Decision 585

Review numbers: [redacted]

Application by [redacted]

for a review under the Accident Compensation Act

Held at	[redacted]
Date of hearing	2 November 2016, adjourned part-heard; and 15 March 2017 via teleconference.
Reviewer	[redacted]
Present	Ms [redacted] Ms Fiona Taylor (advocate) Mr [redacted] for ACC (November hearing), Mr [redacted] and Ms [redacted] for ACC (March hearing).
Issue [1]	Review of ACC's decision of 6 May 2016 declining to fund surgery for a pelvic organ prolapse.
Decision [1]	Dismissed
Issue [2]	Review of ACC's decision of 11 November 2016 declining cover for a pelvic organ prolapse as a treatment injury.
Decision [2]	Dismissed
Costs	Sought.
Action	Required.

Decision

I have considered whether ACC's decision of May 2016, declining funding for the pelvic organ prolapse, and ACC's November 2016 decision, declining to cover the prolapse, are correct. My decision in this matter is that both applications are dismissed.

In reaching my decision, I have considered Ms [redacted] submissions; ACC's case file and submissions; key medical evidence, including but not limited to Ms [redacted]s' records, Dr [redacted] report, Dr [redacted] assessment and surgery proposal, Mr [redacted] clinical opinion, Dr [redacted] report; and relevant case law.

Background

On [redacted] October 2009 [redacted] gave birth to her first child. The delivery was complicated and forceps were used to assist. Ms [redacted] suffered a third-degree perineal laceration (a tear of the skin and soft tissue which separates the vagina from the anus). As a result she suffered incontinence symptoms.

On 24 March 2010 Ms [redacted] consulted pelvic health physiotherapist [redacted] Ms [redacted] reported in part:

> [redacted] presents with symptoms of daily morning faecal urgency/frequency and occasional urge incontinence. She reports poor flatal control and notices a vaginal bulge/discomfort during the day.
>
> History: [redacted] has had these symptoms since the forceps delivery of her baby in October 2009.
>
> [redacted] symptoms are consistent with reduced rectal storage threshold and dysfunction of the anal sphincter. [. . .] She also has an anterior vaginal wall prolapse.

On 19 February 2015 [redacted] Hospital lodged a claim for a third-degree perineal tear as a treatment injury. ACC accepted cover on 2 April 2015.

On [redacted] February 2015 Ms [redacted] gave birth to her second child via elective caesarean section.

Surgery to repair a sphincter defect, February 2016

Colorectal and general surgeon [redacted] arranged for Ms [redacted] to undergo an endoanal ultrasound scan. This took place on 6 October 2015 and showed a "deficient anterior sphincter consistent with a previous significant tear". (The sphincter is a circular muscle that constricts a passage or closes a natural orifice.[1])

[1] www.medical-dictionary.com

On 18 December 2015 obstetric and gynaecological consultant [redacted] assessed Ms [redacted] and her scan results. Dr [redacted] stated: "On examining her today there is anterior wall prolapse." She concluded that Ms [redacted] main problem is prolapse. She also stated: "obviously this is something that cannot be sorted at the same time" as the anal sphincter.

On 11 January 2016 Mr [redacted] proposed surgery to repair an anterior anal sphincter defect. ACC agreed to fund the surgery, and considered the condition as a result of Ms [redacted] perineal tear.

Surgery took place on 5 February 2016. Unfortunately, Ms [redacted] symptoms did not completely resolve.

Assessment report and treatment plan

On 2 March 2016 obstetrician and gynaecologist [redacted] examined Ms [redacted] He stated in part:

> [redacted] sustained a pelvic floor injury after a forceps birth with her first child, she had a fourth degree perineal tear which caused significant perineal scarring as well as pelvic organ prolapse [. . .] She still remains symptomatic with the prolapse.

Dr [redacted] completed an assessment report and treatment plan in which he proposed further surgery. He listed the presence of cystocele and stage II recto-enterocele and specifically diagnosed a pelvic organ prolapse. [2]

Dr [redacted] described the history of the prolapse as a fourth-degree perineal tear post forceps delivery. In relation to the causal link between the proposed surgery and covered injury he wrote: "Child Birth – Forceps Delivery".

