**IN THE DISTRICT COURT**
**AT WHANGAREI**

**[2018] NZACC 116** **ACR 146/17**

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

Hearing: 17 April 2018

Appearances: J Brock for the appellant
F Becroft for the respondent

Judgment: 24 July 2018

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**RESERVED JUDGMENT OF JUDGE DENESE HENARE**
**[Entitlements – S 67 Accident Compensation Act 2001]**

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[1] The appeal concerns the Corporation's decision to decline a request for funding for an occipital branch block procedure.

[2] The appellant, Karmen Harris, sustained contusion injuries to his head, neck and face when he was assaulted on 20 December 2002.

[3] A patient note of 21 December 2002 from Dr Fenton, General Practitioner recorded:

> Subjective
> About 9 pm – assaulted. Blows to head, face – very painful head – confused initially better as day wears on (now 6.35 pm).

> Objective
> Hit to head both sides, left orbit, sore neck headache controlled at present by panadol.
>
> On examination alert clear explanation of occurrence – alleged attacked on two occasions at cousin's place – hit to head quite brutal ... 3.5 cm x 3.5 cm swelling contusion abrasion left scalp – parietal area – right scalp tender slight swelling consistent with contusion – swelling bruising left orbit – all these are consistent with blows to the head – also scratching to left forearm consistent with finger nail scratch ...
>
> Would suggest degree of concussion – which with head pain would have made it difficult to give an accurate statement last night – as well as contusions and abrasions secondary to assault.

[4] On 24 December 2002 an injury claim form was lodged listing diagnoses of concussion, left hand fracture and contusions of the face, scalp and neck. Cover was automatically accepted for these injuries. As recorded in the 2007 Claim Summary Report, cover for concussion syndrome was also accepted by the Corporation following reports from Dr Finucane, Psychiatrist.

[5] On 13 May 2016 Dr Thompson, Musculoskeletal Physician, lodged an Assessment Report and Treatment Plan (ARTP) for diagnostic third occipital branch block. On 1 June 2016 the Corporation declined the request for funding stating that:

> Pain management
>
> We have received your request from Grant Thompson to fund your IN42 diagnostic third occipital branch block.
>
> ACC has looked at all the available medical information and must decline the request because the x-ray and MRI results of 13.5.16 indicate a gradual process condition in the cervical spine leading to osteoarthritis and disc osteophyte complexes which are not related to the injury of 20.12.02.
>
> I have enclosed the recommendation from our Branch Medical Advisor. If you have any further information on any other claim for a neck injury we would be happy to review this information.
>
> We have advised Grant Thompson of this decision.

[6] The Corporation's decision was upheld at review.

**Background**

[7] The schedule of claimant injuries shows a history of multiple injuries, particularly regarding head, scalp and neck. Dr Fenton's patient note of 21 December 2002 noted that Mr Harris had been "hit to head both sides, left orbit, sore neck, headache" and that the assault had resulted in "very painful head".

[8] A review of the schedule of claimant injuries for Mr Harris shows approximately 11 injuries where the injury is described as neck sprain or contusion of face, scalp and neck for which the Corporation provided cover. Of note, are the following accidents identified in the evidence before me:

- A motor vehicle accident on 27 October 2003.
- In December 2004, Mr Harris involved in a fight and spent 7 months in prison.
- In 2007 Mr Harris was hit on the head with a soccer ball.
- Playing rugby in 2006, a player "hammered" his neck.
- There was a further injury to the back of his head playing football in July 2007.
- In October 2008 hit his head on a beam.
- In March 2010 a neck sprain resulted from lifting motorbike on to table.
- In November 2010 Mr Harris was in a fight with a neighbour and was hit over the head.
- The claimant schedule notes contusions to face, scalp and neck in June 2012 but there is no evidence of mechanism of injury before the Court.
- On 1 August 2014 Mr Harris fell off a motorbike and jarred his neck.
- In February 2015 he lost balance off a ladder and landed on back and hurt neck.

- On 30 December 2015 he fell off a motorbike and hurt his neck.
- In March 2016 he fell off a motorbike and jarred his neck. Treatment was provided for this neck injury.

[9] Ms Becroft submitted that there was a period of no contact between the parties from December 2004 until October 2007. The evidence shows that Mr Harris spent seven months in prison until July 2005. The claimant injuries schedule indicates five claims for cover being accepted by the Corporation with two of the claims related to a neck sprain; neck, back of head vertebrae. It appears that the 2006 injuries relate to soccer or rugby accidents.

