemporaneous evidence and the irritable and symptomatic joint problem due to arthritis and not trauma. Relevantly, the covered sprain injuries had resolved and there is no suggestion they are cause for the ongoing symptoms and incapacity.

[63] A further relevant consideration is the investigation leading to postulated diagnoses of non-accident related pathology as cause for the ongoing symptoms and incapacity.

[64] I turn to discuss these potential diagnoses and causation.

a) Shoulder sprain

[65] In April 2016, Dr Ranchhod reported a left shoulder, upper arm and neck sprain from the April accident. The report for the May accident did not include a diagnosis for the shoulder. However, in June 2016, Dr Ranchhod requested an additional diagnosis of sprain of shoulder and upper arm (unspecified side) in relation to the May accident. This was declined on the basis of insufficient medical information. Dr Lonergan also highlighted the shoulder injury was first noted two months after the May accident. However, Mr Insull, opined it is possible the May 2016 accident caused a sprain injury to Mr Hill's left shoulder which could lead to activation or a sub-acromial bursitis or a rapidly thawing frozen shoulder. Despite this, he concluded Mr Hill did not demonstrate a frozen shoulder. Dr Austen stated that Mr Hill's ongoing signs, symptoms and incapacity are not consistent with a sprain. Further, Mr Coleman and Dr Austen opined that the sprain element was not likely to still be causally linked three years after the accident.

[66] Mr Darke submits that a sprain from the April accident would not have healed with Mr Hill continuing to work 50 hours a week despite his injuries. While this argument has some force, the Court observes Mr Hill reported that his shoulder had fully healed before the May accident, so the April sprain is unlikely to be causing ongoing pain. Mr Hill also said he felt his shoulder was aggravated in the May accident. However, there is no medical information noting this situation.

[67] CAP recorded that sprains are likely to resolve within a few weeks, up to three months, with no long-term ongoing problems, symptoms or difficulties. This is consistent with the fact that in August 2016, Dr Ranchhod certified Mr Hill as fit to return to normal duties and work hours. This shows that ongoing symptoms in 2019 were not likely to be caused by the covered sprain injury. In my view, the Corporation could be satisfied that the April sprain injury was no longer causative of ongoing symptoms and the May injury was also not causative.

b) AC joint sprain

[68] Mr Coleman's February 2019 report concludes Mr Hill suffered a sprain to his AC joint in the initial April injury, which represented a new sprain injury in part caused by the force of his bodyweight and in part an aggravation of the underlying arthritis. After the Corporation's decision, Mr Coleman clarified this was not a major injury "as there has been no disruption of the joint resulting in subluxation". This diagnosis is slightly different to Dr Ranchhod's initial report of a left shoulder, upper arm and neck sprain. However, there is no contemporaneous evidence of the AC joint being the subject of a sprain. Mr Coleman commented that only a CT scan of the shoulder was done at the time of the accident and it would not have shown any injury to the AC joint. There is no imaging of the AC joint ligaments or capsule. Despite this, it is difficult to ignore the contemporaneous reports and examinations.

[69] In August 2016, the AC joint was specifically reported on by Dr Allen who states that a static and dynamic examination of the AC joint (among other parts of the shoulder) was performed with the finding “the acromio clavicular joint appears normal”. Dr Austen also highlighted that an AC joint sprain would result in immediate pain. This did not fit with the circumstances of Mr Hill continuing to work the remainder of his shift after the April accident and he continued to work in the weeks following. For these reasons, I prefer the reporting of Dr Allen and Dr Austen.

[70] Even if the original injury was an AC joint sprain, CAP recorded that sprains are likely to resolve within a few weeks, up to three months, with no long-term ongoing problems, symptoms or difficulties. It follows the Corporation could be satisfied that the ongoing symptoms were not directly caused by an AC joint sprain.

c) AC joint arthrosis

[71] There is substantial agreement that Mr Hill had pre-existing AC joint arthritis. Mr Coleman opined the April injury would also have aggravated his underlying arthritis. After the Corporation’s decision, Mr Coleman clarified his stance saying that “Rocky sprained his AC joint but his long-term pain is due to his AC joint arthritis. This is pre-existing and has been rendered symptomatic from the injury due to the sprain injury”.

