NOTE: PUBLICATION OF NAME, ADDRESS, OCCUPATION OR IDENTIFYING PARTICULARS OF APPELLANT PROHIBITED BY S 160 (1), (2) AND (3) OF THE ACCIDENT COMPENSATION ACT 2001. SEE https://www.legislation.govt.nz/act/public/2001/0049/latest/DLM101854.html

IN THE DISTRICT COURT
AT WELLINGTON

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

[2024] NZACC 35 **ACR 163/20**

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

Hearing:	21 November 2023
Heard at:	Wellington / Whanganui-A-Tara
Appearances:	Mr C La Hatte for the Appellant Mr J Sumner and Ms C Wood for the Respondent
Judgment:	22 February 2024

RESERVED JUDGMENT OF JUDGE C J MCGUIRE
(Part 3, Schedule 1, Clause 54,
Lump Sum Compensation for Permanent Impairment)

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[1] At issue on this appeal is the respondent's decision dated 22 October 2019 declining the appellant's application for a further lump sum payment following an impairment assessment by Dr Cheesman, occupational physician.

Background

[2] The appellant is 53 years old. In 2017, the respondent instructed Mr Hamish Peart, Barrister and Solicitor, to investigate a series of the appellant's complaints. Ultimately, Mr Peart found several serious service failures on the respondent's part, which resulted in the mediated agreement between the appellant and ACC dated 19 April 2018, under which ACC agreed to pay the appellant an ex gratia payment of $35,000 as a full and final settlement for the acknowledged historical service delivery failures detailed in Mr Peart's report. ACC also agreed to pay Mr La Hatte's legal representation costs of $15,000 (GST exclusive) in terms of his previous involvement and his attendance at mediation.

[3] ACC also agreed that Mr La Hatte continue to act for the appellant to provide ongoing support as the matters agreed were implemented.

[4] The agreement also included this:

> **Professional Relationship**
>
> (The appellant) expects that:
>
> (a) ACC act in good faith and treat him as a whole person;
>
> (b) ACC will address his physical and mental needs in accordance with its statutory obligations;
>
> (c) ACC will act with honesty and integrity.
>
> Both parties agree to treat each other with courtesy and respect.

[5] It was also agreed that Dr Holtzhausen be approached to be the lead provider of a holistic package for the care of the appellant, which would include possible other providers in psychological/psychiatric treatment and pain management.

[6] ACC also agreed to reassess the appellant's entitlement to lump sum compensation in relation to his physical and mental impairments by referring him to a

qualified impairment assessor. The appellant was to choose an impairment assessor from a list provided to him by ACC. Dr Cheesman's impairment assessments of June 2019 and October 2019 arose in this context.

The Appellant's Injuries

[7] The reviewer records that the Appellant first sought cover for an injury that he sustained while at work in 2003. He fell off the side of a set of stairs and injured his back. He sought and received treatment for this over a number of years.

[8] In 2006, he developed left sided lower back pain and a worsening of his symptoms after lifting an 80 litre pot while at work.

[9] In 2007, he suffered a neck sprain which involved pain to his upper extremities and he saw a chiropractor and a number of doctors for that injury. In 2007, he also attended a chiropractor for help with his chronic back pain. During neck manipulation, he developed an onset of ringing in his right ear and pain on the right side of his neck. An MRI showed no nerve or spinal cord injury.

[10] In 2009, Mr Otto, orthopaedic surgeon, was of the opinion that the appellant's injury appeared to be isolated to the right sacroiliac joint.

[11] The appellant first sought lump sum compensation in 2004. Dr Jan Reeves assessed the appellant's sensitive claim and gave a whole person impairment of 30 per cent after apportioning five per cent for a family history of depression.

[12] In 2009, Dr Watts reported five per cent impairment for the appellant's physical injuries.

[13] In 2010, Dr Fenwicke completed an impairment allowance report. She found a combined whole person impairment of physical injuries, including "somatoform pain disorder" of 19 per cent. The appellant was paid a lump of $7,387.05. This was paid against the 2003 and 2007 injuries, as the 2006 lumbar sprain injury was rated at zero per cent.