ACC's first decision

On 6 May 2016 ACC declined to fund the proposed surgery. ACC determined the prolapse was not caused by the third-degree perineal tear during birth in October 2009.

Ms [redacted] lodged a review application which reached ACC on 10 June 2016. She noted that the first claim for cover of the perineal tear as a treatment injury was completed by obstetric and gynaecological registrar [redacted] and did not include the prolapse. Ms [redacted] stated she would have listed the prolapse because it was "caused as a direct result from the treatment injury on 13/10/2009". She also filed related medical records and research articles.[3]

On 1 November 2016 ACC wrote to Ms [redacted] confirming cover for a third-degree perineal laceration. ACC also stated that its treatment injury unit was assessing cover for her pelvic organ prolapse under a separate claim. ACC therefore queried whether the review of the surgery decision should proceed before the outcome of the cover application was determined.

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[2] Cystocele is a prolapse of the bladder into the front vaginal wall. Recto-enterocele is a combined prolapse of the rectum into the back vaginal wall and of the small intestine into the top of the vagina. www.womens-health-concern.org

[3] Internet articles are of a general nature. My focus is on the medical evidence specific to the case.

First review hearing

I held a hearing on 2 November 2016 to review ACC's May 2016 declining to fund surgery. Ms Taylor and ACC principally discussed the significance of ACC's investigation of cover for the prolapse as a separate treatment injury.

Ms [redacted] case

Ms Taylor stated she was confused as to why there is a new treatment injury claim given Ms [redacted] prolapse related to the same event. She said the condition was almost an additional diagnosis.

Mr [redacted] stated that the basis of a treatment injury claim is different to a personal injury claim by accident: cover is specific to the claim lodged and in this case the injury for which cover was requested is the perineal tear sustained during forceps delivery. It was straightforward for ACC to fund surgery for the sphincter defect because it related directly to the tear.

I summarise Mr [redacted] further main points:

- The prolapse condition is not as clearly linked to the covered treatment injury. That type of pathology can result with or without a treatment injury.

- The main issue is cover and that the condition can only be covered under a treatment injury category of claim.

- A completely new claim should have been lodged to be considered as a treatment injury. Therefore, the second claim was lodged at ACC's instruction.

- On 6 October 2016 ACC instructed specialist obstetrician and gynaecologist [redacted] to assess whether the prolapse was due to the vaginal forceps delivery.

- Following receipt of Dr [redacted] report ACC would determine cover. It would be unwise to proceed before cover is determined.

Ms Taylor made submissions in reply. I summarise her main points:

- Cover was granted for the perineal tear and the first operation was required as a consequence of that tear. The cystocoele and recto-enterocele were also consequences of the covered tear.

- Mr [redacted] is not a gynaecological specialist and his comment in relation to the prolapse condition being common in paras women is incorrect. In Ms [redacted] case, the October 2009 delivery was the first time she had given birth. Paras relates to further births.

Ms [redacted] gave evidence that she was not aware that cover was available for the prolapse condition prior to February 2015. She stated she would have otherwise included this injury in the original claim application.

ACC confirmed it would fund a specialist report in response to Dr [redacted] report, if Ms [redacted] opted to obtain one.

The parties agreed to adjourn the hearing part-heard, pending ACC's decision on cover of the pelvic organ prolapse.

Dr [redacted] report

On 8 November 2016 ACC received Dr [redacted] report. It responded to three key questions posed by ACC:

1. Whether Ms [redacted] suffered a cystocele and/or stage 2 recto-enterocele pelvic organ prolapse injury?
2. If Ms [redacted] did sustain the prolapse injury, whether
   a) it was caused by the forceps delivery; a consequence of the third-degree tear; or another cause? and
   b) whether it was an ordinary consequence of her treatment, considering Ms [redacted] circumstances, such as her age and underlying health etc?

Dr [redacted] conclusions did not support the separate cover claim, or Ms [redacted] submission that her prolapse was caused by the covered tear.

