**IN THE DISTRICT COURT**
**AT WELLINGTON**

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

**[2023] NZACC 144 ACR 177/22**

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| UNDER | THE ACCIDENT COMPENSATION ACT 2001 |
| IN THE MATTER OF | AN APPEAL UNDER SECTION 149 OF THE ACCIDENT COMPENSATION ACT |
| BETWEEN | GRAHAM MADOC<br>Appellant |
| AND | ACCIDENT COMPENSATION CORPORATION<br>Respondent |

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| Hearing: | 18 July 2023 |
| Heard at: | Dunedin/Otepoti |
| Appearances: | Ms B Woodhouse for the Appellant<br>Mr I Hunt for the Respondent |
| Judgment: | 12 September 2023 |

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**RESERVED JUDGMENT OF JUDGE C J MCGUIRE**
**[Revocation of Cover – s 65 Accident Compensation Act 2001]**

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[1] The issue in this appeal is the correctness of the respondent's decision dated 12 November 2021, which revoked cover that had earlier been granted for "pain in the lower back"

## Background

[2] On 22 March 2007, Mr Madoc injured his lower back while lifting deer carcasses weighing approximately 60 kilograms onto an overhead rail. The same day, Mr Madoc went to Dr Anis Khan, GP, who lodged a claim for pain in lumbar spine.

Dr Khan recorded the accident description as "hurt lower back while hanging deer on top of rail".

[3] On 10 April 2007, PPCS Limited, as an accredited employer, advised that Mr Madoc's lower back pain had been accepted as a work-related injury. (Note: The file does not disclose what the letters "PPCS" stand for

[4] On 7 May 2007, Dr Patrick Medlicott, orthopaedic surgeon, provided a report. He wrote, in part:

> He has had episodic low back pain over the years, which is not at all unusual for a man in his job. He has never, however, had pain sufficient to cause him to have long periods off work and his current pain is a-typical in that it extends into his leg as well as lower back. This episode began when he was lifting a carcass of a sheep onto a rail about six weeks ago. The carcass was around 60kgs. He felt something go in his back and developed quite significant low back pain and spasm and pain in the left leg, referred to the lower leg and at times into the foot, with a feeling of numbness in the left foot. He also had pain radiating around to the iliac crest on both sides. He has had some physical therapy and medication, but he still has moderate pain although he would like to think about going back to work reasonably soon.
>
> …
>
> Xrays of his lumbar spine show a bilateral lyric spondylolisthesis at L5/S1. There is minimal slip, less than a few mms. The upper part of the sacrum is prolonged and has adapted to the slip, which suggests that this is pretty chronic. The disc space is not grossly narrowed at this level. The disc space above (L4/L5) is only mildly narrowed, there are some changes in the upper lumbar spine of the disc space narrowing as well, but these are not symptomatic at the present time as his symptoms are all essentially low back.
>
> I have arranged for an MRI scan to see if there is any significant disc protrusion or compression either at the L5/S1 or perhaps at the L4/L5 level and as the spondylolysis and spondylolisthesis has obviously been present for some considerable time and may in fact be the cause of his present problems. I will see him again once his scan has been performed.

[5] On 1 June 2007, Dr Brett Lyons, radiologist, interpreted an MRI of Mr Madoc's lumbar spine. He reported in part:

> Broad based disc bulge at L5/S1 which has a more prominent left paracentral and far lateral component. This abuts both the descending left S1 and exiting L5 roots and both appear slightly swollen relative to their right sided counterparts. Nerve root irritation here is possible.

[6] On 30 June 2007, Dr Medlicott made a referral to Dr Murray Fosbender, orthopaedic surgeon. He stated in part:

> I would be grateful if you could see this man. I enclose a copy of my notes. I had a chat with him today after looking at his MRI and I didn't feel there was a major disc protrusion, although the S1 root on the left side seems quite a lot bigger than on the other side, suggesting swelling, but I can't see any obvious compression of it on the MRI presented. Your review of him would be appreciated as to whether he has anything that would be helped by surgery, or whether he is better to carry on with his non-surgical programme.

