IN THE DISTRICT COURT
AT WELLINGTON

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

[2023] NZACC 85 ACR 193/20

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

Hearing: 5 April 2023

Heard at: Christchurch/Ōtautahi

Appearances: Mr I Stryder, Advocate for the Appellant
Mr I Hunt for the Respondent

Judgment: 24 May 2023

JUDGMENT OF JUDGE C J MCGUIRE
[Personal Injury s 20 Accident compensation Act 2001]

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[1] This appeal concerns two decision dated 18 April 2019.

[2] In the first of those decisions, the respondent declined funding for surgery to treat the appellant's "sacroiliac joint pathology".

[3] In the second decision, the respondent declined to approve cover for "sacroiliac joint pathology".

Background

[4] The appellant is presently aged 49. She suffered an accident on 13 June 2012, which is described in the ACC claim form as: "I was lifting the topiaries at work and injured my back".

[5] The claim for cover for lumbar sprain and sacroiliac ligament sprain was filed by the Papanui Medical Centre on 4 July 2012.

[6] Both of her injuries were recorded as affecting the left side. ACC approved cover for these injuries.

[7] Following an acute exacerbation on 12 August 2012, she underwent an MRI scan on 12 August 2012. The findings noted:

> Several small haemangiomas were noted involving the bodies of L1, L2 and L4.
>
> Modic type 1 changes are noted at the vertebral end plates of L5/S1.
>
> Variable, minor degrees of disc dehydration are noted involving the L2/3, L3/4, L4/5 and L5/S1 disc spaces. There is no significant loss of disc height.
>
> No disc herniations have been identified. There is minor focal disc protrusion noted at the L4/5 and L5/S1 levels towards the left.
>
> No neural foraminal encroachment identified. No central canal stenosis identified.
>
> The cord substance appears normal.
>
> **Comment:** No evidence of any significant disc herniation, neural foraminal stenosis or central canal stenosis.

[8] The Branch Medical Advisor (Orthopaedic), Mr Taime, provided a report on 25 September 2012. Mr Taime noted:

> Multiple past claims for back strains since 2000.
>
> The diagnosis would be one of mechanical back pain: a more specific structural diagnosis is rarely possible. 80% of cases of back pain have no identifiable pain generator. Together with high incidence of a-symptomatic abnormalities seen on MRIs etc, it is common to not establish a structural cause for symptoms.
>
> Unless there is some alternative explanation for symptoms, and none is apparent here, I think that using a term of lumbar sprain is appropriate.

[9] On 21 February 2013, the appellant underwent a further MRI scan of her lumbar spine. The report noted:

> **Clinical Details:**
>
> Back pain. Urinary retention. Shooting pain lower limbs.

Findings:

L5/S1: Mixed type 1/2 bone marrow signal changes around the end plates, particularly on the left. No disc lesion or neural compromise.

No significant disc lesions or evidence of neural compromise at other levels in the lumbar spine.

Comment

Mild endplate changes at L5-S1. No neural compromise.

[10] On 18 March 2013, a further MRI scan was completed. A comparison was made with the previous MRIs of 12 August 2012 and 21 February 2013. Under the heading "Comment" a radiologist, Dr Gooding, said:

> No significant change from the previous MRI of 21/2/2013. No evidence of cord or nerve root compression.

[11] On 27 March 2013, Orthopaedic Surgeon, Mr Schouten, responded to a series of questions from the appellant's case manager. His report included the following:

> *What is the cause of her current incapacity?*
>
> Inpatient MRI and bone scan have suggested that the L5/S1 disc is the most likely source of her current symptoms.
>
> *What is the nature of any injury caused by Natasha? (Sic)*
>
> Natasha gives a consistent repetitive history of exacerbations of her lower back pain after episodes of lifting.
>
> *What is the causal link between event 8.12.12 when Natasha lifted a heavy cricket bag and injured her back and her current incapacity?*
>
> This episode is a further example of the relationship between lifting and exacerbations in her back pain.

[12] Mr Schouten went on to say:

> If her symptoms persist, I would recommend pain assessment and an activity focussed programme with Southern Rehab. Alternatively, I believe that she is in the minority of patients that may benefit from spinal fusion.

[13] On 7 October 2013, the appellant underwent an anterior lumbar interbody fusion L5/S1.

[14] Mr Schouten reviewed the appellant on 14 January 2015 and noted that she was still getting lower back pain and that this required a recent admission to hospital.

[15] Mr Schouten said:

> I have highlighted to her that the health of her back is going to require a multi-faceted approach, including an effort on her part to stay active physically and to optimise her general fitness levels, as well as to try and seriously attempt to reduce her smoking addiction. The stresses at home and at work are not helpful, but she is doing her best to minimise these.

[16] On 25 March 2015, Mr Schouten provided a report to the chronic pain team at the Pain Management Service of Burwood Hospital. The report included:

> Could you please arrange a chronic pain management review of Natasha, a 41 year old lady who normally works in a pharmacy, but has had her life dictated now by recurrent episodes of low back pain.

[17] The next document on the file is an opinion and recommendation from Branch Medical Advisor opinion and recommendation from Ms MacPherson dated 6 October 2016 in respect of a request by the appellant for weekly compensation backdated to 2012. She gave the following opinion and recommendation:

> Mrs Elley finds herself in the very difficult situation, summarised by her GP in recent referrals she has made, requesting assistance for her patient. She has suffered multiple episodes of back pain.
>
> I agree incapacity cannot be attributed to personal injury resulting from the covered event of 13/06/2012.
>
> The effects of those sprains would be expected to have resolved within weeks, months at most.

