

**IN THE DISTRICT COURT
AT WELLINGTON**

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

[2022] NZACC 68

ACR 177/20

UNDER THE ACCIDENT COMPENSATION ACT
2001

IN THE MATTER OF AN APPEAL UNDER SECTION 149 OF
THE ACT

BETWEEN M BROUGHTON
Appellant

AND ACCIDENT COMPENSATION
CORPORATION
Respondent

Hearing: 22 March 2022
Held at: Auckland/Tāmaki Makaurau

Appearances: M Williams for the appellant
R Williams and S Churstain for the respondent

Judgment: 28 April 2022

RESERVED JUDGMENT OF JUDGE P R SPILLER
[Claim for personal injury – ss 25-26 , Accident Compensation Act 2001]

Introduction

[1] This is an appeal from the decision of a Reviewer dated 7 September 2018. The Reviewer dismissed an application for review of the Corporation’s decision dated 7 March 2018 declining funding for arthroscopic surgery to treat Mr Broughton’s right ankle. This decision was made on the basis that Mr Broughton’s ankle injury was not caused by an accident on 10 July 2017.

Background

[2] Mr Broughton was born in 1966. He worked as a machine operator.

[3] On 10 July 2017, Mr Broughton rolled his right ankle. He consulted Dr Amanda Cleland, GP, who recorded:

Tripped downstairs this morning. Inversion ankle injury to right. Unable to weight bear. Immediate pain and swelling. Examination shows: Gross swelling lateral malleolus area.

[4] On 10 July 2017, Mr Broughton also underwent an x-ray of his right ankle. Dr Matt Turei, Radiologist, reported the results as follows:

No acute fracture. The malleoli and talar dome are intact. Prominent soft tissue swelling about the lateral malleolus.

Conclusion:

No acute osseous or joint injury evident.

[5] The Corporation granted Mr Broughton cover for sprain of his right ankle and right shoulder and upper arm.

[6] On 18 July 2017, an ultrasound was undertaken. Dr Brett Lyons, Radiologist, reported:

EXAMINATION FINDINGS

The CFL is intact but appears hypoechoic and is thickened. There is fibre disruption seen of the ATFL, showing multiple small intrasubstance tears with fluid seen anterior to the ligament.

There is a tendon sheath effusion of the FDL and TP. No tear found.

Also a small ankle joint effusion and subcutaneous oedema of the lateral ankle seen.

COMMENTS

Strain of the CFL and multiple intrasubstance tears of the ATFL. Tenosynovitis of the FDL and TP.

Ankle joint effusion and subcutaneous oedema.

[7] On 21 July 2017, Mr Broughton consulted his GP, who noted his ongoing pain and swelling.

[8] On 22 September 2017, Dr Tony Wright, GP, noted that Mr Broughton had been slow to settle with physiotherapy and continued to get pain and swelling of the right ankle. Dr Wright suggested an MRI scan of the ankle.

[9] On 10 November 2017, Mr Broughton underwent an MRI scan of his ankle.

Dr Turei reported:

No definite ankle joint osteochondral lesion. The tiny focus of low signal change deep to the subchondral plate about the lateral talar dome margin is of questionable significance with no overlying chondral abnormality identified.

Osseous change about the fibula and talofibular joint raises the possibility of overlying chondral damage, however the cartilage is poorly resolved. Small amount of synovial thickening about the posterior ankle joint recess suggests synovitis.

Fine intrasubstance tear of the retro fibular peroneal longus tendon. Attenuated ATFL and deep deltoid CFL ligament sprain.

Tiny ganglion overlying the intact anterior inferior tibiofibular ligament arising from the distal tibiofibular joint.

[10] On 27 November 2017, Mr Broughton saw Dr Ian Taylor, GP, who noted that Mr Broughton still described discomfort in various locations around his ankle. Dr Taylor noted that the changes recorded in the recent MRI were no different from what would be expected following a simple inversion injury.

[11] On 8 December 2017, an ACC 18 Medical Certificate found Mr Broughton unfit for work from 1 November 2017 to 29 January 2018, as his ankle was still too painful and prone to swelling. The plan was for Mr Broughton to be referred to an Orthopaedic Surgeon for a second opinion.

[12] On 22 February 2018, Mr Broughton saw Mr Alastair Dray, Orthopaedic Surgeon. He diagnosed:

Severe inversion injury eight months ago with ongoing pain, with suspicion of a talar dome osteochondral injury and peroneal tendon split or tear. Requires surgery.