[7] On 23 July 2007, Dr Fosbender reported:

> **Specific diagnosis:**
> Diagnosis is of discogenic low back pain with instability, most likely at the level of L5/S1.
>
> **Proposed management and diagnosis:**
> I do not think surgery is appropriate for him. Therefore, I have sent him back to physiotherapy to start a more vigorous rehab programme.

[8] On 12 March 2008, Dr Bruce Hodgson, orthopaedic surgeon, provided a report. He concluded:

> Graham is suffering from low back pain which I believe is related to his spondylolisthesis and some change in the extensor mechanism.

[9] On 18 March Dr Hodgson wrote to PPCS. He stated:

> I am unable to completely state that his ongoing symptoms are wholly or substantially due to his pre-existing change, or that the effects of his injury in March 2007 are now completely resolved.

[10] On 12 May 2008, Dr Hodgson submitted an ARTP for posterior/posterolateral lumbar fusion with instrumentation and/or PLIF1 level and L5/S1 spinal stenosis decompression – 1 level. The diagnosis was listed as spondylolisthesis L5-S1 with instability at the lumbosacral junction.

[11] On 19 May 2008, PPCS approved the surgery request.

[12] On 18 June 2008, Mr Madoc underwent posterior/posterolateral lumbar fusion with instrumentation and/or PLIF1 level and L5/S1 spinal stenosis decompression – 1 level surgery, performed by Dr Hodgson.

[13] On 1 July 2019, Dr Reuben Johnson, neurosurgeon, provided a report. He concluded:

> It is evident that Mr Madoc's symptoms are multifactorial. Mr Madoc clearly had an injury to his lumbar spine which resulted in fusion surgery at L5/S1 and then L4/5.

[14] On 5 February 2021, Dr Johnson provided a further report. He stated:

> (1) On the balance of probabilities, based on your clinical review of Mr Madoc and the contemporaneous evidence in the bundles, it is more likely than not:
>
> (a) That Mr Madoc suffered a lumbar sprain in 2007 as a result of an accident?
>
> Looking back at my report in 2019, it is my view that Mr Madoc suffered an injury to his lumbar spine in 2007. I refer you to my letter for further details.
>
> (b) That any of the diagnosed conditions in the documentary evidence in your report are a consequence of, or consequential on, treatment?
>
> I advised in my letter that Mr Madoc's symptoms are multifactorial and I refer you to my answers to question 4 of my previous report. He had an injury to his lumbar spine and went on to have fusion surgery at L5/S1 and L4/5. He subsequently had degeneration at the levels above and this is a combination of natural progress of spondylitic changes, but also the fact there is incomplete L5/S1 fusion requiring revision would have contributed to the duration of symptoms. As before, I cannot identify which is the overriding factor.
>
> …
>
> Alternative questions posted by ACC are as follows:
>
> Claim 10000104975: Mr Madoc has cover for pain in his lumbar spine following the accident on 22.03.2007.
>
> 1. What was the actual physical injury sustained? That is, what was the injury diagnosed by the accident?
>
> It is very difficult in retrospect, by a period of over 13 years, to say exactly what physical injury was sustained. You will see from my previous correspondence that a lumbar injury was diagnosed by the orthopaedic surgeon at the time (Dr Patrick Medlicott). Xrays at the time were said to have shown a PARS defect at L5 and L5/S1 slip. An MRI report at the time (01.06.2007) indicated there was a disc bulge at L5/S1, with prominent left paracentral and bilateral component

> abutting both the descending S1 exiting L5 nerve roots. I have not seen that imaging myself and I am totally reliant on the report. However, it appears from the records that there was an injury to his back with development of symptoms on 22.03.2007. Imaging by xray and MRI has shown that there was a PARS defect, but it does not appear that he was symptomatic before this time. Therefore, it is possible, if not probable that he had a small disc prolapse in the lumbar spine as reported on the MRI. However, it is very difficult to ascertain more than this.

