IN THE DISTRICT COURT
AT WELLINGTON

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

[2023] NZACC 102 ACR 21/23

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

Hearing: 20 June 2023
Heard at: Wellington/ Te Whanganui-a-Tara

Appearances: Ms R Bull and Mr J Pietras for the Appellant
Mr T Lynskey and Mr B Marten for the Respondent

Judgment: 29 June 2023

RESERVED JUDGMENT OF JUDGE C J MCGUIRE
[Causation – s 20 Accident Compensation Act 2001]

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[1] The appellant is a 45 year old former early childhood teacher from Hastings who has a lengthy history relating to cover of her bilateral ankle issues arising from an accident when she slipped on an icy deck on 19 June 2007. The issue on appeal is whether she should have cover for a right peroneal tendon tear from this accident.

[2] She appeals against a decision of the respondent dated 15 September 2022 declining to extend the cover to include a peroneal tear of her right ankle.

Background

[3] On 19 June 2007, Ms Quinney suffered an accident when she slipped on an icy deck and experienced pain in her lower legs and back.

[4] In an affidavit dated 9 June 2023, the appellant said of this accident:

> As the day progressed, the pain and swelling increased immensely, so I contacted my doctor, Dr Blaine Stride. Within approximately two days, I had an appointment where it was determined that I had a contusion of the knee and lower leg.

[5] The clinical note of Dr Stride dated 21 June 2007 says:

> S (subjective) slipped going up icy deck. Hurt R lower back and R lower leg bruised.
>
> O (objective) tender across the R lower lumbar/sacral ligs with full good ROM in all planes. Some bruising R ant lower leg.
>
> …

[6] According to the appellant, the advice from her doctor was to use ice and a heat pack, to wear a supporting band and to elevate her ankle.

[7] She says that the pain did not get any better and an x-ray of her right foot was taken on 17 January 2008. Dr Shipp diagnosed plantar fasciitis.

[8] Over the next three years, the appellant struggled with her day-to-day activities and had to reduce her hours as an early childhood educator due to her pain.

[9] On 1 September 2011, she saw a second radiologist, Dr Fan, who concluded that the suspected plantar fasciitis would ideally be diagnosed with an ultrasound scan.

[10] The appellant attended a specialist review with Mr Dray, Orthopaedic Surgeon, on 24 November 2011. He noted that it was painful in her right heel to do a double stance heel raise and that her main problem was probably plantar fasciitis, plus some postero-lateral hind foot pain.

[11] Mr Dray recorded:

> Examining her today, she can do a double stance heel raise with normal heel varus consistent with normal tib post function. However, it is painful in her right heel to do this. She has good power of peroneal and tib post tendons on the right side, but she does get some discomfort in the region of the lateral ankle joint and sinus tarsi on resisting testing. This is much less of pain than the tenderness at the origin of the plantar fascia, which is consistent with plantar fasciitis.

[12] On 9 December 2011, she underwent an ultrasound of her right ankle. Dr Shipp, the radiologist, noted, under the heading "Findings":

> The plantar fascia appears normal …
>
> Laterally, the peroneal tendons themselves appear normal, although there is a trace of fluid in peroneus brevis tendon sheath at the lateral malleolus. No hypervascularity is seen.

[13] Mr Dray reported again to ACC's clinical advisor on 13 December 2011. In his report, he included this:

> I reviewed Bronwyn today. She continues to have right heel pain, which presents as if it is plantar fasciitis, and pain in the lateral hind foot. Xray is unremarkable and ultrasound has not really shown any abnormality, other than a very small trace of fluid in the peroneus brevis tendon.

[14] An MRI of the appellant's right ankle was carried out on 12 December 2011.

[15] The conclusion was as follows:

> Plantar fasciitis is present and would explain for symptoms. Ultrasound guided cortisone injection is an effective form of treatment if required.

[16] The radiologist found no effusion in the tendon sheaths around the ankle notwithstanding the earlier traces of fluid in the peroneus brevis tendon sheath found on ultrasound.

[17] Mr Dray saw the appellant again on 22 December 2011 and reported:

> Reviewing the MRI myself, there is a very small area of high signal which looks as if it is in the substance of peroneus brevis tendon behind the malleolus, which might be consistent with a small longitudinal tear. This would fit with her pain and the fact that there was a trace of fluid seen on the previous ultrasound.