[10] I observe from Ms Becroft's submissions that the claim file was migrated in 2007 to the Corporation's new file management system called "EOS". Ms Becroft noted that documents from 2002 to 2007 do not appear on the current claim file. The claim summary report of 6 April 2007 records cover for concussion was approved. On 8 October 2007 Dr Hoffer noted Mr Harris suffered from symptoms of traumatic brain injury (TBI) as a complication of the December 2002 accident. Mr Harris was certified as fully unfit to work from 1 October 2007. The Corporation treated the medical certificate as a claim for cover for TBI and requested further notes from Dr Hoffer. An EOS contact note of 9 October 2007 records:

> I have talked to the claimant and primarily he is looking for treatment as he has been suffering the effects of his head injury again. He has been teased about it at work to the point that he has resigned his job and then gone back to the GP. The GP has put him off work from 1 October 2007 ...

[11] The case manager contacted Dr Hoffer. The EOS contact note records:

> He tells me he has known Karmen for a while and he feels that there is a bit of recurrence of his head injury symptoms. This follows an incident where Karment [sic] headed a soccer ball a week or so ago and since then has had this recurrence of fatigue, mood swings and inability to deal with other people. He would like to have Karment [sic] assessed under a neuropsych and after that depending on the results of the neuropsych he feels possibly a neurologist review.

[12] On 19 October 2007 Dr Corbett, Branch Medical Advisor considered Mr Harris' symptoms likely represented an injury related post concussion syndrome and noted it would be appropriate to obtain a neuropsychological report. The

Corporation subsequently accepted Mr Harris had been incapacitated from employment due to TBI symptoms from 1 October 2007 and weekly compensation was granted.

[13] On 23 November 2007 Mr Harris was assessed by Ms Bronseck, Clinical Psychologist who considered symptoms were likely the result of both substance abuse and of multiple concussions resulting in organic damage. Dr Bronseck stated in addition to substance abuse, that:

> In addition to this, he has experienced numerous concussions and many have not received any medical intervention. It is recognised that people who have substance abuse histories are more likely to experience concussions. Unfortunately, concussions are also known to be cumulative in nature.
>
> The examiner believes that it is highly likely that Mr Harris has been experiencing cognitive deficits for a number of years; however, he was able to compensate for them. Unfortunately, with each concussion, his impairments increase and his ability to compensate for them decreases. The examiner believes that these symptoms are consistent with the combined impact of both substance abuse and of multiple concussions thus resulting in organic damage. These results show that, despite the time post injury, Mr Harris continues to exhibit impairments at the physical, cognitive and effective levels.

[14] On 27 November 2007 Dr Kanji, Occupational Medicine Specialist examined Mr Harris and noted the cervical spine flexion and extension were normal and cervical lordosis was normal. Dr Kanji noted the current vocational incapacity "is wholly related to the covered injury". Dr Kanji recommended consultation with a neuropsychiatrist such as Dr Finucane with respect to pharmacological management including consideration of the use of Ritalin.

[15] EOS contact notes in early 2008 record a number of matters including that Mr Harris' incapacity continued to be certified due to TBI symptoms.

[16] In November 2008 Dr Finucane, Psychiatrist considered Mr Harris was suffering from a post concussion syndrome. Dr Finucane noted persisting neurological symptoms including:

> He has ongoing unpleasant sensations in the neck and occipital area, especially a dull ache experience deep in the back of the head which seems to pulling up from the neck. ... with minor blows to the head he develops a feeling as though he has pressure over the back of the head and he can often feel as though his head is in a cage.

[17] Dr Fincuane went on to note that "the only pain is in his neck and head". Dr Finucane also stated:

> Mr Harris, not surprisingly given the multiple minor head injuries he has sustained over the years, reports features of a persisting post concussion syndrome together with at least mild personality change and other common sequelae of traumatic brain injury including benign positional vertigo.
>
> ... the prognosis is for him to remain in work, unless he sustained further head trauma.

[18] The EOS notes record a gradual return to work with symptoms of fatigue and aching in the head and neck. Reporting from Dr Finucane in May and June 2009 noted headaches and neck pain. The EOS notes in 2010 point to numerous contacts between Mr Harris and his case managers.

[19] On 11 September 2010 Dr Finucane noted Mr Harris was seeing Mr Baxter, Chiropractor for his neck and "thinks the neck is back to 90% now".

