IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 138 ACR 159/20

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

Hearing: 28 June 2022
Heard at: Auckland/Tāmaki Makaurau

Appearances: Appellant in person
Ms F Becroft for the Respondent

Judgment: 19 July 2022

RESERVED JUDGMENT OF JUDGE C J McGUIRE
[Section 20(2)(d) – treatment injury – Accident Compensation Act 2001]

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[1] At issue is a decision by the Accident Compensation Corporation dated 25 July 2019 declining cover for a consequential treatment injury.

[2] The appellant underwent a right inguinal hernia repair on 18 May 2017.

[3] On 21 February 2019, an ACC injury claim form was filed for a misadventure said to have occurred during the right inguinal hernia repair on 18 May 2017.

Background

[4] The appellant consulted Dr Miller on 8 March 2017 and described how he felt a sharp strain and pain in his right groin after lifting heavy plywood. He later noted a bulge in his right groin. It was also noted that he had a past left inguinal hernia sustained with heavy lifting in 2009 which was repaired in 2010.

[5] Dr Miller diagnosed a traumatic right inguinal hernia.

[6] On 10 April 2017, ACC approved the appellant's claim for laparoscopic surgery to repair the hernia.

[7] The operation was performed by Michael Booth. Mr Booth's report on the procedure was as follows:

> The right rectus sheath was incised, the muscle retracted laterally and the preperitoneal space developed with a balloon dissector. Camera port inserted. Insufflation. Camera introduced. 2 x suprapubic five MM ports placed. The hernial sac was dissected free from the cord structures, 2 lipomas were reduced and the peritoneum was swept inferiorly, medially and laterally. The gonadal vessels were identified and preserved. A 15 x 10 cm pro grip mesh was then inserted down the camera port site, unfurled and pushed into position. The inferior edges were held down, the pneumopreperitoneum released, final inspection and instruments removed. The rectus sheath was closed with 0 PDS 2.0 nylon to skin. Tegaderm dressings applied.
>
> Post op:
>
> (1) To go home tomorrow all being well
>
> (2) No heavy lifting or straining for six weeks
>
> (3) I will review in my rooms in approximately 7 – 10 days time

[8] The next medical record is a consultation with Dr Miller on 6 July 2017. On that date, Dr Miller provided an ACC 18 medical certificate from 4 – 31 July 2017. The doctor added these notes:

> Ex: abdo: inguinal hernia repaired, no signs recurrence. Mild tender around umbilical surgical site, no erythema or infection evident.

[9] In a further report from Dr Miller dated 2 August 2017, there is this:

> May 2017: laparoscopic right inguinal hernia repair, with the main access port being adjacent to the umbilicus.

Had significant haematoma in this area post op which has settled.

Been seeing physio – helpful.

Has now returned to full work building.

Reached up high lifting a couple of days ago and felt a bit of a sharp painful pull in the umbilical area – keen to get checked that all is still ok.

Ex: small amount residual swelling R abdominus rectus in the wound area (reduced ++ CF previous), minimal tenda, no erythema. No umbilical hernia evidence.

Sit up action ok.

Ok when reaching up now.

No recurrence of inguinal hernia.

A – minor strain abdo wall surgical site. Post op haematoma settling.

P/advised continue with work, advised r/b if giving ongoing probs or deterioration.

[10] The appellant consulted Dr Miller again on 16 October 2017. Dr Miller's report includes the following:

Subjective

ACC

Ongoing niggling pains at high R inguinal hernia repair site and midabdominal area post inguinal hernia repair – done about five months ago.

Motions ok.

To Michael Booth,

Thank you for seeing Miles Williams regarding the following. Ongoing niggling pains in R groin and midabdominal area post R inguinal hernia repair done about five months ago.

On exam, no recurrence of hernia, and ? minimal increased residual swelling R abdominal muscles – where had post op haematoma.

Does heavy building work and his training for 3,000km Cape Reinga to Bluff cycle tour in February – is keen to get review especially in light of this.

P/referral to Mr Michael Booth for opinion.

[11] There was a consultation with surgeon Michael Booth following the operation on 23 May 2017, eight days after the operation. The following is noted:

I saw Miles today. He has made a slightly slow recovery but is now looking great. On examination, his wounds are well healed.

