IN THE DISTRICT COURT
AT WELLINGTON

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

[2023] NZACC 186 ACR 51/23

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

Hearing: 4 October 2023
Heard at: Christchurch/Ōtautahi

Appearances: Ms M Watson, advocate for the Appellant
Ms F Becroft for the Respondent

Judgment: 17 November 2023

RESERVED JUDGMENT OF JUDGE C J MCGUIRE
[Personal Injury - Consequential Injury - Section 20(2)(g)
Accident Compensation Act 2001]

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[1] At issue on this appeal are two decisions of the respondent:

(a) A decision of 16 January 2023 declining cover for radial tunnel syndrome as a consequential injury under s 20(2)(g) of the Accident Compensation Act; and

(b) The respondent's decision of 7 September 2022 declining a right sided radial nerve injury.

[2] The appellant submits that the above conditions are a result of an accident/injury suffered to the right arm and elbow on 16 August 2017.

[3] The Corporation's position is that the weight of medical evidence does not establish the conditions are injury related

Background

[4] On 6 September 2017, an ACC injury claim form was filed by physiotherapist, Mr Fawcett, for a strain of the right elbow/forearm sustained on 16 August 2017. The description of accident was:

> Was sawing up fallen tree branch and felt pain around elbow area.

[5] The claim was accepted on 8 September 2017 and in the months that followed, the appellant received physiotherapy treatment and a cortisone injection to relieve symptoms.

[6] On 28 March 2018, the appellant consulted sport and exercise physician, Dr Tony Edwards. Dr Edwards noted that the appellant had had an x-ray showing some triceps insertional calcific tendonopathy, but no other real bony changes. He had also had an ultrasound scan showing no lateral epicondylar change of the extensor tendon origin, but some mild triceps insertional tendonopathy.

[7] Under the heading "Recommendation", Dr Edwards said:

> I think this pain is likely to be coming from the extensor tendon origin, but his ultrasound scan shows no extensor tendon origin changes and he is now feeling the pain deep in the elbow itself. I think we should get an MRI scan as this is effecting his job markedly …

[8] An MRI scan was taken on 7 April 2018. The scan report recorded mild to moderate right common extensor origin tendinosis with a small low-grade interstitial tear within deep ECRB fibres.

[9] Dr Edwards reported again on 9 April 2018 and confirmed that the MRI scan showed a right elbow extensor tendonopathy "with a little 5mm low-grade interstitial

tear. Otherwise the elbow looks pretty good.". Further physiotherapy was recommended.

[10] Dr Edwards saw the appellant again on 30 April 2018 and modified the physiotherapy technique.

[11] Dr Edwards saw him again on 13 August 2018. He noted that the appellant's right lateral elbow pain had come back three days earlier "having been brilliant since the last cortisone injection six weeks before". He noted the appellant was quite disabled by his pain and causing significant problems at work, and that he was waking at night. Dr Edwards arranged for an orthopaedic review with Stewart Walsh.

[12] On 17 August 2018, the appellant saw Dr Paterson, sport and exercise physician. He described the appellant as battling a right common extensor origin injury, which had been slow to settle. Dr Paterson delivered an autologous blood injection and told the appellant that he must reinstate his eccentric strengthening habit in 48 hours.

[13] Dr Paterson reported again on 28 September 2018. He noted:

> Improving right common extensor origin tendon pain but persisting discomfort possibly relating to irritation of the deep radial nerve as it passes through supinator.

[14] Dr Paterson asked the appellant to embark on a four day intense stretching protocol utilising the common extensor origin stretch, along with a supinator stretch.

[15] On 16 September 2018, an ultrasound was taken of the right elbow to investigate the radial nerve further. The ultrasound findings in regard to the right radial nerve were normal, but right common extensor tendinosis was noted.

[16] Dr Paterson reported again on 4 October 2018, noting the confirmation of tendon damage in the common extensor origin. He recommended adjustments to the medication regime.

[17] Dr Paterson saw the appellant again on 19 March 2019. He noted that the appellant reported that he had made further improvements with his symptomatic right elbow "that shows signs of a combined common flexor origin tendon injury and a supinator injury".