[18] On 3 August 2017, a CT of the appellant's lumbar spine was carried out. Under the heading "Findings" is this:

> Previous ALIF and PLIF with screw positions in expected alignment. No surrounding lucency or other evidence of loosening. Intervertebral prothesis in situ. Additional bone grafting through the L5 and S1 vertebral bodies appears fused.
>
> A satisfactory vertebral body alignment with no significant spondylolisthesis. Mild gradual curvature scoliosis of the lumbar spine, concave to the right with associated reactive end plate sclerosis. Moderate facet arthropathy L5/S1 but without ankylosis. No significant evidence of bony spinal canal or foraminal narrowing.
>
> Severe left and mild right sacroiliac joint arthropathy.
>
> Right adnexal cyst against noted. No significant paravertebral body.
>
> **Comment:**

> Satisfactory appearances of the ALIF and PLIF fixation.

[19] Neurosurgeon, Mr Finnis, saw the appellant on 14 August 2017. His report included:

> With regards to her back pain, this may still be related to some activity around the fusion process and as this continues and matures to being complete, then there may be some settling in the back pain. Other areas of potential contribution could be the sacroiliac joints and this may be worthwhile looking at with some pain management interventional techniques. I note that she does have some modic type 1 changes at the L2/3 and L3/4 levels, but this is higher than where she feels the pain and probably not contributory.
>
> The MRI scan is satisfactory with regards to absence of any neural impingement. The leg pain is not explained on the basis of an L2 or L3 radicular problem and is probably referred from the back. We also do not see any compression of the nerves of the cauda equina. The bladder problem is likely secondary to the pain inhibition and the pain medication in some instances.
>
> From a management perspective, she needs to have a further CT scan in six months time to assess the progress and I will arrange for this and see her in clinic afterwards.
>
> She needs to be now re-evaluated with regards to comprehensive pain management and I will refer her to the Pain Management Service for this. There may be some minor interventional type techniques which may be helpful in the evaluation of this, such as sacroiliac joint injections and they can be responsible for that. They also optimise medication management, but also address the rather extensive functional and psychosocial problems that have emerged over the last few years as a result of chronic pain.

[20] On 4 May 2018, the appellant underwent a PET scan of her lumbar spine. Radiologist, Adrian Balasingam reported:

> Solid L5/S1 fusion with no complications. In particular, no activity is seen around the right S1 screw. Moderately advanced L3/4 facet joint arthropathy (with activity), slightly more marked on the right. Left S1 joint arthropathy (also with activity).

[21] On 17 May 2018, Ms Howell underwent an MRI scan of her lumbar spine. The report contains this conclusion:

- There has been some increase in the bone marrow oedema around the end plates on the right at L2/3.
- No other new abnormality.
- No significant neural compromise.

[22] The appellant saw Mr Finnis again on 18 May 2018. Mr Finnis reviewed the most recent scans and said:

> Natasha has ongoing problems with back pain. This probably isn't related to new problems through the L5/S1 level and this has shown a well established fusion and there is no increased PET activity. It would be expected to be relatively quiet.
>
> The origin of the pain is a little bit difficult to determine. However, the two changes on the recent imaging that may be significant and that is the L3/4 facet activity and the second is the L2/3 and maybe the L3/4 disc problems with the modic type 1 changes. This is intense at the L2/3 level.
>
> …
>
> I will arrange for bilateral L3/4 facet injections to see if this may be helpful. If it is, then this may be of some diagnostic value. I will see her following this. I have arranged her to continue seeing you with regards to managing medically the problem of pain.

[23] On 11 July 2018, Mr Finnis wrote to Dr MacVicar of Southern Rehab Christchurch:

> I would be grateful if you could see Natasha for assessment of whether a medial branch block to the L3/4 joint bilaterally could be helpful to her …
>
> The available information would tend to suggest that there is at least some contribution to her back pain, perhaps most significantly now, from the L3/4 facet. She has of course had a complicated history with regards to her previous L5/S1 fusion and the pain problems have had considerable functional impact on her. This has been enhanced by coverage issues with ACC.

[24] On 23 January 2019, Dr MacVicar wrote to Mr Finnis. He said:

> I have investigated her pain with fluoroscopically-guided intra-articular injections of local anaesthetic into the sacroiliac joint and these have been positive, with complete relief of pain.
>
> I have subsequently performed two intra-articular injections of steroid and they have given her good relief, 100 per cent relief from the first injection and 70 per cent relief from the second, but both times the relief has lasted two weeks only and the duration of relief is too short for this to be a useful way of managing her persisting pain.
>
> Natasha is keen to discuss with you whether or not there may be a surgical solution for her. …

[25] On 22 February 2019, Mr Finnis completed an assessment report and treatment plan.

[26] In respect of the causal medical link between proposed treatment and covered injury, Mr Finnis said this:

> Natasha originally injured her back when she was lifting stones in 2012. She had disruption of the L5/S1 disc requiring fusion. She now has an established fusion, however has developed adjacent segment problems at the sacroiliac joint, which is

> now symptomatic and requires surgery. There is therefore a link between the injury sustained and the need for surgery.