[13] On 27 February 2018, Mr Dray submitted an Assessment Report and Treatment Plan proposing arthroscopy of Mr Broughton's right ankle. On the causal link between the proposed treatment and covered injury, Mr Dray commented:

I believe Michael either has a small osteochondral injury in his ankle which isn't clearly showing on the MRI scan, or there is impinging synovitis in the front of the ankle causing the clicking and catching symptoms he gets. I also think he probably has a tear of the peroneus brevis tendon. I propose to undertake arthroscopy of the ankle, debridement of any synovitis or talar dome injury, then exploration and repair of the peroneal tendons. I believe this is all a consequence of the severe inversion injury he sustained.

[14] On 28 February 2018, following a videoconference pain assessment of Mr Broughton on 31 January 2018, Dr Rajib Ghosh, Occupational Medicine Specialist, provided a report. Dr Ghosh noted that Mr Broughton was still experiencing pain in his right ankle and foot, and occasionally in his back. Dr Ghosh stated that Mr Broughton appeared to be suffering from “chronic pain with a predominant neuropathic component but also a simultaneous mechanical component”.

[15] On 5 March 2018, Dr Ray Fong, Orthopaedic Surgeon, provided a Clinical Advisory Panel/Medical Advisor Statement, having assessed Mr Broughton’s medical records. Dr Fong commented:

X-ray of the right ankle 10/07/2017 shows: No acute fracture. The malleoli and talar dome are intact. Prominent soft tissue swelling.

In other words, the imaging does not show any acute talar dome injury.

MRI scan of 10/11/2017 reported: No obvious osteochondral injury. Tiny signal change of uncertain significance. Attenuated lateral collateral ligament. Intrasubstance tear of the retrofibular peroneus longus tendon.

This intrasubstance retrofibular peroneus longus tendon tear represents peroneus tendonopathy.

This peroneus tendonopathy represents a gradual process condition, symptomatically aggravated by the accident but not caused by it.

In summary, the condition of peroneus tendonopathy now requiring treatment to the claimed PIBA cannot be established.

[16] On 7 March 2018, the Corporation wrote to Mr Broughton declining cover and surgery funding to treat his right ankle possible talar dome osteochondral injury and peroneal tendon split or tear. This was on the basis that this condition was not caused by the accident on 10 July 2017 and related to a pre-existing health condition. Mr Broughton applied to review this decision.

[17] On 2 April 2018, Mr Dray provided responses to a series of questions posed by Mr Broughton’s counsel:

1. When Mr Broughton rolled his right ankle in July 2017 he tells me he tripped on a top step and fell down severely inverting the right ankle as he fell. I note from Dr Ghosh’s report that he estimated he fell about 80cm which is obviously a very significant fall. I believe when he inverted his ankle (rolled it under) that he has sustained a sudden stretching-type force of the peroneal tendons with a likely reflex eccentric contraction of their muscle bellies, which I believe

caused a shearing force within the tendon fibres and a split. I was also concerned he may have injured the edge of the ankle bone within its socket as it rolled, but there is not clear MRI evidence of this. None-the-less it is still possible that there is a small osteochondral injury not picked up by the MRI scan and some ongoing synovitis within the ankle which is hurting and catching, giving him pain.

2. These aspects of this injury are what I propose to address in the surgery I applied for.

3. To quote from the MRI scan report of 10 November 2017, “Central linear high signal within the retro-fibular segment of the peroneus longus tendon ... Intact peroneus brevis tendon. No peroneal tendon sheath effusion”. In this report there is no mention of tendinopathy, but rather a split or tear of the tendon which I believe occurred at the time of injury. There is no evidence to suggest there was tendinopathy prior to this injury, and there is no radiological imaging of this ankle prior to the injury to suggest that he did have pre-existing tendinopathy.

4. I think on the balance of probabilities the need for surgery is attributable to this injury. I have applied for similar combinations of surgery on patients with injuries in the past and most of the time ACC approves these.