[72] Arthritis was discussed by various experts. Dr Ball recorded that the CT scan showed a small degree of degenerative change around the AC joint. Mr Heiss-Dunlop reported early calcifications and prominent AC joint arthrosis. Dr Davis commented there was moderate to severe arthrosis of the AC joint. Dr Austen opined the ongoing symptoms were consistent with pre-existing AC joint arthritis. He thought the arthritis had become symptomatic three years after the 2016 injuries.

[73] In my view, the evidence does not definitively show that arthritis is the main contributor to Mr Hill's present symptoms and incapacity. However, if the pain is from the AC joint, as Mr Coleman suggested, the Corporation could be satisfied that the pain was likely caused by the arthritis around the AC joint rather than due to any other possible explanation.

d) Frozen shoulder

[74] Specialists disagreed whether Mr Hill does or does not have frozen shoulder. Dr Allen took an ultrasound of the left shoulder which had features suggesting frozen shoulder. Ms Diskin, Physiotherapist concluded it was possible Mr Hill had developed bilateral frozen shoulder. Mr Ball concluded that Mr Hill did not have frozen shoulder. Mr Heiss-Dunlop diagnosed left shoulder post-traumatic adhesive capsulitis. In December 2016, Mr Hill received a fluoroscopic guided injection to his left glenohumeral joint for adhesive capsulitis post trauma (frozen shoulder). His pain score decreased within 20 minutes of the procedure, supporting the opinion Mr Hill was suffering from frozen shoulder.

[75] In February 2017, Dr Caughey opined that Mr Hill did have a frozen shoulder. Mr Insull opined that Mr Hill did not demonstrate a frozen shoulder and said it is possible the May 2016 accident caused a local/sprain injury to Mr Hill's left shoulder which could lead to a rapidly thawing frozen shoulder. In July 2017, Dr Callaghan opined it was unlikely that Mr Hill had frozen shoulder.

[76] It is noteworthy that in 2018, Rachel Knight determined she could not be satisfied on the medical evidence before her that Mr Hill was no longer entitled to his entitlements. Therefore, she directed a further report to be provided to resolve uncertainties, particularly in relation to frozen shoulder. Mr Coleman opined that

frozen shoulder was a secondary problem due to the severe pain and immobility that he was experiencing. Dr Austen opined that the most likely explanation was left shoulder stiffness/frozen shoulder caused by abnormal sugar metabolism or diabetes.

[77] The Court observes a diagnosis is difficult as frozen shoulder is characterised by clinically restricted active and passive shoulder motion. Dr Ball noted his examination was difficult because there was a lot of voluntary guarding with attempts to move and test certain functions of the shoulder. Despite this, he was satisfied Mr Hill was not suffering from frozen shoulder. It is telling Mr Hill received at least two glenohumeral joint injections and hydrodilations which CAP stated are designed to provide relief from frozen shoulders. This treatment did not provide long term relief.

[78] While a diagnosis is uncertain, the real issue here is whether the frozen shoulder symptoms are linked to the covered sprains.

[79] Mr Hill highlights that he is pre-diabetic and takes metformin hydrochloride which regulates his blood sugar. Mr Heiss-Dunlop and other experts commented that patients with diabetes are five times more likely to suffer from frozen shoulder. Dr Caughey in 2017 opined that diabetes was likely to be a more important factor than traumatic episodes.

[80] Regardless of the diagnosis and/or the cause of any frozen shoulder symptoms, Mr Coleman opined that the frozen shoulder had resolved and was not causative of the ongoing incapacities. Frozen shoulder symptoms tend to resolve in up to three years. In my view, taking into account this aspect of Mr Coleman's opinion, the Corporation was able to be satisfied that Mr Hill's ongoing symptoms were not caused by frozen shoulder.

e) Other potential diagnoses

[81] The experts also postulated a range of other potential explanations for the symptoms. However, the main inquiry is not whether these are the correct diagnosis for Mr Hill’s ongoing symptoms, but instead, whether they demonstrate a causal link to the original covered injuries.

