**IN THE DISTRICT COURT**
**AT WELLINGTON**

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

**[2021] NZACC 44** **ACR 268/17**
**ACR 269/17**

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

Hearing: 10 February 2021
Heard at: Christchurch/Ōtautahi

Appearances: Mr T Yates, advocate for the appellant
Mr C Light for the respondent

Judgment: 17 March 2021

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**RESERVED JUDGMENT OF JUDGE C J McGUIRE**
**[Section 25, Accident; Section 26, Personal Injury;**
**Section 6, Vocational Independence**
**Accident Compensation Act 2001]**

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[1] The appeal under ACR 268/17 concerns the correctness of three decisions:

[a] A decision of 15 October 2014 declining cover for left ulnar neuritis (also known as Cubital Tunnel Syndrome).

[b] A decision of 10 March 2015 advising the appellant that he had achieved vocational independence in two work types, namely as despatch and

receiving clerk and as a sales assistant (general hardware). At Review, the reviewer in a Decision of 13 June 2017 modified ACC's decision, finding the appellant had achieved vocationally independence in one work type only, that of sales assistant (general hardware). The appellant appeals against that review decision. The appellant's position is that he is not vocationally independent in either work type. The respondent cross appeals against that review decision. The respondent's position is that the appellant has achieved vocational independence in both work types.

[c] A decision of 17 September 2015 declining cover for a left ulnar nerve injury as a consequence of treatment for a covered injury under s 20(2)(d).

[2] In respect of appeal ACR 269/17 the issue is the correctness of the respondent's decision of 10 March 2015 declining cover for right elbow epicondylitis.

[3] There is also a cross appeal by the respondent in respect of ACR 268/17 against the decision of the reviewer of 13 June 2017 deleting the work type of dispatching and receiving clerk.

**Background**

[4] The appellant injured himself on 3 November 2012. His GP recorded:

> Was under the car changing his oil and pulled his shoulder. Later pain went down the L arm. The injury comments refer to pain down the left arm and hand tingling and weakness.

[5] On 9 November 2012 Mr Finnis, Neurosurgeon, diagnosed radiculopathy at T1 or C8 with potentially a disc prolapse causing the symptoms. Mr Finnis also questioned if Mr Waite had ulnar neuritis on the right side. He said that this could account for some of the symptoms, although the sensory changes were more extensive than were typical for an ulnar distribution. He also had significant pain proximally around his shoulder, which was atypical for this condition.

[6] On 20 November 2012 the appellant had an MRI scan of his cervical spine. Dr Sharr, Radiologist, reported:

> 1. Bilateral moderately severe C6/7 foraminal stenosis with effacement appearing slightly more pronounced than the level below.
>
> 2. Left C7/T1 disc protrusion with left C8 effacement at and just medial to the foramen.
>
> 3. No other left sided neural compromise.

[7] Mr Finnis assessed Mr Waite following the MRI on 28 November 2012 reporting the same day. Mr Finnis considered that Mr Waite had clinical features of a left C8 radiculopathy, secondary to a disc prolapse at the C7/T1 level which he said happened at the time of his injury. Mr Finnis said that Mr Waite still had problems with pain in his left arm. Although the pain problem had improved somewhat, he still had weakness in his hand. Mr Finnis proposed assessing Mr Waite again in two months to see if his condition had improved.

[8] On 27 February 2013 Mr Grant Carroll, Neurophysiologist, reported on nerve conduction studies of the left wrist and elbow. His conclusion was that the left ulnar nerve findings were consistent with very mild compromise of the nerve at the elbow. On 23 March 2013 Dr Jackson, Consultant Neurosurgeon, carried out a left C7/T1 laminoforaminotomy and posterior discectomy. A small disc fragment was removed from behind the left C8 nerve root. The C7/T1 foramen itself had no evidence of significant spondylotic stenosis. A good decompression was achieved.

[9] On 23 April 2013 Dr Bell, Sports Medicine Specialist, completed a medical case review report for ACC. He said:

> Mr Waite indicates that while surgery was very successful in easing his very severe left upper limb pain, as time has passed he has become aware of persistent symptoms. He experiences pain even at rest involving the left side of his neck and trapezoid region extending down the posterior upper arm and medial forearm into the ulnar aspect of his hand, including ulnar two digits. Pain is manageable at rest and if he hasn't been undertaking anything too strenuous, however following more strenuous and repetitive left upper limb activity pain increases. …
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> He describes pain involving the left arm as if he has been hit on his funny bone, with this described as a painful burning sensation. Following precipitating activity pain develops within a few hours and when at its worst it can take up to

> several days to settle down. Mr Waite is gradually learning what activities he is able to manage and for how long before he develops a flare up of symptoms. …
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> He is able to drive. Mr Waite is right hand dominant and so manages many day to day activities with his left hand. He has noticed that fine work remains difficult with his left hand, particularly when pain is more severe. He tends to avoid very heavy lifting and carrying as well as activities requiring gripping, such as holding jars or objects firmly.
>
> …
>
> Should management remain non surgical following Mr Finnis's review (and I suspect that it will) then with improvement in symptom control with medication, capacity for more strenuous left upper limb activity may improve a little, however I don't believe it will be to the extent that he will be able to return to heavily or more prolonged repetitive activity with the left upper limb.