ACC's second decision

On 11 November 2016 ACC declined to cover the prolapse condition as a treatment injury. ACC wrote that it would therefore be unable to help with treatment costs or other support for this injury.

Ms Taylor lodged a review application on Ms [redacted] behalf which reached ACC on 2 December 2016.

Second review hearing

I held a second hearing on 15 March 2017. This combined the part-heard review of ACC's surgery decision (review # [redacted]) and ACC's decision declining cover (review # [redacted]

ACC's surgery decision, review # [redacted]

Ms [redacted] case

Ms Taylor made submissions on Ms [redacted] behalf in relation to the first review. I summarise her main points:

- There are two separate decisions. Dr [redacted] mentioned that surgery is required due to the third or fourth degree tear. That is different to whether surgery is required due to forceps delivery.

- The injuries occurred at the same time. Cover was granted in respect of the tear; surgery was approved by ACC; was not successful; and therefore further surgery is required.

ACC's case

Mr [redacted] made submissions on behalf of ACC. His main points in brief were these:

- The claim for the perineal tear as a treatment injury was requested, investigated and accepted for cover. That is the specific claim that ACC considered and accepted for cover. The prolapse was not requested or investigated for cover. Therefore, there is a jurisdictional issue on the earlier claim because cover has been declined for that specific condition.

- ACC had not considered the specific prolapse condition requiring cover. Therefore, ACC would consider there is no cover for the prolapse.

- The prolapse cannot be considered as being secondary, due to the fact that ACC has since declined the condition for cover.

ACC's cover decision, review # [redacted]

Ms [redacted] case

Ms [redacted] gave evidence. I summarise her main points:

- She suffered a severe prolapse and poor bowel control. She identified the prolapse herself immediately after the birth. "The front wall was hanging out".
- She did not receive much medical support at all at the time, but was more supported after the second child's birth, when advised that the prolapse could be repaired.
- After the 2009 birth she had two brief follow-up appointments with a hospital gynaecologist. She had to arrange physiotherapy herself.
- There were no new injuries following the birth of her second child. Rather the problems were ongoing since the first birth.
- Since the forceps delivery, the prolapse condition has varied according to factors such as her menstrual cycle and tiredness.
- The surgery that has taken place was to address bowel control. It was successful, despite a few issues. The prolapse has not gone away.

Ms Taylor made submissions. I summarise her main points:

- Dr [redacted] seems to have indicated that the prolapse occurred later and not subsequent to the first birth. This appears to have coloured the totality of her opinion and conclusion; and ACC's stance seems to be based on a conclusion that the prolapse occurred after the birth of the second child rather than at the time of the forceps delivery.

- Ms [redacted] reported on 24 March 2010 that Ms [redacted] had an anterior wall prolapse and specifically noted the prolapse diagnosis. It is therefore clear that a prolapse was evident following the first delivery.

- Ms [redacted] gave evidence that she noticed the prolapse immediately and there has been no change. The injury has continued through and needs to be addressed via surgery.

- ACC funded surgery for the overlapping interior sphincter tear, which was due to the third or fourth degree tear. ACC accepted the tear, and by similar consideration the prolapse must also be accepted as a consequence of that childbirth and must also qualify for cover, whether as a result of the tear or by the direct use of the forceps. The prolapse must be treated as a treatment injury and surgery approved.

ACC's case

Ms [redacted] spoke to ACC's written submissions. I summarise the main points:

- This case fails in relation to causation.

- Ms [redacted] gave evidence that she identified the prolapse immediately after birth. However, the clinical records do not identify that.

- The forceps delivery occurred in October 2009 and the pelvic therapist reported on 24 March 2010, being sometime later after the birth.

- Dr [redacted] noted that a gynaecology out-patient appointment occurred in May 2010 and that at that time there was "minimal prolapse".

- Dr [redacted] opinion is that Ms [redacted] cystocele was not evident until after her second pregnancy and that she was not reviewed until 2010.

- The clinical records do not support a prolapse at the time of the first birth. There appears to be a gap in the clinical records and the prolapse was not identified until 2010.

