IN THE DISTRICT COURT
AT WELLINGTON

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

[2023] NZACC 72 ACR 44/22

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

Hearing: 24 March 2023
Heard at: Auckland / Tamaki Makaurau

Appearances: Mr B Hinchcliff for the Appellant
Mr F Becroft for the Respondent

Judgment: 11 May 2023

RESERVED JUDGMENT OF JUDGE C J MCGUIRE
[Deemed Cover s 58 Accident Compensation Act 2001]

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[1] This appeal relates to a decision by the respondent dated 8 September 2021 revoking deemed cover for sciatica and a disc protrusion.

[2] The key issue is whether the appellant's disc pathology which generated his symptoms was caused by an accident on 10 February 2020 and/or 31 August 2020.

[3] On 12 February 2020, the appellant went to Counties Urgent Care. He was triaged by a nurse, who recorded:

> Playing frisbee and injured lower back on Monday.
> Tingling down L leg, some discomfort but nil pain (d)own leg.

Nil previous HX of back pain.

Nil issues BM/urinary.

Mobilising slowly with discomfort.

[4] The doctor's notes of the same day include the following:

History:

As per nurse's notes/pain immediately after, but later worsen pain, v difficult with movt/esp bending over N extending/rotation is OK/improving.

Lower back mainly with yest tingling L leg.

Sleeping v painful all positions/had to drive a distance yest (yesterday).

…

Examination:

Some tenderness LT loin area n over LT SI joint.

Flex limitation just below knees/n ext limitation/lateral flex to the LT painful RT OK lateral glide to RT painful on LT/less so on glide to LT.

Balance N WT bear each leg OK.

Limitation SLR L worse than R.

…

Treatment:

Heat massage and stretches physio.

Advice and follow up plan:

See GP if no improvement or return to us if any deterioration. Red flags incl weakness, numbness.

[5] The appellant was interviewed by ACC assessor Ms Broomhall on 17 February 2020. He gave the following injury and accident details:

Playing frisbee, I jumped and something went (I felt a ping) in my lower back and I couldn't walk properly afterwards.

…

> Doctor said I have twisted it and something is pressing on my sciatic nerve, which is making my L leg go numb and weak. I haven't been referred to any physio because the GP wants to see if it resolves on its own.

[6] The appellant also told the interviewer that on 14 February 2020 he went to the Papakura East Medical Centre and was told "that something was pressing on my nerve and the best thing is to rest and see them in a week and a half".

[7] The appellant also saw physiotherapist, Stephanie Wilcox, on 20 February 2020. There are no notes in the bundle relating to this consultation.

[8] The appellant saw the physiotherapist again on 27 February 2020.

[9] The appellant reported to her:

> Sore after last session. Feels like the L (left) LL (left lower limb) gives way every fourth step or so, but not really pain with it …

[10] A week later, on 5 March 2020, the appellant reported to the physiotherapist:

> Back feeling good. Feels like L(LL) (left lower leg) gives way every (sic) occasionally …

[11] The physiotherapist noted on examination:

> L (LL) strength 5/5 – just IRQ (inner range quadriceps) control occ poor.

[12] On 12 March 2020, the appellant reported to the physiotherapist:

> Back feeling good. Looking at RTW (return to work) next week. No issues with leg this week. Has been much more active and done exercises also.

[13] The physiotherapist recorded under the heading "Analysis" the following:

> Good progress and functionally good for RTW. Hopefully able to graduate back to full duties with Ax (assistance) of apprentice.

[14] On 31 August 2020, the appellant had a further accident. He attended Counties Urgent Care, where he was initially assessed by a student nurse who recorded the following history:

This morning Pt was under a house and twisted his body and felt a pain in the lower L side of his back.

Pt states there was an instant sharp pain.

Pt states that there is a tingling feeling going down his L leg.

Pt states that the lower back feels weak when standing and getting up. Feels like he loses strength in his L leg.

Limited ROM.

Hx of spraining lower back, feels like the same pain.

[15] After examination by the doctor, the following was recorded:

Mild antalgic gait.

No central spine tenderness.

Tender left lower lumbar paraspinal muscle – worse on lateral flexion towards R (more than) L.