[10] On 24 April 2013 Mr Finnis reported on progress that Mr Waite had made since surgery. He had no further pain in his upper arm. He had some numbness in the ulnar aspect of his hand which had perhaps only improved a little since surgery. He did not have a great deal of neck pain, but from time to time had pain on neck movement. He still felt that his arm was a little weak. Mr Finnis said that while Mr Waite had some numbness this usually took some time, often several months, to improve.

[11] On 31 October 2013 Mr Finnis assessed the appellant again. He said that he had had improvement in the symptoms in his left arm. He still had a bit of tingling in the arm, but he had noticed improvement all the time. His strength was also returning. Mr Finnis's impression was that the improvement suggested adequate decompression of the nerve.

[12] Dr Bell reported again on 30 April 2014. Dr Bell's diagnosis was a C7/T1 disc prolapse with C8 radiculopathy. He considered that this injury had been caused by the accident event in November 2012. He said that Mr Waite continued to experience mechanical neck pain, although this was not the most dominant ongoing problem. Of significance was activity related radicular upper arm pain and this was a residual effect of the injury that he had suffered in November 2012. He thought that the surgery would have no further role to play in Mr Waite's management, although an MRI that was planned would clarify that with more certainty. He considered that, other than the MRI, scan Mr Waite's rehabilitation was now complete. In a further

report dated 20 June 2014, Mr Finnis referred to an MRI scan of the spine, taken 20 June 2014. He commented that while Mr Waite still had problems with neck pain, which were typical radicular symptoms into his arm of a C8 character, unfortunately there was no good explanation on the MRI scan of why this should be maintained. The characteristics were not those of a C7 radicular problem. Another possibility was ulnar neuropathy.

[13] On 9 July 2014, Mr Carroll commented on further nerve conduction studies of the left wrist and elbow. He said that there had been a mild deterioration in the left ulnar nerve findings since the previous examination on 20 February 2013.

[14] On 10 July 2014, Dr Sharr reported on a CT bone scan of the cervical spine. He concluded there was no abnormality in the left C7/T1 facet joint, there was mild osteoarthritis in the right C7/T1 facet joint and there was disc related spondylosis through the lower three levels and mild left C4/5 facet arthropathy.

[15] Following a sodium chloride PET scan on 10 July 2014 and nerve conduction studies, Mr Finnis considered in a report dated 20 August 2014 that a large part of the symptoms were likely to be related to an ulnar neuropathy. He said that this was shown again with the ulnar nerve compromise on the nerve conduction studies. This would not account for all the symptoms, such as neck pain and the more proximal arm symptoms, but it would be contributing to the more distal problems. Mr Finnis recommended surgical decompression of the ulnar nerve.

[16] Comment was sought from Branch Medical Advisor, Dr Lane, as to whether or not there was a causal link between the ulnar nerve compression and the original covered injuries of cervicalgia and the disc prolapse with radiculopathy. Dr Lane commented on 4 September 2014 that Mr Waite had cubital tunnel syndrome that was longstanding and progressive. This was not a covered injury and ACC would not fund surgical release. The covered injury was a C7/T1 prolapse, which had been surgically treated with a good result and a reduction in pain. The MRI showed no repeat prolapse of that segment. There was bilateral stenosis at other levels that predated the injury and would not be covered, and these levels could be the source of the pain.

[17] On 23 September 2014, Dr Bell responded to an email from the case manager. Dr Bell said that Mr Waite had a non disc injury and a discectomy did not cure an injured disc. His view was that the weight of evidence pointed to Mr Waite's ongoing pain as being likely due to the injury he suffered on 3 November 2012.

[18] In an email to the case manager on 2 October 2014 Dr Bell commented that the neck injury in November 2012 was not responsible for the left cubital tunnel syndrome. The mechanism of injury was not one that would be associated with an injury to the ulnar nerve at the elbow.

[19] On 15 October 2014 the respondent declined cover for left ulnar neuritis. The letter advised that the C7/T1 prolapse had been surgically treated and there was no repeat prolapse at that segment. The pathology in the cubital tunnel was not related to the accident and any surgery request would be declined.

[20] On 3 December 2014 Dr Strack reported on a Vocational Independence Medical Assessment carried out on 1 December 2014. He noted that there was a tremor over the fingers and hands on both left and right sides. The tremor was more notable on the left hand.

[21] He noted a positive Tinel's test over the right ulnar nerve at the elbow. He diagnosed Mr Waite with clinical findings consistent with a right ulnar nerve compression at the elbow. The appellant said that he did not have any right elbow symptoms.

[22] On 22 January 2015 the appellant injured his right elbow while moving furniture. He consulted his GP on 5 February 2015 who noted that he was tender under the lateral epicondyle with elbow pain. A claim for cover for right lateral epicondylitis was filed.

[23] Dr Lane commented on 26 February 2015, on the claim for cover for right elbow lateral epicondylitis. Dr Lane noted that cover had been declined for the same process for surgery on the left elbow. There was no actual personal injury caused by an accident or a series of events accident. Dr Lane noted that lateral epicondylitis

was generally degenerative and was anatomical rather than traumatic. She said that if there was imaging then ACC would reconsider the claim. This would clarify if the already declined condition was bilateral or if the elbow actually had an acute injury rather than a chronic condition that was aggravated by moving furniture.

[24] In a further comment dated 4 March 2015, Dr Lane commented that ACC should decline cover for the right elbow sprain. Dr Lane considered that the pain and pathology and requested diagnosis was lateral epicondylitis and therefore not an elbow sprain.

