IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 97 **ACR 284/18**

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPEAL UNDER SECTION 149 OF THE ACT
BETWEEN	ALEJANDRO GIMENEZ Appellant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Hearing: 29 April 2022
Heard at: Christchurch/ Ōtautahi

Appearances: Appellant in person (via AVL)
Mr C Light for the Respondent

Judgment: 19 May 2022

RESERVED JUDGMENT OF JUDGE C J McGUIRE
[Personal Injury s 26 Accident Compensation Act 2001]

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[1] The issue on the appeal is the correctness of ACC's decision of 20 February 2018, declining cover for the appellant's right wrist sprain injury on the grounds that the wrist issue was more likely an underlying condition that was not caused by a snowboarding accident on 13 July 2016.

Background

[2] On 9 January 2017, the appellant was seen by Dr Davies, GP, complaining of a right forearm problem. The appellant reported that he had been playing table tennis and had experienced "clunking" in his right wrist on adduction for a couple of months with no functional disability.

[3] Dr Davies' notes do not mention the 13 July 2016 accident.

[4] An X-ray carried on 10 January 2017 showed no abnormality.

[5] On 23 February 2017, the appellant was seen by Mr Gary McCoubrey, Consultant Orthopaedic Surgeon, who reported that the appellant probably had midcarpal instability. The appellant was referred for an MRI arthrogram to seek more information on his wrist ligaments.

[6] An MRI was carried out on 13 April and the Radiologist's report from Dr Mekile showed:

> a. A tear of the central TFC (triangular fibrocartilage) measuring 4mm from side to side and 4mm from anterior to posterior. The more peripheral TFCC (triangular fibrocartilage complex) appeared intact.
>
> b. There was a full thickness tear of the scapholunate ligament membranous third of its lunate attachment with some underlying oedema and systic change seen at the attachment of the ligament. The tear extended only slightly into the region of the dorsal band at its proximal aspect extending over approximately 30% of its length from its proximal to distal. The ventral band appeared intact.
>
> c. The lunotriquetral ligament was not well visualised.
>
> d. In respect of the carpal bones, the cystic change in the lunate was again noted. The lunate shows some degree of ventral angulation in the position scanned.
>
> e. In regard to the cartilage, there was some chondral thinning of the lunate where it articulates with the radius towards this more ulnar aspect. There was underlying bone oedema. No other chondral abnormality was seen.

[7] On 17 August 2017, Mr Gimenez was seen by Ms Fiona Timms, Orthopaedic Hand and Wrist Surgeon, who diagnosed him with midcarpal instability of his right wrist.

[8] Dr Timms recorded the history as one where Mr Gimenez "while snowboarding…. fell and sustained a hyperextension injury to his right wrist. It was very painful at the time but it seemed to settle and he pretty much got on with life. Last summer when he was playing a lot of table tennis with his son he noticed that the pain recurred…"

[9] In the ACC Injury Claim Form dated 24 August 2017, Dr Davies diagnosed Mr Gimenez with a right sprain wrist ligament, the injury description is "fell onto R wrist when snowboarding".

[10] Dr Davies' notes recorded that Mr Gimenez:

> Saw Dr Timms in Dunedin last Thursday – he has a ligament rupture and needs a fusion likely. In retrospect, Alejandro records a fall causing a painful injury to his wrist. The table tennis post dated this: wrist still clunking.

[11] On 25 September 2017, Dr Timms saw Gimenez and reported:

> Alex is aware that this doesn't mean I would treat him surgically but the only surgical option I would offer him is a partial wrist fusion. However, this option does not change over the next year or more, so a trial of conservative management is worthwhile considering.

[12] On 13 November 2017, Mr Tim Tasman-Jones, Orthopaedic Surgeon and ACC medical adviser commented on the claim for cover:

> It appears the client has sustained a hyper-extended injury to the right wrist following a fall while snowboarding. The described mechanism of injury is of sufficient force to cause a ligament injury.
>
> The subsequent MRI scan has confirmed a full thickness tear to the scapholunate ligament with disruption of the dorsal and volar ligaments. The lunotriquetral ligament is not well visualised. These changes may be causally linked to the snowboarding injury.
>
> …
>
> The chondral thinning and cystic changes in the lunate, on balance, are more likely to be longstanding and predates the recent injury. This raises the possibility that there was a degree of midcarpal instability prior to the recent snowboarding injury of 13 July 2016.