[15] On 21 September 2021, Dr Sefton Moy, provided a report. He said in part:

> None of Mr Madoc's treating orthopaedic surgeons commented whether the pathology in his lumbar spine was injury. However, one can make some inference by the nature of their referrals, their comments, and their management. Mr Medlicott was uncertain of the cause of symptoms. While he raised the possibility that the spondylolisthesis was not, he also did not think the disc protrusion was significant. He referred to Mr Fosbender, who diagnosed discogenic back pain with instability. This is significant because a traumatic disc injury itself does not cause instability. He made no causal link to the accident, only that the pain originated from the disc and it was associated with instability. On balance, this favours instability from spondylolisthesis causing discogenic pain rather over a traumatically symptomatic disc causing instability. Mr Hodgson stated that he felt the spondylolisthesis was the cause of Mr Madoc's pain and then performed a significant surgical procedure to treat it to stabilise the back. Mr Johnson, a neurosurgeon, was not able to provide a rationale that any of the pathologies was accident related, citing the length of time elapsed and the lack of first hand assessment of imaging. An orthopaedic surgeon for ACC, Mr Fong, clearly articulated a case for pre-existing pathology causing ongoing symptoms. He stated that the PARS defect and the disc pathologies at both L5/S1 and L4/5 were the cause of pain and that they were degenerative in nature. While he did not examine Mr Madoc, it is unlikely a physical exam 14 years later would add any clinical insight into the question of causation. It is apropos that Mr Fong, an orthopaedic surgeon, commented on causation of bony and disc pathology.
>
> That he had an accident is not disputed, but on balance the evidence supports that more likely than not, the cause of Mr Madoc's symptoms in 2007 was underlying spondylolisthesis and consequential degenerative change in both the L5/S1 and the L4/5 discs which pre-existed the accident. It is plausible that he suffered a soft tissue sprain, but this would have resolved relatively quickly and by the time he saw Mr Hodgson a year later, spondylolisthesis at L5/S1 and the disc bulges at L4/5 and L5/S1 were the cause of symptoms. The evidence supported that they were rendered symptomatic but not caused by the accident on 22/3/07.

[16] On 7 October 2021, David Barnes, technical specialist, provided an opinion. He wrote:

> Mr Madoc has cover for pain in lumbar spine. He has, but does not have cover for, spondylolisthesis and disc pathologies at L5/S1 and L4/5. Mr Johnson stated that Mr Madoc probably had a disc prolapse but said it was very difficult to ascertain more than this. If a claim for cover for a disc injury (or any other physical injury) was to be lodged now, on the evidence we have (and it seems highly unlikely that there is evidence that we don't have), the claim would be declined under the provisions of s 53 relating to prejudice to ACC's ability to make decisions. Therefore, we only have to consider whether granting cover for pain in lumbar spine was appropriate and if it was, whether the current symptoms and resultant entitlements can be linked to the covered injury.

[17] On 12 November 2021, ACC revoked cover for "pain in lower back". The decision was made on the basis that the original decision was incorrect because pain in and of itself is not a physical injury.

[18] On 20 January 2022, an application to review the decision was lodged.

[19] On 21 July 2022, Dr Hodgson provided a report. He said:

> He did have his initial injury on 22 March 2007, while hanging a deer carcass onto a rail. He developed significant back pain, with pain in his buttock and left hip. Sometimes it would go to the left leg, thigh and calf, and would be associated with discomfort.
>
> …
>
> I formed the opinion that he had sustained a left sided prolapse of the lumbosacral disc (disc prolapse) that had abutted the left L5 nerve root causing his discomfort and particularly sciatic symptoms.
>
> …
>
> **Conclusion and Opinion**
>
> In my opinion, Graham has suffered a left foraminal lumbosacral disc protrusion at the time of his original injury on 22 March 2007. This leading to the onset of his left L5 radicular sciatica as confirmed on clinical grounds. Xrays and on MR scanning in 2007.

[20] On 5 August 2022, the appellant's review application was dismissed.