[25] The Clinical Advisory Panel (the Panel) recommended on 10 March 2015 that the description of the accident did not equate to a right elbow epicondylitis injury and therefore ACC should decline this claim for cover.

[26] The branch medical advisor on the same day commented that the medical notes did not confirm an elbow sprain.

[27] On 10 March 2015 ACC declined cover for right elbow lateral epicondylitis. In the decision, ACC explained that the injury was not caused by an accident but instead a degenerative anatomical condition rather than traumatic.

[28] On 18 May 2015 the appellant and Dr Wanty, completed an injury claim form. The diagnosis was nerve/spinal cord injury (left). The claim was for ongoing left arm/hand pains and loss of function after surgery to his neck, with the assumption that he may have been turned or positioned wrongly during surgery. The accident was said to have taken place on 12 March 2012, but instead should be 21 March 2013, the date of the neck surgery.

[29] On 22 July 2015 neurosurgeon, Mr Finnis, commented on the claim for cover for a treatment injury from the surgery of 21 March 2013. Mr Finnis noted that nerve conduction studies done on 7 February 2013, before the surgery, showed changes consistent with early mild compromise at the elbow. He said that having read the surgery report there were no obvious complications during surgery.

Mr Finnis said that he was unable to identify an injury to the ulnar nerve following surgery. He said:

> No, I am not able to identify an injury to the ulnar nerve during surgery. He had some pins and needles in the ulnar nerve distribution considered to be a C8 radiculopathy prior to surgery and by then did have altered ulnar nerve function on nerve conduction studies. He could have had some pressure on the nerve during the course of the surgery and therefore got an ulnar neuropathy following the procedure and this phenomenon is actually not that uncommon. Most people do settle however. The problem therefore is largely positioning and despite usually quite extensive and detailed attention to the ulnar nerve as compressive problems are recognised, patients still have this problem post operatively.
>
> Electrical studies show progression of the impairment in conduction, although mild and this could be related to surgery or it could be related to the natural history of the problem. I don't think there are necessarily firm conclusions that can be given. He had some pain before surgery and this often masks some of the sensory symptoms which become more evident once pain settles.

[30] On 17 September 2015, ACC declined cover for the claim for ulnar nerve damage said to have been caused by the surgery on 22 March 2013. ACC's reasons for the decision were summarised in a consequential injury report which noted that Mr Waite had nerve compression of the ulnar nerve symptoms before the surgery and there was no evidence that there had been an injury caused by treatment.

[31] Dr Holmes, a neurosurgical registrar, reviewed Mr Waite on 7 October 2015, reporting to Mr Waite's general practitioner the following day. He referred to the left ulnar neurolysis surgery into the left elbow to treat the left cubital tunnel syndrome that had been carried out on 20 July 2015 by Dr Jackson. Mr Waite thought that his strength had improved in his left hand. He was still suffering with a tremor of his left ring and little finger with occasional cramping. He also suffered with numbness on the left ulnar aspect of his forearm and hand.

[32] Dr Holmes reviewed the imaging and said that there was no surgical cause for the symptoms although they would organise another MRI of the cervical spine.

[33] There are additional reports on the file by Dr Jackson and her neurosurgical registrars. The final report appears to be that of 12 August 2016, an assessment by Dr Terence Tan, a neurosurgical registrar. He said that he had reviewed Mr Waite on 27 July 2016. He referred to the cervical spine surgery in 2013 and also to a left

sided ulnar nerve neurolysis at the elbow in July 2015, in an attempt to alleviate his left forearm symptoms. Mr Waite had said he had initial improvement over a couple of weeks after the ulnar nerve decompression, but after that his left arm returned to his usual baseline level.

[34] Dr Tan said that having reviewed the MRI of the cervical spine and the previous nerve conduction studies with Mr Waite, he had explained to him that there was no good surgical option in terms of improving his left arm pain or neck pain. Dr Tan encouraged Mr Waite to continue with conservative management, including physiotherapy and also analgesic management.

[35] Dr Xiong assessed Mr Waite on 14 February 2017. In his report of the same day he expressed his opinion in respect of the claims for cover and also regarding Mr Waite's vocational independence.

[36] On the issue of cover for left ulnar neuritis Dr Xiong said:

> From my assessment it was clear that Greg probably had a mild ulnar nerve neuropathy prior to his surgery. However it was quite clear that after surgery the ulnar nerve neuropathy had got worse.

[37] A little further on in his report the following was underlined:

> I would feel there was a high probability that a treatment injury has occurred in terms of compressive neuropathy for the ulnar nerve especially in relation to the positioning of the arms that the ulnar nerve would be under direct pressure either due to excessive elbow flexion or by direct pressure on the table lying in a prone position.

[38] Further on in his report is this:

> **2. Cover for right lateral epicondylitis**
>
> As far as I understand he did have a shorter duration impairment and symptoms in relation to the lateral epicondylitis due to an injury that occurred on 22.01.15.
>
> According to the history and review of documentation it was more likely to be trauma or accident related but I do not feel there is any evidence to suggest ongoing regional pain issue in relation to the lateral epicondylitis (tennis elbow).

**Individual rehabilitation plan**

[39] The most recent individual rehabilitation plan before the commencement of the vocational independence process is dated 23 July 2014. The rehabilitation plan recorded as actions that a six week functional reactivation programme had taken place; Mr Waite had attended a prevocational independence medical case review with Dr Bell that depending on the outcome of his meeting with Mr Finnis on 20 August 2014, ACC may continue down the vocational independence track. On 23 October 2014 ACC wrote to Mr Waite to advise that his individual rehabilitation programme was now complete and that his vocational independence would be assessed.