[18] On 14 May 2018, Dr Andrew Kingzett Taylor, Radiologist, provided the Corporation with an opinion on whether Mr Broughton’s radiological imaging provided evidence of, among other things, an osteochondral injury and peroneal tendon split tear and, if so, whether there was evidence to support those conditions being causally linked to the appellant’s covered ankle injury. Dr Taylor advised:

There are *several* small ankle chondral defects in conjunction with anterior tibial osteophytosis, probably best characterised as early osteoarthritis rather than a “talar dome osteochondral lesion”:

Findings include

- a partial thickness focal chondral defect anterolateral tibial plafond accompanied by an anterolateral tibial spur (osteophyte)
- a partial thickness chondral defect distal fibula at the talofibular recess
- small lateral and medial talar defects with minimal subjacent oedema. ...

There is a small longitudinal intrasubstance tear of the supramalleolar peroneus longus as defined by normal MRI criteria. The supramalleolar brevis is flattened within the retromalleolar groove.

Neither tendon appears to be frankly “split”.

Note is made that there is no tenosynovitis (defined as fluid encircling the tendon) and the superior peroneal retinaculum is not torn

There are partial tears of both the lateral ligament and deltoid ligament.

[19] On the causal connection between the conditions and the accident Dr Kingzett Taylor advised:

NOT EXCLUDED BUT CONSIDERED LESS LIKELY THAN NOT

This is an intrasubstance tear peroneus longus as defined by normal MRI criteria but the tear does not appear to extend to the surface of the tendon (differential is mucoid tendinosis). Brevis is flattened within the retromalleolar groove.

Peroneal tendon tears may be post-traumatic but absence of tendon sheath fluid on both the US and the MR is thought to argue against an acute tear.

There is no superior retinacular injury.

[20] On 15 June 2018, Mr Broughton underwent surgery. Mr Dray's operation note recorded:

PROCEDURE:

... Peroneus longus had a short deep full thickness split of about 15mm in length just behind the lateral malleolus. Sheath then repaired, the wound closed with 2/0 Vicryl and 4/0 Rapide Vicryl. ...

...The tib post had a complex short split with two components to it over a length of about 15mm immediately at the back of the posterior malleolus, with some stripping-off of the tib post retinaculum in its distal portion as it runs around the back of the malleolus, but it was still stable and not subluxing. I believe this is from trauma. This tear was repaired...

The ankle was then scoped and there was no significant arthritis although there was a small antero-lateral spur in the tibia which did not impinge. There was thick meniscus-like scar tissue formed in the lateral half of the front of the joint which had potentially been impinging and this was shaved. The talar dome was inspected and there were no osteochondral lesions...

[21] On 30 July 2018, Mr Dray provided a response to Dr Taylor's report:

I can't really comment on Mr Kingzett-Taylor's report. All I can comment on is that at the time of surgery I sometimes find subtle pathologies not seen within the limitations of MRI scans. People put great faith in the ability of the MRI to diagnose all problems and they are not infallible. I often find small splits or tears that the scans can either not detect or misinterpret. Small splits or tears that can extend to the surface of a tendon may not show up on the MRI if the split is not slightly open so that fluid can track into the split. This applies to both ultrasounds and MRI's from my experience at the time of surgeries.

I can only go by the history Michael gives me and how that relates to his injury and the subsequent findings. I point out again that from my surgery application (ARTP) that when he injured himself he tripped over the top step, fell down, and thinks he significantly inverted his right ankle, but he did black out and woke up with a sore head, and may have been knocked out briefly...

[22] On 30 July 2018, Dr Mike Sexton, General Surgeon and Senior Medical Advisor with the Corporation, reviewed Mr Broughton's medical records, and provided the following comment:

The operation note from 15/06/2018 noted that the client had developed new pain in the medial hindfoot consistent with tibialis posterior pathology, although this was not sore when the surgeon had seen him four months ago. The operation consent was amended to include an explanation of this. The findings at operation were those of a split of the peroneus longus tendon just behind the lateral malleolus with flattening of the peroneus brevis and a short complex split of the tibialis posterior in relation to the posterior aspect of the medial malleolus. Longitudinal splits in these tendons are attritional and related to the impingement of the tendon as it passes from the leg to the foot around the lateral and medial malleoli respectively. These differ from traumatic tears which tend to occur transversely across the line of the tendon fibres rather than longitudinally in the line of fibres.

The CAP document on peroneal tendon tears is relevant to this comment.

An inversion event is an unlikely mechanism to damage the tibialis posterior tendon and the other features found at operation in terms of the anterolateral impingement signs and the meniscal tissue in the lateral gutter are evidence of anterolateral impingement of the ankle. There was no talar dome lesion at arthroscopy.