[20] On 3 October 2011, Dr Frith, a visiting Neurologist reported symptoms of swelling at the back of the neck. Dr Frith also noted that imaging of the cervical spine was normal. Dr Frith was unable to reach a neurological diagnosis or offer any specific therapy.

[21] In the period from late 2010 until 2016 the schedule of claimant injuries notes neck sprain in 2010, contusion of face, scalp and neck in June 2012, neck sprain in August 2014, neck sprain on 21 February 2015, neck sprain on 2 December 2015, neck sprain on 30 December 2015, neck sprain on 21 March 2016, a neck sprain on 15 June 2016 with two further neck sprains in August 2016 and October 2016.

[22] In May 2016 Dr Thompson applied for funding for diagnostic right third occipital nerve block. A CT scan and MRI was carried out on 12 May 2016. The CT scan showed minor degenerative changes of the cervical spine with no fractures or malalignment. The MRI also showed no fractures but neuroforaminal stenosis at C5-6 and C6-7 with likely compression of the right C6 and bilateral C7 nerve roots.

[23] On 13 July 2016 Dr Thompson wrote to Mr Harris' GP stating that, despite the number of claims accepted by the Corporation for a neck sprain, the Corporation had

declined the application to perform a third occipital nerve block because of the lack of contemporaneous evidence to support neck symptoms.

[24] For the purposes of review, Dr Thompson provided a report on 3 October 2016 responding to questions from Ms Brock that:

> 3. It is my opinion that Mr Harris has suffered from a number of traumas, as per my report of 12 May 2016, resulting in distinct injuries. While some of his symptoms may reflect central neurosensitisation, this is a result of injury.
>
> 4. In my opinion Mr Harris is not suffering from symptoms due to wholly and substantially caused by a gradual process (age related) disease or congenital defect. You will note the imaging reports (below) mention minor disc degenerative changes in the mid and lower cervical spine. These are normal age related changes. As per my comments on the drawings above, any pathology in this region is very unlikely to refer to the upper neck or head.

[25] Dr Thompson went on to explain the reasons why he applied to the Corporation to fund the diagnostic procedure that:

> ... **if we cannot identify where his pain is originating, we will have to continue to manage his neck pain with treatment similar to that which he has had in the past which, unfortunately, to date, has not been successful**.
>
> [Emphasis added]

[26] On 2 December 2016 Dr Mair, Branch Medical Advisor, noted:

> There is no cover for any neck injury.
>
> This from an IMA of Nov 2007.
>
> Cervical lordosis was normal. There were no visible scars. Cervical spine flexion was to within one finger breadth of the sternum. Cervical spine extension was normal. Lateral flexion was mildly decreased and symmetrical. Lateral rotation to the right was normal and lateral rotation to the left was normal. There was no tenderness on palpation of the cervicothoracic spine.
>
> Palpation of the cervicothoracic soft tissue is normal and there were no tender points.
>
> There was no tendon is [sic] I assume means tenderness of the occiput. There was no vertigo experienced when moving his neck.
>
> There was no paravertebral muscle spasm.

[27] Dr Mair referred to Dr Thompson's report of May 2016 and the comments of Dr Gemmell, Branch Medical Advisor in May and July 2016, and he concluded:

> Whilst the discussion of Z/A joint conditions producing symptoms as described is valid I still cannot see a causal link to the 2002 event and Dr Thompson has not provided a rationale for his assertion that the current symptoms are due to the 2002 event. However if further supporting evidence becomes available I should be happy to comment further.

[28] On 20 February 2017 Dr Finucane provided his fifth report. His first report having been provided in November 2008. All of Dr Finucane's reports refer to symptoms linked to the index event of December 2002. Dr Finucane reported persisting pain from the neck, noting that 400 mg tramadol daily was the main pain relief. Mr Finucane also noted that the accidents in recent times had been due to falls from farm bikes when riding on rugged terrain. Dr Finucane commented:

> On the other hand, medicinal cannaboids when more readily available could be trialled for the pain given that cannabis assisted with the neck discomfort, and stimulants in the past, as Ritalin SR did improve his fatigue.
>
> The pain remains problematic, but the opiate use might be exacerbating his poor concentration and fatigue. This suggests that he should reduce the dose of tramadol, and add an anti inflammatory, which ought not to effect cognition.