[18] Dr Paterson noted that the appellant's elbow "is the best that it has been but it is still focally tender under the lateral epicondyle and more laterally over supinator. He still has easily provoked pain with resisted third MCP extension. Dr Paterson arranged for further consultations "due to the fact that Campbell is still at best operating at 50% normal right elbow function".

[19] Subsequently, further treatment funding requests were made to the Corporation. The Corporation sought clinical advice as to whether ongoing symptoms were related to the covered accident.

[20] Mark Harris, clinical advisor to ACC, reviewed the file on 12 April 2019 and concluded that the current diagnosis was right common extensor origin tendinosis, which he did not consider to be linked to the covered injury (a sprain) on the personal injury by accident claim.

[21] On 12 April 2019, the Corporation declined to provide further treatment on the claim, confirming that the appellant was covered only for a sprain of the elbow and forearm.

[22] On 11 June 2019, the appellant, through his advocate, Ms Watson, applied for a review of the Corporation's decision. That review application was subsequently withdrawn and the focus shifted to the work-related gradual process claims.

[23] A claim was filed on 23 July 2019 for lateral epicondylitis and enthesopathy of the elbow. Cover was declined for these conditions on 2 March 2020. A review application was lodged, but later withdrawn. A second claim was lodged in April 2020 for radial tunnel syndrome and olecranon.

[24] In September 2020, an ultrasound injection into the interosseous nerve was undertaken. This was arranged by Dr Walls, occupational medicine physician, who was considering the second work-related gradual process claim.

[25] Mr Tasman-Jones, hand and upper limb surgeon, also commented in relation to the second work-related gradual process claim in April 2021. His report provides a useful summary of the work-related gradual process investigations. He diagnoses chronic radial tunnel and triceps tendinosis through a gradual process. He said:

> At best the sawing of a branch from a fallen tree on 16 August 2017 has rendered the underlying conditions more symptomatic.

[26] He said:

> The activity is controlled and there is no evidence that a sudden unexpected force was applied to the elbow.

[27] ACC sought further advice from Dr Walls. In his report of 27 April 2021, he said:

> In terms of ACC coverage, I would accept/propose:
>
> 1. The right lateral tendinosis/epicondylitis should be considered as a consequence of the personal injury by accident (sawing falling tree for two hours).
>
> 2. I would accept that the right radial tunnel would not have occurred as a direct injurious consequence of this activity, although this activity certainly aggravated and brought it to clinical light.
>
> a. I would agree that a de novo gradual process injury is not plausible.
>
> b. Although Mr Merrylees has had 15 years as a storeman, I would acknowledge that the occupational factors linked to radial tunnel syndrome are rather tenuous and scant and could not support Campbell's occupation as being more likely than not to have lead to this condition.
>
> 3. I am unaware of any occupational association with olecranon spurs etc.

[28] This led the Corporation to decline cover for radial tunnel syndrome and olecranon spurring as a work-related gradual process condition on 29 April 2021.

[29] Following this, the appellant continued to seek treatment and evidence that his condition was something caused by either an accident or work, and that it should attract ACC cover.

[30] Dr Anderson, specialist physician in occupational medicine, completed a report on 22 October 2021 summarising the various diagnosis that had been made. In his view, the sawing of the tree caused a partial tear in the tendon and that started a pain problem. He said:

> He needs acceptance by ACC that (he) has a diagnosis of chronic pain following injury, which is a personal injury by accident …

[31] On 8 February 2022, the appellant's general practitioner filed an additional claim for a right elbow joint lateral collateral ligament sprain and pain in the joint (arthralgia) as a result of a partial tendon tear to the elbow in the 2017 accident.

[32] The claim was reviewed by Dr Happy, medical advisor, on 30 May 2022.

[33] Amongst other things, Dr Happy was of the view that there was insufficient evidence supporting an accident mechanism of sawing branches which resulted in lateral epicondylitis or tendinosis. He also said that a small tendon tear from the accident would have healed in the eight months until the MRI unless the cause of the tear was continuing. He said the cause of the tendinopathy was repetitive micro trauma and tendon loading that is not related to the accident. The sprain could only have been very minor and likely resolved within a few days or a week of the accident.