Forward flexion up to 40 deg before mild tightness at back.

SLR (straight leg raise) negative. Normal sensation in lower legs throughout. Normal power 5/5 except left HP flexion limited by pain in the back.

[16] Under the heading "Advice and Follow Up Plan" is this:

Avoid bending/heavy lifting.

Discussed re: ACC - patient reports no alternative duty from heavy duty – process of ACC, patient would like to have unfit for work straight away, rather than prescribed alternative duty.

Given off work for 10 d.

Advised to return/see GP if it needs further extension.

See Dr if worsening pain/develop urinary retention/bowel incontinence/fever.

[17] On 27 November 2020, the appellant underwent an MRI scan. Under the heading "Impression" is this:

Moderate L4-5 and L5-S1 spondylosis with disc bulging, central protrusions and annular fissures at each level. No significant canal or foraminal narrowing and no significant neural compression.

[18] On 4 February 2021, the appellant was seen by Mr Ferguson, Spinal Surgeon.

[19] Mr Ferguson recorded a diagnosis of:

> L4/5, L5/S1 disc herniations.
>
> …
>
> **History:**
>
> Andrew injured himself in February of last year and again in September. Both occasions he describes sudden onset low back pain with left sided gluteal pain and radiation down the left lower limb. Despite this, he continued working until November when ongoing issues with his employers conduct led him to decide to resign.
>
> …
>
> **On Examination:**
>
> *Pain Diagram*: He draws a fairly clear L5 radiculopathy on the left.
>
> *Neurological Exam*: There is a little bit of gastrocsoleus complex on the left and he has a clear pattern of sensory alteration in the L5 dermatome.
>
> There is difficulty in maintaining a single leg deep knee bend on the left; he has no problems whatsoever on the right.
>
> **Imaging:**
>
> He has an MRI scan which demonstrates loss of T2 weighted signal and significant disc bulges of both L4/5 and L5/S1 that are really very central but potentially worse on the left hand side. There is also some pain films done in the supine positive, but none done erect.
>
> **Impression and Treatment Plan:**
>
> From my point of view, I believe both discs are probably part of his pain generator. It is quite likely that when he loads his spine, either in a seated or standing position, the neural compression is worse than it is on the MRI. I have ordered a standing xray to test this theory … I think some nerve conduction studies should be done to determine whether or not there is peripheral neuropathy at work here as well.

[20] X-rays carried out on 4 February 2021 confirmed mildly reduced disc heights at L4-5 and L5-S1.

[21] Nerve conduction studies carried out on 17 March 2021 were normal.

[22] Mr Ferguson reported again on 8 April 2021. He said:

> I believe Andrew's original condition was disc herniations at L4/5 and L5/S1. I do believe they were caused by the event described, which in February was jumping up to catch a frisbee, twisting, rotating and falling to the ground. This combination of axial load, flexion and rotation is classic in producing a lumbar disc injury. It would seem he partially recovered from this and then when, in September, he was examining the underside of a house, once again on hands and knees, flexed and rotated with a degree of load, he aggravated the pre-existing disc injury and caused an enlargement of the herniation.
>
> …
>
> With regard to the recent MRI scan, one could choose to describe the pathology seen as degenerative, but one must ask what the event that occurred that precipitated the degeneration was. From my point of view, Andrew is an otherwise healthy young male. He has no clinical signs of connective tissue disorder, or significant family history of spinal pathology. He has a clear history of trauma, with the exception of the two injured discs at L4/5 and L5/S1. I can see no evidence of widespread pathology through the rest of his MR imaged spine. I therefore think on the balance of probabilities it is most likely that he has post traumatic disc degeneration and should be covered by ACC.

[23] In a written guidance transcript dated 4 May 2021, ACC's clinical advisor, Mr Troughton (BFC, BPhty, PG Cert Clinical Teaching) says this:

> Mr Ferguson's contention is that the client sustained two disc herniations as a result of jumping to catch a frisbee. It is considered somewhat implausible that this activity would cause two simultaneous disc herniations. Significantly, and as described, the client's initial presentation following the frisbee catching incident and the clinical course of recovery is not consistent with two levels of acute disc herniation.