[40] On 20 November 2014 Bruce Haye of Vocational Insight conducted the occupational assessment.

[41] In setting out the vocational rehabilitation outcomes, Mr Haye noted that Mr Waite had obtained his class 5 diver's licence with P, F and D endorsement to widen his driving options for employment and he had also received computer skills training and first aid certificate training.

[42] Mr Haye said that Mr Waite had a considerable number of transferable skills gained through being in the work force for approximately 27 to 28 years. Mr Haye identified 12 work types as being suitable for Mr Waite.

[43] On 3 December 2014 Dr Strack completed a Vocational Independence Medical Assessment.

[44] Dr Strack noted that the appellant had the following diagnoses:

1. Previous left cervical radiculopathy – despite surgery there appears to be a degree of residual pain and sensory symptoms relating to this.
2. Left cubital tunnel syndrome with ongoing pain and sensory symptoms.
3. Clinical findings suggestive of right ulnar nerve compression at the elbow – Mr Waite does not experience any symptoms in relation to this.
4. Some stress and frustration.

5. Some sleep disturbance.

[45] Dr Strack made medication suggestions. He suggested that an occupational therapist should assess Mr Waite's capacity to drive safely and that a left ulnar nerve decompression would be appropriate.

[46] As to limitations or workplace restrictions, Dr Strack's opinion was as follows:

> **A Due to covered conditions**
>
> As a result of his previous left cervical radiculopathy (now with residual pain and sensory symptoms) I believe that it would be appropriate for Mr Waite to avoid excessive neck movement or awkward postures with the left neck. He should avoid activities that involve significant jolting of the body or neck. He should avoid highly repetitive movement of the upper limb or highly repetitive medium lifting involving the left upper limb or forceful movement of the left upper limb. I believe these should be seen as current restrictions and they may well be long term restrictions.
>
> It is difficult to completely disentangle residual symptoms from his previous cervical radiculopathy from the symptoms and problems associated with his left ulnar nerve compression at the elbow.
>
> **B Due to other factors**
>
> As a result of his left cubital tunnel syndrome, I believe it would be appropriate for Mr Waite to avoid highly repetitive flexion and extension of the left elbow. He should also avoid highly repetitive and/or forceful upper limb manual activity. He may have difficulty with work involving significant left hand grip strength. This should be seen as a current restriction. It is likely to be a long term restriction unless this problem can be appropriately treated.

[47] Dr Strack considered that the majority of the work types identified in the occupational assessment were not medically sustainable. In fact the only work types that Dr Strack considered medically sustainable were that of sales assistant (general hardware), the sales representative (building and plumbing supplies) and despatching and receiving clerk.

[48] Dr Strack excluded work types that involved driving, including the work of truck driving, which Mr Waite in fact began doing in December 2015, after the vocational independence decision.

[49] In respect of the three work types identified as suitable for Mr Waite, the key factors that made these work types suitable appear to be that there were opportunities

for change of position from sitting, standing and walking and that lifting and carrying movements were not typically significant components of the jobs.

[50] On 24 February 2015, ACC requested a transport assessor Mike Gaffney to conduct an assessment of Mr Waite's ability to do the sales representative (building and plumbing supplies) safely when he was required to drive.

[51] Mr Gaffney found that using an automatic vehicle would be the best option to meet functional limitations and to make any work role involving driving more sustainable.

[52] As a result of Mr Gaffney's assessment, in its vocational independence decision of 10 March 2015, ACC omitted the work type of sales representative (building and plumbing supplies) from the work types for which Mr Waite had vocational independence

[53] ACC wrote to Mr Waite on 10 March 2015 advising that the Vocational Independence Assessments showed that he was able to work for 30 or more hours a week in the following types of work:

[a] Despatching and receiving clerk;

[b] Sales assistant – general hardware.

[54] ACC advised that because the injury no longer prevented Mr Waite from working, his weekly compensation payments would end on 9 June 2015.

[55] In his report of 14 February 2017 Dr Xiong also commented on Mr Waite's vocational independence.

[56] As to Mr Waite's work capacity, Dr Xiong said:

> [a] In respect of the covered conditions, because of the left cervical radiculopathy it would be appropriate for him to avoid excessive neck movement or awkward postures with the left neck. He should avoid activities that involve significant jolting of the body and neck. He should also avoid highly repetitive movement of the upper limb or highly

repetitive medium lifting involving the upper limb or forceful movement of the left upper limb;

[b] In respect of other factors, i.e. non covered conditions Dr Xiong said that as a result of the left cubital tunnel syndrome it was appropriate for Mr Waite to avoid highly repetitive flexion and extension of the left elbow. He should also avoid highly repetitive or forceful left upper limb manual activities. Dr Xiong's view was that Mr Waite may have difficulty with work involving significant left hand grip strength.

[57] Dr Xiong's opinion was that the cervical spine problems together with radiculopathy were the main impairments and the dominant factors that influenced Mr Waite's capacity to work. Dr Xiong said that for these reasons, Mr Waite was not able to work in the following roles that involved:

[a] Heavy physical duties;

[b] Significant lifting, pulling and carrying requirements;

[c] Repetitive movements that may involve upper limbs particularly the left arm;

[d] Significant amounts of twisting, flexion and rotation movement of the cervical spine.

