IN THE DISTRICT COURT
HELD AT WELLINGTON

Decision No. [2010] NZACC 86

IN THE MATTER of the Injury Prevention, Rehabilitation and Compensation Act 2001

AND

IN THE MATTER of an appeal pursuant to Section 149 of the Act

BETWEEN **WAYNE MEYRICK**

(AI 268/08)

Appellant

AND **ACCIDENT COMPENSATION CORPORATION**

Respondent

HEARD at WELLINGTON on 4 May 2010

APPEARANCES

Mr M Dixon-McIver, Advocate for Appellant.
Ms S Churstain, Counsel for Respondent.

RESERVED JUDGMENT OF JUDGE M J BEATTIE

[1] This appeal encompasses two primary decisions of the respondent, both determined within one review decision given on 19 December 2006.

[2] The first decision was that of the respondent dated 23 May 2006, whereby it determined that the appellant's then incapacity was not attributable to a cervical and shoulder strain injury suffered on 24 April 2005, but was as a consequence of generalised degenerative changes to the appellant's cervical spine.

[3] The second decision of the respondent was on 14 December 2006, whereby it determined that there was no causative link between the appellant's ongoing incapacitating back condition and a head injury suffered by the appellant on 29 November 1996 and for which he had had received cover.

[4] It is the respondent's contention that in respect of both issues, the medical evidence is overwhelmingly to the effect that the appellant is displaying severe multi-level degenerative changes in his cervical spine but there is no causal nexus with either the head injury of 1996 or the shoulder sprain injury of April 2005.

[5] The background facts relevant to the issue in this appeal may be stated as follows:

- On 29 November 1996 the appellant, then aged 36 and employed as a builder, fell approximately three metres from a roof onto a concrete surface, landing on his head.
- He was briefly unconscious and taken immediately to Wellington Hospital.
- The principal injury suffered by the appellant was an occipital skull fracture extending towards vertex.
- He also suffered some small contusions and the only other injury identified was a fracture of the left clavicle.
- A CT scan of his cervical spine identified it as being satisfactory.
- After several months of rehabilitation, the appellant was able to re-engage in his pre-injury employment as a builder, eventually becoming a self-employed builder in his own business.
- On 26 April 2005 the appellant was lifting a child out of a child restraint seat when he felt a sharp pain in his neck and left shoulder.
- He consulted a physiotherapist, Mr G Matthews, and began receiving treatment for his shoulder and cervical spine.
- Through the agency of Mr Matthews the appellant lodged a claim for cover for injuries stated as being "cervical strain and strain of left shoulder".
- Cover for those injuries was accepted by the respondent on 28 April 2005.
- The neck and shoulder pain settled shortly after the incident, but some months later the appellant began to experience progressive weakness in his left arm with reduced grip strength and weakness of flexion and extension of that elbow.

- In October 2005 the appellant's GP referred him to Mr Christopher Hoffman, Orthopaedic and Spinal Surgeon, who obtained X-rays and an MRI scan and reported that the appellant was suffering from significant spondylosis affecting the cervical spine with central and foraminal stenosis at multiple levels, most significant at C6/7.
- The appellant was referred on from Mr Hoffman to Mr Mark Sherwood, Orthopaedic and Spinal Surgeon for assessment and consideration of treatment.
- Further X-rays and MRI scans of the cervical and lumbar spine were obtained by Mr Sherwood.
- The appellant sought cover in relation to this condition, principally for the purposes of treatment and the matter was considered by Dr D A Waite and the respondent's Branch Medical Advisor, Mr Moynagh.
- Consequent upon their assessment of the appellant's medical condition, the respondent issued its first decision, which is now the subject of appeal, on 23 May 2006, and which declined to grant cover for the medical condition identified in the appellant's cervical and lumbar spine, stating that it was not the consequence of any strain injury suffered on 24 April 2005. The respondent's decision went further and indicated that the claim could not be considered to be a re-aggravation of his 1996 injury.
- The appellant did undergo surgical treatment with Mr Sherwood in 2006.
- At some point in the latter part of 2006 the appellant, through Mr Sherwood, sought to have cover extended to include his then back condition as part of the personal injuries suffered by him in November 1996.
- After considering Mr Sherwood's report of 18 November 2006, the respondent issued a further decision on 14 December 2006 declining to accept that there was a causative link between his November 1996 injury and the back condition causing his current incapacity, and it therefore declined to grant weekly compensation in respect thereof.
- Both the respondent's decisions were taken to review and considered at the one hearing before Mr J R Orange, Reviewer.