[18] A report from Dr Bowmer, Radiologist, on 29 December 2021, said:

> I have reviewed the MRI dated 20/12/11. The peroneus brevis tendon is of slightly decreased signal compared with the peroneus longus tendon, suggesting tendinosis, but no tear identified. This is confirmed by the appearance on ultrasound.

[19] On 16 February 2012, Mr Dray asked for a second opinion from fellow orthopaedic surgeon, Mr Rao. In his letter of instruction, he said:

> … she injured her foot five years ago now, in June 2007 and continues to have ongoing hind foot pain since that time.
>
> …
>
> She is mild to moderately tight on Silfverskiolds's test and she does have some tenderness under the heel consistent with plantar fasciitis. However, the main pain is the lateral hind foot pain, rather than the plantar heel pain.
>
> …
>
> I did get her to have an MRI scan, which was initially reported as showing plantar fasciitis, but otherwise normal. However, I was concerned that there might be a small longitudinal tear in the peroneus brevis tendon and I asked that they review the scan.

[20] In his report of 7 July 2012 Mr Rao noted that by the end of most working days, the appellant had significant discomfort in the postero-lateral aspect of her right ankle. He said:

> She was, on the whole, a little bit uncomfortable in the postero-lateral aspect around the peroneal tendon behind the fibular on the right.
>
> …
>
> But the MRI scan I think is quite interesting. It confirms that there is a high intensity zone which may be some sort of fluid collection or ganglion-like lesion in the postero-lateral aspect of her right ankle.

[21] It is noted that this is the area of the peroneus brevis tendon.

[22] A bone scan ordered by Mr Rao "confirmed marked increased uptake in both heels and certainly very suggestive of plantar fasciitis".

[23] Mr Rao also discussed orthotics and a cortisone injection.

[24] The appellant continued to experience substantial foot pain and her GP prescribed medication for the pain.

[25] Moving forward to 2022, the appellant was examined by orthopaedic surgeon, Mr Blackett, who in a report dated 17 June 2022 said:

> The reported mechanism is one that could reasonably have caused a traumatic injury to the right ankle, in particular, the peroneal tendons and on the basis of the more contemporary clinical assessments of both Mr Dray and Mr Rao, it is more likely than not that a right peroneal tendon injury occurred in 2007.

[26] ACC took advice from its clinical advisor, who has qualifications in physiotherapy. In her review dated 30 August 2022, she said:

> … Mr Blackett's opinion that the RIGHT peroneal pathology is likely traumatic is based on Mr Dray and Mr Rao's advice. However, Mr Rao has not provided any opinion regarding causation of the right ankle pathology, and neither Mr Dray nor Mr Blackett have provided any evidence for why the right peroneal pathology would be considered traumatic given it exists in both ankles – and the left pathology has been clearly determined to be accident related.

[27] On 15 September 2022, ACC wrote to the appellant saying that it was unable to accept her claim for cover in respect of peroneal tendon on the lower right leg.

[28] ACC's clinical advisory panel, comprising five orthopaedic surgeons, a general surgeon, sports medicine specialist and occupational and environmental medical specialist, reported on 24 November 2022.

[29] Amongst other things, it said:

> The clinical picture was most consistent with intermittent, progressive, painful flareups of Ms Quinney's chronic plantar fasciitis, first in her right foot from 2007 and then in both feet from 2011. Those records started five months after Ms Quinney's 9/06/2007 accident. Although there is a suggestion that her plantar fasciitis symptoms may have been triggered with that accident and there is no evidence to support the impression that the plantar fasciitis was caused by the accident. It is most likely that Ms Quinney had plantar fasciitis for some years, and that it became symptomatic at a point in time, but that was not accident related as discussed above.

[30] Earlier, the panel had said:

> The only mention of peroneal tendons was Ms Quinney's 09/12/2011 ultrasound scan which reported a trace of fluid in the peroneus brevis tendon. This was non-specific, incidental finding and certainly could not be considered an acute finding four years after the 19/06/2007 accident. There were no concerns noted about the peroneal tendon on the 19/12/2011 right ankle MRI scan, which confirmed Ms Quinney's plantar fasciitis.

[31] The panel also said:

> Minor peroneal tendinosis, like Ms Quinney's, is often not seen on imaging. Because we don't scan the entire population, the true prevalence of peroneal tendinosis remains unknown.
>
> …
>
> Peroneal tendinosis progresses over time, and it is often not seen by the surgeon's naked eye … the changes are often at microscopic level. Peroneal tendinosis can remain a-symptomatic for many years, or it can become painful for no apparent reason without any trauma or accidents.