## Appellant's Submissions

[21] Ms Woodhouse submits that pain may be a physical injury. The contrary view overlooks the fact that pain cannot exist in a vacuum and that injury may be at a microscopic level.

[22] She refers to *Falwasser v Attorney-General*[1]. The factual question for determination in that case was: Does the reaction of Mr Falwasser to pepper spray constitute physical injury?

[23] The Court said at paragraph 90:

> The approach to the question of interpretation of "physical injury" discussed in *Teen* is helpful and I propose to adopt it. Further, I accept that the natural meaning of "physical injury" involves hurt or harm that affects the body rather than the mind, or any incorporeal aspects of human existence.
>
> …
>
> [90] Applying such an approach to the interpretation of "physical injury", I am satisfied that Mr Falwasser suffered physical injuries from the effects of his exposure to pepper spray during the incident.

[24] Ms Woodhouse submits that the High Court took a generous and expansive approach as to what was an injury.

[25] She says that the primary diagnosis in Mr Madoc's case is pain over a number of years. She says the real focus should be on whether this was due to degeneration, rather than the accident event.

[26] She refers to the case of *Teen.*[2] She submits that in line with *Falwasser* "pain in lower back" is capable of being understood as a physical injury pursuant to the Act's requirements.

**Respondent's Submissions**

[27] Mr Hunt identifies two issues in this case that he says are primarily legal. The first is, is pain an injury? Secondly, can an assessment report and treatment plan be regarded as an upgraded request for cover?

[28] He says that ACC has made it clear a long time ago as to how it considers a claim for cover.

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1 *Falwasser v Attorney-General* CIV 2008-463-000701.

2 *Teen v Accident Rehabilitation and Compensation Insurance Corporation* [2003] NZHC 1006 (11 November 2003).

[29] He refers to the decision of *Jans*[3], where Her Honour Judge Henare said:

> The underlying principle in Accident Compensation law is that pain (or numbness) is not a personal injury. This principle was endorsed by the High Court in *Teen v ARCIC* (HC 11/11/03, CIV-2003-485-1478).

[30] Judge Henare in *Jans* also referred to the case of *Longtime*[4] where there was a claim for back pain from a hide process worker under the gradual process provisions of the Act. The court confirmed that no personal injury had been established for ACC purposes and the claim was declined.

[31] Also referred to in *Jans* was *Meneses*[5]. This was a treatment injury claim for a dispensing error where the error caused a patient functional difficulties, but no physical damage. Again, the Court confirmed that there had been no personal injury.

[32] Also referred to was *Baldwin*[6] where a claim for hip and thigh pain attributed to repetitive jumping during timber yard work was found by the Court not to constitute "personal injury".

[33] Likewise, in *Alexander*[7] chronic wrist pain on the part of a librarian was found by the Court not of itself to be a "personal injury" for ACC cover purposes.

[34] Mr Hunt also notes that *Falwasser* was not an ACC case. Rather, it was an action for damages in tort and under the New Zealand Bill of Rights Act. He submits that it cannot be regarded as authoritative in deciding what is an injury for the purposes of the Accident Compensation Legislation.

[35] Mr Hunt also refers to *Videbeck,*[8] where Judge Henare stated:

> There is much case law that pain is not evidence of a physical injury. It may be a symptom of a physical injury. Descriptions such as pain, stiffness, aching and swelling are symptoms and not evidence of physiological or bodily harm. *Monk v ACC* [2012] NZCA 615, *Mura v ACC* [2003] NZACC 133, and *Studman v ACC* [2013] NZHC 2598.

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3 *Jans v Accident Compensation Corporation* [2014] NZACC 80 at [16].
4 *Longtime v Accident Compensation Corporation* [2012] NZACC 188.
5 *Meneses v Accident Compensation Corporation* [2012] NZACC 328.
6 *Baldwin v Accident Compensation Corporation* [2013] NZACC 78.
7 *Alexander v Accident Compensation Corporation* [2013] NZACC 111.
8 *Videbeck v Accident Compensation Corporation* [2017] NZACC 121 at [23].

[36] Mr Hunt also submits that an assessment report and treatment plan (ARTP) has not been accepted as a new claim for cover.