[29] On 22 March 2017 Dr Ng, Musculoskeletal Specialist reported, noting left upper cervical somatic pain since injury on 20 December 2002 and provided the following opinion:

> Karmen Harris was kicked hard in the back of the head three times which would be expected to cause significant head and/or neck injury. Initially, there was significant neck pain, dizziness, fatigue and mood changes. The neck pain and fatigue have persisted. The most troublesome neck pain is a constant pain in the left upper part of the neck. This could be arising from any of the somatic structures in this part of the neck. However, the only structure for which there is an accurate diagnostic procedure and effective treatment is pain arising from the C2-3 facet joint. The C2-3 facet joint could be the source of pain and can only be diagnosed or excluded with fluoroscopically – guided third occipital nerve blocks. It cannot be diagnosed or excluded with imaging. The imaging has identified C5-6 and C6-7 disc space and neuroforaminal narrowing. However, the left upper neck pain is not arising from the C5-6 and C6-7 segmental levels as these levels would cause pain in the lower part of the neck and periscapular areas.
>
> Mr Harris feels that his symptoms of fatigue and malaise are associated with his neck pain. However if the nerve blocks and radiofrequency treatment relieve the neck pain but do not improve the fatigue and malaise, then an alternative

explanation for the symptoms needs to be found. Traumatic brain injury could be considered.

[30] In response to questions, Dr Ng stated:

1. Mr Harris' neck pain is located in the left upper neck/suboccipital area and is arising from a cervical somatic structure. The only cervical somatic structures for which there is a diagnostic procedure which leads to effective treatment are the facet joints. The left C2-3 facet joints is the most common source of pain in this location. Facet joint damage can be produced which causes pain in the absence of demonstrable changes on the imaging.

2. Mr Harris suffered significant trauma as a result of the injury and has had ongoing symptoms. He did not have the symptoms prior to the date of injury. The procedure that Dr Grant Thompson has recommended is a diagnostic procedure to either diagnose or exclude the left C2-3 facet joint as the source of pain. The third occipital nerve block is a diagnostic procedure – it is not the treatment. The treatment that follows is radiofrequency neurotomy.

[31] Dr Ng's report was referred to the Corporation. Dr Gemmell commented:

> It is not in doubt that the client has ongoing symptoms in his neck, what is at issue is causation and whether there is a link to the accident of 2002. Dr Ng in his assessment has relied purely on the reports from the patient regarding his symptoms.
>
> As per Dr Mair's comment the IMA dated November 2007 demonstrated a full, pain free range of movement of the cervical spine which points away from continuous pain or pathology since 2002. There are no contemporaneous notes presented from 2002 and if looking historically no account seems to have been taken of the reported "high speed (120 km.hour)" MVA that occurred in Australia in 1999.
>
> There is no cover for neck pathology on this claim see earlier BMA comments re the detail of this discussion. The client has multilevel degenerative change in this cervical spine which is unlikely to be causally linked to any one accidental event and is much more likely to have occurred as part of general wear and tear over time.
>
> There is insufficient clinical evidence to support any neck pathology to be causally linked to this accident nor the accident of 2002. The requested procedure is not for an injury caused by accident.

[32] Following review, Dr Thompson produced two further reports on 14 June 2017 and 19 August 2017. In his June report, Dr Thompson wrote to Dr Esser advising he had performed the third occipital nerve block procedure followed by a C2-3 injection.

[33] In his August report, Dr Thompson responded to various questions put by Ms Brock as follows:

> *1. What symptoms is Mr Harris experiencing as a consequence of his Injuries to his cervical spine?*
>
> Mr Harris complains of chronic upper neck pain, headache, phonophobia (intolerance of noise), photophobia (intolerance of bright lights), loss of balance, and, as a result, has suffered from a number of falls and quad bike accidents in his work as a dairy farmer.
>
> *2. Why Is It necessary for you to provide diagnostic injections at the point of C2-3, or any other part of the cervical spine?*
>
> Neck pain can arise in a number of structures including the zygapophyseal (facet) joints, cervical discs, vertebrae, and soft tissues. The relatively delicate structure of the cervical spine carries the heavy weight of the cranium. The articular pillars (that part of the cervical spine containing the joints) are half the size of the vertebrae and discs in cross sectional area, and carry half the weight of the cranium. Because the joints are narrow, they are particular vulnerable to injury as a result of direct trauma to the skull, or whiplash type injuries ...
>
> *3. Could you explain how the injection is administered and what outcome would you expect if there Is damage at that particular part of the cervical spine?*
>
> The injections are purely diagnostic, not treatment. Under x-ray control, we identify the joint to be targeted, precisely line up joint lines, and, for the C2-3 zygapophyseal joint (the joint between the articular pillars of C2 and C3 vertebrae) injection 0.3 millilitres of local anaesthetic at three precise site, as per the study paid privately by Mr Harris on 14th June 2017.
>
> To rule out placebo, we use comparative nerve blocks of short acting and long acting local anaesthetic. The patient, and our assessing nerve, are blinded to the nature of the local anaesthetic, to reduce the risk of bias.
>
> If the source of Mr Harris's pain was the C2-3 ZAJ, I would expect his pre-procedure pain intensity to drop to, or near, zero, after the procedure.
>
> *4. Is it also your opinion that even if there Is a good response at C2-3, that this may not only be the other joint that has been damaged? In other words, is it necessary to administer other joints with an anaesthetic as they may have also been damaged by injury?*
>
> If there is near 100% response to the diagnostic injections at C2-3, other joints would not have to be checked for upper neck pain and/or headache. If there is a positive, but incomplete, response, I would want to check the adjacent joints, which would likely Include C3-4, and possibly the lateral atlanto-axial joint (Cl-2).
>
> In fact, in the trial injection funded privately by Mr Harris on 14/06/17, he had complete relief of pain from the injections targeting the C2-3 ZAJ.

*5. If the diagnostic injection is administered at the correct point of the cervical spine, and there is some relief, what is the next step in the treatment plan that you would recommend?*

As mentioned above, we always perform at least two blinded injections for each joint. If the response Is strongly positive on both occasions, the nerve can be treated with radiofrequency neurotomy. This involves apply]ng a heat to the nerve which incapacitates it for a period.

*6 And what treatment outcome would Mr Harris likely achieve from a radiofrequency neurotomy?*

Following positive response to two blinded Third Occipital Nerve (TON) injections, Mr Harris would have a 70% likelihood of having pain relief for a median time of 400 days.

*7. In regards to the comment from Dr Gemmell in regards to "there is insufficient clinical evidence to support any neck pathology to be causally linked to this accident not the accident of 2002", please explain in more detail if you agree or disagree with this statement?*

In spite of suffered injury sufficient to cause persistent neck pain or resultant headache, clinical examination will frequently be negative, as will imaging, for the reasons given above.

A negative examination, and negative imaging, does not rule out pain of zygapophyseal joint origin.

The only valid investigation for chronic neck pain or resultant headache (after fracture-dislocations or red flag conditions have been ruled out) are the diagnostic image-guided injections of minute amounts of local anaesthetic placed strategically.

*8. Are you still of the opinion that Mr Harris has never made a recovery from his symptoms due to the fact that he has suffered a series of injuries?*

Absolutely. Mr Harris has had consistent neck pain and headaches since his injuries. He has never had relief apart from the diagnostic injection on 14/06/17.

[34] An opinion was obtained from the Clinical Advisory Panel (CAP) on 13 December 2017, which reported that no physical injury has been identified and radiological imaging does not show evidence of a physical injury. CAP opined the diagnostic procedure cannot demonstrate a physical injury and will not demonstrate that trauma is the cause of any particular symptoms. CAP noted no evidence to support a structural injury at the C2-3 level. CAP was asked whether the reported accidents of 1999 and 2013 are relevant. CAP responded, with regard to the 1999 claim, the same arguments apply as to the 2002 claim. If there was a structural

injury at the time it would be expected to be seen on imaging some 17 years later. CAP noted the symptoms being addressed predated the 2013 claim and stated:

> As noted above the CAP agrees that the management proposed by Dr Thompson is entirely appropriate in this clinical setting. However, the lack of any objective evidence of a structural injury to the level in question does not support the attribution of a causal link to an ACC accepted injury. In his report of 03/10/2016 Dr Thompson confirms his view that there are a number of structures in the neck which can cause pain (zygapophyseal joints, discs, vertebrae, ligaments and muscles). He also, in the same report, notes that the degenerative changes noted on the imaging are a sign of successful aging and are not necessarily related to past trauma. It is presumed that he is referring to the pathology reported in the lower levels of the cervical spine, and the CAP would agree with this view. This however is not the anatomical location that is the subject of the proposed block procedure.