[32] In response, Mr Blackett reported again on 13 September 2022, saying:

> … in terms of the mechanism of injury, I have purely transcribed Bronwyn's description of this to me when I met her in person. I would agree that it is a more in depth description that any previous medical reports and can only take Bronwyn at her word. This is the described mechanism and I believe the mechanism she describes at least, could be one that could cause an acute peroneal tendon injury.
>
> …
>
> I would agree the contemporary notes do not specifically mention the peroneal tendons, until Mr Dray's assessment in November 2011, noting that at that stage he still felt plantar fasciitis was the cause, but that Ms Quinney specifically had pain in the sinus tarsi and lateral ankle on clinical stressing of the peroneal tendons. This of course was followed by the ultrasound suggesting a small amount of trace were present and the subsequent investigations as noted both in my report and the advisory panel's report.
>
> Additionally, it is worth noting that MRI is not wholly accurate in terms of excluding peroneal tendon injury. A longitudinal spilt of the peroneal tendon tear can be difficult to diagnose radiologically on MRI.

Counsels' submissions

[28] Both counsel highlighted portions of the evidence already referred in the background portion of this judgment. Ms Bull submits that Mr Dray, Mr Rao and Mr Blackett had the advantage over the clinical advisory panel of being able to examine the appellant and in Mr Dray's case, he had long history of treating her.

[29] She takes issue with clinical advisor Ms Hughes' criticism of Mr Blackett as basing his opinion on that of Mr Dray and to a lesser extend Mr Rao.

[30] Ms Bull draws attention to the fact that Mr Blackett bases his conclusions on his 'in person' history and assessment of the appellant on 7 June 2022.

[31] She is critical of the CAP report in that it does not explain why the mechanism of accident would not cause the acute damage to the peroneal tendon. She accordingly submits that the CAP report should not have more weight than that of Mr Blackett who saw the appellant.

[32] She submits there is a clear and strong temporal connection with the sudden onset of symptoms that were not present before her accident, and that therefore on the balance of probabilities therefore, her peroneal tear was caused by the 2007 accident.

[33] Mr Lynskey emphasises that ACC takes no issue with the fact that the appellant suffered an accident in 2007. He says however that this case is about the causal link to the peroneal issue in her right ankle.

[34] He submits that ACC has a problem in reconciling Mr Blackett's evidence with the clinical evidence.

[35] ACC's position is that causation is not demonstrated, therefore, there can be no cover.

[36] He submits that in the initial GP's consultation notes of 19 June 2007, there is no mention of an ankle injury. The diagnosis was that of plantar fasciitis.

[37] He says that it is not until 2011 that the first mention is made of right lateral hind foot pain.

[38] He submits there are therefore large gaps in the clinical record and that by 2010, the appellant was unable to recall exactly how the injury was caused.

[39] As at 2011, Mr Dray concluded that the appellant's pain and tendinosis at the origin of the plantar fascia is consistent with plantar fasciitis.

[40] He notes that MRI of the right ankle of 19 December 2011 revealed "some crepitus on peroneal testing with trace of fluid on ultrasound".

[41] However, the conclusion was that "plantar fasciitis" is present and would explain her symptoms.

[42] He notes that in his report of 22 December 2011, Mr Dray says that "reviewing the MRI itself, there is a very small area of high signal which looks as if it is in the substance of peroneal brevis tendon behind the malleolus which might be consistent with a small longitudinal tear.

[43] He also refers to the ultrasound of 23 December 2011 which says "the peroneal brevis tendon is of slightly decreased signal compared with the peroneus longus tendon suggesting tendinosis but no tear identified."

[44] He submits that "suggesting tendinosis" does not amount to proof an injury.

[45] He notes that Mr Dray refers the appellant to Mr Rao for a second opinion and ultimately Mr Rao suggests a bone scan. He notes that in 2012, Mr Dray and Mr Rao were not treating her injury as a tendon tear but rather as plantar fasciitis. The question of the right foot tendon tear at this stage remains unresolved.

[46] He notes that the appellant then had problems with her left side which predominated her medical care for a number of years.

[47] He notes that in a report of 22 July 2013, David Gardner consulted Rheumatologist concludes from looking back at the appellant old letters and imaging, that the appellant's problem was mechanical rather than inflammatory.