[37] He said the way the Act works is that a claimant makes a claim for cover.

[38] Mr Hunt says that the decision of *Lister* put forward by Ms Woodhouse in support of her submission that an assessment report and treatment plan would satisfied the requirement for lodging a claim for cover, is not tenable.

[39] Mr Hunt refers to Judge Barber's decision in *Sinclair,*[9] where Judge Barber said:

> [53] The appellant acknowledges that there is no obligation upon ACC to instigate a claim for cover by lodging such a claim on behalf of a claimant. Nevertheless, the appellant submits that it is open to ACC to instigate such an investigation and if it chooses to do so, it must follow the statutory process including, where relevant, the provisions of s 54 and s 56-58.
>
> [54] I agree with Mr Hunt that this conclusion is simply not tenable. The whole scheme of ss 56-58 – as analysed by Judge Beattie in *Thomas* (supra) arises as and when, and only when, a claim is "lodged". The notion that ACC should "lodge" a claim with itself is untenable with the legislation.

[40] Mr Hunt summarises the position in this way:

> The assessment report and treatment plan is a request for ACC to grant to an entitlement which can only occur when cover is in place. He submits that in this regard, the authorities have been quite consistent in the approach that they have taken.

[41] Mr Hunt submits that if ACC were to accept an assessment report and treatment plan as a claim for cover, it would be ignoring its own statutory processes.

[42] He concludes by saying that the burden of the authorities supports the stance taken by ACC in this case.

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9 *Sinclair v Accident Compensation Corporation* [2009] NZACC 175.

**Appellant's Reply**

[43] So far as lodging a claim for cover, Ms Woodhouse notes that it is not necessarily easy for claimants to see a GP in order to have a claim lodged for cover. Indeed, routine claims for cover are not always signed off by GPs.

[44] She submits that in line with ACC's investigative functions, there is no reason why ACC cannot use the information that it has to revoke existing cover and to add a different injury for which there would be cover.

**Decision**

[45] At issue on this appeal is the respondent's decision of 12 November 2021 revoking the appellant's cover for "pain in the lower back".

[46] On 22 March 2007, the appellant injured his lower back when lifting deer carcasses onto an overhead rail. That same day, he saw his GP, Dr Khan, who lodged a claim for pain in lumbar spine.

[47] On 10 April 2007, PPCS Limited, as an accredited employer, advised that Mr Madoc's lower back pain had been accepted as a work related injury.

[48] Following the submission of an assessment report and treatment plan dated 12 May 2008, PPCS Limited approved surgery and on 18 June 2008, the appellant underwent postero/posterolateral lumbar fusion and spinal stenosis decompression, performed by Dr Hodgson.

[49] In 2019 ACC initiated a medical review of the appellant's file which was conducted by neurosurgeon Reuben Johnson. This occurred on 1 July 2019 and included a face to face meeting with the appellant and his wife. An MRI of the appellant's cervical and lumbar spine was carried out on 16 July 2019, following which Mr Johnson said that treatment options of non-operative pain control or further lumbar fusion could be considered.

[50] On 5 February 2021, Mr Johnson reported again. He noted that the appellant:

> … subsequently had degeneration at the levels above and this is a combination of natural process of spondylitic changes, but also the fact that there was incomplete L5/S1 fusion requiring revision would have contributed to the duration of symptoms. As before, I cannot identify which is the overriding factor.

[51] Mr Johnson went on to say:

> It is very difficult in retrospect, by a period of over 13 years, to say exactly what physical injury was sustained. You will see from my previous correspondence that a lumbar injury was diagnosed by the orthopaedic surgeon at the time (Dr Patrick Medlicott). Xrays at the time were said to show a PARS defect at L5 and L5/S1 slip. An MRI report at the time (01.06.2007) indicated there was a disc bulge at L5/S1 with prominent left paracentral and bilateral component abutting both the descending S1 exiting L5 nerve roots. I have not seen that imaging myself and I am totally reliant on the report. However, it appears from the records that there was an injury to his back with development of symptoms on 22/03/2007. Imaging by xray and MRI has shown that there was a PARS defect, but it does not appear that he was symptomatic before this time. Therefore, it is possible, if not probable, that he had a small disc prolapse in the lumbar spine as reported on MRI. However, it is very difficult to ascertain more than this.