- At that review hearing all the medical evidence was presented and the appellant was represented by counsel.
- In his decision of 19 December 2006, Mr Orange made the following determination:

> Mr Meyrick's current incapacity is not causally related to a personal injury he sustained in the incident on 24 April 2005. The evidence is that he did no more than aggravate the widespread degenerative changes in his spine on that date. The degenerative changes became symptomatic. However the action of lifting a child out of a child restraint did not cause the degenerative changes.
>
> There is no evidence that Mr Meyrick's incapacity after 24 April 2005 is causally related to the personal injury in 1996, for which he has cover.

- No further medical evidence has been introduced for the purposes of this appeal.

[6] The relevant medical evidence which has been presented to the Court, as it was for the Review, is as follows:

1. Report from Mr M K Hunn, Neurosurgeon, dated 10 December 1996, to Mr H Cook, General Surgeon, Hutt Hospital.

This was a letter from Mr Hunn who had been in charge of the appellant's care following his admission to Wellington Hospital and who was requesting that he be transferred to Hutt Hospital under the care of Mr Cook. This letter identifies the nature of the injuries suffered by the appellant in the fall from the roof on 29 November 1996. The letter advised that the appellant had mild left hemiparesis and a CT scan had revealed right occipital skull fracture, a fracture of the left clavicle, but that his cervical spine was satisfactory. He also noted that there were contusions in the right frontal and temporal lobes.

2. Letter from George Matthews, Physiotherapist, to appellant's GP.

The appellant saw Mr Matthews after the strain incident on 24 April 2005 and this letter is a report from Mr Matthews to Dr Koerbin of the treatment he provided to the appellant. It identified that the appellant suffered cervical strain of left shoulder, for which he received treatment, with that treatment ceasing on 26 May when he was discharged.

3. Letter from Mr Christopher Hoffman, Orthopaedic and Spinal Surgeon, dated 13 October 2005 to Dr Koerbin.

Dr Koerbin had referred the appellant to Mr Hoffman for assessment for ongoing cervical spine problems. In the course of identifying the appellant's history, Mr Hoffman stated that his recent incapacity seems unrelated to the head injury. From X-rays he identified that the appellant had significant osteophytic formation in the foramen affecting the right C4/5, C5/6 and C6/7, with similar changes on the left side. He identified this condition as degenerative and that these would account for his symptoms. Mr Hoffman then referred the appellant on to Mr Sherwood to consider cervical decompression and stabilisation.

4. Assessment Report and Treatment Plan from Mr Sherwood dated 28 February 2006 and 20 March 2006.

Mr Sherwood prepared two reports for suggested treatment and he noted that there were degenerative changes at all levels, but no obvious instability. He stated: "Most of the foramine bilaterally appear to be compromised down to the cervico thoracic junction."

In the second report Mr Sherwood stated as follows:

> Wayne has three main problems:
>
> 1. Potential spinal cord compression from the thoracic spine secondary to disc prolapses due to multilevel degenerative disc disease. On examination today he does not have any long tract signs. Knee jerks are 2+, ankle jerk on the lft 1+, on the right absent. Power is normal. Planters are down going. There is no clonus.
> 2. This patient has left T1 dysaesthesia. He has multilevel degenerative disc disease in his cervical spine with bony foraminal narrowing and central stenosis with cord flattening between C4 and C6.
> 3. He has disc prolapses in the lower lumbar spine at multiple levels causing likely left sciatic syndrome.
>
> All of these disc prolapses are unlikely to have been caused by one event. This man must be predisposed to this condition. There is of course no way or proving that the most recent all didn't cause a disc prolapsed which has brought on his left leg symptoms.
>
> ...

Mr Sherwood indicated that they may need to move quite quickly to compress the appellant's thoracic spine.

5. Report from Martin Hunn, Neurosurgeon, dated 4 April 2006 to Mr Sherwood.

Mr Sherwood had referred the appellant to Mr Hunn for a second opinion. He reviewed the medical evidence including the MRI scans ofthe cervical, thoracic and lumbar spine, and identified the degenerative conditions that were shown in those scans. He then stated as follows:

> ...It is difficult to make sense of all this as his neurological signs are confused by his previous history of head injury (possibly accounting for the brisker reflexes on the left side) and the cauda equine compression is possibly masking upper motor neuron signs. Although I couldn't demonstrate any weakness today, the patient himself is convinced that his legs are becoming weaker, and therefore, in the presence of such spectacular radiology, I would agree that surgical intervention must be considered.
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> ...
>
> In summary, I don't think the cervical spine needs to be addressed at this point. However, both the thoracic disc prolapsed and the lumbar spinal stenosis do require surgery. Based on the principle that the thoracic spinal cord is more vulnerable, I would be inclined to address this region first but the reverse order would also be reasonable. I have suggested that he return to see you in the next few days to discuss this further.