[13] On 4 January 2018 in response to Mr Tasman-Jones' suggestion, Dr Timms reported:

> I did assess Alejandro's left wrist and measured his range of motion and there was no obvious midcarpal instability with an active range of motion though I did not specifically do a midcarpal shift test. I also did not assess him for ligamentous laxity.
>
> I have recently spoken to his hand therapist, who advises that his right wrist pathology is deteriorating further despite splinting though they are continuing to work on trying to strengthen his ECU (extensor carpi ulnaris) and there is some minor improvement.

[14] On 12 February 2018, Mr Tasman-Jones commented:

> Midcarpal instability is a clinical diagnosis and the degree of instability often does not correlate with MRI scan finding. There is a degree of laxity in the ligaments which is often bilateral. There are often residual signs of instability in the asymptomatic wrist.
>
> The client has sustained a hyper-extension injury to the right wrist following a fall while snowboarding 13 July 2016. Potentially the described mechanism of injury is of sufficient force to cause ligament injuries.
>
> The wrist remains painful and the client was reviewed by Mr Gareth Laws, who noted evidence of "bilateral midcarpal instability".
>
> The subsequent MRI scan of the right wrist which confirmed a full thickness tear to central membranous third of the scapholunate ligament with some slight extension into the lunate attachment with some underlying oedema. The lunotriquetral ligament was not well visualised. These changes may be causally linked to the snowboarding injury. There is no evidence of a significant intercarpal or carpal bone injury.
>
> The MRI scan also confirmed chondral thinning of the lunate, where it articulates with the radius towards its more ulnar aspect. There was underlying bone oedema. There are cystic changes in the lunate along with some degree of ventral angulation in the scanned position.
>
> The chondral thinning and cystic change in the lunate, on balance are more likely to be longstanding and predates the injury of 13 July 2016.
>
> A central TFC tear measuring 4 mm from site to site and 4mm from interior to posterior was also noted and more likely to be longstanding.
>
> Mr Gareth Laws noted evidence of bilateral midcarpal instability and this along with the clinical findings and MRI findings is suggestive that there was a degree with bilateral midcarpal instability prior to the snowboarding injury of 13 July 2016.
>
> Although there may have been some contribution from the snowboarding injury on reflection it appears the injury has rendered the underlying midcarpal instability more symptomatic.

[15] By letter dated 20 February 2018, ACC advised Mr Gimenez that it was unable to accept his claim for cover for a sprain of his right wrist because:

> a. There is no medical documentation available from the time of the accident diagnosing a right wrist injury as a result of the accident. Current medical information and ACC's clinical advisor reviews support the wrist issue is more likely to be an underlying condition that may have been rendered symptomatic since the accident, but does not considered accident related.

[16] The appellant saw Dr Timms again on 26 February 2018, Dr Timms commented:

> I would suggest to ACC that they relook at Alejandro's case, he has got no risk factors for having a midcarpal instability. There is no features to suggest Marfan's or any form of connective tissue disorder that would predispose him to this. It is normal to not see any associated changes on MRI scan which though frustrating and makes it difficult to explain this problem, it doesn't exclude the fact that this occurs post-injury.

[17] In response to Dr Timms' report, Mr Tasman-Jones confirmed his previous report and concluded that:

> On review, there may be some contribution from the snowboarding injury of 13 July 2016, however, there is still evidence of previous underlying pathology affecting the radius, lunate, and midcarpal joints.

[18] Following receipt of the appellant's review application, ACC requested Mr Tasman-Jones to confirm whether the likely cause of Mr Gimenez's condition was the underlying pathology or as a result of an acute event.

[19] In his report of 30 April 2018, Mr Tasman-Jones said:

> Dr Fiona Timms has re-examined the patient and stated that there are no signs of any midcarpal instability in the left wrist which is why I changed opinion to there may have been some contribution from the snowboarding injury of 13 July 2016. However, there were still evidence of previous underlying pathology affecting the radius, lunate and carpal joints.
>
> Midcarpal instability is a clinical diagnosis not well demonstrated on imaging. Assessing the degree of instability requires clinical examination. Without actually examining the patient, I cannot be more specific.