[52] Then there is the report of Dr Sefton Moy of 21 September 2021 who said:

> That he had an accident is not disputed but on balance, the evidence supports that more likely than not, the cause of Mr Madoc's symptoms in 2007 was underlying spondylolisthesis and consequential degenerative change in both the L5/S1 and L4/5 discs, which pre-existed the accident. It is plausible that he suffered a soft tissue strain, but this would have resolved relatively quickly and by the time he saw Mr Hodgson a year later, the spondylolisthesis at L5/S1 and the disc bulges at L4/5 and L5/S1 were the cause of symptoms. The evidence supported that they were rendered symptomatic not caused by the accident of 22/3/07.

[53] In its decision of 12 November 2021, ACC revokes its decision of 10 April 2007 pursuant to s 65(1) of the Act. Section 65(1) provides that:

> If the Corporation considers it made a decision in error, it may revise the decision at any time, whatever the reason for the error.

[54] Relying on s 65(1), in its decision letter of 12 November 2021, ACC revoked its decision of 10 April 2007, saying:

> The original decision was incorrect at the time because pain itself is not a physical injury. Section 26(1)(b) of the Accident Compensation Act defines personal injury as meaning "a physical injury" suffered by a person including, for example, a strain or sprain. This definition requires evidence or identification of a discrete physical injury, that is, physical harm caused to the

> body. It requires more than there mere experiencing of pain which itself is not an injury but may be a symptom of injury. The physical injury itself needs to be identified.

[55] In making this decision, ACC relied on a medical case review dated 25 January 2021 by Mr Johnson. Mr Johnson found that That Mr Madoc suffered an injury to his lumbar spine in 2007. And in response to the question as to whether any of the appellant's diagnosed conditions recorded in the documentary evidence are a consequence of or consequential upon treatment, he said:

> I advised in my letter that Mr Madoc's symptoms are multifactorial and I refer you to my answer to question 4 in my previous report. He had an injury to his lumbar spine and went on to have fusion surgery at L5/S1 and L4/5. He subsequently had degeneration at the levels above and this is a combination of natural progress of spondylitic changes, but also the fact there was incomplete L5/S1 fusion requiring revision which would have contributed to the duration of symptoms. As before, I cannot identify which is the overriding factor.

[56] In response to the question "what was the actual physical injury sustained?", Mr Johnson said:

> … it is possible, if not probable that he had a small disc prolapse in the lumbar spine as reported on the MRI. However, it is very difficult to ascertain more than this.

[57] However, the focus ultimately in this case is whether, at the time of the revocation decision on 12 November 2021, the appellant had a physical injury.

[58] That is why counsel reviewed a number of decisions relevant to this issue. In Judge Henare's decision in *Jans,*[10] she states that the underlying principle in Accident Compensation Law was that pain (or numbness) is not a personal injury. A principle endorsed by the High Court in *Teen.*[11] Judge Henare went on to refer to four other recent decisions where the District Court had reached the same conclusion.

[59] Accordingly, on the basis of settled law in this respect, I am unable to find that the pain experienced by the appellant is an injury for which cover may be granted.

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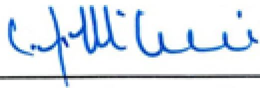
[10] See *Jans* n3 above.
[11] See *Teen* n2 above.

[60] Likewise, I find that the assessment report and treatment plan cannot be regarded as a claim for cover. Its reason and purpose is to provide ACC with information in respect of the covered injury and how it is proposed to be treated. Accordingly, I must find that the appellant has not shown on the balance of probabilities that ACC's letter of 12 November 2021 revoking cover was wrong. Therefore, I must dismiss this appeal.

[61] Costs are reserved.



CJ McGuire
District Court Judge

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