The pathology which has been addressed does not relate to a single injury event, but is more indicative of chronic ankle impingement and attritional changes in the tibialis posterior and peroneal tendons over a long period of time.

Dr Kingzett-Taylor's review of the imaging is also noted and his comments are consistent with this advice.

[23] On 9 August 2018, Mr Dray provided a letter addressed to Mr Broughton's GP after a follow-up consultation following Mr Broughton's recent surgery:

... The peroneal and tib post tendons all have good power to resisted testing without any significant discomfort, but he does get some minor nerve-type pain over the lateral dorsum of his foot consistent with one of the branches of the superficial peroneal nerve. There is no tenderness at the arthroscopy portal to suggest the nerve was caught up in this, and the incision for the peroneal tendons is quite posterior so I don't think this would have affected the main branches and I am hoping this will settle down with time.

[24] On 10 August 2018, review proceedings were held. On 7 September 2018, the Reviewer dismissed the review, on the basis that the Corporation's decision to decline Mr Broughton cover and surgery for his right ankle injury was correct as the need for surgery was not caused by the accident on 10 July 2017.

[25] On 26 September 2018, a Notice of Appeal was lodged. However, this was overlooked by the Registry and not registered. On enquiry by Ms Williams for Mr Broughton, the Registry registered the appeal on 28 August 2020.

[26] On 12 October 2020, Mr Dray provided further clinical comment at the request of Mr Broughton's counsel. Mr Dray noted:

... Looking at my operation note from that day [of surgery, on 15 June 2018], peroneus brevis was flattened which is a typical pattern of injury of peroneus brevis, peroneus longus had a short deep full thickness split tear of 15mm which was not clearly seen on the MRIs, and this was repaired. In addition, the tibialis posterior tendon had a short complex tear of two components, the overall combined length of the two components of the split tear being about 15mm and in addition to this, there was some stripping of the tibialis posterior retinaculum from the back of the tibia where it runs behind the medial malleolus, and I believe this is post-traumatic. There was no typical degenerative changes visible on any of these tendons. Degenerative changes include swelling and enlargement of the tendon, synovitis, and abnormal tendon tissue - none of these were present.

...Although it sounds unlikely that patients can roll their ankle in both directions, it does happen. I propose this is probably what happened to Michael although because he wasn't fully conscious, he can't give a clear description and I have encountered this with patients before, as well. ...

In terms of the radiology, the ultrasound report from 18th July 2017 reports disruption of the ATFL and this would be consistent with trauma. Likewise, the adjacent CFL ligament was reported as being strained. This is all consistent with an inversion injury. Similarly, there is an ankle joint effusion seen and subcutaneous edema, all signs of trauma. I note the initial MRI report did not report any chondral or osteochondral injury within the ankle joint itself, although it does note there is an effusion which is consistent with ankle trauma. However, a subsequent review by Dr Kingzett-Taylor noticed several small ankle chondral defects. Different radiologists will potentially interpret and report scans differently and I can't explain this variance.

[27] On 21 October 2020, Dr Daniel Gierhake, Radiologist, having reviewed Mr Broughton's MRI scan of 10 November 2017, as well as a later MRI scan of 6 August 2020 and a CT scan of 10 August 2020, advised:

Anterior osteophytes at the tibiofibular distal anterior joint are consistent with a post-traumatic pathology following anterior syndesmotic injury. Residual irregularity of the anterior syndesmotic ligament demonstrated on the MRI from 6/8/2019.

The small calcifications demonstrated on the CT at the level of the deltoid ligament complex are in keeping with post-traumatic aetiology/previous avulsion injuries, shown as with more acute appearance on the MRI from 10/11/2017.

Comment:

Above-mentioned injuries consistent with post-traumatic origin, with the history and previous images given, these are considered to be related to the inversion/rolling of ankle injury.

[28] On 4 March 2021, the Corporation's clinical advisory panel ("CAP"), having reviewed Mr Broughton's medical records, provided an opinion. The CAP concluded as follows:

The right ankle tendinopathy and split tears in the tendons and ligaments were most likely present prior to the covered event. The fall down the stairs is likely to have symptomatically aggravated the chronic changes in Mr Broughton's right ankle; but did not cause it. It is common for most people, like Mr Broughton, not to have pre-existing right ankle symptoms from their tendinopathy, even those with severe changes on imaging. Mr Broughton's pre-existing, longstanding changes to the tendons and ligaments in his right ankle were addressed by Mr Dray's 15/06/2018 surgery. Mr Broughton's ongoing right ankle symptoms and problems are due to his tendinopathy and postsurgical scarring and tethering. A causal link with his 10/07/2017 fall down the stairs cannot be established.