[14] In reports of 19 June 2019 and 6 October 2019, Dr Cheesman completed the impairment assessment at the heart of this appeal as part of a mediation agreement. He assessed three injuries:

- Complex regional pain syndrome (CRPS) (achilles tendon) (23 April 2003);
- Lumbar sprain and somatoform pain disorder (9 June 2006); and
- Neck sprain (23 February 2007).

[15] The appellant also has cover for PTSD under a sensitive claim. PTSD was rated in Dr Cheesman's assessment, but does not appear to be an issue in respect of this appeal.

[16] In respect of the complex regional pain syndrome and achilles injury, Dr Cheesman referred to evidence of mottling discolouration, but found no more evidence of complex regional pain syndrome and so rated the achilles/complex regional pain syndrome at zero per cent. He stated:

> The criteria for rating using complex regional pain are therefore not fully met and as there is no specific major nerve injury, the rating using the method on AMA IV page 56 in any case is zero per cent as range of movement in the joint is preserved. The pain rating in my opinion is better considered using the mental and behavioural method as detailed in the handbook and supported by Chapter 14. If there had been a rating using the complex regional pain syndrome method, this would have been deducted from any chapter 14 rating to avoid duplication.
>
> The reported achilles sprain was also considered. There was full ankle movement. The handbook page 27 through 31 was considered. There are no applicable ratings. This is a zero per cent impairment. Persistent pain is also considered using chapter 14 below.

[17] Dr Cheesman found no objective injury in relation to the 2006 or 2007 injuries and so rated both at zero per cent.

[18] Dr Cheesman also concluded that the appellant's ongoing pain and impairment was best rated under Chapter 14:

> In my opinion, the ongoing complaints of pain are best rated using chapter 14 and the mental and behavioural section. This encompasses the injuries from 2003 and any subsequent aggravation from additional trauma.

> A simple lumbar sprain and cervical sprain would not be permanent injuries and the current presentation appears better explained by the reported pain disorder.
>
> The mental and behavioural section is used for rating as described in the handbook, page 33 through 41, chapter 14 was also considered.
>
> This also considers pain as per the handbook page 42. This notes that chronic pain syndromes can be rated using the mental injury method.

[19] Dr Cheesman traversed the various categories of the appellant's impairment. He concluded:

> Most of the ratings are within Class II, with one Class III. Overall he is independent but not fully effective or sustainable in some areas of function. This is considered to be a 23 per cent whole person impairment.

[20] Dr Cheesman then apportioned this rating on the following basis:

> The mental and behavioural rating reflects a mix of the effects of PTSD and the more recent pain disorder. I have not derived any physical injury impairment for the achilles tendon sprain, lumbar sprain or cervical sprain. I have also not derived impairment for a complex regional pain syndrome type I. Therefore there is no need for deduction for duplication. (Such deduction would occur if there had been such a rating.)
>
> The current presentation is thought mainly to be related to the pain disorder based on review of the psychiatric reports, but there is some contribution from the sexual abuse, which had impact on his relationship and required treatment. The 23 per cent rating is therefore a split, 13 per cent to pain disorder and 10 per cent to post traumatic stress disorder.
>
> A larger figure being chosen for pain disorder based on psychiatric opinion that this was a greater contributor to incapacity.

[21] On 22 October 2019, the respondent issued its decision advising that in terms of lump sum, the level of impairment had decreased six per cent to 13 per cent and therefore the appellant was not entitled to a further lump sum payment.

[22] In respect of a separate independence allowance, the appellant's level of impairment for PTSD was assessed at ten per cent. This was a decrease of 20 per cent since the last assessment and his independence allowance payments were adjusted accordingly.

[23] On 28 July 2020, the reviewer, Darren Rawlins, issued a review decision upholding ACC's decision.

[24] Following the filing of this appeal in 2021, Dr Collier peer reviewed Dr Cheesman's assessment. He noted that Dr Reeves' 2004 assessment had not been provided to Dr Cheesman, but ultimately agreed with Dr Cheesman's ratings and his report.

[25] In August 2021, Dr Cheesman provided a supplementary assessment after reviewing Dr Reeves' report. He explained that Dr Reeves' report did not change his assessment and the differences in ratings between the two reports were in part due to the passage of time between them.

