IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 110 ACR 224/19

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

Hearing: 2 June 2022
Held at: Auckland/Tāmaki Makaurau
BY AVL

Appearances: The appellant is self-represented
A Miller for the respondent

Judgment: 9 June 2022

RESERVED JUDGMENT OF JUDGE P R SPILLER
[Claim for entitlement - s 67, Accident Compensation Act 2001]

Introduction

[1] This is an appeal from the decision of a Reviewer dated 9 August 2019. The Reviewer dismissed an application for review of the Corporation's decision dated 3 December 2018 declining Mr Hunter funding for surgery.

Background

[2] Mr Hunter was born in August 1951. He became a barista and journalist.

[3] On 13 March 2007, Mr Hunter fell off a ladder while cleaning the gutters of his house. He presented to the Emergency Department of the local hospital, where he was diagnosed with a fracture of his distal radius (broken wrist). The Corporation granted cover for fracture of the lower end of both ulna and radius hand/wrist on the left side.

[4] On 14 March 2007, Mr David Bartle, Orthopaedic Surgeon, performed a closed reduction and internal fixation of the distal radius fracture. Mr Bartle fixed the position of Mr Hunter's wrist for healing with wires, and the wrist was then put in a cast below the elbow.

[5] On 16 March 2007, Mr Hunter returned to hospital with swelling of the left elbow. An x-ray was taken and reported:

> Following MVA the communicated fracture has been brought to a reasonable position.
>
> Subsequent screening films show internal fixation.
>
> The left elbow shows some minimal soft tissue swelling, but no obvious fracture.

[6] On 22 March 2007, Mr Hunter was followed up again at the hospital fracture clinic, and a new cast was applied. Dr James Myer, Orthopaedic Registrar, recorded in an outpatient note:

> Originally the wrist was extended so we changed him into a flexed position. X-rays shows on the lateral that the joint line is neutral. The fracture is slightly mal-reduced.

[7] On 29 March 2007, Mr Hunter again attended hospital. Dr Jason Donovan, Orthopaedic Registrar, recorded that Mr Hunter had full extension and not quite full flexion of the fingers. X-rays taken that day showed that the fracture remained in an acceptable position with nil obvious displacement.

[8] On 26 April 2007, Mr Rob Guthrie-Brown, Orthopaedic Surgeon, assessed Mr Hunter and removed the internal fixation wires without complication. Mr Hunter was discharged from the Fracture Clinic. Mr Guthrie-Brown noted that Mr Hunter had been undergoing physiotherapy, and was experiencing a painful elbow and

shoulder, probably as a consequence to the injury and also not using his left upper limb for a significant period of time. Mr Guthrie-Brown advised that, on examination, neurovascularly was intact and range of motion although stiff throughout was good for his length of time after the injury.

[9] On 28 May 2007, David Crouchman, Occupational Therapist, noted that Mr Hunter had received follow-up as an outpatient treatment from the hospital, and had undergone further x-rays to monitor his progress.

[10] On 29 June 2007, Mr Hunter's Request for Prior Approval of Treatment recorded that he could dress independently, drive and could sleep through the night, but he was unable to use the handbrake in his vehicle and had difficulty typing and surfing.

[11] There were no further medical records produced in relation to Mr Hunter's condition for the next 11 years.

[12] On 12 June 2018, Dr William Chang, GP, recorded that Mr Hunter had reported experiencing weakness when holding objects or using tools over the previous six months.

[13] On 6 July 2018, an x-ray was taken of Mr Hunter's wrist. Dr Alina Leigh, Consultant Radiologist, reported:

> There is marked positive ulnar variance with sclerotic change of the adjacent lunate and triquetral. Soft tissue swelling adjacent to the ulnar is pronounced. Advanced osteoarthritic changes of the first carpometacarpal joint with complete loss of joint space and probable subluxation associated with osteophytosis and sclerosis. Mild deformity of the distal radius would be in keeping with history of previous fracture.

[14] On 22 August 2018, Mr Simon Hadlow, Orthopaedic Surgeon, examined Mr Hunter and recorded wasting and weakness of the left hand and some wasting of the ulna border of the forearm. Ulnar nerve compression was noted.

[15] On 11 September 2018, Mr Hunter underwent nerve conduction studies performed by Dr James Cleland, Neurologist, which found evidence of left ulnar neuropathy at the elbow but no evidence of ulnar neuropathy at the wrist.