[48] He refers to the report of Dr Hewitt, Musculoskeletal Surgeon, of 7 February 2013 who said "it is quite difficult to be sure what is going on especially in that this is a bilateral thing…"

[49] He acknowledges that Mr Blackett was Orthopaedic Surgeon in his report of 17 June 2022 says that the reported mechanism of the appellant's accident could reasonably have caused traumatic injury to the right ankle, in particular the peroneal tendons "and on the basis of particularly the more contemporary clinical assessments of both Dr Dray and Dr Rao, it is more likely than not, that a peroneal tendon injury occurred in 2007. Mr Lynskey submits however that Mr Blackett is in effect recalling what he believes occurred 14 years earlier and so there is a question of the reliability of his opinion.

[50] He says that ACC's position is that the problem was over two days after the accident. There was bruising but not to the ankle. He also says that the difficulty ACC has is with the reliability of the evidence put forward on the appellant's behalf.

[51] He refers to the clinical advisory's panel conclusion at page 11 of its report namely:

> The clinical picture was most consistent with intermittent, progressive, painful flareups of Ms Quinney's plantar fasciitis, first in her right foot from 2007 and then in both feet by 2011. The first record started five months after Ms Quinney's 7/6/2007 accident. Although there is suggestion that her plantar fasciitis symptoms may have been triggered by that accident, and there is no evidence to support the impression that plantar fasciitis was caused by the accident. It is most likely that Ms Quinney had plantar fasciitis for some years and that became symptomatic at a point in time, but that was not accident related as discussed above.

[52] Mr Lynskey finally refers to Mr Blackett's letter of 13 December 2022 where he agrees that contemporary notes do not specifically mention the peroneal tendons until Mr Dray's assessment in November 2011.

[53] The respondent's position therefore remains that there is insufficient show that Ms Quinney's accident of 19 June 2007 caused a right peroneal tendon injury.

Judgment

[52] The issue in this appeal is whether or not ACC was correct in its decision of 15 September 2022 declining to extend the cover to include a peroneal tear of the appellant's right ankle. The appellant saw her GP on 21 June 2007 following an accident two days earlier where she reported that she slipped going up an icy deck and hurt her right lower back and right lower leg was bruised.

[53] Her GP Dr Stride noted at the consultation that she was "tender across the R lower lumbar/sacral ligs with full good ROM in all planes". Some bruising R ant lower leg.

[54] It seems that the appellant who presents from the file as a person who "got on with the job", did just that, after her accident. It seems plain however that her fall was a significant one and the skeletal details recorded at her first appointment do not present anything like an adequate picture of what in fact had happened to her.

[55] The evidence is that she was a very active person who was aged 30 at the time and working full time in early childhood teaching.

[56] It is significant that although the initial extremely brief clinical note referred to her lumbosacral region and right lower leg, (and not her ankles or feet), she was eventually diagnosed with plantar fasciitis.

[57] I do not read anything of significance into the failure of her GP to refer to her ankles and feet. Plainly, the doctor's first concern was for her back and legs.

[54] The available records show that this diagnosis was made on 18 January 2008.

[55] It is fair to say that the initial investigations were incomplete and the medical notes as, appellant's counsel points out, incorrectly recorded that just the right foot was injured. It seems that this occurred because from the appellant's perspective, it was more painful.

[56] On 17 January 2008, consulted radiologist Dr Ship diagnosed plantar fasciitis in respect of her right foot.

[57] Over the next three years, the appellant struggled with her day-to-day activities and had to reduce her hours as an early childhood educator due to the chronic pain.

[58] On 12 September 2011, Ms Quinney's GP reported that subjectively the pain was "now sore upper right achilles and around the edges of the calcaneum".

[59] On 24 November 2011, she attended a specialist review with Mr Dray who noted:

a right heel pain, to a lesser extent right lateral hind foot pain;

b Ms Quinney could not record the exact mechanism of injury but the notes recorded a slip on an icy floor;

c her main problem was probably plantar fasciitis, plus some postero-lateral hind foot pain.

[60] It is the latter pain source that is the focus of this case.

[61] An ultrasound scan was taken on 9 December 2011 and amongst the findings was this:

> Laterally, the peroneal tendons appear normal although there is a trace of fluid in peroneus brevis tendon sheath at the lateral malleolus.

[62] The radiologist Dr Ship concluded his report:

> Comment: no abnormality demonstrated in this examination apart from a trace of fluid in the peroneus brevis tendon sheath. MRI may be informative.

[63] An MRI scan on 19 December 2011 concluded that plantar fasciitis was present "and would explain for symptoms".