[34] He also said:

> The chronic pain is due to the pathology in his elbow, which is the lateral epicondylitis and is not accident related.
>
> The chronic pain diagnosis should not be added to his injuries.
>
> The tendon tear should not be added.
>
> The sprain elbow could have been a result of the accident. However, with the accident mechanism the sprain could only be very mild and likely resolved within a week of the accident.

[35] On 1 June 2022, the Corporation issued the decision declining cover for chronic pain/lateral epicondylitis of the elbow/a partial tendon tear.

[36] In subsequent discussions with the Corporation, Ms Watson clarified that the appellant was in fact seeking cover for radial tunnel syndrome.

First Decision on Appeal

[37] On 1 July 2022, a further claim was filed for right elbow sprain and a radial nerve injury as a result of the accident on 16 August 2017. The Corporation reviewed that claim in light of the evidence already available and declined it on 7 September 2022.

[38] The parties then went to conciliation to try and unpick the various interconnected claims/diagnoses that had been made.

[39] There were subsequent discussions between the parties as to whether epicondylitis (which had been declined) and tendinosis were the same thing.

[40] Ms Watson subsequently advised that her view was that the appellant had suffered an elbow sprain and that radial tunnel syndrome was a gradual process condition consequential on that covered injury.

[41] On 1 January 2023, Dr Monigatti provided further advice in regard to radial tunnel syndrome. He did not think that that condition was caused by any personal injury by accident.

[42] On 16 January 2023, the Corporation issued a further decision declining cover for radial tunnel syndrome as a consequential injury on the personal injury by accident claim. The appellant also applied for a review of that decision and it was agreed that the two matters could be heard together.

[43] The appellant was unsuccessful at review and a notice of appeal was filed against the reviewer's decisions on 14 March 2023.

[44] For the appeal, the appellant has filed another report from Dr Walls dated 15 June 2023. Dr Walls concluded that the tear in the elbow led to disordered elbow mechanics and that the "condition was brought to clinical awareness by an episode of intense sawing".

Agreement Between the Parties

[45] At the commencement of the hearing on 4 October, Ms Watson and Ms Becroft advised the Court that it was agreed that radial tunnel syndrome is difficult to diagnose and quite rare.

Appellant's Submissions

[46] Ms Watson referred to the report of the clinical advisor, Mr Harris, dated 12 April 2019 in which he noted that to that point the appellant had had 17 physiotherapy treatments, three urgent care consultations, one GP consultation, x-ray and ultrasound and a cortisone injection between 6 September 2017 and 12 March 2019.

[47] He then saw sports medicine specialist, Dr Edwards, on 28 March 2018.

[48] She refers to the recommendation section of Dr Edwards' report where he says:

> I think this pain is likely to be coming from the extensor tendon origin, but his ultrasound scan shows no extensor tendon origin changes and he is now feeling pain deep in the elbow itself. I think we should get an MRI scan as this is effecting his job markedly now, which involves using a taping machine on a regular basis …

[49] Ms Watson notes that except for a few days off at the beginning, the appellant continued to work throughout. She notes that he had worked in this role for 15 years.

[50] The findings of the MRI scan of 7 April 2018 were:

> The common extensor tendon origin is thickened with T1 intermediate signal change. There is a low grade tear 5x5x2 mm.

[51] As a result, Dr Edwards referred him back to physiotherapy for six weeks with a very specific regime. She also refers to the fact that Dr Edwards noticed in the assessment that the appellant had "a lot of trigger points in his right extensor forearm".

[52] An ultrasound on 26 September 2018 noted that there was right common extensor tendinosis with no tear of the extensor tendon origin identified.

[53] She next refers to the report of Dr Paterson, sport and exercise physician, dated 19 March 2019, where Dr Paterson says:

> The lack of overall improvement, having achieved better length in the common extensor origin, made me consider the possibility of an entrapment of the deep radial nerve or posterior interosseous nerve as it passed through the supinator.