[29] In reaching its conclusions on causation, the CAP noted that peroneal tendinopathy and tearing is most likely to have developed as a gradual onset process over some years before Mr Broughton's accident. As far as Mr Dray's comments in respect of Mr Broughton's peroneus longus tendon, it was noted:

The CAP did not consider it probable that Mr Broughton's peroneus longus tendon was torn longitudinally with Mr Broughton's fall downstairs on 10/07/2017. There was no concomitant injury such as tendon subluxation, tenosynovitis, lateral ankle instability, fracture of the lateral process of the talus, Achilles rupture or other injuries known to accompany peroneus tendon tears.

Longitudinal (vertical) splitting of Mr [Broughton's] peroneus longus tendon is not consistent with the sudden forces around the malleolus during the 1/07/2017 fall, described in Mr Dray's report, including his latest 12/10/2020 report. If the peroneus longus tendon had been torn acutely, then we would have expected transverse tearing and avulsion off the bone, with a bone flake or fracture. That was not the case here.

[30] In addition, the CAP noted that Mr Broughton's initial right ankle ultrasound scan, eight days after his fall downstairs, did not report a peroneal tendon tear, and that it was improbable that the ultrasound scan would not have reported it, if his peroneus longus tendon had in fact been acutely torn during the accident.

[31] As far as Mr Dray's suggestion that Mr Broughton had rolled his right ankle both inwards and outwards, the CAP noted that this mechanism of injury was not

supported by the contemporary record, including that of Dr Cleland who on the day of the injury noted “no medial tenderness”, and Mr Dray who had himself noted, on 22 August 2018, that the tendon on the medial side (the tibialis posterior) “has good power and is not tender”. In the CAP’s opinion, all of this provided a sufficient indication that there was no significant injury, including tendon tearing, to the medial side of Mr Broughton’s right ankle.

[32] At the conclusion of the appeal hearing, counsel for the Corporation was granted leave to obtain further comment from the CAP with respect to the report of Dr Gierhake dated 21 October 2020, prior to the appeal being decided.

[33] On 29 March 2022, the CAP reported that its comment and recommendations from its meeting held on 23 February 2021, that the surgeries performed by Mr Dray on Mr Broughton’s ankle was to manage pre-existing tendinopathy not caused by the accident on 10 July 2017, remained unchanged.

Relevant law

[34] Section 20(2)(a) of the Act provides that a person has cover for a personal injury which is caused by an accident. Section 26(2) states that “personal injury” does not include personal injury caused wholly or substantially by a gradual process, disease, or infection (unless it is personal injury of a kind specifically described in section 20(2)(e) to (h)). Section 25(1)(a)(i) provides that “accident” means a specific event or a series of events, other than a gradual process, that involves the application of a force (including gravity), or resistance, external to the human body. Section 25(3) notes that the fact that a person has suffered a personal injury is not of itself to be construed as an indication or presumption that it was caused by an accident.

[35] Section 67 of the Act provides:

A claimant who has suffered a personal injury is entitled to 1 or more entitlements if he or she—

- (a) has cover for the personal injury; and
- (b) is eligible under this Act for the entitlement or entitlements in respect of the personal injury.

[36] In *Cochrane*,¹ Miller J found:

[25] An appellant may not establish causation simply by showing that the injury triggered on underlying condition to which the appellant was already vulnerable (the ‘eggshell skull’ principle) or that the injury accelerated a condition that would have been suffered anyway (the ‘acceleration’ principle): *McDonald v ARCIC* ... The question is simply whether the necessary causal nexus continues to exist between the injury and the condition.

[37] In *Coleman*,² Judge Cadenhead stated:

[34] The issue, here, is whether the appellant can show that the accident was wholly or substantially related to the need for the operation. If that accident merely rendered symptomatic an underlying condition of ageing and that was the whole or substantial need for the operation that would not be sufficient. In *Gazzard* (High Court Wellington CIV 2005-485-2388, 22 May 2006) Justice Miller held that a temporal connection was not sufficient, when the medical evidence established that cause complained was a function of degeneration rather than injury.