[82] *Acute injury to the AC joint fibrocartilage disc, ligaments and/or cartilage:* Mr Coleman opined the April wrenching injury would result in these injuries, all of which contribute to his ongoing pain. This brought to light a dispute whether these parts would have been injured prior to 2016, due to arthritis. Dr Austen concluded "the presence of pre-existing AC joint arthritis, almost certainly means that the ligaments, the fibrocartilaginous disc and the articular cartilage joint surface were all 'damaged' prior to the wrenching injury because of disease, not injury, and that this damage is much more likely to be symptomatic now based on degenerative AC joint disease". After the decision, Mr Coleman clarified he agreed that arthritis causes damage to the fibrocartilage disc and the articular cartilage and he does not agree arthritis means there is a pre-existing ligamentous pathology.

[83] The main inquiry is whether the symptoms in the fibrocartilage disc, ligaments and/or joint surface are causally linked to the covered accidents. Dr Austen highlighted there was no evidence of acute injuries at the time of the accidents. In the absence of contemporaneous evidence, the diagnosis is speculative as there is no available evidence to support it.

[84] *Impingement/bursitis*: Mr Insull commented the May accident could have caused a left shoulder sprain which activated Mr Hill's subacromial bursitis. Again, this is speculation rather than an opinion based on fact. The Corporation highlights that this was a gradual process which progressed over time. Neither Mr Coleman nor Dr Austen in 2019 thought this was the cause of ongoing symptoms. The Corporation could be satisfied that, if Mr Hill was suffering impingement/bursitis, the ongoing symptoms were not linked to it.

[85] *Chronic/regional pain condition*: In 2016, Mr Ball and Mr Heiss-Dunlop suggested the lack of explanation for Mr Hill's symptoms suggested they were caused by a chronic pain condition. Mr Darke submitted the onus was on the Corporation to obtain sufficient evidence to show that Mr Hill was not entitled to cover, and this possibility was not investigated thoroughly. In his report prior to suspension, Mr Coleman opined the "majority of his pain is likely to be coming from his AC joint." He thought a cortisone injection into the joint would be beneficial and then only if no response, then management through a pain team setting.

[86] In my view, the evidence shows that the pain symptoms were not due to the covered injuries as at the date of suspension. Rather, in the main, it was thought to emanate from the AC joint where Mr Coleman acknowledged there was pre-existing arthritis. CAP explained the AC joint arthritis means that the ligaments, the disc and cartilage were all "damaged" prior to the wrenching injury because of disease, not injury, with damage symptomatic based on degenerative AC joint disease. The important point is as at the date of suspension there was no basis to investigate a pain condition caused by the covered sprain injuries.

Conclusion

[87] Mr Darke submitted the legal test for suspension carries a high threshold. In *Ellwood* terms if the evidence is uncertain, the Corporation has not satisfied the legal test to suspend entitlements.

[88] Having reviewed the evidence carefully, I find there was sufficient evidence for the Corporation to conclude that the covered sprain injuries resolved. Against this evidence, it would be unreasonable to expect the Corporation to continue seeking reports to investigate all potential including speculative diagnoses.

[89] The Court agrees with Reviewer Munro's assessment of the evidence from Mr Coleman and CAP that the covered sprains had long resolved. Specifically, Dr Austen noted the ongoing signs, symptoms and incapacity are not consistent with sprain pathology. Rather they were consistent with non-accident-related pathology.

[90] The Court finds the weight of the evidence as at the date of suspension conclusive that the Corporation had a sufficient basis to be not satisfied that Mr Hill was entitled to continue to receive entitlements for his covered injuries.

Issue Two – Whether the Corporation had a sufficient basis to suspend entitlements on the basis of all the evidence before the Court

[91] After the Corporation's decision, the following documents were provided:

[i] Mr Coleman's clarification emails dated 9 September 2020 and 15 September 2020; and

[ii] The CAP report dated 12 January 2021.

[92] Mr Hill did not provide any new evidence.