[27] On 8 April 2019, Dr Medlicott, Principal Clinical Advisor Orthopaedic Surgery, provided clinical opinion to ACC. He said:

> At this stage I do not think there is any causal link. In my brief experience of medicine and orthopaedic surgery, over a period of 42 plus years, sacroiliac joint pathology is caused by very severe motor vehicle accidents or falls from a height onto the legs and/or buttocks, associated with a fracture of the sacrum or of the sacroiliac joint or of the pelvic ring. If there have not been any of these problems associated, then a bilateral sacroiliac joint fusion, in my opinion, does not have any causal link to any of the previous covered episodes. There does not appear to be an accident of any significant nature which would have caused post traumatic damage to the sacroiliac joints. Sacroiliac joint problems, if not traumatic, and I do not believe this is the case here, are also due to rheumatic and/or inflammatory disease of the joints. These, of course, are not covered and do not attract ACC entitlements.

[28] On 16 April 2019, Dr MacVicar, musculoskeletal pain doctor provided further comment to ACC on the appellant's claim for a treatment injury.

[29] Amongst other things, he said:

> It is possible that Natasha has had sacroiliac pain since the 2012, but it is also possible that the current diagnosis is a consequence of the surgery because it is known that sacroiliac joint pain is more common in patients who have undergone lumbosacral fusion.
>
> When I assessed her, she provided a history of constant pain low in her back and intermittent pain in her right buttock and right thigh. I have not seen any contemporary records from the time between the injury and the surgery and perusal of these might give an indication of the location of the pain and an indication if the sacroiliac joint has been suspected to be the source of the pain. It would seem to be a serious omission not to have investigated this possibility before proceeding to fusion if sacroiliac joint pain was suspected.
>
> You asked if there had been a misdiagnosis in Natasha's case.
>
> I commented in my 18.10.18 report on a statement in a comprehensive pain assessment report from 2015 that an MRI was "essentially normal". This was incorrect, as the MRI that was performed on 12.08.12 was not normal. I have not seen a radiologists report, but I have viewed the images and there is significant modic changes in the vertebral bodies on both sides of the L5/S1 disc. There is a correction between such changes and discogenic pain and it is understandable that the disc would have been suspected to be the source of Natasha's pain. The modic changes however were type 2, indicating that they were long standing and unlikely in my opinion to have caused the 13.06.12 injury.

[30] Dr MacVicar concluded:

> If Natasha suffered from an injury to her sacroiliac joint on 13.08.12, it would appear that this either wasn't appreciate or investigated. If she did have sacroiliac joint pain, lumbosacral fusion was an unnecessary procedure that was destined to fail to provide her with pain relief. As noted above, however, I do not have sufficient information about her presentation in 2012 to be able to conclude that she did have sacroiliac joint pain at that time.

[31] On 18 April 2019, ACC wrote to Ms Howell declining to approve funding for surgery to treat her sacroiliac joint pathology and declining cover for this condition.

[32] On 12 May 2019, Orthopaedic Surgeon, Mr Pai, provided a paper file review.

[33] At the conclusion of his review, Mr Pai answered these questions:

> *In your opinion, what is the physical injury that Ms Howell sustained as a result of treatment?*
>
> I have gone through the extensive documents and in my opinion, she has been assessed satisfactorily by the doctors in 2009, 2012, 2013 and her clinical presentation was with multiple admissions to the hospital with urinary retention and pain, and she was on a significant number of medications. She also has had several MRIs in 2013 and there is no doubt in my mind that at that stage her pathology was localising at L5/S1, with type 1 modic change at L5/S1. In my opinion, her presentation was more than likely related to the L5/S1 site, rather than her sacroiliac joint. The earliest MRI report available to me is of 12/08/2012 where it has been documented that her sacroiliac joint showed no abnormalities. It is clear that she has been seen by various doctors at that stage and also by a senior spinal surgeon, Mr Schouten, and on 7/10/13, she underwent an appropriate surgery for anterior fusion at L5/S1, which in my opinion appears to have technically healed, but her pain continued requiring further intervention on 13 February 2017 in the form of posterolateral fusion. Subsequent SPECT scan suggested solid spinal fusion both anteriorly and posteriorly and there were no complications from the surgery and there was no increased uptake at L5/S1. In my opinion, therefore, the indication for surgery both in 2013 and 2017 was satisfactory on investigation, and the scan of 4/5/2018 suggested that pain was not arising from L5/S1 at that stage. Therefore the surgery of 2013 from imaging point was successful from the report of 4/5/2018. However, her back pain symptoms continued. Literature is quite clear that even with successful fusion, about 10 to 15 per cent who are operated with fusion may continue to have back pain and the causation for pain may vary.
>
> …
>
> I cannot relate her ongoing symptoms as being related to her surgical treatment of 3/10/13 as a misdiagnosis of right sacroiliac strain as there was no suggestion on imaging that she had right sacroiliac joint disorder in 2013 on the MRI.

[34] Mr Pai went on to say that there had not been a misdiagnosis in his opinion and that she had appropriate surgery for lower lumbar pain, which had not responded to conservative management.

[35] On 27 June 2019, Dr MacVicar again reported to the ACC case manager following a review of the appellant on 11 June 2019.