[58] On further analysis of the movements required in the role of despatching and receiving clerk and in the role of sales assistant general hardware, Dr Xiong considered that Mr Waite did not have vocational independence for either work type.

[59] At review, the Reviewer held that although Dr Xiong had provided an alternative view or opinion about the sustainability of the sales assistant role, he had not identified a fundamental flaw or error in Dr Strack's report. The Reviewer found that ACC was correct when it determined that the appellant was vocationally independent, albeit in relation to only one work type, that of sales assistant (general hardware).

[60] Following review, Dr Emrys, Occupational Medicine Physician, commented on the appellant's claim for cover for right lateral epicondylitis. In his report of

10 July 2017 Dr Emrys explained what was meant by the term (lateral epicondylitis) and that it was very common in the normal population. Dr Emrys concluded that there was no evidence to support that a single strenuous event or a single event caused by an accident (except a direct blow) could cause lateral epicondylitis. This was not the accident history, which was a one off lifting or lowering event. Dr Emrys concluded that the single activity as described by Mr Waite did not cause the lateral epicondylitis.

**The appellant's submissions relating to cover for left ulnar neuritis from the accident of 3 November 2012 and relating to cover for left ulnar nerve injury arising from surgery on 21 March 2013**

[61] Mr Yates submits there is a clear temporal connection between Mr Waite's left shoulder, arm and hand symptoms and his accident on 3 November 2012. He submits he was free of any such symptoms before the accident, but they were there afterwards. He refers to *Newstead's* case 301/2004. Such a temporal connection is an important piece of circumstantial evidence.

[62] In his report of 9 November 2012, he submits that in the days following the accident the appellant's distribution of symptoms was regarded by Mr Finnis as typical of C8 radiculopathy, with the possibility of ulnar neuritis raised at the outset.

[63] Nerve conduction studies conducted a few weeks later confirmed the appellant had "very mild" compression of the ulnar nerve. He also submits that there is no evidence to support a non traumatic cause of the appellant's ulnar neuritis.

[64] Likewise, Mr Yates submits that he should have cover for ulnar neuritis as a result of his surgery on 21 March 2013. He says that his left ulnar nerve injury resulted from his position during the operation itself, that is to say the appellant's position on the operating table during the operation.

[65] Following surgery Mr Waite's left arm symptoms partially improved but have never resolved with further nerve conduction studies showing a mild deterioration in the left ulnar nerve findings.

[66] Mr Yates submits that the increased compression of the nerve or greater nerve "compromise" is not simply an aggravation of a pre-existing condition but a further injury on top of the pre-existing condition. He refers to *Sparks v Accident Compensation Corporation*[1] where it was found that an extension of a tear to a tendon is a discrete injury attracting cover. He also notes that Mr Finnis, on 22 July 2015, noted that it was not uncommon for patients undergoing the procedure to suffer ulnar nerve compression causing an ulnar nerve neuropathy.

[67] He also refers to the underlined passage in Dr Xiong's report where he says:

> I would feel there was a high probability that a treatment injury has occurred in terms of compressive neuropathy of the ulnar nerve especially in relation to the positioning of the arms that the ulnar nerve would be under direct pressure either due to excessive elbow flexion or by direct pressure on the table lying in prone position.

**The respondent's submissions relating to cover for left ulnar neuritis from the accident of 3 November 2012 and relating to cover for left ulnar nerve injury arising from surgery on 21 March 2013**

[68] Mr Light submits that the ulnar neuritis was not caused by the accident of 3 November 2012 but is an underlying gradual process condition.

[69] He notes that as early as 9 November 2012 the appellant might have an ulnar neuritis.

[70] This was confirmed on nerve conduction studies on 27 February 2013 which worsened by the next nerve conduction study on 9 July 2014.

[71] In his report of 20 August 2014, Mr Finnis noted that nerve conduction studies done on 9 July 2014 showed changes consistent with compression of the ulnar nerve at the elbow of a mild degree.

[72] He said:

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1 *Sparks v Accident Compensation Corporation* [2006] NZACC 45.

> A large part of his symptoms is likely to be related to an ulnar neuropathy. This is shown again with ulnar nerve compromise on electrical examination.
>
> …
>
> I have discussed management with him which includes ulnar nerve decompression at the elbow and he does wish to go forward for this. He will first approach ACC with regards to whether he does have cover for an ulnar nerve problem. He will get back to me with their decision.

[73] Dr Bell said this on 2 October 2014:

> Based on the information available to me, Mr Finnis considers that there is an element of cubital tunnel syndrome contributing to Mr Waite's presentation.
>
> Mr Waite's history is consistent with an injury to his neck occurring on 3 November 2012, however I don't believe this accident to be responsible for cubital tunnel syndrome. The mechanism of injury is not one that would be associated with an injury to the ulnar nerve at the elbow.

[74] In his report of 22 July 2015, Mr Finnis answers the question whether in his opinion the ulnar nerve was damaged during surgery. He said:

> It is possible that the ulnar nerve did have some compression on it during the course of the surgery. Sometimes even with rotation of the forearm this can also tighten up the cubital tunnel with some pressure on the nerve even if there is no direct external pressure. He did have some mild evidence of ulnar neuropathy prior to surgery and if he had some susceptibility to this then this would put him in a position more likely to have the problem aggravated.
>
> Electrical studies followed progression of the impairment in conduction, although mild and this could be related to surgery or it could be related to the natural history of the problem. I don't think there are necessarily firm conclusions that can be given. He had some pain before surgery and this often masks some of the sensory symptoms which become more evident once the pain settles.