[16] On 18 September 2018, Mr Hadlow assessed Mr Hunter again and lodged an assessment report and treatment plan (ARTP) with the Corporation, requesting funding for a left ulnar nerve decompression/transposition operation. The formal diagnosis was listed as left ulna neuritis secondary to cubital tunnel syndrome. Mr Hadlow noted the accident in March 2007, and stated that there were no known pre-existing factors that wholly or substantially contributed to the injury covered by the Corporation which required surgery. Mr Hadlow commented on the causal medical link between the proposed treatment and the covered injury as follows:

> On 13.3.07 in Hamilton he fell two metres off a ladder sustaining a displaced fracture of the distal radius which require manipulation and wiring in theatre followed by a cast. He jarred his elbow in the fall and this healed up reasonably well but in the last twelve months he has noticed increased wasting and weakness of the muscles of his non dominant left hand, doing buttons is okay but he gets intermittent numbness and tingling in the elbow down to the little finger, weakness of the left hand gripping a screwdriver or pulling the Expresso machine wand out but continues to surf. He has less grip strength using a paddle.

[17] On 29 November 2018, Mr Ray Fong, Orthopaedic Surgeon, provided a report in which he stated:

> Recent x-ray of the wrist 06/07/2018 found mild positive ulnar variance sclerotic changes adjacent lunate small lucency triquetrum. Advanced osteoarthritis the first metacarpal joint, loss of joint space. Mild deformity distal radius in keeping with history of previous fracture. There is no cover for any left elbow.
>
> There is no contemporaneous clinical record relating to the injury of left elbow.
>
> Recently in the last 12 months the client has developed weakness of the muscles of the left hand with numbness and paraesthesia the ulnar border of the hand.
>
> Clinical examination shows positive Forment's test, wasting of the ulnar thinning eminence with some sensory change. Compression of the ulnar nerve in the cubital tunnel reproduces the symptoms.
>
> In summary, the client is suffering from his left ulnar neuritis on the basis of cubital tunnel syndrome at the level of the elbow joint.

> There is no causal link of the neuritis from cubital tunnel syndrome to the claimed personal injury by the accident of 13/03/2007.
>
> The injury involves the left wrist but not the elbow.
>
> A direct causal link of the condition now requiring surgical treatment to the claimed accident of 13/03/2007 cannot be established.

[18] On 3 December 2018, the Corporation issued a decision declining Mr Hunter funding for surgery, on the basis that the purpose of the surgery was to treat an underlying condition. On 5 February 2019, Mr Hunter lodged an application for

[19] On 12 April 2019, Mr Fong provided a second report as follows:

> 1. What is ulnar neuropathy? How is it caused?
>
> Ulnar neuropathy is caused by ulnar nerve impingement, usually around the level of the elbow joint. This is a gradual process condition.
>
> 2. How long does it take to develop?
>
> This is a gradual process condition. As I have commented previously, [Mr Hunter] suffered from a significant injury to his left wrist with a fractured distal radius and now secondary changes around the wrist area, but there is no ACC-covered condition referable to the left elbow.
>
> He is now suffering from ulnar neuropathy and ulnar neuritis on the basis of a cubital tunnel syndrome, a gradual process condition.

[20] On 30 May 2019, a review hearing took place. This was adjourned to allow Mr Hunter to have a further x-ray taken of his left elbow. The Reviewer instructed Mr Hadlow to comment on the causal medical link between the 2007 accident and the condition now requiring surgery. Mr Hadlow was asked to comment on whether structural damage to the elbow in 2007 would be needed in order for there to be a causal link and what he considered was the whole or substantial cause of Mr Hunter's condition, that is, post-traumatic or unrelated to an accident.

[21] On 30 May 2019, an x-ray was done on Mr Hunter's left elbow.

[22] On 26 July 2019, Mr Hadlow provided a report as follows:

> The x-ray of your left elbow done on 30 May this year shows well preserved joint spaces with no significant marginal osteophytes nor significant subchondral sclerosis.

> In summary, there is no evidence on the x-ray of previous trauma or of secondary post-traumatic arthritis.
>
> In view of the x-ray findings, which concur with the clinical examination of your left elbow performed on 28 August 2018, which showed a full range of motion of the left elbow without significant deformity, and the interval between the fall injuring your left arm, which occurred on 13 March 2007, and the onset of the symptoms of left ulnar palsy/neuritis in the left hand, it is difficult for me to identify a specific causal link between your injury and your current problem requiring surgery.

[23] On 9 August 2019, the Reviewer dismissed the review, on the basis that the 2007 injury was not the cause of Mr Hunter's left ulna neuritis secondary to cubital tunnel syndrome. The Reviewer relied on the temporal gap between the 2007 accident and the onset of Mr Hunter's current symptoms. The Reviewer also relied on the medical images and the expert advice to find that Mr Hunter's condition was a gradual process condition, rather than one caused by trauma.

[24] On 9 September 2019, a Notice of Appeal was lodged.

[25] On 11 March 2020, Mr Hadlow further reported as follows:

> The significant time interval between 2007 injury and the presenting elbow complaint and the lack of any post traumatic deformity or stiffness of the elbow means that I am unsure about a specific causal link.