[36] Dr MacVicar answered these questions:

> *Is Natasha's current incapacity due to the left lumbar sprain and/or left sacroiliac ligament sprain which ACC has covered under claim …? If so, on what basis do you make that determination and what evidence supports that?*
>
> Her current incapacity is not due to left lumbar sprain and/or left sacroiliac ligament sprain. Her pain is on the other side; as indicated in several previous reports, the source of her current pain is the right sacroiliac joint. The evidence for this is complete relief from two fluoroscopically guided diagnostic injections of local anaesthetic into the joint and from one injection of steroid, and she had 70 per cent reduction in the intensity of the pain when a second intra articular injection of steroid was performed.
>
> It is interesting that she should have cover under claim … for a left sacroiliac ligament sprain. There is no evidence of injury to a ligament, but the left sacroiliac joint was markedly abnormal on a sodium fluoride PET/CT scan that was performed on 4.5.18. This has shown joint space narrowing, subchondral cysts, sclerosis and anterior and posterior osteophytes. In addition to these features, which were apparent on CT scanning, there was avid sodium fluoride uptake in the antero-inferior aspect of the joint, in the region of the CT changes. This does not mean that the left sacroiliac joint is the cause of her current incapacity, but it does provide evidence that the joint may have been injured in the past, and it would be reasonable to assume that this injury may have occurred on 13.6.12 if a left sacroiliac injury had been suspected at that time.
>
> Independent assessor, Vasudeva Pai, has stated several times in his report that the sacroiliac joint appeared normal on MRI of 12.8.12. I have not seen the radiologist's report, but I have studied the MRI, which was an MRI of the lumbar spine. The most caudal views in the axial plane are at the level of this junction between the first and second sacral segments, the sagittal views do not extend far enough laterally to include the sacroiliac joint, the coronal views were not obtained. The only views of the sacroiliac joint are axial views of its upper third. The lower end of joint, which was abnormal on the PET/CT scan of 4.5.18, was not imaged and it cannot be concluded from the limited views of the joint that were obtained that it appeared normal in 2012.

[37] Dr MacVicar went on to comment on Mr Medlicott's opinion, stating:

> Several accidents as he described would certainly be the type of trauma that would cause pelvic fractures, but that is not what we are dealing with here, and he has implied that Natasha's pain is due to an inflammatory disease, with no evidence that she has such a condition.

[38] Dr MacVicar continued:

> Severe accidents are not required to cause sacroiliac joint pain. Weksler reported that 35/50 (70 per cent) of patients with positive responses to sacroiliac joint injections

> reported that lower back pain began after a road accident or work accident and 10 (20 per cent) after lifting a load.
>
> …
>
> The other matter I wish to raise is that the literature suggests the prevalence of sacroiliac joint pain is between 33 per cent and 59 per cent in those who have had lumbar spine fusion, ie. higher than the prevalence of sacroiliac joint pain generally.
>
> …
>
> In summary, the source of the pain that is causing incapacity for Natasha currently is the right sacroiliac joint. This has been established with complete relief from controlled diagnostic injections and corroborated by positive responses to two subsequent injections of steroid, though the responses were disappointingly brief.
>
> I believe the pain is injury related, and a result of the 13.06.12 injury, as a sacroiliac injury was suspected at the time, and all other claims that Natasha has made have been diagnosed as lumbar injuries. Also, there is no evidence of non-injury conditions that would otherwise cause sacroiliac joint paint such as rheumatoid arthritis or a spondyloarthropathy.
>
> The left sacroiliac joint is radiologically abnormal, but the current pain is on the other side. A plausible explanation for this is that there was an injury to the left sacroiliac joint in 2012 and the joint has become relatively immobile in time, with joint space narrowing and bridging osteophytes, placing greater load on the right sacroiliac joint.
>
> Alternatively, sacroiliac joint pain may have developed as a complication of the lumbosacral fusion. This is a known risk factor for sacroiliac joint pain.

[39] Mr Finnis provided a further report on 14 August 2019. In his report, Dr Finnis included the following:

> The information at hand would tend to support the potential origin of pain as at L3/4 facet arthropathy. This appears to be two levels above now and established L5/S1 fusion. There are little changes around the L4/5 facet. The discs through this area look healthy. She has, however, the sacroiliac joint inflammation, worse on the left side. I think these may be contributing to the back pain as well.
>
> It is of note that she has had a number of steroid injections from Dr John MacVicar on 25/10/18 and 6/12/18, directed at the right sacroiliac joint. She recollects that she did have clinical benefit from these, which is perhaps supportive of the diagnosis that the sacroiliac joint inflammation is contributory.

[40] On 7 February 2020, Dr Walker, Occupational and Environment Medicine Specialist, provided a medical case review to ACC.

[41] In order to prepare this, Dr Walker assessed the appellant in person on 30 January 2020.

[42] Dr Walker was of the opinion that the accident of 13 June 2012 had not caused her current incapacity. He said:

> … If there was an acute injury, then it would be expected that Natasha would have developed pain at the time of the accident. The initial clinical notes in regards to this claim are those of the general practitioner dated 4 July 2012 and read as follows:
>
> > She has been experiencing increasing low back pain since lifting topiaries at work in June. Now gets stabbing pain into L leg.
>
> Such practitioner records do not indicate a specific accident and suggest that pain arose in association with repeated lifting activity. Similarly, Christchurch Hospital notes dated 29 July 2012 refer to pain arising whilst in bed, with a history of lifting a heavy object three weeks previously …

[43] He noted that sacroiliac joint injuries require significant specific and substantial sudden acting forces in order to arise. He also noted that successive bone scans demonstrated progressive degenerative changes at the right sacroiliac joint.

[44] Dr Walker went on to say that the appellant's pain syndrome significantly accounts for her incapacity.