[24] ACC's Clinical Advisory Panel considered the appellant's case in a report dated 20 July 2022. The Clinical Advisory Panel consisted of six orthopaedic surgeons, a sports medicine specialist and an occupation and environmental medicine specialist.

[25] The CAP concluded that the appellant's covered accidents, including those of 10 February 2020 and 31 August 2020 did not provide a causal link with the appellant's lumbar disc deterioration and the surgery proposed by Spinal Surgeon, Mr Ferguson.

Appellant's Submissions

[26] Mr Hinchcliff, on behalf of the appellant, submits that the Clinical Advisory Panel's decision is flawed. He first turns to the ACC interview script dated 17 February 2020 between ACC's assessor, Ms Broomhall, in which the appellant described the accident as:

> Playing frisbee, I jumped and something went (I felt a ping) in my lower back and I couldn't walk properly afterwards.

[27] The interview also records that on attending Counties Urgent Care on 12 February 2020, he told the assessor:

> No-one has said much about what's happening apart from something is pressing on my nerve and to go home and rest for 30 days.

[28] Mr Hinchcliff notes that the appellant's back did not get better, with the physiotherapist giving a provisional diagnosis of "lumbar sprain … - ?? disc but resolving".

[29] Mr Hinchcliff refers to the accident on 31 August when there was instant sharp pain with tingling going down his left leg and that his "lower back feels weak when standing and getting up, feels like he loses strength in his L leg".

[30] Mr Hinchcliff notes that the MRI of 27 November 2020 recorded a finding:

> There is mild narrowing of the right foramen, with contact but no compression of the foraminal portion of the right L5 nerve.

[31] In this regard, Mr Hinchcliff also notes that Spinal Surgeon, Mr Ferguson, in his report of 4 February 2021, said:

> It is quite likely that when he loads his spine, either in a seated or standing position, the neural compression is worse than it is on the MRI.

[32] Mr Hinchcliff also takes issue with the Clinical Advisory Panel's statement that:

> If there had been L4/5 and/or L5/S1 disc damage then we would have expected pins and needles, numbness and weakness in that specific dermatome on one side, in one leg …
>
> That is not the case here. There were no motor or sensory or other neurological deficits.

[33] Mr Hinchcliff points to the triage nurse on 12 February 2020, noting "Tingling down L leg, some discomfort …".

[34] He also points to Dr Henrys' note of the same day:

> See GP if no improvement or return to us if any deterioration. Red flags incl weakness, numbness.

[35] Mr Hinchcliff submits that there is no evidence to support the Clinical Advisory Panel's statement that the appellant had slowly developed gradually worsening lower lumbar disc symptoms and signs.

[36] Mr Hinchcliff also points out that after February 2020, there was the Covid lockdown.

[37] Mr Hinchcliff notes that the Clinical Advisory Panel has not recorded that when the appellant returned to work, he did so having the assistance of an apprentice.

[38] Mr Hinchcliff submits that the appellant did sustain an acute injury and that the evidence of Mr Ferguson, Spinal Surgeon, should be preferred.

Respondent's Submissions

[39] Ms Becroft submits that the appellant's initial presentation is not consistent with an acute disc injury.

[40] She notes that the appellant drove for eight hours on the day following the accident of 10 February 2020. She notes that the doctor's initial recommendation was for "heat massage and stretches physio".

[41] Ms Becroft notes that on seeing the physiotherapist, the appellant made good progress. The physiotherapist recorded on 12 March 2020:

> Good progress and functionally good for a RTW. Hopefully able to graduate back to full duties with (assistance) of apprentice.

[42] She therefore submits that the appellant's recovery is consistent with a soft tissue injury.

[43] Ms Becroft refers to the MRI of 27 November 2020 which notes that there are disc changes at L3-4; L4-5; and L5-S1.

[44] She refers to the CAP report that the range of the appellant's symptomology is not consistent with acute injury, but is more consistent with a slow degenerative condition.

[45] She says that Mr Ferguson is incorrect in his report of 8 April 2021 when he describes the February accident as including a fall to the ground.