**Decision on cover relating to left ulnar neuritis arising from accident of 3 November 2012 and decision relating to cover for left ulnar nerve injury from surgery of 21 March 2013**

[75] In the claim form the injury is described:

> Was under the car changing his oil and pulled his L shoulder. Later ? went down L arm.

[76] The inference that arises from the injury description is that the mechanism of the injury was mild.

[77] Mr Finnis notes in his report of 20 August 2014 following nerve conduction studies, that there has been deterioration since earlier studies. He goes on to say the large part of the appellant's symptoms is likely to be related to ulnar neuropathy.

[78] Then there is the opinion of Dr Bell of 2 October 2014, where he says he does not believe the accident in 2012 is responsible for cubital tunnel syndrome. I conclude from the evidence, that the appellant has not established on the balance of probabilities that the accident of 3 November 2012 caused his left ulnar neuritis and that the accident of 3 November 2012 rendered symptomatic the underlying natural process.

[79] However, I find that the appellant did suffer a treatment injury as a result of the surgery of 23 March 2013.

[80] Mr Finnis advised that it was "not uncommon" for patients undergoing the procedure to suffer ulnar nerve compression causing ulnar nerve neuropathy. Dr Xiong is more emphatic saying he would feel that there was a high probability that a treatment injury occurred due to excessive elbow flexion or by direct pressure on the table lying in a prone position.

[81] While s 32, in defining treatment injury, excludes injuries that are an ordinary consequence of treatment I find that that is not the position here. Dr Finnis's opinion that such injury is "not uncommon" does not make it an ordinary consequence of the treatment. Accordingly, this part of the appeal is allowed and the respondent's decision of 17 September 2015 declining cover for left ulnar nerve injury as a consequence of treatment is reversed.

**Appellant's submissions on cover for right elbow epicondylitis**

[82] Mr Yates notes that cover for right lateral epicondylitis was declined on the advice of Dr Lane and the panel on the basis that:

[a] The mechanism of injury described (shifting furniture) does not amount to an accident or series of accidents as defined.

[83] Mr Yates also says that there is no imaging in this instance because ACC declined to provide cover and that imaging would have clarified the position.

[84] He says that imaging would have clarified whether the declined condition is bilateral or whether the right elbow actually had an acute injury rather than a chronic condition aggravated by moving furniture.

[85] Mr Yates submits that the matter is not straightforward and that the decision to decline cover cannot have been made on reasonable grounds. He says that ACC cannot have met its investigative obligations in these circumstances.

[86] He says that Dr Lane misdirected herself as to the mechanism of injury (repeated lifting over a defined and limited period of time) which clearly qualifies as an accident in law.

[87] Next there is a temporal connection between Mr Waite's right elbow symptoms and his accident.

[88] He also refers to Dr Xiong's report of 14 February 2017 where he says:

> According to the history and review of the documentation it was more likely to be trauma or accident related but I do not feel there is any evidence to suggest ongoing regional pain issue in relation to the lateral epicondylitis.

[89] Mr Yates submits that the diagnosis was confirmed by the general practitioner's examination revealing tenderness over the lateral epicondyle.

[90] Mr Yates reminds the Court of what Judge Beattie said in *Sykes* (227/2011) that:

> In this jurisdiction the Court endeavours to be generous and unniggardly in its approach to such issues.

**The respondent's submissions on cover for right elbow epicondylitis**

[91] When Dr Strack was conducting a Vocational Independence Medical Assessment on 1 December 2014, he noted there was a tremor over the fingers and hands on both left and right sides. He also noted a positive Tinel's test over the right

ulnar nerve at the elbow. He notes that Mr Waite said that he did not have any right elbow symptoms.

[92] On 5 February 2015, Mr Waite saw his general practitioner regarding his right elbow. The general practitioner's note recorded that he was moving all of his furniture on 22 January 2015 when he hurt his right elbow. An injury claim form for cover for lateral epicondylitis was completed on that day.

[93] Dr Lane, on 26 February 2015, on the claim for cover for right elbow epicondylitis, noted that cover had been declined for the same process for surgery on the left elbow and that there was no actual personal injury caused by accident or series of accident events. Dr Lane noted that lateral epicondylitis was generally degenerative and was anatomical rather than traumatic.

[94] The Panel on 15 March 2015, recommended that the description of the accident did not equate to right elbow epicondylitis injury and therefore ACC should decline the claim for cover.

[95] Dr Strack examined the appellant on 1 December 2014, some six weeks prior to the identified accident date of 21 January 2015, when the appellant was shifting furniture. Dr Strack noted under the heading 'diagnosis':

> Clinical findings suggestive of right ulnar nerve compression at the elbow – Mr Waite does not experience any symptoms in relation to this.

**Decision on claim for cover for right elbow epicondylitis**

[96] The ACC injury claim form submitted by the appellant's GP on 5 February 2015 has a description of accident:

> Hurt R elbow – shifting all his household possessions.

[97] Mr Yates' position is that ACC failed to investigate this injury and no imaging of the elbow occurred.