[26] On 1 September 2020, Dr Cleland responded to Mr Hunter's query as to whether or not trauma injury, such as major fracture to an arm, might cause the issue found in his examination (ulnar neuropathy). Dr Cleland advised Mr Hunter that trauma to the elbow could certainly cause an ulnar neuropathy.

[27] On 5 May 2021, Dr Cleland advised that the nerve conduction study in September 2018 had confirmed a fairly severe left ulnar neuropathy at the elbow. He acknowledged that he was not familiar with the nature of the index injury in 2007. In addition, Dr Cleland commented:

> It is also well recognised that ulnar neuropathies of this type can be delayed many years after the injury ("tardy ulnar palsy") when the injury involved the left elbow (particularly fractures with partial or non-union).

[28] On 20 May 2021, Mr Hunter underwent left cubital tunnel release surgery to address his ulna neuritis secondary to cubital tunnel syndrome.

[29] On 28 June 2021, Mr Hunter was discharged from the orthopaedic clinic following his surgery. The discharge clinical note of Dr R Penumarthy noted that Mr Hunter had apparently suffered major elbow trauma in 2007, and that it was "entirely possible" that significant trauma at the elbow with scar tissue production could cause compression of the ulnar nerve.

[30] Following receipt of Dr Penumarthy's clinical note, the Corporation decided to refer the question of whether Mr Hunter should have cover for an elbow injury to its Clinical Advisory Panel (CAP) for investigation. On 4 November 2021, the CAP (comprising four Orthopaedic Surgeons, a Physiotherapist, and an Occupational and Environmental Medicine Specialist) provided its report. Based on a review of the medical records on Mr Hunter's file, the CAP determined that it was likely that Mr Hunter had jarred his left elbow and that this resulted in a haematoma and swelling and was consistent with a left elbow soft tissue contusion. The CAP did not consider that the clinical records contained any evidence of a more serious injury to Mr Hunter's elbow:

> There was no evidence of internal disruption to Mr Hunter's left elbow joint, scarring or any other long-term damage. His left elbow soft tissue injury was clinically expected to resolve in a few weeks or months. By all accounts, it did resolve.
>
> There was no indication of left elbow fracture, dislocation, nerve damage or any serious physical consequences of the 13/03/2007 ACC-covered accident.

[31] The CAP also addressed the cause of Mr Hunter's ulnar neuritis. The CAP concluded that, while the exact cause of Mr Hunter's ulnar neuritis secondary to cubital tunnel syndrome was unknown, it was most likely caused by a gradual onset process. The CAP was certain that the condition had nothing to do with the injury suffered in the accident in 2007, because the elbow injury Mr Hunter suffered was not serious enough to cause the development of the condition:

> Mr Hunter's cubital tunnel syndrome could not have been caused by a superficial contusion with bruising and swelling 10+ years beforehand, with no symptoms in the following decade.

> If Mr Hunter had sustained a significant left elbow injury on 13/03/2007 leading to cubital tunnel syndrome and ulnar neuritis, then the CAP would have expected clinically recorded symptoms within the first few months, at least in the first year, and not 10+ years later.

Relevant law

[32] Section 67 of the Act provides:

> A claimant who has suffered a personal injury is entitled to 1 or more entitlements if he or she—
>
> (a) has cover for the personal injury; and
>
> (b) is eligible under this Act for the entitlement or entitlements in respect of the personal injury.

[33] Clause 1 of Schedule 1 of the Act provides that the Corporation is liable to pay or contribute to the cost of a claimant's treatment "for personal injury for which the claimant has cover".

[34] In *Dobbs*,[1] Cadenhead DCJ stated:

> [26] The crux of this case is a causal issue: the appellant to have an entitlement for the costs of surgery has to satisfy the respondent on the balance of probabilities that the need for surgery arises from and is an effective consequence of the original injury or injuries, for which cover was granted. This issue will generally involve a consideration of the type of injury or injuries suffered, the x-rays, and medical reports evaluating the present symptoms against what has brought about the need for present surgery. I would have thought that on this type of issue the view of the general practitioner and the medical specialists, who have actually examined and seen the claimant would be important.
>
> [27] The appellant must demonstrate on a probability basis that the need for surgery arose from the accident or accidents and that the need for surgery was not 'wholly or substantially' caused by the ageing process'. The onus of proof of this step is upon the appellant upon a balance of probabilities.