[26] In August 2021, Dr Collier provided an updated peer review, having considered Dr Reeves' 2004 report and Dr Cheesman's response to it. Dr Collier advised that he considered Dr Reeves' ratings in some domains were higher than justified and the elevated rating of 30 per cent likely reflected the proximity between the assessment and a recent episode of workplace sexual abuse. Dr Collier fully endorsed Dr Cheesman's assessment based on a review of function at the time of the assessment.

[27] On 19 April 2023, Dr Russell Meads met with the appellant in person for three hours to carry out an impairment assessment.

[28] In his Impairment Assessment Report that followed on 24 April 2023, he comments at page 24 on one of the appellant's diagnoses, that of complex regional pain syndrome Type I. He noted:

> Complex regional pain syndrome (CRPS) is a chronic pain condition most often affecting one of the limbs (arms, legs, hands, or feet), usually after an injury or trauma to that limb. CRPS is believed to be caused by damage to, or malfunction of, the peripheral and central nervous systems. The central nervous system is composed of the brain and spinal cord, and the peripheral nervous system involves nerve signalling from the brain and spinal cord to the rest of the body. CRPS is characterised by prolonged or excessive pain and mild or dramatic changes in skin colour, temperature, and/or swelling in the affected area. There are two similar forms, called CRPS I and CRPS II, with the same symptoms and treatments. CRPS II (previously called Causalgia) is the term used for patients with confirmed nerve injuries. Individuals without confirmed nerve injury are classified as having CRPS I (previously called Reflex Sympathetic Distrophy Syndrome).
>
> …

[29] Dr Meads noted that expert opinion dictated that some of the symptoms related to the lower back and right lower extremity were related to CRPS. He said:

> The assessor notes that CRPS in any part of the body can lead to symptoms and signs in other parts of the body. In [the appellant]'s case, the question posed is, are the symptoms and signs in the right upper extremity related to CRPS, are they related to cervical spine syndrome with radiculopathy, are they related to both these entities?
>
> The assessor is of the opinion that in all probability, symptoms and signs in the right upper extremity are related to CRPS.
>
> The assessor notes that as the diagnosis is of CRPS Type I (ie. there is no specific nerve involved), impairment is assessed by relating it to a range of motion. It is noted that there is no rateable loss of motion in the right upper extremity. There is rateable loss of motion in the right lower extremity.
>
> The assessor is of the opinion that a rating for loss of motion alone would not account for all impairment that the injuries and pain have created in the right upper and lower extremity.
>
> The guidelines allow us to consider impairment other than physical impairment. By relating it to mental impairment and the somatoform pain disorder (sic).

[30] Dr Meads concluded that in respect of the appellant's sensitive claim of 22 March 2022 of PTSD and major depressive disorder, the appellant had a 15 per cent whole person impairment.

[31] In addition, in respect of the appellant's sacroiliac sprain of 23 April 2003; his somatoform pain disorder injury of 9 June 2006; and his neck sprain injury of 23 February 2007, the appellant had a 55 per cent whole person impairment.

[32] Dr Meads also concluded that there was no additional impairment for the injuries of 1 August 2008 and 10 August 2008.

[33] On 1 June 2023, at the request of the respondent's lawyers, Dr Collier, specialist psychiatrist and physiotherapist, carried out a peer review of Dr Meads' 19 April 2023 impairment assessment.

[34] Amongst Dr Collier's criticisms of Dr Meads' report are these:

> 4.10 Dr Meads does not provide a full mental state examination, particularly with regard to the symptoms of depression and PTSD and does not describe pain in terms of what modulates pain, what the ratings are and what relieves pain.

5.6 Dr Meads has produced a convoluted argument to assess pain twice, and that he has then proceeded to assess CRPS from the right sacroiliac joint and has extended it to the whole of the right lower extremity. Once Dr Meads has gone down the wrong pathway for the assessment, it produces inflated ratings.

[35] And in answer to the question:

Subject to your answer above, can you please explain how the different impairment ratings (Cheesman v Meads) were arrived, and which ratings, in your opinion, are correct.

It is my opinion that Dr Meads has incorrectly rated CRPS and has incorrectly related the SI joint pain which has led to an inflated figure. The correct rating for an SI joint sprain would be the same rating system for the lumbosacral sprain (they are the same anatomical area) and that a single rating for the neck sprain and the lumbar sprain is plausible, but the ratings for the lower extremities are incorrect.