6. Report from Dr D A Waite dated 1 May 2006 to ACC.

Dr Waite interviewed the appellant at Bowen Hospital. Dr Waite was asked to respond to a number of questions and the relevant points in his answers were as follows:

- The head injury of 1996 is not the major cause of the current disability/incapacity.
- The MRI findings suggest multiple cervical, thoracic and lumbar spine changes.
- The degenerative changes in the discs are the major cause of the appellants present problems.

In a subsequent email to ACC, Dr Waite did indicate that the appellant's tendency to fall may well refer back to his head injury, as balance problems could arise from this.

7. Report from Mark Sherwood dated 18 November 2006 to appellant's counsel.

Mr Sherwood advised that the appellant had undergone complex surgery under his care which surgery consisted of anterior compression of the spinal cord in the lower thoracic region, cage reconstruction of the vertebral column, and second surgery being posterior decompression of the spine, both thoracic and lower lumbar.

Mr Sherwood was asked a series of questions, the first question being whether the degeneration in the appellant's spine was causally connected to his 1996 covered injury. His reply was as follows:

> I can neither confirm, nor deny, whether the fall in 1996 caused each and every disc prolapsed. There is always a chance that one of them may have been caused by this. If there had been injury to discs in the fall, the degeneration seen in his spine could have been causally connected to the 1996 covered injury. On the other hand, it is my opinion that if all the degeneration and (sic) his spine was caused by that fall, spinal symptoms at the time of that injury should have been overwhelming. They certainly should have been prominent enough to be assessed, imaged and documented. I am not aware of such information being available for this patient. My opinion is that it is more likely that the plethora of degeneration and disc prolapses were not entirely caused by the fall. Again I should stress that I do not have sufficient historical information or current clinical information, to prove this either way. My findings at that surgery, for all of the disc prolapses I accessed, was that they were mature, almost chondrified prolapses which must have been present for some months to years.

The second question was whether the back condition was wholly or substantially due to non-injury related factors. He replied:

> Having performed the surgery and having the benefit of the intraoperative findings, it is my opinion that it is more likely to be due to non-injury related factors. Having said that, there is clear history of a number of injuries which have led to clinical deterioration and onset of symptoms in this gentleman. Without imaging in the form of plain x-rays and scans prior to injury and post injury showing an interval change, it is impossible to define just what hard pathology was caused by which injury.

The third question was "In your opinion did the 1996 injury exacerbate/accelerate/render symptomatic a pre-existing condition?" He replied:

> It is my opinion that there is a balance between exacerbation of pre-existing condition and new symptom onset following injury. I do not think anyone can put a figure on this. If he was functioning excellently prior to his significant injury in 1996, clearly this injury heralded the onset of symptoms for this gentleman. Therefore, yes, it did exacerbate/accelerate/render a pre-existing condition symptomatic, but it also must have caused injury and generated symptoms at that time. The scientific literature clearly states that the incidence of back symptoms is comparable in patients with degeneration as in those without. In the setting of this patient, this means that the degeneration and disc prolapses may have remained quiescent and not limited his function for many years, in the absence of external trauma. I think a safe figure, overall, should be 50%:50% in order to give the patient and his injury the reason of the doubt.

[7] Mr Dixon-McIver, in his submissions on behalf of the appellant, relied principally on the report from Mr Sherwood of 18 November 2006, set out above. Mr Dixon-McIver submitted that the specialist was attributing a percentage to a difficult and complex medical situation.

[8] Ms Churstain, for the respondent, submitted that the medical evidence clearly identified that the appellant's current condition was the result of degenerative change and was multi-level degenerative disc disease. She further submitted that the appellant had resumed full-time work after the 1996 accident and the final words of Mr Sherwood of a 50:50 figure does not establish a factual situation on the balance of probabilities. She further referred to the fact that earlier in his report Mr Sherwood had stated that the medical condition was more likely to be due to non-injury related factors.

DECISION

[9] Both of the decisions which are now the subject of the appeal bear on the same medical diagnosis, assessment and opinions provided post-April 2005, although the contentions of the appellant are mutually exclusive,that in relation to the first decision of 23 May 2006, the contention is that the medical condition is as a consequence of a re-aggravation of the injury suffered on 24 April 2005. The second contention is that the medical condition, more particularly identified in the latter part of 2006 is in fact attributable to the personal injury suffered in November 1996.