[38] In *Johnston*,³ France J stated:

[11] It is common ground that, but for the accident, there is no reason to consider that Mr Johnston’s underlying disc degeneration would have manifested itself. Or at least not for many years.

[12] However, in a passage that has been cited and applied on numerous occasions, Panckhurst J in *McDonald v ARCIC* held:

If medical evidence establishes there are pre-existing degenerative changes which are brought to light or which become symptomatic as a consequence of an event which constitutes an accident, it can only be the injury caused by the accident and not the injury that is the continuing effects of the pre-existing degenerative condition that can be covered. The fact that it is the event of an accident which renders symptomatic that which previously was asymptomatic does not alter that basic principle. The accident did not cause the degenerative changes, it just caused the effects of those changes to become apparent ...

[13] It is this passage which has governed the outcome of this case to date. Although properly other authorities have been referred to, the reality is that the preceding decision makers have concluded that Mr Johnston’s incapacity through back pain is due to his pre-existing degeneration and not to any injury caused by the accident.

[14] ... I consider it important to note the careful wording in the *McDonald* passage. The issue is not whether an accident caused the incapacity. The issue is whether the accident caused a physical injury that is presently causing or contributing to the incapacity.

¹ *Cochrane v Accident Compensation Corporation* [2005] NZAR 193 (HC).

² *Coleman v Accident Compensation Corporation* [2007] NZACC 18.

³ *Johnston v Accident Compensation Corporation* [2010] NZAR 673.

[39] In *Sultana*,⁴ Judge Sinclair stated:

[42] Accordingly, it follows that to be eligible for a surgery entitlement there must be a causal link between the covered injury and the condition for which the proposed surgery is required. The onus is on the appellant (Mrs Sultana) to prove causation on the balance of probabilities.

[43] In assessing causation, it is necessary to take into account the principles set out by the Court of Appeal in *Ambros v Accident Compensation Corporation*. Importantly, it must always be borne in mind that there must be sufficient material pointing to proof of causation on the balance of probabilities for a Court to draw even a robust inference on causation. Risk of causation does not suffice.

[40] In *Yde*,⁵ Judge MacLean stated:

[21] Applying the test in *Ambros* [2007] NZCA 304, drawing robust inferences of causation where medical evidence suggests a possible connection, coupled with the “generous and unniggardly” approach of *Harrild v Director of Proceedings* [2003] NZCA 125; [2003] 3 NZLR 289 and *Cochrane v ACC CIV 2003-485-2009*, the Court’s task is to step back and ask the question of whether the evidence as a whole, bearing in mind that there is conflicting views by specialists, justifies the conclusion of the necessary nexus between injury and incapacity.

[22] The absence of early temporal pain in this case is not determinative as there are possible explanations for that, so the exercise for the Court becomes one of analysing the respective expert views.

[23] I prefer the analysis of CAP as the more likely explanation when weighing up matters. ...

[28] As between the contrasting views, I do not think that the specialist opinion of the treating clinician necessarily has to prevail over that of the CAP. At the end of the day, both are applying their medical expertise to make an analysis of the total picture based on the various reports and MRI information.

[29] Accordingly, the Court concludes that it has not been established that the reviewer’s conclusion was wrong. This is not to say that there is any particular onus or starting point of preference with respect to the reviewer’s decision, but results from stepping back and looking at the totality of the information as a whole.

[41] In *J*,⁶ Kos P stated:

[52] In *Accident Compensation Corporation v Mitchell Richardson J* observed that the proper approach to construing the Act was that it be given a “generous and unniggardly” construction. We endorsed that approach in *Harrild v Director of Proceedings*. The importance of this principle lies where more than one available interpretation exists. If the Act is unavoidably niggardly or

⁴ *Sultana v Accident Compensation Corporation* [2019] NZACC 74.

⁵ *Yde v Accident Compensation Corporation* [2015] NZACC 108.

⁶ *J v Accident Compensation Corporation* [2017] NZCA 441, [2017] 3 NZLR 804.

ungenerous, that is that. But if a reasonable choice presents, the more generous path should be taken.