In addition, as mentioned in my peer review, Dr Meads has duplicated ratings and has, in my opinion, incorrectly assessed the PTSD, and from reading his report, it is not possible to determine how much of the current presentation is a function of historic sexual abuse and how much is a function of the original injury in 2003.

…

Based on my review of all the reports, particularly those of Dr Cheesman and Dr Meads, I would recommend that the report by Dr Cheesman, which I peer reviewed in 2021, stands as correct.

[36] On 10 July 2023, Dr Meads provided a further report in response to Dr Collier's peer review.

[37] Dr Meads noted that:

His (Dr Collier's) mindset was obviously influenced by the previous report he had peer reviewed and his previous peer review (that is to say Dr Collier's peer review dated 29 April 2021 of Dr Cheesman's 2019 impairment assessment of the appellant.

[38] Dr Meads continued:

My belief is that as Dr Collier has gone down this pathway of totally refuting chronic regional pain syndrome being rated under the physical portion of the report, his misunderstanding of what chronic regional pain syndrome is, and how it affects the body in its totality, creates an overwhelming flaw of his whole peer review.

Having given a rating for physical injury, I then went on to do a rating for mental injury. I believe that people who have a physical injury can also have a mental injury. I believe in rating pain, rating for physical impairment does not deny a rating for mental impairment, and vice versa. I have looked at my ratings of functional categories.

> Dr Collier would see my ratings as being high. I would see his, as I would have of Dr Cheesman's, as being low.
>
> It is noted that Dr Cheesman's report was done over two years ago.
>
> …
>
> I would see with all functional categories that Dr Collier/Dr Cheesman have completely underrated impairment. Maybe the flaw being that apportionment has been done, before considering this later.

Appellant's Submissions

[39] Mr La Hatte briefly traced the background of this case, the mistrust that had arisen between the appellant and ACC, the independent review carried out by Mr Peart and the mediated agreement of 19 April 2018.

[40] Mr La Hatte noted that it was ACC's failings that had led to the need for Mr Peart's report and the mediated agreement. So Mr La Hatte asked the rhetorical question, is Dr Collier correct or is Dr Meads correct?

[41] He notes that Dr Meads is an impairment specialist, not just a general practitioner.

[42] He submits that Dr Holzhausen has a different view from Dr Collier.

[43] It is noted that in her report of 20 April 2023, she says:

> (The appellant) returns for review today of his recent CT SPECT scan imaging of the thoracic spine to try and clarify the cause of his right thoracic and referred chest wall pain …
>
> On examination today (the appellant) has evidence for painful arc with discomfort subacromially between 60 and 120 degrees of left glenohumeral joint abduction. He is maximally tender on palpation over his insertion area of the left supraspinatus to the left greater humeral tuberosity.

[44] Mr La Hatte refers to Dr Meads' further comment in his response of 10 July 2023 where he says:

> Overall, having re-read my report, read Dr Collier's peer review, I believe that I have gone down a correct way in terms of methodology for doing an impairment rate for (the appellant). I have looked at the physical injury, looked at the mental injury. I have applied the correct methodology for rating both physical and mental.

> **I would see Dr Collier's misinterpretation, in not allowing complex regional pain syndrome to be rated as a physical injury, creates a major flaw in his peer review when it comes to physical injury.**

[45] In essence, Mr La Hatte submits that in his report Dr Collier underrates the appellant's mental injury and his complex regional pain syndrome and that therefore Dr Meads' assessment should prevail.

Respondent's Submissions

[46] Mr Sumner referred to the history of this case set out in Mr Peart's report. He acknowledges that the appellant had an unsatisfactory relationship with ACC and that Mr Peart had recommended payments for ACC's failures. There was an agreement for a further impairment assessment. This was carried out by Dr Cheesman in June 2019 and peer reviewed by Dr Collier on 29 April 2021.

[47] He refers to the fact that in his impairment assessment report of 19 June 2019, Dr Cheesman noted that the impairment rating was deferred pending further information. Dr Cheesman said:

> In order to reliably rate and apportion mental injury, recent psychiatric/ psychology opinion on the current diagnosis and linked to specific claims and detail of ACC cover decisions in this respect would be necessary.