[46] Ms Becroft also submits that the MRI scan does not support Mr Ferguson's view that he can see no evidence of widespread pathology through the rest of the appellant's MR imaged spine.

[47] Ms Becroft notes that the Clinical Advisory Panel refers to a study from the American Journal of Neuro Radiology entitled "Systematic Literature Review of Imaging Features of Spinal Degeneration in A-symptomatic Populations". In the appellant's age cohort, disc degeneration is present in 52 per cent of cases and disc bulge is present in 40 per cent of cases.

[48] Ms Becroft submits that the Clinical Advisory Panel report is comprehensive and compelling.

Appellant's Reply

[49] Mr Hinchcliff explained that his client drove for eight hours on the day following the 10 February 2020 injury because he had been best man at a wedding in Masterton and had to drive back to Auckland the following day to see his children. He also notes that the respondent has not stated that his client's condition was wholly or substantially caused by pre-existing conditions.

Decision

[50] On 10 February 2020, the appellant, then aged 28, had an accident whilst playing with a frisbee at a wedding celebration. In the claim form lodged with ACC two days later, the description of the accident was:

> Playing frisbee and jumped to catch it and somehow twisted my lower back.

[51] In a telephone interview with ACC on 17 February 2020, described the accident as follows:

> Playing frisbee, I jumped and something went (I felt a ping) in my lower back and I couldn't walk properly afterwards.

[52] Before the reviewer, the appellant described the accident:

> I was playing frisbee. I jumped up to catch the frisbee and as I did, I rotated and bent forward, umm, and when I landed, I had immediate pain in my lower back.
>
> …
>
> And then I, so, I got a tingling sensation down my left leg, so I went and lay down on the deck, umm, any movement that I made I got a, a sharp pain.

[53] He also described what occurred to the nurse at Counties Urgent Care on 12 February 2020

> Playing frisbee and injured lower back on Monday.
>
> Tingling down L leg, some discomfort but nil pain (d)own leg.
>
> Nil previous HX of back pain.

[54] The nurse noted also:

> Mobilising slowly with discomfort.

[55] On the same occasion, Dr Henrys also examined the appellant, noting the following:

> Some tenderness LT loin area N over LT SI joint.
>
> Flex limitation just below knees/n ext limitation/lateral flex to the LT painful RT OK lateral glide to the RT painful on LT/less so on glide to LT.
>
> Balance N WT bear each leg OK.
>
> Limitation SLR L worse than R sensation N power OK.

[56] The GP listed the following under the heading "Treatment":

> Heat massage and stretches physio.
>
> **Advice and follow up plan:**
>
> See GP if no improvement or return to us if any deterioration. Red flags incl weakness, numbness.

[57] The appellant did as the doctor had recommended and underwent physiotherapy, starting on 20 Febraury 2020.

[58] The physiotherapist noted on 27 February 2020:

> **Subjective:**
>
> Sore after last session. Feels like the L (left) LL (left lower limb) gives way every fourth step or so, but not really in pain with it. Has had cramps behind his L knee for two-three nights, but not last night.

[59] On 5 March 2020, the appellant reported to the physiotherapist:

> Back feeling good. Feels like L(LL) (left lower leg) gives way very occasionally …

[60] Under "Analysis", the physiotherapist noted:

> Build up muscles required for RTW – plumber. Work on knee control – nil pain or neural referral in the LL/B&S.

[61] The physiotherapy session of 12 March 2020, the physiotherapist noted:

> Good progress and functionally good for RTW - hopefully able to graduate back to full duties with Ax of apprentice.

[62] What follows from both the GPs and the physiotherapist's notes is that the appellant had recovered in the manner that each professional had expected.

[63] The appellant had a further accident on 31 August 2020. That morning, whilst underneath a house, he had twisted his body and felt pain in the lower left side of his back.

[64] The history recorded by the nurse at Counties Urgent Care was as follows:

> This morning Pt was underneath a house and twisted his body and felt a pain in the lower L side of his back.
>
> Pt states there was an instant sharp pain.
>
> Pt states that there was a tingling feeling going down his L leg.

> Pt states that the lower back feels weak when standing and getting up. Feels like he loses strength in his L leg.
>
> Limited ROM.
>
> Hx of spraining lower back, feels like the same pain.