[20] An ACC employee had a conversation with Mr Gimenez on 18 May 2018. The note of that conversation is as follows:

> Snowboarding was with wrist protection. It was hard on ice and he felt travelling about 100 km/h before falling putting his hands out. He has to stop. At first he can't move his right hand. Pain was immediate and thought he broke something. After a while, the hand was ok. He went down the mountain and went to café.
>
> …
>
> Did not think there was a need to seek immediate treatment. He didn't think there was a need to be brought down the mountain on a stretcher. He did not seek assistance from someone on the mountain or from a doctor that time.

…

> A right hand kept popping in/out. Only after 3 – 4 months when he was playing table tennis that he realised something was really wrong. He then went to the GP.

[21] On 6 June 2018, Dr Snyman, Occupational Physician and ACC Clinical Lead complex cover reported:

> I find no evidence to support any injury of substance relating to 13 July 2016...
>
> The option of a new injury to the right wrist involving TFCC, secondary to a high energy transfer event of 13 July 2016, is not supported by the clinical presentation considering the symptoms, signs and clinical cause described. This of course remains a possible scenario, but on the evidence on file I'm not in the position to consider the scenario…on the balance of clinical possibilities, the more likely.

[22] Following the review decision, Dr Timms reported again on 10 September 2018 saying:

> With no history of ligamentous laxity or significant collagen disorder then a midcarpal instability to the degree that Alejandro has, in my opinion would be associated with trauma. Alejandro has a significant history of trauma, he was travelling at almost 100 km/h when he fell snowboarding.
>
> …
>
> The fact that MRI scan does not show any traumatic pathology in his wrist to explain the midcarpal instability is frustrating, however, this unfortunately is the norm in the situation and always makes these cases more complicated.
>
> I think the only issue that needs to be decided here is not if the midcarpal injury is due to a traumatic event, but rather whether the traumatic event in July 2016 was the event that resulted in the midcarpal instability. With reference to my comments on the report tabled at the time of the review and the inaccuracies in this report, I would recommend that ACC reconsiders this case.

[23] ACC requested the advice of its clinical advisory panel which consisted of ten medical professionals, 6 of whom were orthopaedic surgeons. Also represented was an urgent care specialist, a physiotherapist, an occupational and environmental medicine specialist and a general surgeon.

[24] The panel reported on 2 April 2019.

[25] The panel first noted that the event on 13 July 2016 was not consistent with severe internal derangement of the right wrist saying:

> Mr Gimenez described snowboarding on 13/07/2016, falling on ice at 100 kph, and putting his hands out to stop the fall. He recalled the event some six months later, on 09/01/2017, after playing table tennis, when he reported that his wrists were clunky, right more than left. He lodged a claim for a right wrist sprain 13 months after the event on 24/08/2017.
>
> The CAP noted that this is not consistent with a serious acute injury on 13/07/2016. Mr Gimenez reported that he was wearing wrist guards which are designed to protect wrists from serious injury. He said that his right wrist was painful and that he couldn't move it at first. After a while, he forgot about it and went down the mountain to the café.
>
> Mr Gimenez did not report any swelling, deformity, bruising or open wounds of his right wrist, which would be expected if there was a significant injury of his right wrist. He did not seek medical assistance, as would be expected if there were problems. A fall on an outstretched hand can lead to severe problems, such as bad pain, swelling, bruising, fractures and damage to the many internal structures of the wrist, which has a very complex structure.
>
> None of the records recorded any related symptoms or dysfunction over six months. Mr Gimenez did not report difficulty combing or washing his hair, lifting kettles, opening jars, turning door handles or other daily activities. It appears that Mr Gimenez recalled the 13/07/2016 snowboarding event after getting sore wrists when playing table tennis. The absence of clinically recorded right wrist symptoms for six months does not support the impression of an acute cause.
>
> …
>
> Mr Gimenez reported falls from his sporting activities such as snowboarding, hand gliding, mountain biking, wake boarding and so on. The CAP could find no ACC claims related to these reported events. The CAP noted that Mr Gimenez had a previous left wrist injury with a fracture, bone infection, and muscle wasting.
>
> After playing table tennis, Mr Gimenez reported to a general practitioner on 09/01/2017 that both his wrists were sore and clunky, the right wrist worse than the left. This was also reported in Mr Laws report. These symptoms are consistent with Mr Gimenez midcarpal instability.
>
> Mr Gimenez current symptoms are most likely related to longstanding midcarpal instability. The features include his ventral angulation, cartilage wear and loss and tears of the scapholunate ligament and triangular fibrocartilage complex (TFCC). Each of these changes are part and parcel of longstanding pre-existing pathology in Mr Gimenez's right wrist. Each can remain symptom free for years, and each can contribute to his symptoms now.
>
> …