[45] He said:

> In conclusion, Natasha's current pain likely relates to the right sacroiliac joint and is possibly a degenerative arthropathy of the sacroiliac joint. A pain syndrome is also contributing to her presentation. The origin of the sacroiliac joint pathology is unclear and may have become symptomatic in 2012, but alternatively may potentially have been caused or aggravated by fusion surgery in 2013, or may have been aggravated by fusion surgery in 2017.

[46] Neurosurgeon, Mr Finnis, provided a further report to ACC on 24 November 2021 in response to a letter from ACC regarding injuries sustained to the L5 disc on 13 June 2012. Mr Finnis concluded:

> It is therefore the injury of 13 June 2012 which quite possibly was an important trigger in initiating the pain problems because of the further disruption of the disc. There was the lifting of the stones which caused the increased loading through the disc.

[47] Finally, ACC obtained a report from its Clinical Advisory Panel on 24 February 2022. ACC asked the question:

> Can you please confirm that, based on the information found in Mr Finnis' report dated 24/11/21 … that Mr Finnis' report does not change the original suspension decision dated 10/03/20 and the review decision?

[48] The panel reached the following conclusions:

- Ms Howell is not entitled to cover for her gradual onset, normal age changes in her L5/S1 lumbar disc and/or her bilateral sacroiliac joints.
- The mechanism of injury – lifting topiaries, cricket bags and other items on various duties – did not have sufficient force to internally disrupt the spinal column, or any lumbar disc, or the sacroiliac joints, which require violent forces to be acutely damaged.
- There was no evidence in any of the contemporary clinical records of any significant internal spinal disruption.
- There was no evidence of anything but soft tissue injury in the initial 2012 records.
- At best, Ms Howell sustained sprain type soft tissue injuries on 13/06/2012 and with her other ACC claims, which all resolved within a few weeks or months.
- Ms Howell's persistent pain, urinary problems and leg symptoms cannot be explained from a physical point of view. The presentation is complex multi-dimensional and not causally (related) to any of her ACC claims, or any combination of these.
- The initial scans did not show any sacroiliac joint pathology until some years later.
- Ms Howell had painful, degenerative sacroiliac joint pathology, which is a gradual onset process not related to trauma. Her latest scans show that she has already had sacroiliac fusion surgery.
- There is no evidence to support the impression of trauma related sacroiliac pathology.
- There is no evidence to support the impression of "overloading" or other pathology of one or both sacroiliac joints from the L5/S1 disc deterioration or fusion surgeries in 2013 and/or 2017. These theories are speculative at best and not supported by current medical evidence or surgical experience.
- This is supported by reports from Mr Evison, Mr Taine, Mr Schouten, Dr MacPherson, Mr Pai, Mr Medlicott, Mr Hunter and Dr Walker.
- The CAP agreed with Mr Finnis that Ms Howell's ACC claims triggered her pain problems. However, there is no evidence of an L5/S1 or sacroiliac joint or facet joint injury with any of her ACC claims, or any combination of these.

Appellant's Submissions

[49] Mr Stryder read to the Court his pre-prepared written submissions. He relies on the various reports of Mr Finnis from 2017 onward. He also relies on the report of Dr MacVicar, specialist in musculoskeletal pain medicine, dated 27 June 2019.

[50] He says that ACC has failed to assess/recognise/acknowledge the causation of Ms Howell's 13 June 2012 injury and the causal link of the condition for which surgery is requested.

[51] He submits that ACC has adopted the narrow view and has not considered the 13 accidents/injuries arising since Ms Howell's prolapsed disc accident/injury of 18 October 2000.

[52] He says there is a clear injustice that ACC still refuses to acknowledge medical evidence from Neurosurgeon, Mr Finnis, regarding Ms Howell's current injuries/incapacity caused by her 13 June 2012 accident.

[53] He says that treating surgeon, Mr Finnis, has clearly shown to ACC that Ms Howell has suffered personal injury and that Mr Finnis has provided ACC with clear proof of causation of her injuries.

[54] He says that Dr MacVicar also confirms Ms Howell's injuries are from her 13 June 2012 accident.

[55] Mr Stryder quotes from Mr Finnis' report, which includes reference to the fact that a significant component of the appellant's pain is related to the sacroiliac joints. He refers to Mr Finnis' statement that surgical fusion could lead to more definitive management, hence the application to ACC for funding.

[56] He also refers to Mr Finnis' view that the injury of 13 June 2012 included sacroiliac ligament sprain. He quotes Mr Finnis:

> It is my opinion that the evidence available regarding the problems with the sacroiliac joint reflect an adjacent level effect from the L5/S1 fusion as there are progressive changes in regards to radionucleotide uptake here.

[57] He refers to the assessment report and treatment plan of Mr Finnis dated 22 February 2019 in which Mr Finnis summarises the appellant's history of her condition from the time she injured her back in July 2012 lifting pots of stones. He says that the assessment report and treatment plan sets out the link between the injury sustained and the need for surgery.

[58] He refers to Dr MacVicar's report of 27 June 2019 to ACC case worker, Judy Smith, where he says:

> I believe the pain is injury related, as a result of the 13.06.12 injury, as the sacroiliac injury was suspected at the time, and all other claims that Natasha has made have been diagnosed as lumbar injuries.

[59] Mr Stryder accordingly submits that the combined reports of Mr Finnis and Dr MacVicar provide clear medical evidence that there should be cover for sacroiliac joint pathology and that the decision to decline to fund surgery should be reversed.