[54] Ms Watson emphasises that with 17 visits to the physiotherapist without significant improvement, this is more than a simple sprain.

[55] She refers to Dr Paterson's assessment on 4 October 2018, which refers to ultrasound confirming some tendon damage at the common extensor origin.

[56] She next refers to Dr Edwards in March 2019 considering the possibility of an entrapment of the deep radial nerve or posterior interosseous nerve as it passed through the supraspinatus. Due to the lack of progress the appellant is still at best operating at 50 per cent normal right elbow function.

[57] She refers to the assessment of Dr Walls, dated 9 October 2019 where, under the heading "The Diagnosis", he says:

> I accept the findings of the MRI scan which showed injury to the right common extensor origin, but I would concur with my colleagues, Dr Edwards and Dr Paterson who, in their reports, both have considered the possibility of a radial tunnel syndrome and I wonder whether that is present today.

[58] Dr Walls also noted that the appellant had been exposed to 15 years of force, non-neutral postures of the wrist, which are recognised wrist factors for work-related injury and also similar risk factors for radial tunnel syndrome.

[59] Dr Walls reported again on 3 February 2020. His report included the following:

> …
>
> - Radial tunnel syndrome remains a clinical possibility and such a condition is consistent with the described incident (hand sawing through a large branch).
>
> …
>
> - Radial tunnel syndrome is recognised as being difficult to diagnose and as both Dr Antoniadis and I note, is usually done by means of an ultrasound guided local anaesthetic injection (looking for a temporary abolishment of symptoms).
>
> …
>
> - I remain of the opinion that the diagnosis is insecure and would look for further testing (as above) to confirm or exclude the diagnosis of radial tunnel syndrome before declining ACC coverage.

[60] On 19 April 2020, Dr Walls' reported again, noting that the diagnosis was unclear. He went on to say:

> Radial tunnel syndrome is as Dr Monigatti states, much less common, but the role of the specialist is to consider the less common pathologies where the clinical tests, imaging and clinical course follow an uncommon pathway.

[61] Ms Watson refers to the written guidance transcript of principal clinical advisor, John Monigatti, dated 24 April 2021. Dr Monigatti noted that radial tunnel syndrome was an uncommon disorder with prevalence in the general population of less than one per cent. Dr Monigatti referred to research in which the authors found three significant associations between work factors and radial tunnel syndrome. They were:

1. Hand exertion of effort of more than ten times per hour.

2. Static work of the hand, such as firmly pinching or squeezing objects or hand tools.

3. Working with the elbow fully extended regularly.

[62] She refers to a report from Michael Anderson, specialist physician and occupational medicine, dated 22 October 2021. Mr Anderson says:

> I note the diagnosis radial tunnel syndrome made by both Drs Wall and Tasman-Jones as a clinical diagnosis – there is constant agreement about this in the literature that outcomes from injections, nerve conduction studies do not give a conclusive diagnosis.
>
> In the final analysis of this, it appears to me that the sawing of the tree caused the partial tear in the tendon, which started his pain problem … there had been no complaint of pain until then.
>
> …
>
> He needs acceptance by ACC that has a diagnosis of "chronic pain following injury, which is a personal injury by accident, that was originally WPOTK-related".

[63] In a final report from Dr Walls dated 15 June 2023, he says:

> …
>
> My summary is:
>
> (a) Mr Merrylees has a right radial tunnel syndrome. The diagnosis is secure.
>
> (b) The condition was brought into clinical awareness by a prolonged period of similar right upper limb action sawing a tree down in a storm.
>
> (c) The diagnosis is difficult to make and often presents or is misinterpreted as lateral epicondylitis (tennis elbow) which is the case with Mr Merrylees and indeed there was a small tendon tear at the start of this process contributing to his pain problem.
>
> (d) Mr Merrylees in my opinion has developed a significantly worsened radial tunnel syndrome (contributed to to some extent by his work activities) as a consequence of the sawing incident on 16 August 2017.

[64] Ms Watson concludes by saying that Mr Merrylees is in an occupation that had forceful repetitive hand actions and the sawing of the trees was the mechanism of injury that caused the tendinosis and tear. She submits that his constant work related gripping and movements would continue to aggravate the resulting pain problem.