- Dr [redacted] opinion is that the recto-enterocele was caused by the delivery of the baby's head, and not necessarily by treatment. It did not become evident until after the second childbirth.

- The use of forceps is implicated as an increased risk of damage to the pelvis structures causing prolapse. However, an increase risk of causation does not prove a causal link to the injury.

- Even if it were proven that treatment caused the prolapse, the injury would be considered an ordinary consequence of Ms [redacted] treatment.

- ACC relies on Dr [redacted] opinion as the expert evidence.

Ms Taylor in reply

Ms Taylor stated in reply that “minimal prolapse” does not equate with no prolapse.

In response to questions, she agreed that Dr [redacted] does not discount the 2009 delivery as a factor. However, she submitted that the doctor included the later delivery as causative, whereas the prolapse was already in existence; and it seemed that Dr [redacted] had already concluded that the prolapse was not present until the second delivery. ACC also refers heavily in its decision tool to this incorrect opinion.

Relevant law

The following sections of the Accident Compensation Act 2001 are relevant:

- Section 26 – This section sets out the definition of personal injury
- Section 32 – This section sets out the definition of treatment injury

Section 32 (2) provides that treatment injury does not include personal injury that is wholly or substantially caused by a person’s underlying health condition.

The full text of these sections can be accessed at www.legislation.govt.nz.

Analysis

I must decide whether ACC was correct to determine that Ms [redacted] did not suffer a prolapse as a consequence of her covered perineal tear; and that her prolapse fails to meet the required criteria for a treatment injury.

Did Ms [redacted] suffer a prolapse?

In her report, Dr [redacted] first considered the records of Ms [redacted]. Dr [redacted] cites at length Ms [redacted] report of 24 March 2010, including for instance, that Ms [redacted] had suffered her symptoms “since a forceps delivery in October 2009.”

Dr [redacted] refers in some detail to Ms [redacted] symptoms, as noted by Ms [redacted]. She acknowledges the conclusion in 2010 that Ms [redacted] had symptoms consistent with anal sphincter and that “she also had an anterior vaginal wall prolapse”.

Dr [redacted] conclusions can be distinguished from those of Ms [redacted] in terms of the development of the prolapse. However, I am satisfied that Dr [redacted] gave Ms [redacted]’ records due consideration.

Dr [redacted] also refers to the report from a consultant obstetrician and gynaecologist dated 6 May 2010. She notes that Ms [redacted] symptoms were reportedly improving. She therefore acknowledged the presence of the symptoms and that they had been worse earlier. Dr

[redacted] quoted the consultant's record that "the vagina and vulva were normal [and that there] was minimal prolapse."

Dr [redacted] concluded (in part):

> She definitely had a cystocele as identified by Dr [redacted] [. . .]. I think it is likely that she had a rectocele with or without an enterocele because she had that significant impaction of faecal material following secondary sphincter repair. However, nowhere in the notes does it describe this.

In view of these remarks, I am satisfied that Dr [redacted] accepted that Ms [redacted] suffered from the diagnosed cystocele, and that she likely suffered a rectocele. As indicated, this is largely consistent with the evidence of other treating medical professionals, such as Ms [redacted], Dr [redacted] and Dr [redacted]; and with Ms [redacted] own assessment. Therefore, I am persuaded that the Ms [redacted] suffered a pelvic organ prolapse.

What caused the prolapse?

Dr [redacted] reasoned that the prolapse was due to three factors. She recounted significant detail from Ms [redacted] first childbirth experience in 2009 and listed the factors as pregnancy, vaginal delivery, and forceps delivery.

As indicated, Dr [redacted] concluded that the forceps-assisted delivery caused the anterior but not posterior prolapse. She explained that forceps take up space in the vaginal canal, causing fibres to stretch beyond their capability and: "hence the reason for the anterior wall prolapse. The posterior wall fibre rupture/stretch is due to the delivery of the head".

Dr [redacted] also stated:

> The prolapse was not noted to be present after the first delivery-so it occurred after the second delivery which was done by an elective caesarean section.