[60] He further seeks a direction that ACC abide by a mediation and for ACC to direct Mr Finnis to answer the six questions attached to his submissions and that ACC reinstate cover for the appellant's 13 June 2012 back injuries.

[61] He also seeks directions that ACC provide treatment, rehabilitation and pain management and that they provide backdated entitlements to the appellant for her 2012 injury and incapacity. Finally, he seeks a direction that ACC accept cover for Ms Howell's failed L5/S1 back fusion surgery and approve Dr Hayes' treatment injury claim declined by ACC on 2 March 2018.

Respondent's Submissions

[62] Mr Hunt submits that a number of Mr Strider's submissions do not relate to the issues squarely before this Court on this appeal.

[63] Mr Hunt submits generally that in this case, ACC has relied upon multiple medical reports and finally the Clinical Advisory Panel report of 24 February 2022, which he says explains why the evidence in support of cover and surgery declined by ACC are correct.

[64] Mr Hunt submits that the review decision sets out a fair and accurate summary of what occurred in this case since the accident date, being the lifting incident on 13 June 2012.

[65] He notes that Ms Howell did not appear at the review hearing.

[66] He notes that the first surgery was performed on 7 October 2013 by Mr Schouten, who undertook a fusion at L5/S1.

[67] He notes that the assessment report and treatment plan of Mr Finnis of 14 March 2019 was some seven years after the accident event.

[68] He submits that it is unclear whether Mr Finnis is aware of the "multiple" claims for injuries to her back commencing in 2000.

[69] He refers to the principal clinical advisor, Mr Hunter's conclusion in his report of 25 October 2019, in which he said:

> In summary, treatment is to be directed at facet joint arthritis and probable sacroiliac arthritis, which is gradual process change not due to any single event of injury.
>
> Sacroiliac fusion surgery in the public system has been considered but now decided against in view of uncertainty of outcome.
>
> Instead, referral has been made to Burwood Pain Management Service and the need for ongoing psychological and psychiatric support emphasised.

[70] He notes that Dr MacVicar, in his further report of 29 October 2019, says:

> There is a correlation between modic changes and discogenic pain, but it is unlikely that these changes were caused by the June 2012 injury, as the MRI was performed only two months after the injury and type 2 changes suggest the presence of a chronic process.

[71] He refers to the report of Branch Medical Advisor, Dr MacPherson, of 6 October 2016 where she says:

> Mrs Elley finds herself in the very difficult situation, summarised by her GP in recent referrals she has made, requesting assistance for her patient. She has suffered multiple episodes of back pain.
>
> I agree incapacity cannot be attributed to personal injury resulting from the covered event of 13/06/2012.
>
> The effects of those sprains would be expected to have resolved within weeks, months at most.

[72] Mr Hunt refers to the clinical comment of Principal Clinical Advisor, Dr Medlicott - Orthopaedic Surgery – who gave a detailed analysis and clinical comment on 8 April 2019.

[73] Dr Medlicott referred to what Mr Hunt described as multiple claims by the appellant that Dr Medlicott listed. The first being on 18 October 2000, which she pulled a muscle lifting a car seat out of a car.

[74] Dr Medlicott's analysis shows some nine accepted claims for back injury by the appellant between 2000 and 2012.

[75] Dr Medlicott's clinical comment in part reads:

> In my brief experience of medicine and orthopaedic surgery, over a period of 42 plus years, sacroiliac joint pathology is caused by very severe motor vehicle accidents or falls from a height onto the legs and/or buttocks, associated with a fracture of the sacrum or of the sacroiliac joint or of the pelvic ring. If there have not been any of these problems associated, then a bilateral sacroiliac joint fusion, in my opinion, does not have any causal link to any of the previous covered episodes. There does not appear to be an accident of any significant nature which would have caused post traumatic damage to the sacroiliac joints. Sacroiliac joint problems, if not traumatic, and I do not believe this is the case here, are also due to rheumatic and/or inflammatory disease of the joints. These, of course, are not covered and do not attract ACC entitlements.

[76] Mr Hunt refers to the paper file review of 12 May 2019 by independent orthopaedic assessor, Mr Pai.

[77] He was asked:

> In your opinion, what is the physical injury that Ms Howell sustained as a result of treatment?

[78] He concluded his answer by saying:

> I cannot relate her ongoing symptoms as being related to her surgical treatment of 3/10/13 as a misdiagnosis of right sacroiliac strain as there was no suggestion on imaging that she had right sacroiliac joint disorder in 2013 on the MRI.

[79] Mr Hunt refers to the medical comment of Principal Clinical Advisor, Orthopaedic Surgery, Mr Hunter, dated 25 October 2019. He concluded:

> Cover is reasonable for a sacroiliac joint sprain, which would be expected to have resolved in a few weeks.
>
> Surgical treatment by sacroiliac joint fusion is no longer contemplated and the previous CAP advice is unchanged by the new information.

[80] Mr Hunt refers to the reports of Dr MacVicar of 29 October 2019 and Dr Walker of 7 February 2020. Mr Hunt again submits that reports at the time of the accident tend to be the most helpful. He submits that all these were carefully analysed by the reviewer. Mr Hunt

refers to Mr Finnis' detailed report of 24 November 2021 regarding the injury of 13 June 2012.

[81] Mr Hunt notes that Mr Finnis concluded the report by saying:

> It is therefore the injury of 13 June 2012 which quite possibly was an important trigger in initiating the pain problems because of the further disruption of the disc.