> On balance, the CAP concluded that the chronic changes in Mr Gimenez's radius, lunate and midcarpal joints developed over a long time related to the bony and joint abnormalities that were developed mental.
>
> The chronic features such as ventral angulation, cartilage wear and loss, and tears or perforations of the scapholunate ligament and triangular fibrocartilage complex can all contribute to Mr Gimenez's current presentation. There are no residual physical or anatomical symptoms or signs related to the resolved right wrist sprain from the 13/07/2016 snowboarding event.

[26] The appellant obtained a further report from Mr Heiss-Dunlop, Orthopaedic Upper Limb Surgeon on 9 February 2021.

[27] Under the heading "Conclusion", Mr Heiss-Dunlop said:

> In conclusion, the question whether Alejandro's current symptomatic midcarpal instability is post traumatic or constitutional, finds supportive and non-supportive features in his assessment. The main issue with this presentation is that he whilst initially having an injury that is suitable to cause ligament damage leading to midcarpal instability, his symptoms initially were short lived. His initial description of his symptoms that was felt "as if he had broken his wrist", is certainly suitably consistent with a ligament injury; however, he did settle and then sought medical review only in a delayed fashion.
>
> …
>
> In summary, it is my opinion that Alejandro's injury and subsequent imaging are consistent with a traumatic midcarpal instability; however, distracting from this is his delayed presentation following the injury.

[28] The clinical advisory panel added further comment on 4 June 2021 saying:

> Acute midcarpal disruption is a major injury. Anyone with such an injury would have severe tenderness, pain, swelling, bruising and loss of wrist motion. They would present immediately for medical assistance. They would probably need urgent surgery and specialist reviews.
>
> People with acute midcarpal instability certainly would not have symptoms that "settle" in a few hours, like Mr Gimenez described, go downhill to a café afterwards, do their usual work and have no clinically recorded right wrist problems for months afterwards.

Appellant's submissions

[29] Mr Gimenez told the Court that the problem he faced was the length of time it took for "someone" to find out what happened following his accident. He noted that

his first referral from his GP was to a general surgeon who did not know what was going on with his right wrist.

[30] He said there was no limitation in the movements of his left hand. He invites the Court to conclude therefore that the clinical advisory panel's conclusion that his midcarpal instability was most likely incremental and existed long before the snowboarding accident, was wrong.

[31] He says that the clinical advisory panel did not include any wrist specialists.

[32] He is critical of the fact that the clinical advisory panel and others can make a diagnosis without seeing him.

[33] He says that the two specialists who saw him reached a completely different conclusion from those practising medicine "behind the desk".

Respondent's submissions

[34] Mr Light notes that the ultimate question is whether the appellant's right midcarpal instability was caused by the snowboard accident.

[35] Mr Light took the Court through the clinical advisory panel's explanation of the appellant's long standing midcarpal instability.

[36] He notes that the opinion of Fiona Timms, Orthopaedic Hand and Wrist Surgeon, on 17 August 2017 was "midcarpal instability of the right wrist". There is no attribution by Ms Timms to an accident related cause.

[37] He also submits that Ms Timms, in a later clinical letter dated 10 September 2018, says that with no history of ligamentous laxity or significant collagen disorder, then a midcarpal instability to the degree that Alejandro has, in her opinion would be associated with trauma.

[38] He notes however that in the same report there is this:

> The only thing in Alejandro's history that goes against this episode as being the cause of his midcarpal instability is the fact that it was a number of months until he noticed the obvious clunk in his wrist.

[39] Mr Light places considerable reliance on the clinical advisory panel's reports and says that ultimately the report of orthopaedic upper limb surgeon Mr Heiss-Dunlop is unclear with the final sentence of that report being:

> In summary, it is my opinion that Alejandro's injury and subsequent imaging are consistent with a traumatic midcarpal instability; however, distracting from this is his delayed presentation following the injury.

Decision

[40] Put simply, the issue here is whether the appellant's snowboarding accident of 13 July 2016 caused his right wrist midcarpal instability or whether it was an underlying condition not injury related.