[93] In my view, Mr Coleman's clarification emails do not establish a causal relationship between the ongoing symptoms and the covered personal injuries. Instead, they point away from a causal connection. He states:

[i] AC joint arthritis and injuries do not directly cause frozen shoulder but he believes the pain resulted in him developing a secondary frozen shoulder.

[ii] The frozen shoulder is due to his significant pain and possibly his altered blood sugar metabolism.

[iii] In his opinion, AC joint arthritis does not mean there is pre-existing ligamentous pathology. However, he does agree that the fibrocartilage disc and articular cartilage are damaged in arthritis.

[iv] Mr Hill sprained his AC joint but his long term pain is due to his AC joint arthritis. The arthritis is pre-existing and rendered symptomatic from the sprain injury.

[v] He confirms that "in general this is not substantially different from ACC's clinical advisory panel".

[vi] The sprain element of the injury should have resolved more than three years after the injury.

[94] The CAP report does not establish a causal link between any of the symptoms and the covered personal injuries. It negates a causal link for every possible diagnosis:

[i] Shoulder and neck sprains – these have "most certainly" resolved. They are clinically expected to resolve within a few weeks, up to three months, with no long-term ongoing problems, symptoms or difficulties.

[ii] Frozen shoulder – this was unlikely there was one as no convincing medical evidence, but if so, it was likely non-traumatic and secondary to

diabetes. The likelihood of developing a frozen shoulder is five times more likely if there is abnormal sugar metabolism as it causes abnormal collagen repair and neovascularisation. This occurs even if the blood tests are normal. Secondary traumatic frozen shoulders occur with shoulder dislocations or fractures to the upper end of the humerus. Mr Hill had not had such an injury. Regardless, any frozen shoulder has resolved.

[iii] AC joint arthrosis – this was rendered symptomatic from the accident. Imaging was consistent with long-term, gradual onset arthrosis changes. While Mr Darke submits that this does not mean automatic disqualification from cover, there is no further evidence to show causation.

[iv] AC joint injury (including ligament, fibrocartilage capsule/cartilage injury) – no contemporaneous medical evidence. The AC joint is sturdy and the mechanisms of the April and May accidents did not have enough force to injure the AC joint. If there was an injury, it would have resulted in immediate pain and or swelling, bruising and damage to the surrounding structures. This did not occur. Mr Darke highlights that Mr Coleman saw and assessed Mr Hill. However, I find his later opinions more akin to speculation three years after the accident events.

[v] Shoulder impingement, tendinosis, bursitis – the imaging is consistent with a chronic left shoulder impingement process not related to the accidents. The accidents were not causative, rather the pathology likely made symptomatic from the accident. Mr Darke argues there is no basis for the conclusion of no causal link. There is no evidence on this point showing that there is a causal link.

[vi] Multi-level degenerative changes of the cervical spine – this is a common age-related feature and is the natural process of deterioration. There is no proof of a causal link. It is not related to single traumatic events. Mr Darke submits that the report does not say whether it was excessive or not for a man of his age. However, again, Mr Hill has not provided any evidence. He simply wishes to cast doubt on the report.

[vii] Left C6 radiculopathy/ Acute cervical disk prolapse – the immediate symptoms do not support this diagnosis and the mechanism of the accidents do not support this. Mr Hill did not report numbness or tingling along the arm and fingers. Cervical degenerative disc disease has complex, multifactorial causes, influenced mainly by mechanical and genetic factors. The imaging shows issues not causally related to trauma.

[viii] Chronic pain – Mr Hill does not meet the criteria. There is also no evidence linking this to the trauma. Mr Darke says this is a wide- ranging generalisation but provides no evidence that Mr Hill's chronic condition is causally linked to his covered injuries.

[95] As a result, when the suspension decision is considered in the light of all evidence before the Court, it is clear the situation remains as it did at the date of suspension.

Decision

[96] The Court concludes the Corporation's decision to suspend entitlements is correct.

[97] The appeal is dismissed. There is no issue as to costs.

Judge Denese Henare
District Court Judge

Solicitors: Ford Sumner, Wellington, for the respondent