In reaching this conclusion Dr [redacted] considered that at the time of Ms [redacted] first surgery to repair the sphincter defect the surgeons did not attempt to carry out a combined repair of the sphincter and prolapse.

This conclusion disputes the personal evidence provided by Ms [redacted] It also runs contrary to the comment from Dr [redacted], that "obviously" the prolapse could not be surgically repaired at the same time as the anal sphincter.

However, Dr [redacted] reasoning reads as thorough and specific. She assessed relevant medical reports on file, and there is breadth and depth to her analysis.

By comparison, Dr [redacted] notes are relatively brief. He attributes the prolapse to the 2009 forceps delivery, but does not discuss, for example, the absence of contemporaneous medical evidence.

I note also that ACC's referral letter to Dr [redacted] stated it had requested a further report from Dr [redacted] which was not yet received. Despite enquiries with ACC, no further comment from Dr [redacted] was filed. Neither has Ms [redacted] opted to obtain an alternative specialist report.

In *Studman v Accident Compensation Corporation* [2013] NZHC 2598 the High Court said that a personal injury must be identified with precision, something which was 'fundamental to whether or not coverage for treatment injury exists'.

The case of *Stewart* (109/03) also found that an applicant's evidence can be significant, but if the individual is not medically qualified, she/he cannot determine the causal link. For these reasons, and in the absence of alternative specialist opinion, I prefer Dr [redacted] assessment of causation.

Was the prolapse an ordinary consequence of Ms [redacted] treatment?

Dr [redacted] noted that Ms [redacted] is fit and lean, having a physical condition which "augurs well for vaginal delivery". On the other hand, Dr [redacted] stated that Ms [redacted] has a short perineum which predisposed her to anal sphincter injury; and that as an older mother (Ms [redacted] was [redacted] in 2009), her tissue was not as distensible.[4] Such details demonstrate that Dr [redacted] considered Ms [redacted] specific circumstances.

The doctor went on to conclude as follows:

> A cystocele and/or stage 2 recto-enterocele/ pelvic organ prolapse are an [sic] ordinary consequence of a forceps delivery and of vaginal childbirth and the conditions of the patient's anatomy, though it does not always happen. [Emphasis added.]

Moreover, it is evident that Dr [redacted] was aware Ms [redacted] symptoms were present in 2009, but concluded the prolapse developed with the second pregnancy; that the causative factors in 2009 led to the condition being an ordinary consequence of both pregnancies; the treatment during the first childbirth; Ms [redacted] predisposing characteristics; and the use of forceps (in relation to the anterior prolapse).

Conclusion

I find it unnecessary to consider in depth the jurisdictional issue of whether the first review was rendered redundant by ACC's decision declining cover. I am persuaded there was still merit in considering whether Ms [redacted] prolapse was consequent to her covered perineal tear, within the context of the cover review. For the reasons outlined above, I am satisfied that Dr [redacted] opinion is cogent and clear that the prolapse did not result from the perineal tear injury.

I have found that this review included issues that were fairly finely balanced. For instance, I found Ms [redacted] to be a sincere and credible witness. I had no reason to doubt the evidence she gave in relation to her symptoms; about when they started; and their ongoing nature.

However, where there are contrary views I must be guided by the courts on how to weigh differing evidence. Therefore, in the absence of opposing specialist opinion, I am satisfied that ACC was correct to rely on Dr [redacted] report.

[4] Dr [redacted] noted Ms [redacted] as [redacted] at the time.

Costs

Ms [redacted] sought review costs in relation to both reviews. ACC had no objections in either case. While unsuccessful, I am satisfied that Ms [redacted] acted reasonably in applying for these reviews.

Therefore, under the Injury Prevention, Rehabilitation, and Compensation (Review Costs and Appeals) Regulations 2002, I award the following costs:

Lodging application (x2)	$233.88
Preparation for hearing (x2)	$701.66
Appearance at hearing (x2)	$350.82
Other expenses (disbursements x2)	$100.00
Total	$1,386.36

[redacted]

Reviewer

12 April 2017

Review rights: The applicant and ACC each have the right to appeal to the District Court; see the attached letter for more information.