[48] In his subsequent amended impairment assessment report of 6 October 2019, Dr Cheesman referred to complex regional pain syndrome and commented:

> There is no longer evidence of persistent bruising. There is no identified persistent orthopaedic injury. The achilles tendon is intact. I note that Dr Holtzhausen had suggested a complex regional pain syndrome. There is also pain present but swelling was not identified and circumferential limb measurements were symmetrical. There was also a full range of movement.

[49] Dr Cheesman continued:

> The criteria for rating using complex regional pain were therefore not fully met "and as there is no specific major nerve injury, the rating using the method on AMA IV page 56 in any case is zero per cent, as range of movement in the joints is preserved".

[50] Counsel notes that Dr Jan Reeves had made an earlier whole person impairment assessment in 2004 of 30 per cent. Her assessment, of course, necessarily was exclusive of the effect of later injuries.

[51] Mr Sumner also referred to the 19 per cent whole person impairment of Dr Fenwicke of 11 November 2010.

[52] Mr Sumner points out that there is a distinction between disability and impairment and the impairment assessment we are dealing with is as at 2019. He acknowledges that impairments may increase or decrease over time.

[53] He submits that Dr Meads' assessment is flawed and he points to the conclusion of Dr Cheesman's report of 9 October 2019 where he does apportionments prior to concluding final assessments. He says that in doing this, Dr Cheesman has followed what the AMA Guides precisely require.

[54] Mr Sumner refers to Dr Collier's peer review of 29 April 2021 of Dr Cheesman's 2019 impairment assessment report and makes the comment:

> I think Dr Cheesman apportioned less than I would have considered. He noted that the mental and behavioural ratings due to PTSD were mixed with more recent pain disorder, and considered that of the final 23 per cent, 10 per cent of it was due to PTSD. This assessor would consider that was an error, as the previous rating of 35 per cent for PTSD in 2004 was deemed permanent and stable by Dr Reeves.

[55] Mr Sumner submits that here there is a significant difference between Dr Cheesman's report of June 2019 and Dr Meads' 2022 report. He says that Dr Meads has not made any deduction for pre-existing conditions.

[56] He points to the fact that Dr Collier is a trainer of impairment assessors.

[57] Dr Collier also refers to what might be described as unreliable evidence, including a sensitive claim when the appellant was aged eight. He also points to discrepancies in previous dates given to earlier assessors. He also says that complex regional pain syndrome is attributable to many parts of the body and that Dr Meads' assessment does not include any diagnoses regarding the ongoing presence of PTSD, ongoing depressive symptoms or any diagnoses associated with long term benzodiazepine dependency and long term opiate dependency. He submits therefore that Dr Meads' assessment should be set aside and that Dr Cheesman and ACC are correct.

[58] He also made the point that we are now four years post assessment and that the appellant had obtained a further assessment.

Appellant's Reply

[59] Mr La Hatte noted that Dr Meads had, during his career, completed many such reports and that Dr Cheesman's report was now four years old. He suggested that one option might be to get an agreed person to do a new assessment. He said, however, that Dr Meads' impairment assessment report of 19 April 2023 took some three hours.

Decision

[60] Historically the relationship between the appellant and ACC has been a troubled one. Long standing issues with ACC eventually resulted in ACC, in late 2016, appointing Mr Peart to undertake an independent investigation into the appellant's complaints.

[61] Mr Peart identified some serious service failures that had occurred in respect of ACC's management of the appellant's claims.

[62] These had included a lack of holistic and integrated management of his claims; inappropriate referrals at times; incorrect disclosure and non-disclosure of information which amounted to breaches of privacy; unfounded fraud investigations; an inadequate response to the appellant's request for a higher rate of weekly compensation, as well as hurt, humiliation and stress as a result of his prolonged dispute with ACC.

[63] Mr Peart's report resulted in an ex-gratia payment to the appellant and Mr Peart also recommended a contribution towards his significant legal costs. Mr Peart also recommended an apology by ACC to the appellant in respect of the failures identified in his report.

[64] This report led to a mediated agreement dated 19 April 2018 between the appellant and ACC.