[65] The doctor diagnosed lower lumbar sprain. The Appellant was given medication and advised to do gentle stretching and to consider physiotherapy. He was to avoid bending and heavy lifting.

[66] The doctor declared him unfit for work for ten days and he was advised to return and see the GP if he needed a further extension.

[67] In November 2020, the appellant was referred to Mr Ferguson, Orthopaedic Surgeon, who arranged for an MRI scan to be taken. The MRI scan showed moderate L4/5 and L5/S1 spondylosis with disc bulging and the central disc protrusions and annular fissures at each level. There was no significant neural compression.

[68] The report also noted minor disc bulging at the L3/4 level.

[69] On 4 February 2021, xrays of the lumbosacral spine were taken, confirming mildly reduced disc heights at L4/5 and L5/S1.

[70] The appellant was referred to Spinal Surgeon, Mr Ferguson, by his GP.

[71] In his first report dated 4 February 2021, Mr Ferguson said:

> I believe both discs (L4/5 and L5/S1) are probably part of his pain generator. It is quite likely that when he loads his spine either in a seated or standing position, the neural compression is worse than it is on the MRI. I have ordered a standing xray to test this theory but also given the relative significance of the weakness that he has relative to the findings on MRI, I think some nerve conduction studies should be done to determine whether or not there is a peripheral neuropathy at work there as well. Once these studies have been performed, we will review him and discuss whether or not I think he would be better served with a lumbar micro decompression or a lumbar decompression, discectomy infusion.

[72] Prior to his MRI scan in November 2020, there had been a further consultation with his GP on 2 November 2020. On this occasion, his GP reported:

> In February 2020, injured lower back jumping up and twisting to get a frisbee, with instant lower left back pain in mid-air and needed to go and lie down – since then left leg has felt weak and there has been tingling and numbness intermittently in the left foot on outside. His leg can give way at times.
>
> May experience shooting pains down back of left thigh to lower leg. There is grad 4/5 power left knee flexion and extension and ankle flexion.
>
> Difficulty walking on toes, but not heels.
>
> Has full range of movement lumbar spine and normal SLR (some hamstring limitation) – very brisk reflexes all round.
>
> Re-injured back in September when under a house checking for a leak and twisted.
>
> Imp – mechanism of injury is more for a facet sprain rather than a significant disc prolapse, but has significant neurological symptoms which coincide with injury.
>
> For xray and will prob refer.

[73] Mr Ferguson, Spinal Surgeon, next reported on 8 April 2021. He commenced that report saying:

> I believe Andrew's original condition was disc herniations at L4/5 and L5/S1. I do believe these were caused by the event described, which in February was jumping up to catch a frisbee, twisting, rotating and falling to the ground. This combination of axial load, flexion and rotation is classic for producing a lumbar disc injury. It would seem he partially recovered from this and then when, in September, he was examining the underside of a house, once again on hands and knees, flexed and rotated with a degree of load, he aggravated the pre-existing disc injury and caused an enlargement of the herniation.

[74] Mr Ferguson went on:

> One could choose to describe the pathology seen as degenerative, but one must ask what the event that occurred that precipitated the degeneration was. From my point of view, Andrew is an otherwise healthy young male. He has no clinical signs of connective tissue disorder, or significant family history of spinal pathology. He has a clear history of trauma, and with the exception of the two injured discs at L4/5 and L5/S1. I can see no evidence of widespread pathology through the rest of his MR imaged spine. I therefore think on the balance of probabilities it is most likely he has post traumatic disc degeneration and should be covered by ACC.

[75] The respondent's strongest evidence against an accident or accidents causing the appellant's presentation comes from the Clinical Advisory Panel report from 21 June 2022.

[76] At page 3 of its report, the Panel explained that if there had been L4/5 and/or L5/S1 disc damage, "then we would have expected pins and needles, numbness and weakness in that specific dermatome on one side, in one leg". The Panel goes on to say:

> There were no motor or sensory or other neurological deficits. Dr Jane Henrys documented normal power and sensation two days after the accident, which points away from disc damage or internal spinal disruption.