[98] Mr Light however refers to the Vocational Independence Assessment Medical Assessment carried out on 1 December 2014 by Dr Strack, where the doctor conducted a Tinel's test over both elbows and noted in his report:

> Tinel test over right ulnar nerve at the elbow was positive, producing reports of tingling in the right little and ring fingers.

[99] Also under the heading 'diagnoses' Dr Strack says:

> Clinical findings suggestive of right ulnar nerve compression at the elbow – Mr Waite does not experience any symptoms in relation to this.

[100] Mr Light accordingly submits that the condition was pre-existing the accident date.

[101] Next he refers to Dr Lane's comment on 26 February 2015 that lateral epicondylitis was generally degenerative and anatomical rather than traumatic.

[102] Mr Light also refers to the comments of Dr Emrys on 10 July 2017. Dr Emrys commented that the condition was very common in the normal population and there was no evidence to support that a single strenuous event or single event caused by an accident (except a direct blow) could cause lateral epicondylitis. Dr Emrys' conclusion was that the single activity described by Mr Waite could not cause the lateral epicondylitis.

[103] The weight of medical evidence therefore supports the proposition that the right elbow epicondylitis suffered by the appellant was not caused by the event of shifting furniture on 21 January 2015.

[104] Mr Yates is critical of ACC in that it did not conduct an adequate investigation.

[105] However, the investigations by Dr Strack six weeks prior to the accident date were thorough, given that the purpose of his assessment was to decide whether or not the appellant had vocational independence. With this and other information relating to the appellant's health status particularly with regard to both arms, and the further report in 2017 by Dr Emrys, all lead me to conclude that while the investigation of

this particular issue did not follow in a set piece fashion it was nevertheless an adequate investigation overall.

[106] The evidence of a traumatic cause from the shifting of furniture is thin and not persuasive. Accordingly, I must find that in respect of the claim for right elbow epicondylitis, the appellant has not established on the balance of probabilities, that it was caused by accident while shifting furniture on 21 January 2015. Accordingly, his appeal in respect of the respondent's decision of 10 March 2015 is dismissed.

**The appellant's submissions in respect of the respondent's decision of 13 March 2015 that the appellant was vocationally independent in two work types – despatch and receiving clerk and sales assistant (general hardware)**

[107] The appellant submits that the role of despatch and receiving clerk is not sustainable for the appellant.

[108] He notes that the job data sheet that accompanied the vocational independence occupation assessment, showed that the role had characteristics involving repetitive tasks on an occasional to frequent basis. Mr Yates notes that occasional means 0% to 33% and frequent means 33% to 66% of the working day.

[109] He refers to Dr Xiong's report that:

> It is clear if a job does involve significant repetitive movements then Mr Waite would not be able to achieve vocational independence.

[110] Mr Yates notes that Dr Xiong's report also identifies another omission in Dr Strack's report, namely consideration of the medication that the appellant takes. In this regard, Dr Xiong has seen fit to underline this portion of his report, namely:

> <u>From the medical point of view, taking into consideration his neck pain, radicular pain to the left arm which is compounded by the ulnar nerve neuropathy, together with his reported fatigue and his difficulty coping with prolonged sitting position and difficulty with repetitive movements, he does not have the capacity to work 30 hours or more per week.</u>

[111] Mr Yates also submits that the job data sheet identified a requirement for "mental activities", and Dr Strack's report was deficient in that he did not consider this.

[112] Mr Yates refers to the failure of work trials which he says did not receive adequate consideration by Dr Strack.

[113] Mr Yates also notes that the Reviewer found that Dr Strack failed to properly account for the fact that repetitive tasks could be frequent when considering the role of despatch and receiving clerk.

[114] So far as the role of sales assistant (general hardware) is concerned Mr Yates notes that while Dr Strack recognised that stretching with the left limb would present a problem for Mr Waite he said in respect of this work type:

> In this type of situation there are usually ladders or platforms available for accessing items on higher shelves.

[115] Mr Yates submits that this is a clear qualification of the work tasks involved in this role and that such qualification effectively means that the role is not suitable.

[116] Mr Yates submits that again Mr Xiong's opinion in respect of this work role is to be preferred to that of Dr Strack in that he considered all the relevant information, his report is more consistent with the other opinions on the file and he is the more appropriate specialist to provide such a report.

**The respondent's submissions in respect of the respondent's decision of 13 March 2015 that the appellant was vocationally independent in two work types – despatch and receiving clerk and sales assistant (general hardware)**

[117] Mr Light notes that in his vocational independence decision Dr Strack took account of all the appellant's conditions equally whether covered or not.

[118] He notes that pain is not a barrier to finding vocational independence or that a claimant does not have to be pain free to be able to work. The occupational assessor has to have taken account of the claimant's condition and considered if the claimant can do the job despite the pain. He refers to *Accident Compensation Corporation v Hucklebridge*[2].

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2 *Accident Compensation Corporation v Hucklebridge* [2014] NZACC 68.

[119] He submits that Dr Strack took into account Mr Waite's pain levels in all the work types that he found suitable.

[120] He notes that Mr Waite is right hand dominant as indicated in Dr Strack's and Dr Bell's reports and that therefore the appellant can use his right arm or hand to carry out tasks that Dr Xiong says he cannot do with his left arm or hand.

[121] Mr Light accepts that the appellant's condition may have worsened by the time that Dr Xiong assessed him on 14 February 2017 and that there is opportunity for Mr Waite to apply for reassessment if his vocational independence has deteriorated.