*Evidence of Dr Thompson at Hearing*

[35] At hearing, Dr Thompson made the following points:

- That he first saw Mr Harris on 12 May 2016. Mr Harris presented with a range of symptoms including upper neck pain. Mr Harris mentioned the 2002 fight and that he had suffered head injuries and neck problems since this time.

- Dr Esser, GP, referred Mr Harris to Dr Thompson. Apart from a referral note of 22 February 2016, Dr Thompson had not received other medical reports, though he was aware of Dr Fenton's patient note of 21 December 2002. Mr Harris informed Dr Thompson he had also rolled his quad bike a few times since then.

- The nerve block procedure identifies a source of the pain but it does not identify an injury per se. The only way to identify the pathology is to do an autopsy. Dr Thompson referred to work undertaken by Professor Taylor in Australia who considered the imaging of people with cervical spine injury, which had not shown up on imaging. His work showed trauma was related to the zygapophyseal joints and also to disc rim lesions.

- Dr Thompson stated in cross examination from Ms Becroft that:

> A: Damage to the joint. The nerve supplies the joint and it also supplies some skin on the back of the scalp, so we're targeting the transmitter if you like, the transmission of pain from the joint. So I can say that the pain is coming from the joint but I can't – I can have a guess as to what pathology could be causing it but without cutting the joint open we can't be sure.
>
> Q: What would the guess be?
>
> A: Well the commonest seems to be the synovial fold contusions.
>
> Q: Ok.
>
> A: And they seem to be common but you get joint capsule ruptures, you get subchondral fractures, so a number of injuries that will never show up on scanning and if they did show– if the scans were that sensitive, there'd probably be so much background noise they would be of little benefit in just having an imaging that shows radiologic pathology is not an indication of pain because as I say with aging we all have changes in our spine, we all have changes within our peripheral joints that we wouldn't know were there until we have an x-ray or an MRI scan. …
>
> Q: Ok so back to the injection, it can't identify the actual injury and it also can't identify the cause of the injury.
>
> A: It identifies the site of injury.
>
> Q: The source of the pain.
>
> A: The source of the pain.
>
> Q: The source of the pain. So coming back to what I started with at the beginning, the only reason that you attributed this particular neck pain to the 2002 event was because the appellant advised you that he had been having pain since then. That's the only basis for that conclusion.
>
> A: I'm reliant on his history.

[36] In questioning from the Court, Dr Thompson said that a blow to the head will impact the whole of the cervical spine but:

> A: We know from referral patterns that C3 upwards is more likely to refer into the base of the skull or to the head.

[37] Dr Thompson went on to say:

> A: Your Honour when Dr Fenton saw Mr Harris acutely and said he would have been no doubt distressed and confused and what I'm talking about were the upper neck problems, with all due respect to Dr Fenton, I would not have expected a general practitioner to have picked that up, particularly acutely. A lot of my colleagues would be unaware of the extensive literature in this field and from the one injection that we've done, we'd managed to take away his headache completely and that would be indicative that – it would at least, as I say, suggest one into thinking that that is quite highly likely to be the source of his headache and **his upper neck pain and headache from that joint but I wouldn't normally rely on one injection only. So we're trying to – at the moment the man doesn't have a diagnosis, apart from traumatic brain injury and concussion, he doesn't have a diagnosis for his pain, for his headache, there is no diagnosis and what I'm simply asking is that we complete the investigations that we have available to us to try and reach diagnosis.**
>
> [Emphasis added]

[38] In response to questioning on causation to the accident of 2002, Dr Thompson stated:

> … it would be, in my opinion, **highly consistent that a head injury would be expected to cause a neck problem at the same time. The impact on the scalp is going to impact on the cervical spine and that's certainly a source of, it's potentially a pain generator for headache. … the pain generator is in the neck. So the impact on the scalp is sufficient to traumatise the cervical spine and then that acts as a pain generator for cervical cranial headache.**

[Emphasis added]

*Submissions of the parties*

[39] Ms Brock submitted that the decision to decline the ARTP from Dr Thompson, for further treatment is wrong for the following reasons:

[i] Mr Harris has suffered significant personal injuries to his head, neck region dating back to 2002. An accumulation of injuries to his neck which finally caused him to seek medical assistance from Dr Thompson, who only seems to want to treat Mr Harris in a correct manner.

[ii] New evidence from Dr Thompson confirms Mr Harris has had neck symptoms from his original injury.

[iii] Dr Thompson has made reference to symptoms coming not from the lower part of the cervical spine but instead occipital base of the skull and cervical spine which casts doubt on the flawed opinions of the Branch Medical Advisors.