[65] She submits therefore that his radial tunnel syndrome and other damage to his right elbow arose from and are consequential on the injury of 16 August 2017.

Respondent's Submissions

[66] Ms Becroft, with Ms Watson's approval, handed up to the Court two drawings of the human arm, the first depicting radial tunnel syndrome and the second showing the path of the radial nerve.

[67] Ms Becroft briefly referred to the claims history and confirms that it is the personal injury by accident claim that is before the Court today. She refers to the fact that ACC declined cover for radial tunnel syndrome in its decision letter of 16 January 2023.

[68] ACC's position is that it does not accept that the appellant's radial tunnel syndrome was caused by the accident of 16 August 2017.

[69] She acknowledges that Drs Monigatti, Tasman-Jones and Walls are the key witnesses in this case.

[70] She refers to the report of sport and exercise physician, Dr Paterson dated 20 September 2018 in which reference is made to "improving right common extensor origin tendon pain".

[71] She submits that there was a slight shift over time of the site of the appellant's pain.

[72] She notes that radial tunnel syndrome was first diagnosed by Dr Tasman-Jones in his report of 1 April 2021, but that Dr Tasman-Jones does not draw a link with the accident of 16 August 2017.

[73] She refers to the report of ACC's lead occupational health advisor, John Monigatti, dated 5 February 2020, where he says:

> There is agreement here that any injury Mr Merrylees might have suffered is unlikely to have been caused by his work. In the unlikely event that he does have radial tunnel syndrome as well as lateral epicondylosis, there is no sound evidence that sawing a tree branch, or any other specific activity, can cause it.

[74] She refers to a further report by John Monigatti of 1 January 2023 which includes the following:

> Radial tunnel syndrome arises from compression of the radial nerve in the proximal forearm before and after it splits into the posterior interosseous nerve (the main trunk) and the superficial branch of the radial nerve (minor trunk) …
>
> Compression can arise from bone fractures, trauma causing oedema or bleeding in the soft tissues surrounding the nerve, inflammation of the muscles in the proximal forearm prolonged or repeated construction of the wrist … and pressure to the upper arm from arm positions during sleep or coma. Whilst Mr Merrylees implicated none of these as having caused his radial tunnel syndrome, he did put it down to a forearm/elbow sprain. I do not think a minor soft tissue injury such as a sprain (acute overstretching or tearing of a ligament) a plausible cause of radial tunnel syndrome by any mechanism. Historically, radial tunnel syndrome was thought to be caused by repetitive or strenuous use of the arm (ie. overuse) …

[75] She refers to Dr Walls' report of 27 April 2021 where he says:

> I would accept that the right radial tunnel would not have occurred as a direct injurious consequence of this activity although this activity (sawing fallen tree for two hours) certainly aggravated and brought it to clinical light.

[76] Ms Becroft's ultimate submission is that there is no evidence tying the appellant's radial tunnel syndrome to a covered injury.

Decision

[77] The appellant lodged a claim form on 6 September 2017 with his physiotherapist, for an injury that occurred on 16 August 2017 at 6.45pm. The description of injury was:

> Sawing up fallen tree branch and felt pain around elbow area.

[78] At the time he was 39 years old.

[79] In evidence before the review, Miriam Sainsbury, on 14 February 2023, the appellant gave the following descriptions of what occurred:

> … there was a storm and it knocked over a big branch at our flats … it was quite bit and they had thrown it down by my kitchen, so I decided to saw it all up, so I started doing that and it was fine and then after about two hours my arm started sort of feeling heavy. Sort of weird and I tried to keep going but I couldn't, so I stopped and then woke up the next day and it was really, yeah, it

> was painful, ah, couldn't, couldn't use it, um, yeah, couldn't hold, couldn't grip anything, like had no grip action or anything like that, um, yeah, that was it and then I went to tell my boss and he said go to the doctor. So I went to the doctor and I think I had that day off and then I think the next day I just came back in, into work and then, I after that I was going to the physio for, and this went on for ages, um, so yeah, physio and then sports physician after that, various ones, um, that the physio recommended. Yeah, then I had all, yeah, a lot of different treatments to try and sort it out. Yeah, and it just continued.