[122] He says significantly, according to Dr Xiong's report, Mr Waite has been working as a truck driver at the airport since 2015. This work involves delivering food items to aircraft and at the time of Dr Xiong's report he was working 40 to 45 hours per week and at that stage had been doing so for some 15 months.

**Decision in respect of the respondent's decision of 13 March 2015 that the appellant was vocationally independent in two work types – despatch and receiving clerk and sales assistant (general hardware)**

[123] In *Martin v Accident Compensation Corporation*,[3] Ronald Young J, summarised the principles applicable in respect of an appeal relating to vocational independence. At paragraph [36] he said that the approach requires the Reviewer or the District Court to consider all the relevant evidence and to decide if they are satisfied the claimant is vocationally independent. The medical assessor's opinion is to be given no pre-eminence solely because of its statutory basis. At subparagraph (e) His Honour said:

> (e) In assessing expert medical evidence factors such as (non-exhaustive) the extent and relevance of the practitioners qualifications and experience, the comprehensiveness of the evidence gathered, the quality of the report, where the preponderance of opinion lies and the validity of criticism of other medical opinions, will all be relevant in deciding the ultimate question.

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3 *Martin v Accident Compensation Corporation* [2009] 3 NZLR 701.

[124] Furthermore, as Mr Light points out, the appellant was holding down a full-time job as a driver even though the job was found not to be physically sustainable for him.

[125] The appellant is to be commended for his initiative and determination in finding and maintaining that employment. It is also evidence of a wholly positive attitude towards achieving and maintaining full participation in society in spite of disability and injury, an attitude that is completely congruent with the social contract that underpins the accident compensation scheme.

[126] Likewise, as Mr Light points out, *Hucklebridge* and other cases have decided that pain is not a barrier to finding vocational independence.

[127] Based on Dr Xiong's report Mr Yates is on strong ground when he submits that for the role of despatch and receiving clerk the appellant would have upper limb activity for up to 66% of the working day. Dr Xiong points out the difficulty that the appellant would face with repetitive movements.

[128] Dr Strack notes that lifting and carrying movements are not typically significant components of this job type.

[129] So, on this particular aspect of the role of despatch and receiving clerk the experts appear to differ although Dr Strack does somewhat qualify his position by saying that such movements are not typically significant components of this job (my emphasis).

[130] In respect of this job type therefore and because, at least statistically, there is a likelihood of up to 66% of the appellant's working day being involved with upper limb activity I find that the appellant has established that he does not have vocational independence in respect of the role of despatch and receiving clerk. Accordingly, the Reviewer's decision of 13 June 2017, that the despatch and receiving clerk job type was not sustainable, was correct. The respondent's cross appeal in respect of this is therefore dismissed.

[131] However, the same proposition does not hold with the vocational role of sales assistant (general hardware). In that work role stretching and/or twisting movements are likely to be required occasionally when reaching up and down to shelves for merchandise, also bending, squatting or crouching movements may be required when demonstrating a product's use, picking items up or stocking shelves. Lifting, pulling and carrying requirements will be occasional and generally of a light to medium demand level for most sales of these types of products. Mr Xiong is of the opinion that overall considering the appellant's neck problems, radiculopathy and regional pain left arm, Mr Waite does not have the capacity to work 30 hours or more per week in this role.

[132] Mr Light points out however that the appellant is right hand dominant.

[133] In his report of 3 December 2014 Dr Strack notes that the appellant "feels that he manages his pain quite well".

[134] Dr Strack commented further in respect of this job type:

> Lifting or carrying will be occasional and generally of a light to medium demand level. Taking into account injury related factors, pain levels and current level of functioning, I believe this is medically sustainable on a full time basis now.

[135] Ultimately it appears that Dr Xiong regards pain as the barrier to this work role. While that is a very important consideration it is ultimately not a critical one where on the preponderance of evidence the work role is unlikely to result in a pain response on a frequent basis. I therefore conclude that the appellant does have vocational independence in respect of the role of sales assistant (general hardware) and the decision of the respondent of 10 March 2015 so far as it relates to this work type is confirmed. It follows that the appellant's appeal in respect to this is dismissed.

**Summary of decisions.**

**In respect of Appeal ACR 268/17:**

a. The respondent's decision of 15 October 2014 declining cover for left ulnar neuritis is upheld. Therefore, the appeal against this decision is dismissed.

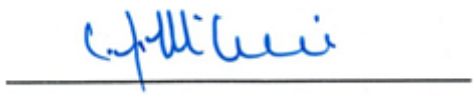
b. The respondent's decision of 17 September 2015 declining cover for a left ulnar nerve injury as a consequence of treatment for a covered injury under s20(2)(d) is reversed and cover is granted for this treatment injury. Therefore, the appeal against this decision is allowed.

c. The Reviewer's decision of 13 June 2017 advising the appellant that he had achieved vocational independence in one work type only, that of sales assistant (general hardware) is upheld. Accordingly, both the appellant's appeal and the respondent's cross appeal against this review decision are dismissed.

**In respect of Appeal ACR 269/17:**

a. The respondent's decision of 10 March 2015 declining cover for right elbow epicondylitis is upheld. Therefore, the appeal against this decision is dismissed.

[136] Should there be any issue as to costs counsel have leave to file memoranda in respect thereof.



Judge C J McGuire
District Court Judge

Solicitors: Young Hunter, Christchurch for the respondent