Discussion

[42] The issue in this case is for determination in this appeal is whether Mr Broughton can establish a causal nexus between the accident of 10 July 2017 and the changes to his tibialis posterior and peroneal tendons addressed during surgery on 15 June 2018. If a causal connection is established, Mr Broughton would be eligible for funding for arthroscopic surgery. In order to obtain cover (and resulting entitlements), Mr Broughton needs to establish that his condition resulted from a personal injury by accident, which does not, in principle, include personal injury caused wholly or substantially by a gradual process or disease.⁷ If medical evidence establishes that Mr Broughton had pre-existing degenerative changes which were brought to light or which became symptomatic as a consequence of an accident, it can only be injury caused by the accident and not the injury that is the continuing effects of the pre-existing degenerative condition that can be covered.⁸ In construing claims brought under the Act, a generous and “unniggardly” construction is the proper approach where more than one available interpretation exists.⁹

[43] The Corporation submits that a causal nexus between the accident of 10 July 2017 and the changes to Mr Broughton’s tibialis posterior and peroneal tendons requiring surgery on 15 June 2018 has not been established. The Corporation submits that the right ankle tendinopathy and split tears in the tendons and ligaments of Mr Broughton’s right ankle were, on balance, present prior to the covered injury event. The Corporation submits that the pathology addressed during surgery did not relate to a single injury event but was more indicative of chronic ankle impingement and attritional changes in the tibialis posterior and peroneal tendons over a long period of time. The Corporation refers, in support, to the evidence of Dr Kingzett Taylor (Radiologist), Dr Sexton (General Surgeon and Senior Medical Advisor with the Corporation), and the CAP, who all provided reports based on the medical records at hand.

⁷ Sections 20(2)(a) and 26(2) of the Act.

⁸ See *Johnston* n3 above at [12].

⁹ See *J* n6 above at [52].

[44] The Court acknowledges the submissions and medical evidence provided by the Corporation. However, the Court refers to the following further medical evidence.

[45] First, on 27 November 2017 (four months after Mr Broughton's ankle injury), he saw Dr Ian Taylor, GP, who noted that the changes recorded in a recent MRI were no different from what would be expected following a simple inversion injury.

[46] Second, Mr Alastair Dray, Orthopaedic Surgeon, the specialist who attended Mr Broughton on a number of occasions and who conducted surgery on him, consistently assessed that there is a causal link between Mr Broughton's ankle injury and his condition requiring surgery. The Court refers to Mr Dray's reports of 22 and 27 February 2018, 15 June and 30 July 2018. In Mr Dray's further report of 12 October 2020, he referred to his operation note which recorded that Mr Broughton's peroneus brevis was flattened, his peroneus longus had a short deep full thickness split tear, his tibialis posterior tendon had a short complex tear of two components, and there was some stripping of the tibialis posterior retinaculum. Mr Dray assessed the injuries to be post-traumatic and noted that there were no typical degenerative changes visible on any of these tendons. Mr Day also referred to the ultrasound report of 18 July 2017, which referred to the disruption of the ATFL, which he considered to be consistent with trauma.

[47] Third, on 21 October 2020, Dr Daniel Gierhake, Radiologist, having reviewed Mr Broughton's MRI scan of 10 November 2017, as well as a later MRI scan and CT scan, assessed that Mr Broughton's injuries were consistent with a post-traumatic origin, being related to the inversion/rolling of his ankle injury. This Court notes that Dr Gierhake's assessment is entitled to some weight, notwithstanding the comments from the CAP.

Conclusion

[48] In light of the above considerations, the Court finds that Mr Broughton has established a causal nexus between his accident of 10 July 2017 and the changes to his tibialis posterior and peroneal tendons addressed during surgery on 15 June 2018. The Court places particular weight on the assessment of the Orthopaedic Surgeon

who attended and conducted surgery on Mr Broughton, as Mr Dray's ongoing, first-hand and intimate insight into Mr Broughton's condition is not shared by any other medical specialist who has provided an assessment. The Court finds that Mr Dray's medical evidence, backed by the other medical evidence in support (noted above), outweighs the medical evidence arising out of the paper-based assessments to the contrary.

[49] The appeal is therefore allowed, and the review decision is set aside.

[50] Mr Broughton is entitled to costs. If these cannot be agreed within one month, I shall determine the issue following the filing of memoranda.

A handwritten signature in black ink, appearing to read 'P R Spiller', written in a cursive style.

P R Spiller
District Court Judge

Solicitors: Ford Sumner, Wellington, for the respondent.