Discussion

[35] The issue in this case is whether Mr Hunter's condition requiring surgery, ulnar neuritis secondary to cubital tunnel syndrome, was caused by a covered injury suffered in an accident in March 2007. Mr Hunter must prove, on the balance of

---

[1] *Dobbs v Accident Compensation Corporation* [2005] NZACC 46. See also *Stevenson v Accident Compensation Corporation* [2014] NZACC 139.

probabilities, based on medical evidence, that his need for surgery arises from, and is an effective consequence of, the original injury in March 2007, for which cover was granted.[2]

[36] Mr Hunter submits the hospital records prove that, in March 2007, he had a traumatic injury to his wrist and his elbow. He notes the injury caused ongoing problems to his elbow that ultimately required surgery and there is medical opinion in support of a link between his injury and the need for surgery:

(a) Dr Hadlow provided a report in support of funding for his surgery and referred to the accident in March 2007 and his condition requiring surgery.

(b) Dr Penumarthy noted that it was entirely possible that significant trauma at the elbow with scar tissue production could cause compression of the ulnar nerve.

(c) Dr Cleland advised that trauma to the elbow could certainly cause an ulnar neuropathy and that ulnar neuropathies of Mr Hunter's type could be delayed many years after an injury.

[37] This Court acknowledges Mr Hunter's submissions and evidence. However, the Court refers to the following considerations.

[38] First, there is the available medical evidence relating to Mr Hunter's elbow following his accident in March 2007. The x-ray taken on Mr Hunter, three days after the accident, revealed that his left elbow showed some minimal soft tissue swelling, but no obvious fracture. There were medical follow-ups over the ensuing three-and-a-half months, but thereafter there are no further medical records regarding Mr Hunter's elbow until 11 years later. The next medical record with reference to Mr Hunter's elbow was that of Dr Chang, GP, on 12 June 2018, who advised that the "elbow x-ray reported normal", and that Mr Hunter's injury was "actually not nearly as bad as he recalled according to his ortho clinic letters".

---

2 *Dobbs*, above n 1.

[39] Second, the medical evidence that Mr Hunter has referred to, in relation to a posited link between the accident of March 2007 and his condition requiring surgery, does not establish a link on the balance of probabilities. Dr Hadlow noted the significant time interval between the 2007 injury and the presenting elbow complaint, and the lack of any post-traumatic deformity or stiffness of the elbow, which meant that he was unsure about a specific causal link. Dr Cleland's opinion, that ulnar neuropathies of Mr Hunter's type "could" be delayed many years after an injury, referred particularly to injuries involving fractures, and was subject to the qualification that he (Dr Cleland) was not familiar with the nature of the injury in 2007. The opinion of Dr Penumarthy was provided on the basis of Mr Hunter's self-report that he had suffered major elbow trauma in 2007, and was to the effect that it was "entirely possible" that significant trauma at the elbow with scar tissue production "could" cause compression of the ulnar nerve.

[40] Third, an x-ray of Mr Hunter's left elbow, taken on 30 May 2019, showed well-preserved joint spaces with no evidence of previous trauma. This x-ray was cited by Mr Hadlow as a further reason why it was difficult for him to identify a specific causal link between Mr Hunter's injury and his current problem requiring surgery.

[41] Fourth, Mr Fong, Orthopaedic Surgeon, reported that there was no causal link between the elbow condition requiring surgery and the personal injury by the accident of March 2007. Mr Fong advised that Mr Hunter was now suffering from ulnar neuropathy and ulnar neuritis, on the basis of a cubital tunnel syndrome, which was a gradual process condition. This Court acknowledges that Mr Fong incorrectly noted that there was no contemporaneous clinical record, at the time of the 2007 accident, relating to the injury to the left elbow. However, the Court does not regard this error as materially undermining Mr Fong's opinion.

[42] Fifth, the CAP was certain that Mr Hunter's cubital tunnel syndrome could not have been caused by his injury 10+ years beforehand. The CAP noted that the absence of clinically recorded left elbow ulnar neuritis and/or cubital tunnel symptoms, for over 10 years after the 2007 injury, pointed away from an acute cause. The CAP concluded that Mr Hunter's ulnar neuritis secondary to cubital

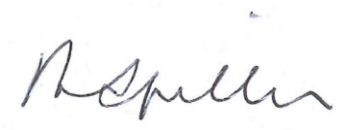
tunnel syndrome was most likely caused by a gradual onset process. This Court acknowledges that Mr Fong was a member of the CAP that provided the report on Mr Hunter. However, the Court observes that the CAP comprised three other Orthopaedic Surgeons, a Physiotherapist, and an Occupational and Environmental Medicine Specialist, and does not regard the CAP's views as having been compromised by Mr Fong's membership of the Panel.

Conclusion

[43] In light of the above considerations, the Court finds that medical evidence has not established, on a balance of probabilities, that Mr Hunter's condition requiring surgery (ulnar neuritis secondary to cubital tunnel syndrome) was caused by his covered injury suffered in an accident in March 2007.

[44] The decision of the Reviewer dated 9 August 2019 is therefore upheld. This appeal is dismissed.

[45] I make no order as to costs.



P R Spiller
District Court Judge

Solicitors: Claro Law for the Respondent.