[10] The respondent's response to those two contentions is that the appellant's medical condition, as it came to be identified in the latter part of 2005 and onwards, was a condition wholly brought about by multi-level degenerative changes in the appellant's spine which were now considerably seriously symptomatic.

[11] The contention that the appellant's ongoing multi-level degenerative condition could be the result of a minor strain suffered in April 2005, is just not a proposition which has any foundation in medical fact. There is no evidence to support that contention and this Court takes judicial notice of the medical fact that multi-level foraminal stenosis of the magnitude identified in the MRI scan cannot occur in the short space of time that elapsed from the date of the back strain injury to the identification thereof in October 2005.

[12] Accordingly, I find that the respondent's decision of 23 May 2006 was correct and that the appellant's then incapacitating condition was not as a consequence of the injury sustained on 24 April 2005.

[13] Turning now to the second decision of the respondent, namely the decision which determined that the appellant's medical condition as it was identified in the latter part of

2006, was not causatively linked to the injuries suffered by the appellant in the fall he suffered on 29 November 1996.

[14] The starting point for consideration of this issue must be an identification of what were the injuries that the appellant suffered in that fall and that evidence is contained in the letter from Mr Hunn, the Neurosurgeon of 10 December 1996. That letter identifies that the major injury suffered by the appellant was an injury to his head and which involved a skull fracture and mild paralysis down his left side associated with the fracture of his left clavicle.

[15] I find it to be significant that in that letter from Mr Hunn to the surgeon, Mr Cook at Hutt Hospital, he stated "His cervical spine was satisfactory. His only other injury was a left clavicle fracture".

[16] That statement clearly identifies that the appellant's spine was not damaged or affected by the fall and it is the case that once the appellant had recovered from the head injury and shoulder fracture he was able to resume his pre-injury employment and was so gainfully engaged in the work of a builder until the latter part of 2005.

[17] As I have already found, the cervical strain and left shoulder strain suffered in April 2005 did not in any way cause the multi-level disc condition that was identified in October 2005, and the Court has received no evidence of any other events prior to April 2005 which might have been causative or partially causative of the appellant's condition as it was identified in the subsequent X-rays and MRI scans.

[18] The fact of the matter is that the appellant's condition is multi-level in his cervical spine and it is the case that the MRI scans sought by Mr Sherwood in April 2006 identified facet joint osteoarthritis in the lower levels of the cervical spine, principally at C5/6 and C6/7, facet joint osteoarthritis in the lumbar spine and broad-based disc bulge and disc dessication in the thoracic spine.

[19] It was this wide based medical condition that was causing pain by reason of cord compression and hence the need for the significant surgical procedures carried out by Mr Sherwood as treatment thereof.

[20] The evidence from the MRI scans is conclusive that the appellant has multi-level degenerative change in his spine and from an entitlement perspective it would have to be established that the cause of that medical condition was in fact the traumatic

incident of the fall in November 1996. It is the case that degeneration brought about by the aging process is specifically excluded from being able to be covered or be the subject of entitlements.

[21] The appellant relies on the advice of Mr Sherwood, which has been set out above. His first comment is that he can neither confirm nor deny causation. He appears not to have been aware of the fact that no part of the appellant's spine was injured in the 1995 fall, and indeed he says that it was his opinion that if all the degeneration in the spine had been caused by the fall, spinal symptoms at the time of that injury would have been overwhelming.

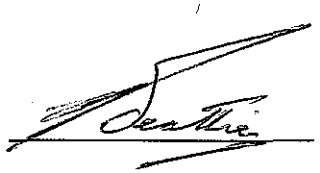
[22] That is simply not the case on the facts either medical or general, as we know that the appellant recovered from that injury and was able to resume his employment.

[23] Mr Sherwood in his next breath, as it were, then says that it was his opinion that it was more likely that the condition was due to non-injury related factors, but then somehow, as he says, to give the patient and his injury the reason of the doubt, he settles on a 50:50 figure.

[24] Frankly, I find the reasoning of Mr Sherwood quite confusing and from a medico-legal perspective it is entirely unconvincing as establishing causation. Accordingly I find that the appellant's multi-level degenerative condition in his spine is simply age related degeneration and not attributable to any covered personal injury. For this reason the respondent's decision of 14 December 2006, that there was no causative link with his covered injury was the correct decision both in fact and in law.

[25] Having determined that the two decisions which were the subject of this appeal were correct, it follows that this appeal must be dismissed.

DATED this 22 day of June 2010



M J Beattie
District Court Judge