[iv] Whilst Mr Harris suffers from some evidence of degeneration, it does not exclude him from cover or entitlements for his original injuries.

[40] Ms Becroft for the Corporation submitted that:

[i] While the medical practitioners agree the occipital block procedure is an appropriate diagnostic tool, the specialists do not consider there to be reasonable evidence that the procedure is required as a result of any of the covered injuries.

[ii] Mr Harris has cover for a neck contusion suffered in December 2002. Occipital block procedures are not used to treat bruises.

[iii] It is unclear why the December 2002 accident has been implicated as having caused some unidentified cervical spinal injury, given the large number of accident events over the years, and only intermittent reporting of any neck symptoms since 2002.

[iv] In terms of causation there are gaps in reporting neck symptoms. Imaging does not report a physical injury; the proposed procedure cannot demonstrate pathology in the facet joints or demonstrate any pathology caused by trauma.

[41] Ms Becroft submitted the evidence does not support Mr Harris suffered an injury to his cervical spine in December 2002. As such, the proposed procedure cannot attract funding under the 2001 Act.

[42] In Ms Becroft's submission, there is insufficient evidence on which to draw a robust inference of causation between an unidentified injury to the cervical spine, and the December 2002 accident.

**Discussion**

[43] This is a complex case. Complex in two respects.

[44] First, Mr Harris' medical history is intertwined with his family and social history. I find Dr Bronseck's neuropsychological report is instructive. Dr Bronseck described a profile of a person who in his younger years was caught up in a cycle of substance abuse and fighting, of which the 2002 accident is significant. The significance of the contusions to neck, face and scalp is to be considered against Dr Fenton's description that Mr Harris was "assaulted with head injuries". The gaps in the periods identified by Ms Becroft following the assault, are explained by the fact Mr Harris was in prison.

[45] Secondly, Mr Harris' peripatetic life has had consequences. Whilst claim forms were filed by practitioners, there was no early referral for imaging. The imaging that is available, focused on Mr Harris' left hand because the GP in question noticed he had developed a "boxers hand". The various football and motor vehicle accidents he sustained, following his release, are evidenced by multiple claims lodged and cover accepted for neck injuries. The evidence shows that following discussion between Mr Harris and his case manager, referral was made to Dr Bronseck and Dr Finucane who completed the information gaps. Referral was not made by a general practitioner, despite claims lodged by practitioners.

[46] The fact questions concern whether the need for the procedure is causally linked to the covered head, scalp and neck injuries and concussion syndrome. The evidence shows that the need derives from neck pain and headaches which pharmaceutical management is ineffective.

[47] CAP agrees the diagnostic procedure is "entirely appropriate to help guide the future management of the client's ongoing neck pain" and neck pain can arise from a number of structures in the neck, but does not agree there is evidence of a structural injury at the C2-3 level linked to a covered injury.

[48] Ms Becroft submitted that cover for a neck injury in the 2002 accident is a contusion. Based on Dr Thompson's evidence, Ms Becroft submitted if there is a

problem in the neck which has its origins in the zygapophyseal joint, then a claim for cover for a zygapophyseal injury should be lodged.

[49] Whilst the imaging undertaken in 2016 makes no mention of pathologies at the C2/3 level, it is the case that an entitlement is sought in respect to the 2002 covered injuries of which concussion and TBI have been accepted by the Corporation.

[50] The reports from Dr Finucane since 20 November 2008 show persisting neurological symptoms which Dr Finucane opined are features of post concussion syndrome together with other common sequelae of traumatic brain injury. I observe headaches and neck pain are a feature of all of Dr Finucane's reports for which clinical psychological management and occupational therapy strategies together with various medications have been prescribed as part of the treatment process.

[51] I take into account the five reports from Dr Finucane recording continuing symptoms of neck and headaches as a result of concussion and TBI.