[65] The agreement also included a provision that ACC would provide a list of impairment assessors for the appellant to choose from.

[66] On 19 June 2019, Dr Cheesman, consultant occupational physician, completed an impairment assessment report, but deferred an impairment rating pending further information. Dr Cheesman's impairment assessment report was amended on 6 October 2019. Dr Cheesman concluded a whole person impairment of 23 per cent being split 13 per cent to pain disorder and 10 per cent to post traumatic stress disorder.

[67] Dr John Collier provided a peer review report of the 2019 impairment assessment by Dr Cheesman. In his report dated 29 April 2021, Dr Collier said:

> Overall, Dr Cheesman's ratings of 23% reflect his current function. It is observed that the highest rating of 36% is a similar rating to that likely to have been rated by Dr Reeves in 2004 when she was not assessing pain but was assessing his functionality based on reported PTSD symptomatology …
>
> Based on all of the comments above, I think Dr Cheesman had apportioned less than I would have considered. He noted that the mental and behavioural ratings due to PTSD were mixed with more recent pain disorder, and considered that in the final 23%, ten per cent of it was due to PTSD. This assessor would consider that was an error as the previous rating of 35% for PTSD in 2004 was deemed permanent and stable by Dr Reeves.
>
> **Summary**
>
> I agree with Dr Cheesman's report and ratings. The areas of dispute are whether or not it was correct to rate 0% for neck and back sprains and in the absence of radiculopathy or fracture, these can be justified.

[68] In a document entitled "Impairment Assessment Report – Supplementary Comment 5/8/2021", Dr Cheesman noted a different approach between himself and Dr Reeves, who was of the opinion that as at 19 October 2004, the overall figure was 40% and that figure would have suggested that the appellant was independent, but not fully effective or sustainable in all areas of function.

[69] It is noted also that in advice to ACC of 17 August 2021, Dr Collier commented further following Cheesman's supplement commentary of 5 August 2021. Dr Collier said:

> It is quite common for people with multiple injuries over multiple timeframes to have fluctuating levels of symptoms and I think Dr Cheesman's report correctly reflects the situation in June 2019. It is of course likely that in the ensuing two years, the situation may have further changed.

[70] Dr Meads carried out a further impairment assessment report on 19 April 2023 over a period of three hours. In his summary at page 35 of his report, he assessed a 15 per cent whole person impairment for PTSD and major depressive disorder following a sensitive claim injury of 22 March 2002.

[71] For the further injuries of 23 April 2003, being a sacroiliac sprain, CRPS Type I and torn achilles left, together with a somatoform pain disorder injury from 9 June 2006 and a neck sprain from 23 February 2007, Dr Meads found a 55 per cent whole person impairment.

[72] Also noted in his report that lumbar sprain injury of 1 August 2008 and back contusion on 10 August 2008 resulted in no additional impairment.

[73] The day after his assessment with Dr Meads, the appellant saw musculoskeletal medicine specialist, Dr Holtzhausen, who notes in her report:

> [The appellant] returns for review today of his recent CT SPECT scan imaging of the thoracic spine to try and clarify cause for his right thoracic and referred chest wall pain.
>
> …
>
> On examination today, [the appellant] has evidence for painful arc with discomfort subacromially between 60 and 120 degrees of the left glenohumeral abduction. He is maximally tender on palpation over his insertion area of the left supraspinatus to the left greater humeral tuberosity.

[74] At this consultation, Dr Holtzhausen carried out a corticosteroid injection in the appellant's left supraspinatus tendon.

[75] The doctor also noted that the appellant had requested injections for the left perineal tendons, pes anserine tendon attachment to the medial proximal tibial metaphysis and both sacroiliac joints. These were duly given.

[76] What then occurred was that on 1 June 2023, Dr John Collier, specialist psychiatrist and physiotherapist, peer reviewed Dr Meads' 19 April 2023 impairment assessment finding of 15 per cent whole person impairment for the 2002 sensitive claim and a 55 per cent rating for the 2003 sacroiliac sprain injury, 2006 somatoform pain disorder and 2007 neck sprain.

[77] Dr Collier was critical of Dr Meads' report in that he did not provide a full mental state examination, particularly with regard to symptoms of depression and PTSD and did not describe pain in terms of what modulates pain, what the ratings were and what relieved pain.