[77] The triage nurse on 12 February 2020 did note:

> Tingling down L leg, some discomfort but nil pain down leg.

[78] The appellant reported similarly on 31 August 2020, after the incident underneath the house. The nurse's note of 31 August records:

> Pt states there was an instant sharp pain.
>
> Pt states that there is a tingling feeling going down his L leg.
>
> Pt states that the lower back feels weak when standing and getting up, feels like he loses strength in his L leg.

[79] Likewise, GP Dr Holmes records the following clinical note in a consultation on 2 November 2020:

> In Feb 2020 injured lower back jumping up and twisting to get a frisbee – instant lower left back pain in mid air and needed to go and lie down – since then left leg has felt weak and there has been tingling and numbness intermittently in left foot on outside.
>
> His leg can give way at times.
>
> May experience shooting pains down back of left thigh to lower leg.
>
> …
>
> Imp – mechanism of injury is more for a facet sprain rather than a significant disc prolapse, but has significant neurological symptoms which coincide with injury.

[80] I have no reason to not take these reports at their face value. They indicate weakness, tingling and numbness intermittently from February 2020 onwards. Accordingly, I disagree with the Panel's view that there were no motor or sensory or other neurological deficits. The physiotherapist on 27 February 2020 also noted the appellant reporting that:

> Feels like the left lower leg gives way every fourth step or so, but not really pain with it.

[81] Whilst I accept the Panel's report that there is "no documented neurological motor and sensory deficits, I have no reason to disbelieve the appellant's descriptions of the same on different occasions over a period of almost nine months.

[82] The CAP agreed that jumping, twisting, rotating and falling can cause significant injuries. However, the Panel says that Mr Tutts' contemporary records over some weeks by multiple providers contain no convincing evidence of neurological deficits, spinal instability or acute disc herniations.

[83] What the appellant did following both injuries was to go to his GP very promptly. An MRI undertaken within days of his first injury may have put the whole issue of causation beyond doubt. However, what Mr Tutt did was reasonable in the real world.

[84] While the research referred to by the Panel plainly shows that a significant portion of the population by age 30 have disc bulges and disc degeneration, the issue here remains whether or not the appellant's disc bulging at L4/5 and L5/S1 levels was natural degeneration or whether it was caused by, or materially contributed to, by the injuries he sustained.

[85] Mr Ferguson, in his report of 8 April 2021, says:

> I believe Andrew's original condition was disc herniations at L4/5 and L5/S1. I do believe they were caused by the event described, which in February was jumping up to catch a frisbee, twisting, rotating and falling to the ground. This combination of axial load, flexion and rotation is classic for producing a lumbar disc injury. It would seem that he partially recovered from this and then when, in September, he was examining the underside of a house, once again on hands and knees, flexed and rotated with a degree of load, he aggravated the pre-existing disc injury and caused an enlargement of the herniation.

[86] This case is finely balanced. In reaching my decision, I must weigh all of the evidence that in this case include that of the Spinal Surgeon, the Clinical Advisory Panel, the GPs, the GP Practice Nurses, the Physiotherapist and the evidence of the appellant himself. The conclusion that I reach is that the appellant took all appropriate steps to rehabilitate himself after both the February and August accident. He initially went back to work in March, knowing that he had the assistance of an apprentice.

[87] When he had the further accident on 31 August 2020, the appellant reported to the Nurse that it "feels like the same pain". The appellant reported "an instant sharp pain; …tingling feeling going his L (left) leg… that the lower back feels weak when standing and getting up, feels like he loses strength in his L (left) leg … limited ROM (range of movement)".

[88] His accounts of injury and consequences are consistent.

[89] On the balance of probabilities therefore, I conclude that the appellant's disc protrusions were caused by or materially contributed to the two accidents in February 2020 and therefore the respondent's decision of 8 September 2021 revoking deemed cover for sciatica and disc protrusion is wrong and is hereby reversed.

[90] Accordingly, the appeal is allowed.

[91] Should there be any issue as to costs, Counsel have leave to file memoranda in respect thereof.

CJ McGuire
District Court Judge

Solicitors: ACC and Employment Law, Ellerslie
Medico Law Limited, Grey Lynn