[80] Then in response to being asked how his elbow is now, he said:

> Oh, its really bad, its, its actually got worse in the last, oh, I'd say few months, its actually increased a lot in pain, um, like at night time, but its always there and its actually got sort of really, yeah, really bad. I have it in a certain position, it'll just sort of seize up. And I have to stretch it out, um, just, just, any of it, like any tasks that involved gripping onto you know vacuuming or anything like that. Um, just, yeah, just no, its not good.
>
> …
>
> My fingers are sort of, its affecting my fingers now too. And like it must, it must have something to do with the nerve I suppose …

[81] What followed the lodging of the claim and its acceptance back then in 2017 was extensive physiotherapy, some 17 treatments between September 2017 and March 2018.

[82] Dr Edwards, sport and exercise physician, noted in a report of 28 March 2018:

> He has pain which is felt around the lateral aspect of his right elbow that radiates down into his extensor muscle belly especially. However, he also has been getting some more diffuse anterior elbow pain and possibly pain felt deep in the elbow in the last two or three months. He had a cortisone injection to the extensor tendon origin in about September 2017 and this took 95% of his pain away for about three months. However, the pain has come back with a vengeance and is felt more diffusely and deeper in the elbow now. …
>
> **Recommendation:**
> I think this pain is likely to be coming from the extensor tendon origin, but his ultrasound scan shows no extensor tendon origin changes and he is now feeling the pain deep in the elbow itself.

[83] Then followed an MRI scan which Dr Edwards described as follows:

> His MRI scan has shown a right elbow extensor tendinopathy with a little 5mm low-grade interstitial tear. Otherwise the elbow looks pretty good.

[84] Dr Edwards prescribed a focussed "eccentric loading programme".

[85] On 13 August 2018, Dr Edwards wrote a letter of referral to Dr Paterson, another sport and exercise physician. Dr Paterson recommended an autologous blood injection and also recommended reinstatement of his eccentric strengthening habit.

[86] Dr Paterson next reported on 20 September 2018 and there was an adjustment to his exercise regime.

[87] In his report back to Dr Edwards of 19 March 2019, Dr Paterson said these things:

> …
>
> The lack of overall improvement, having achieved better length in the common extensor origin, made me consider the possibility of an entrapment of the deep radial nerve or posterior interosseous nerve as it passed through supinator.
>
> …
>
> Due to the fact that Campbell is still at best operating at 50% normal right elbow function, I feel it would be wise to secure three further consultations. I have suggested I should review Campbell in eight to 12 weeks and ask that he continues with his current eccentric strengthening programme …

[88] On 9 October 2019, the appellant was reviewed by Dr Walls, occupational specialist physician, who was of the opinion that although the most likely diagnosis was lateral epicondylitis from 15 years repetitive loading while working as a storeman, a radial tunnel syndrome could not be excluded.

[89] Investigations continued in 2020 and on 1 April 2021, Mr Tasman-Jones, hand an upper limb surgeon, after reviewing what had occurred and the earlier treatment regimes, was of the following opinion:

> Mr Campbell Merrylees presents with evidence of a chronic radial tunnel and triceps tendinosis. Clinically the lateral tendinosis involving his right elbow has now settled and is not causing him any symptoms. I have explained to Campbell he has developed a chronic right radial tunnel syndrome and olecranon spur through a gradual process.
>
> …
>
> Radial tunnel syndrome develops through a gradual process and is rarely traumatic in origin. Sawing a branch off is extremely unlikely to result in a traumatic structural injury to the components of the radial tunnel. It is much

> more likely that Mr Merrylees has developed some radial nerve/posterior interosseous nerve irritation in conjunction with his chronic tendinosis.

[90] Dr Walls, occupational medical specialist, also reported to ACC on 27 April 2021. He said:

> I would accept that the right radial tunnel would not have occurred as a direct injurious consequence of his activity although this activity certainly aggravated and brought it to clinical light.
>
> …
>
> (b) Although Mr Merrylees has had 15 years as a storeman, I would acknowledge that the occupational factors linked with radial tunnel syndrome are rather tenuous and scant and could not support Campbell's occupation having been more likely than not to have led to this condition.