[78] He questioned whether Dr Meads adequately assessed impairment of the neck in the absence of examination of movements of the neck and lumbar spine.

[79] Dr Collier was also critical that no EMG or nerve conduction studies were carried out.

[80] He said that Dr Meads' assessment is fundamentally flawed because following a 2015 document from ACC, pain should be assessed under chapter 15 of the AMA Guides unless there is evidence of CRPS Type II or a diagnosed mental disorder of somatoform pain disorder.

[81] He said:

> 5.6 Dr Meads has produced a convoluted argument to assess pain twice, and that he has then proceeded to assess CRPS from the right sacroiliac joint and has extended it to the whole of the right lower extremity. Once Dr Meads has gone down the wrong pathway for the assessment, it produces inflated ratings.

[82] He noted that Dr Meads then moved on to assess, under chapter 14, for the accepted mental injuries of PTSD, major depression and somatoform pain disorder, but he noted in Dr Meads' assessment that he had not provided any diagnoses regarding the ongoing presence of PTSD, ongoing depressive symptoms or any diagnoses associated with long term benzodiazepine dependence and long term opiate dependency.

[83] Dr Collier said:

> 5.21 At this point, as peer reviewer, I would consider this to be a flawed impairment assessment, particularly with regard to double assessment of pain. The correct methodology is that Dr Meads should assess neck movement, lumbar spine movement and rate accordingly, and should assess the integrity of the left achilles tendon and movement, and should then move on to the chapter 14 impairment assessment, which provides a global rating for activities of daily living, social function, concentration and adaption. At that point apportionment should be made for non-covered factors.

[84] Dr Collier then went on to make comments on reports from other health professionals, including a report by Dr Rosy Fenwicke dated 11 November 2010. He referred to numerous reports from Dr Holzhausen. He then devotes a further two pages of his report to discussing Dr Cheesman's report as amended on 6 October 2019.

[85] He again says that he agrees with Dr Cheesman's report and ratings and under his heading "Summary and Response to Advice Sought", he again says that Dr Meads, in his opinion, has incorrectly assessed movement of the hip, knee, ankle and foot, producing incorrect ratings and that he has incorrectly rated the left achilles sprain. He also considers Dr Meads has incorrectly assessed the right and left lower extremities and has incorrectly rated the chapter 14 rating and the apportionment section. He also says that Dr Meads has duplicated ratings and has:

> … in my opinion incorrectly assessed the PTSD, and from reading his report, it is not possible to determine how much of the current presentation is a function of historic sexual abuse and how much is a function of the original injury in 2003.

[86] He recommended that the report of Dr Cheesman, which he peer reviewed in 2021, stands as correct.

[87] On 10 July 2023, Dr Meads commented on Dr Collier's report. Dr Meads said:

> It is noted that the ACC wish to direct (the appellant) to have another assessment with Dr Cheesman or Dr Collier. It seems to me a little strange that this direction was made, when they had previously been involved in doing reports or peer reviewing reports relating to the appellant.
>
> It seems a little unusual that Dr Collier is doing this peer review, reviewing an assessment of (the appellant) by myself, other assessors, previous peer reviewers, when he was the generator of previous peer reviews. That is his peer reviewing himself, which in my opinion leads him down a pre-designated pathway. His mindset was obviously influenced by the previous report he had peer reviewed and his previous peer review. I think this is unfair to the appellant.

[88] Dr Meads also says:

> Dr Collier sees the big flaw, that nullifies all my report, is that in the physical injury impairment assessment, I gave a rating for complex regional pain syndrome. He seems to be of the belief that one cannot have a physical or mental injury related to pain that can be assessed by using the guidelines both rating physical and mental injury. There has been a diagnosis, complex regional pain syndrome Type I made. There has been cover given for this by ACC. There has been cover accepted for mental injury.

Dr Collier states that all other assessors who have attended ACC training and ACC peer review monthly are agreed following the 2015 document from ACC that pain should be assessed under chapter 15 unless there is evidence of CRPS Type 2.

In my opinion, this statement is completely wrong and makes Dr Collier's peer review totally incorrect. The AMA Guidelines give a methodology for rating complex regional pain syndrome. I gave a brief summation of how in the AMA Guidelines this was recommended to be done.