[52] Dr Thompson referred to an overlap of head, neck and concussion injuries and stated:

> Dr Thompson
>
> > ... there's an overlap because cervical spine pain will often cause discognition, difficulty thinking, difficulty processing which can also be the result of concussion as well. So we have this dilemma quite a lot in that our head injury patients may have pain originating in the neck, they may have memory problems, they may have cognitive difficulty and that could be the result of direct brain trauma, but it could also be just because they're in pain.
>
> Q: So which is it here in your opinion?
>
> A: Mr Harris has already had extensive treatment with Dr Greg Finucane who is a neuropsychiatrist and I'm sure that there are some memory difficulties here and some cognitive difficulties but the pain is – certainly the pain disappeared completely with a single block the nerve to the C2/3 joint. So we go into these investigations with no preconception that the nerve block is either going to relieve the pain or not. If it relieves it then we will repeat the block and if it still relieves it then we'll be looking at the radiofrequency neurotomy. If it doesn't relieve it, then we rely on traditional medical treatment for neck pain and headache. But then that means the downside of that is that then the patient may end up on medications which can cause difficulty with thinking processes as well. So if we can remove the pain with a simple nerve block and then do the

radiofrequency neurotomy, that may save that patient having to have any other treatment.

[53] Dr Thompson went on to describe a cervicocranial headache as referred pain from the neck. Dr Thompson explained:

> A: Your Honour when Dr Fenton saw Mr Harris acutely and he would have been distressed and confused and what I'm talking about with the upper neck problems, with all due respect to Dr Fenton, I would not have expected a general practitioner to have picked that up, particularly acutely. A lot of my colleagues would be unaware of the extensive literature in this field and from the one injection that we've done, we'd managed to take away his headache completely and that would be indicative that – it would at least, as I say, seduce one into thinking that the is quite highly likely to be the source of his headache and his upper neck pain and headache from that joint but I wouldn't normally rely on one injection only … **at the moment the man doesn't have a diagnosis, apart from traumatic brain injury and concussion**, he doesn't have a diagnosis for his headache, there is no diagnosis and what I'm simply asking is that we complete the investigations that we have available to us to try and reach a diagnosis.
>
> [Emphasis added]

[54] Taking a broad view of all the evidence before me, I am of the opinion that to view the overall injury in terms of the physical damage to the head and neck is an unfairly narrow approach to the claim. The reports of Dr Bronseck and Dr Finucane refer to substantial effects particularly of headaches, fatigue and cognitive functioning as a result of the post concussion syndrome and TBI. Dr Finucane did not think that the provisions of the mental health legislation were applicable. Whilst there is no doubt Mr Harris suffers consequences from substance abuse I take into account the significant medications over time being used to manage the post concussion and TBI injuries.

[55] While it is possible that the neck may gradually have deteriorated and there is no evidence of a new injury, I conclude that Ms Brock's submission is right that the medical information adopts an overly restricted view of requiring a structural injury. That is not a fair approach when considering the index injuries including concussion which have real functional consequences.

[56] I adopt the reasoning of Judge Ongley in *Hamilton*[1] that a reasonable assessment of causation should involve both structural and functional aspects of an injury. A great deal of medication has been provided to treat Mr Harris. CAP agrees that in the clinical context the procedure is appropriate to guide management of the ongoing neck pain which as Dr Thompson has explained at hearing is interwoven with the significant headaches, and the overlap of the covered concussion injury.

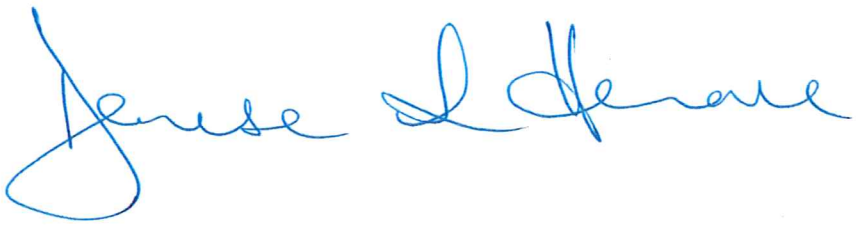
[57] A claim for cover for damage to the zygapophyseal facet joint may also be lodged, as submitted by Ms Becroft. That is a matter for Mr Harris and his advisers.

[58] On balance, I conclude there is a causal link between the covered injuries arising from the 2002 accident, particularly the concussion syndrome and its consequences, and the need for the diagnostic procedure. For this reason, I conclude Mr Harris is entitled to receive treatment in accordance with s 67 of the Act.

**Result**

[59] Accordingly, the appeal is allowed. The review decision of 18 April 2017 is quashed and the Corporation's decision of 1 June 2016 is set aside.

[60] Mr Harris is entitled to reasonable costs which I am confident the parties can agree.



Judge Denese Henare
District Court Judge

Solicitors: Medico Law, Auckland for the respondent

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1 [2006] NZACC 318.