[91] Earlier that month, on 1 April 2021, hand and upper limb surgeon, Tim Tasman-Jones was of a similar opinion, saying:

> Mr Campbell Merrylees presents with evidence of a chronic radial tunnel and triceps tendinosis. Clinically the lateral tendinosis involving his right elbow has now settled and is not causing him any symptoms. I have explained to Campbell he has developed a chronic right radial tunnel syndrome and olecranon spur through a gradual process. At best the sawing of a branch from a fallen tree on 16 August 2017 has rendered the underlying conditions more symptomatic. The activity is controlled and there is no evidence that a sudden unexpected force was applied to the elbow.

[92] On 15 June 2023, Dr Walls responded to a request by Ms Watson to comment further on the appellant's condition and its relationship to his work and the wood sawing incident of 16 August 2017. Dr Walls confirmed that the appellant had right radial tunnel syndrome, a diagnosis also supported by Mr Tasman-Jones, orthopaedic surgeon.

[93] In his concluding paragraph, Dr Walls said this:

> My summary is:
>
> (a) Mr Merrylees has a right radial tunnel syndrome. The diagnosis is secure.
>
> (b) The condition was brought into clinical awareness by a prolonged period of similar right upper limb actions sawing a tree down in a storm.
>
> (c) The diagnosis is difficult to make and often presents or is misinterpreted as lateral epicondylitis (tennis elbow) which is the case with

> Mr Merrylees and indeed there was a small tendon tear at the start of this process contributing to his pain problem.
>
> (d) Mr Merrylees in my opinion has developed a significantly worsened a radial tunnel syndrome (contributed to to some extent by his work activities) as a consequence of the sawing incident on 16 August 2017.

[94] The diagnosis of right radial tunnel syndrome in this case has taken quite some time but is now accepted.

[95] It is a rare condition and it is not surprising that final and correct diagnosis has taken the time that it has.

[96] The ultimate question in this case is whether the appellant's right radial tunnel syndrome was caused or contributed to by the event on 16 August 2017 when the appellant was sawing up a fallen tree branch.

[97] Dr Walls' closing comment in his report of 15 June 2023 was:

> Mr Merrylees in my opinion has developed a significantly worsened a radial tunnel syndrome (contributed to to some extent by his work activities) as a consequence of the sawing incident on 16 August 2017.

[98] The respondent's position is that in effect the appellant had right radial tunnel syndrome which was rendered symptomatic by the incident of 16 August 2017.

[99] The evidence is that at the time, the appellant was a fit 39 year old. What occurred in the course of the event of 16 August 2017, led the appellant to seek physiotherapy advice on 6 September 2017 when a claim was lodged. Then intensive and focussed exercises to resolve the issue failed.

[100] I conclude that in all of the circumstances as we know them, Dr Walls' closing comments of his report of 15 June 2023 fairly and accurately set out the medical position as well as it can be described, given the history and evidence that we have.

[101] Accordingly, I find that the accident event did develop or significantly worsen the appellants radial tunnel syndrome, which was contributed to, to some extent by his work activities, as a consequence of the incident on 16 August 2017.

[102] Therefore, his appeal against ACC's decision of 16 January 2023 declining cover for radial tunnel syndrome as a consequential injury under s 20(2)(g) is overturned and cover is given for that injury.

[103] Accordingly, in respect of ACC's said decision of 16 January 2023, the appeal is allowed.

[104] The other decision appealed from is that of 7 September 2022 declining right sided radial nerve injury. Rightly, the appeal has focussed on whether or not the appellant's radial tunnel syndrome was caused by accident on 16 January 2023. The 7 September 2022 decision declining cover for right sided radial nerve injury was not argued. The appeal against that decision is therefore dismissed.

Costs

[105] Costs are reserved.

CJ McGuire
District Court Judge

Solicitors: Medico Law Limited, Grey Lynn