…

My belief is that as Dr Collier has gone down this pathway of totally refuting chronic regional pain syndrome being rated under the physical portion of the report, his misunderstanding of what chronic regional pain syndrome is, and how it affects the body in its totality, creates an overwhelming flaw of his whole peer review.

Having given a rating for physical injury, I then went on to do a rating for mental injury. I believe that people who have a physical injury can also have a mental injury. I believe in rating pain, rating for physical impairment does not deny a rating for mental impairment, and vice versa. I have looked at my ratings of functional categories.

Dr Collier would see my ratings as being high. I would see his, as I would have of Dr Cheesman's, as being low.

It is noted that Dr Cheesman's report was done over two years ago.

…

In a man who struggles to do basic things such as shower, feed himself, surely puts him into the range of Class III Mid Upper Range, rather than Class II for activities of daily living.

I would see with all functional categories that Dr Collier/Dr Cheesman have completely underrated impairment.

[89] Dr Meads concluded:

Overall, having re-read my report, read Dr Collier's peer review, I believe that I have gone down a correct way in terms of methodology for doing an impairment rate for (the appellant). I have looked at the physical injury, looked at the mental injury. I have applied the correct methodology for rating both physical and mental.

I would see Dr Collier's misinterpretation, in not allowing complex regional pain syndrome to be rated as a physical injury, creates a major flaw in his peer review when it comes to physical injury.

I believe he has grossly underrated the functional categories when rating mental injury and this creates a major flaw in terms of his Peer Review when he comes to mental injury rating.

[90] It is unfortunate that Dr Collier and Dr Meads are at variance.

[91] At the end of the day, it was Dr Meads who carried out the impairment assessment with the appellant over a period of three hours and he concluded a whole person impairment, different from and greater than that of Dr Cheesman in 2019.

[92] In earlier advice to ACC on 17 August 2021, following his peer review "of most of the reports on (the appellant)" Dr Collier said of a report from Dr Reeves:

> I thought the social functioning rating was high considering his ability to attend work ...
>
> I would have rated social functioning lower …
>
> She rated concentration at 15% which again appears high for someone who is able to work full time, and I felt her rating for adaptation was high, although this was justified at the time by his frequent decompensation.
>
> Dr Reeves estimated whole person impairment was 35% and she apportioned 5% for family history of depression, so the final WPI was 30%. As Peer Reviewer, I think that rating was likely elevated because at the time he had only recently experienced further harassment in the workplace.

[93] Dr Collier concluded that advice to ACC by saying:

> It is quite common for people with multiple injuries over multiple timeframes to have fluctuating levels of symptoms and I think Dr Cheesman's report correctly reflects the situation in June 2019. It is of course likely that in the ensuing two years, the situation may have further changed.

[94] In this case, although Dr Collier is highly critical of Dr Meads' report, Dr Meads rejects that criticism and maintains that his assessment is proper.

[95] Plainly, where opinions differ in this highly nuanced area, there can be no absolute, correct answer. I note that in his peer review of Dr Cheesman's 2019 report, Dr Collier considers that Dr Cheeseman apportioned less than he, Dr Collier would have considered.

[96] It is noted that on 20 April 2023, the day after Dr Meads' impairment assessment, Dr Holzhausen, musculoskeletal medicine specialist, was trying to clarify the cause of the appellant's right thoracic and referred chest wall pain. Whilst at one level, a relatively minor issue, it serves to illustrate the challenges inherent in completing accurate impairment assessments.

[97] It is plainly not an exact science and as illustrated in this case, medical opinions differ.

[98] In this case I am not satisfied that Dr Meads' assessment has been shown on the balance of probabilities to be wrong.

[99] Accordingly, I find that ACC's decision dated 22 October 2019, declining the appellant's application for a further lump sum based on Dr Meads' assessment of 19 April 2023, was wrong.

[100] It follows that ACC is now required to make a further lump sum payment to the appellant based on Dr Meads' impairment assessment report. Accordingly, the appeal is allowed.

[101] Costs are reserved.

CJ McGuire
District Court Judge

Solicitors: JC La Hatte, Barrister
Ford Sumner, Solicitors, Wellington