[64] The MRI of 19 December 2011 was reviewed by Dr Downer, Radiologist, on 23 December 2011. His findings included:

> The peroneus brevis tendon is of slightly decreased signal compared with the peroneus longus tendon suggesting tendinosis but no tear identified. This is confirmed by the appearance on ultrasound.

[65] The appellant continued to have consistent pain in the postero-lateral aspect of her right heel and ankle. In his report of 5 July 2012, Mr Rao said:

> I have reviewed the plain X-rays which are essentially unremarkable but the MRI scan I think is quite interesting. This confirms that there is a high intensity zone which may be some sort of fluid collection of ganglion type lesion in the postero-lateral aspect of her right ankle. Dr Rao arranged for a bone scan.

[66] It is plain that the appellant's condition did not improve and she was unable to work.

[67] I next refer to the report Mr Blackett dated 17 June 2023. He notes:

> Mrs Quinney's current significant disability secondary to bilateral ankle pain is difficult to fully attribute to her diagnosed tendon injuries on the basis of the chronicity and generalised nature. However, Mrs Quinney did sustain a traumatic injury to the right leg in June 2007. The reported mechanism is one that could reasonably have caused a traumatic injury to the right ankle, in particular, the peroneal tendons and on the basis of particularly the more contemporary clinical assessments of both Mr Dray and Mr Rao, it is more likely than not, that a right peroneal tendon injury occurred in 2007.

[68] When it reviewed the matter, the clinical advisory panel said:

> The clinical picture was most consistent with intermittent, progressive, painful flareups of Mrs Quinney's chronic plantar fasciitis, first in her foot from 2007 and then in both feet by 2011. The first records started five months after Mrs Quinney's 9/06/2007 accident. Although there is a suggestion that her plantar fasciitis symptoms may have been triggered by that accident, and there is no evidence to support the

impression that the plantar fasciitis was caused by the accident. It is most likely that Mrs Quinney had plantar fasciitis for some years, and that it became symptomatic at a point in time, but that it was not accident related as discussed above.

[69] In his final report of 13 December 2022, Mr Blackett, reviewing the case, says:

> I would agree that the contemporaneous notes do not specifically mention the peroneal tendons, until Mr Dray's assessment in November 2011, noting that at that stage he still felt plantar fasciitis was the issue, but that Ms Quinney specifically had pain in the sinus tarsi and lateral ankle on clinical stressing of the peroneal tendons. This of course was followed by the ultrasound suggesting a small amount of trace fluid present and the subsequent investigations as noted both in my report and the advisory panel's report.
>
> Additionally, it is worth noting that MRI is not wholly accurate in terms of excluding peroneal tendon injury. A longitudinal split of the peroneal tendon tear can be difficult to diagnose radiologically on MRI.

[70] In that regard, Mr Blackett refers to an article in the Indian journal of musculoskeletal radiology 2022.

[71] It is fair to say that following her fall on an icy deck in 2007, the appellant has been beset by injury and pain problems. This has resulted in her having to give up her employment in early childhood education.

[72] It is a notorious fact in the diagnostic process that obvious diagnoses occur quickly and more difficult or elusive diagnoses take time.

[73] Given the diagnosis the appellant has of plantar fasciitis, it is not surprising that her request for answers in respect of her ongoing pain in her postero-lateral right ankle have been slow in the coming. The postero-lateral pain in her right ankle broadly speaking includes the area where her peroneus brevis tendon is located.

[74] The ultrasound carried out on 9 December 2011 revealed a trace of fluid in the

peroneus brevis tendon sheath at the lateral malleolus. I conclude on the balance of probabilities that that finding supports a conclusion that she received an injury to her right peroneus brevis tendon.

[75] It is understandable in the circumstances that as plantar fasciitis had also been diagnosed, that the issue of a peroneal injury was somewhat overshadowed by the plantar fasciitis diagnosis. The two injuries were in colloquial terms adjacent to each other.

[76] Accordingly, taking account of the whole of the lay and medical evidence as the case of *Ambros*,[1] requires me to do, and applying the generous and unniggardly approach referred to in *Harrild*,[2] I find that ACC's decision of 15 September 2022 declining to extend the cover to include a peroneal tear of the right ankle was wrong.

[77] Accordingly, that decision is reversed and the appeal is allowed.

[78] Costs are reserved.

CJ McGuire
District Court Judge

Solicitors: Thomas Dewar Sziranyi Letts, Lower Hutt, for the appellant.
Izard Weston Lawyers, Wellington for the respondent.

[1] *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.
[2] *Harrild v Director of Proceedings* [2003] 3 NZLR 289 (CA) at [19].