[82] Mr Hunt notes that Mr Finnis does not engage in challenging the reports of the other doctors. Mr Hunt submits that the Clinical Advisory Panel report of 24 February 2022 is a very careful analysis of the appellant's injury record and this report concludes that the appellant is not entitled to cover "for her gradual onset, normal age changes in her L5/S1 lumbar spine, disc and/or her bilateral sacroiliac joints".

Respondent's Reply

[83] In his reply, Mr Stryder submits that Mr Finnis has shown on the balance of probabilities that an accident caused an injury for which the appellant requires surgery. He notes there are 14 accepted back injury claims since 2000.

Decision

[84] This appeal concerns the two decisions of the respondent of 18 April 2019. In the first, the respondent declines funding for surgery to treat the appellant's sacroiliac joint pathology and in the second, the respondent declined to approve cover for sacroiliac joint pathology.

[85] It is noteworthy in this case that the medical reports that have been obtained and that are before the Court are, many, extensive, and detailed.

[86] As mentioned, Mr Stryder, on behalf of the appellant, notes that there have been 14 accepted back injury claims for the appellant since 2000. The issues before the Court on this appeal are confined to the two decisions of ACC of 18 April 2019.

[87] It is always helpful to look carefully at the circumstances surrounding the accident that is now said to require the requested surgery.

[88] The mechanism of the accident of 13 June 2012 was "lifting topiary pots outside the shop and has had severe low back, left buttock and thigh pain radiating into the knee".

[89] Following an MRI scan, the report said:

> No evidence of any significant disc herniation, neural foraminal stenosis or central canal stenosis.

[90] The Branch Medical Advisor commented on 25 September 2012:

> Multiple past claims for back strains since 2000.
>
> The diagnosis would be one of mechanical back pain: a more specific structural diagnosis is rarely possible. 80% of cases of back pain have no identifiable pain generator.

[91] After a further MRI in 2018, Mr Finnis saw the appellant. The MRI had shown no other new abnormality and no significant neural compromise.

[92] Mr Finnis saw the appellant again on 18 May 2018. Mr Finnis noted on that occasion that:

> The origin of the pain is a little bit difficult to determine …

[93] On 23 January 2019, Musculoskeletal Specialist, Dr MacVicar, reported as follows:

> I have investigated her pain with fluoroscopically-guided intra-articular injections of local anaesthetic into the sacroiliac joint and these have been positive, with complete relief of pain.

[94] Dr MacVicar also said, in a letter of the same date to ACC Case Manager:

> As far as diagnosis for an injury to her sacroiliac joint is concerned, I believe this has been established. She has had complete relief from injections of local anaesthetic into her right sacroiliac joint on two occasions, and the relief was accompanied by the restoration of activities that would usually aggravate her pain. Though steroid injections have been disappointing in terms of duration of relief, a diagnosis of sacroiliac joint pain has been corroborated by Natasha reporting complete relief following the first injection and 70 per cent relief following the second.

[95] Following this, on 22 February 2019, Mr Finnis, Neurosurgeon, completed an assessment report and treatment plan.

[96] In it, he described the causal medical link between the proposed treatment and the covered injury as follows:

> Natasha originally injured her back when she was lifting stones in 2012. She had disruption of the L5/S1 disc requiring fusion. She now has an established fusion, however has developed adjacent segment problems at the sacroiliac joint, which is now symptomatic and requires surgery. There is therefore a link between the injury sustained and the need for surgery.

[97] Dr Medlicott, Principal Clinical Advisor, commenting on the proposed treatment plan in an opinion of 8 April 2019 noted that:

> Sacroiliac joint pathology is caused by very severe motor vehicle accidents or falls from a height onto the legs and/or buttocks, associated with a fracture of the sacrum or the sacroiliac joint or of the pelvic ring. If there have not been any of these problems associated, then a bilateral sacroiliac joint fusion, in my opinion, does not have any causal link to any of the previous covered episodes.

[98] However, Dr Medlicott does not comment on the proposition in the ARTP that, at least impliedly, the problems at the sacroiliac joint are causally linked to the L5/S1 fusion.,

[99] In his further report of 16 April 2019, Dr MacVicar recognises two possibilities, namely that the appellant had sacroiliac joint pain since the 2012 injury:

> But it is also possible that the current diagnosis is a consequence of the surgery, because it is known that sacroiliac joint pain is more common in patients who have undergone lumbosacral fusion.

[100] Two days after Dr MacVicar's report, on 18 April 2019, ACC declined cover for her sacroiliac joint pathology and declined to pay for surgery to treat her sacroiliac joint pathology.

[101] In the paper file review by Mr Pai of 12 May 2019, he said he could not relate the appellant's ongoing symptoms to her surgical treatment in 2013. However, he does not comment on whether the surgery is causally related to the sacroiliac joint pain.

[102] In a further report of 27 June 2019, Dr MacVicar said this:

> In summary, the source of the pain that is causing incapacity for Natasha currently is the right sacroiliac joint. This has been established with complete relief from controlled diagnostic injections and corroborated by positive responses to two subsequent injections of steroid, though the responses were disappointingly brief.