[41] The starting point always in cases of this kind is an examination of the event that is identified as having caused the injury and the steps that followed that event.

[42] In this case, the history of the injury event appears to be first recorded with a medical professional on 17 August 2017. Fiona Timms, orthopaedic hand and wrist surgeon recorded:

> Last year whilst snowboarding, he fell and sustained a hyperextension injury to his right wrist. It was very painful at the time but seemed to settle and he pretty much got on with life. Last summer when he was playing a lot of table tennis with his son, he noticed that the pain recurred and he became more aware of not only pain but also a clunking in his wrist and with time this clunking has become easier and easier to occur to a point where it now occurs multiple times throughout the day…

[43] It is noted that the snowboarding accident is not mentioned in the appellant's GP's clinical note of the appellant's consultation on 9 January 2017. What is recorded on that date is:

> …Also having a problem in R forearm – has been playing a lot of table tennis (lost 6 kg in 6/12). Also clunking R on adduction – for a couple of months no functional disability.

[44] The description of the snowboarding accident provided by the appellant is not challenged. However, it does appear from the narrative that for the six months following the accident, what occurred, was largely forgotten. The immediate effects of the snowboarding accident resolved, and it was only recalled to mind following a clunking of the right wrist while playing table tennis at some six months later.

[45] Here, the report of the clinical advisory panel of 2 April 2019 provides a detailed and cogent analysis of the accident and what followed.

[46] The panel noted that the appellant did not report any swelling, deformity, bruising or open wounds of his right wrist which would be expected if there had been a significant injury to that wrist. Likewise, the panel noted that none of the records recorded any related symptoms or dysfunction over the following six months. It was the panel's conclusion that the appellant's current symptoms were most likely related to longstanding midcarpal instability. The panel said:

> The features include his ventral angulation, cartilage wear and loss and tears of the scapholunate ligament and triangular fibrocartilage complex (TFCC). Each of these changes are part and parcel of longstanding pre-existing pathology in Mr Gimenez right wrist. Each can remain symptom free for years, and each can contribute to his symptoms now.

[47] The panel concluded:

> The CAP consensus was that Mr Gimenez's midcarpal instability is most likely developed mental and existed long before the snowboarding accident of 13/07/2016. The imaging features such as ventral angulation, chondral thinning, bone oedema and scapholunate and fibrocartilage and triangular fibrocartilage perforations are all gradual onset features not related to any single episode of trauma, or any combination of these.

[48] Likewise, Orthopaedic Upper Limb Surgeon Mr Heiss-Dunlop's report of 9 February 2021, although in support of traumatic causation, is less than categorical. This report concludes:

> In summary, it is my opinion that Alejandro's injury and subsequent imaging are consistent with traumatic midcarpal instability; however, distracting from this is his delayed presentation following the injury.

[49] Mr Light, rightly refers to *Ambros* where the Court said at [67]:[1]

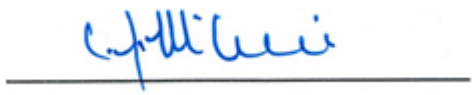
> The different methodology used under the legal method means that the Court's assessment of causation can defer from the expert opinion and Courts can infer causation in circumstances where the experts cannot. This has allowed the Court to draw robust inferences of causation in cases of uncertainty… However, a Court may only draw a valid inference based on facts supported by the evidence and not on the basis of supposition or conjecture… Judges should ground their assessment of causation on their view of what constitutes the normal course of events, which should be based on the whole of the lay, medical, and statistical evidence, and not be limited to expert witness evidence.

[50] Applying this dictum to this case, I am driven to conclude that causation is not established in the case.

[51] I find the clinical advisory panel report detailed and persuasive. Also, the evidence supporting the appellant's position, as already indicated, is equivocal.
I therefore find that the respondent's decision of 20 February 2018, declining cover on the ground that the appellant's wrist issue was more likely an underlying condition that was not caused by the snowboarding accident of 13 July 2016, is correct.

[52] Accordingly, I must dismiss this appeal.

[53] There is no issue as to costs.



Judge C J McGuire
District Court Judge

Solicitors: Shine Lawyers NZ Limited, Christchurch.

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1 *Accident Compensation Corporation v Ambros* [2008] 1 NZLR 340.