> I believe the pain is injury related, and a result of the 13.06.12 injury, as a sacroiliac injury was suspected at the time, and all other claims that Natasha has made have been diagnosed as lumbar injuries. Also, there is no evidence of non-injury conditions that would otherwise cause sacroiliac joint paint such as rheumatoid arthritis or a spondyloarthropathy.
>
> The left sacroiliac joint is radiologically abnormal, but the current pain is on the other side. A plausible explanation for this is that there was an injury to the left sacroiliac joint in 2012 and the joint has become relatively immobile in time, with joint space narrowing and bridging osteophytes, placing greater load on the right sacroiliac joint.
>
> Alternatively, sacroiliac joint pain may have developed as a complication of the lumbosacral fusion. This is a known risk factor for sacroiliac joint pain.

[103] In his further report of 14 August 2019, Mr Finnis again discusses the possible origins of the appellant's pain and says:

> It is of note that she has had a number of steroid injections from Mr John MacVicar from 25/10/18 to 6/12/18, directed at the right sacroiliac joint. She recollects that she did have clinical benefit from these, which is perhaps supportive of the diagnosis that the sacroiliac joint inflammation is contributory.

[104] Dr Gerard Walker, Specialist in Occupational and Environmental Medicine, provided a medical case review on 7 February 2020 following a meeting with and assessment of the appellant for just over one hour on 30 January 2020.

[105] Dr Walker rejects the proposition that the appellant's current incapacity is due to the accident of 13 June 2012. He says that:

> If there was an acute injury, then it would be expected that Natasha would have developed pain at the time of the accident. The initial clinical notes in regards to this claim are those of the general practitioner dated 4 July 2012 and read as follows:
>
> > She has been experiencing increasing low back pain since lifting topiaries at work in June. Now gets stabbing pain into L leg.

[106] Dr Walker poses the possibility of degenerative arthropathy of the sacroiliac joint but says that most people with such a degree of arthropathy of the sacroiliac joints would not be so disabled. He suggests a pain syndrome significantly accounts for her incapacity.

[107] He does say, however:

> The origin of the sacroiliac joint pathology is unclear and may have become symptomatic in 2012, but alternatively may potentially have been caused or aggravated by fusion surgery in 2013, or may have been aggravated by fusion surgery in 2017.

[108] Finally, there is the Clinical Advisory Panel of 24 February 2022.

[109] Suffice it to say that the Clinical Advisory Panel rejects the proposition of the 13 June 2012 accident causing injury to her sacroiliac joint.

[110] As to the proposition that the sacroiliac joint pathology shown in the 2018 bone scan, had arisen from the fusion surgery, the Panel is less certain. The report notes:

> The CAP could not find strong clinical evidence to support his (Mr Finnis') impression, only case studies and descriptive articles.

[111] Just what has caused the appellant's presentation and her need for surgery to deal with the sacroiliac pain, has in this case been the subject to exhaustive investigation.

[112] The medical opinions referred to in this judgment demonstrate a long term conscientious effort on behalf of those involved to get to the bottom of the cause of the appellant's sacroiliac pain presentation. What is clear is that the mechanism of injury in 2012 was plainly insufficient to damage the sacroiliac joint to the point where it resulted in the pain experienced by the appellant.

[113] That then leaves the issue of whether her presentation now was a consequence of the fusion surgery in 2017.

[114] Following that surgery, Ms Howell reported ongoing low back pain.

[115] Musculoskeletal Pain Specialist, Dr MacVicar, in his report of 16 April 2019 raised the issue of her presentation, if not from the 2012 injury, then being a consequence of the surgery.

[116] Mr Finnis, as the operating surgeon, acknowledged in his report of 14 August 2019 that the sacroiliac joint inflammation was perhaps contributed to by the fusion surgery.

[117] In his medical case review of 7 February 2020, Dr Walker, Specialist in Occupational and Environmental Medicine, acknowledged that the origin of the sacroiliac joint pathology was unclear and may potentially have been caused or aggravated by fusion surgery in 2013 or 2017.

[118] It is notable also that while the Clinical Advisory Panel firmly dismisses the possibility of sacroiliac injury arising from the 2012 accident, it is less certain as to whether the sacroiliac joint pathology had arisen from the fusion surgery. The Panel commented:

> The CAP could not find strong clinical evidence to support his impression, only case studies and descriptive articles.

[119] What is clear from this file is that the appellant's pain and injury presentation has proven to be a real challenge, not only for ACC, but also for those medical specialists involved in her appraisal.

[120] The appellant has plainly had a significant pain presentation arising from her sacroiliac joint. The fact that it responded well to controlled diagnostic injections and subsequent injections of steroid, established that that joint was the source of the appellant's pain.

[121] Mr Finnis, who was the operating surgeon in respect of the appellant's earlier fusion surgery, acknowledged that her sacroiliac joint pathology had arisen from that surgery. The Clinical Advisory Panel could not rule that out and indeed acknowledged that there was support in case studies and descriptive articles.

[122] Accordingly, this is a case for applying the *Ambros*[1] principles of a generous and unniggardly approach to draw robust inferences of causation in individual cases. I find that the appellant did suffer a treatment injury arising from the fusion surgery and that therefore the respondent was wrong to decline to approve cover for sacroiliac joint pathology. Albeit that that sacroiliac joint pathology did not arise from the 2012 accident, but rather from the complications of the fusion surgery.

[123] Accordingly, the appellant is entitled to cover for this injury and it follows that the respondent's decision declining funding for surgery to treat her sacroiliac joint pathology is reversed.

[124] Accordingly, the appeal is allowed.

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1 *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.

[125] Costs are reserved. Any memoranda in respect of costs are to be filed within one month.

CJ McGuire
District Court Judge

Solicitors: Young Hunter, Christchurch