…

I have advised Miles to avoid heavy lifting for six weeks following his surgery. He can gradually return to gentle cycling approximately two weeks from surgery.

I have not made further arrangements to see him again, but if he has any problems at all, he knows to contact me.

On 10 December 2018, the appellant undertook a radiology ultrasound scan. The report reads as follows:

Indication: laparoscopic right hernia repair 15/05/2017. Ongoing increase in pain around appear site? Recurrence? Mesh

Findings:

There is no evidence of hernia recurrence in the right groin. The surface of the mesh appears unremarkable with no haematoma, no surrounding fluid collection or vascularity.

The inguinal region muscles appear unremarkable.

Comment:

No cause for symptoms detected.

[12] The appellant was referred by Dr Booth for an MRI scan on 21 January 2019. The report of Radiologist, Dr Morganti, reads as follows:

Indication: right groin pain 8 months. Laparoscopic hernia repair 2017.

Technique: coronal and axial t1 and t2 fat–sat sequences have been obtained through the whole pelvis. Coronal sagittal and oblique axial PD fat – sat, axial t1 and t2 fat–sat sequences were obtained through the right hip.

Findings: there is no evidence of a right hip groin effusion. There was focal cartilage loss with subchondral marrow reaction involving the superolateral acetabulum from the 2 o'clock position anteriorly to at least the 12 o'clock position superiorly. This is associated with complex labral tearing/degeneration involving most of the labarum. The cartilage seen is reasonable over the femoral head.

No significant abnormality is identified at the femoral head neck junction.

There was mild diffuse t2 hyperintensity involving gluteus medius and minimus tendons in keeping with insertional tendinosis/enthesopathy. No bursal fluid collection is identified. These changes are bilateral but slightly more marked on the right. There is a small focus of linear t2 hyperintensity associated with the semimembranosus tendon origin suggesting a minor interstitial tear. There is

nothing to suggest complete rupture and no bony reaction. No abnormality is identified at the left hamstring origin.

Mesh associated with the all the previous hernia repair seems to present on the left but not the right however, there is some scar tissue in the right inguinal region. There is no evidence of a residual or recurrent hernia on either site.

There does appear to be some early cartilage loss and labral tearing/degeneration on the left also.

Comment: established cartilage loss involving the right acetabulum. Interstitial tear involving the right hamstring tendons. Extensive labral tearing and degeneration which is in keeping with age. No abnormality/complication identified associated with the previous hernia repair.

[13] On 11 February 2019, his GP, Dr Hodges recorded:

Has had both inguinal hernias repaired.

Was builder.

More recently R side – R side was sore post op

Increasing pain

Is cyclist

Feels like cardboard digging in

Cannot keep working as builder

Seeing surgeon – has had scan – cannot see mesh

Had to stop work – has been advised to get ACC

Has had MRI – mesh not seen

Examination: in discomfort, cannot work

Impression: ACC going to get second opinion

Plan: ACC M45 completed

[14] The appellant saw Mr Booth again on 8 February 2019. Mr Booth reported:

Problem: right groin pain

I saw Miles today. He has had MRI of his pelvis. This confirms established cartilage loss involving the right acetabulum. There is also an interstitial tear involving the right hamstring tendons. There is extensive labral tearing and degeneration in keeping with his age. Pleasingly, there has been no abnormality or complication identified associated with the previous hernia repair. Interestingly, I am unable to see mesh on the right side but we certainly put a pro-grip on that side.

> Miles is adamant that the hernia repair has caused his right groin pain. He is saying that he had substantial swelling at the area after the surgery and he took a long time to recover. Certainly looking at my notes, I saw him one week post operatively in which the comment was made that he was making a somewhat slow recovery but there was no mention of significant swelling. I did not see him again until January 2018 and indeed since his surgery, he was able to do long and active cycling events including the tour of Aotearoa. Unfortunately although he is able to cycle, his groin pain appears to interfere with his work. This is aggravated particularly when he is crouching which has affected his ability to work he says. When he points to the pain, it is actually low down in his groin.
>
> Management:
>
> While I cannot say that his pain is not due to his hernia repair, my gut feeling is that he has significant degenerative disease affecting his right hip which is probably the cause of his pain.
>
> I have asked him to see Matt Brick for an opinion.

[15] Dr Brick reported on 25 March 2019. In his report, Dr Brick said:

> …
>
> Miles underwent a mesh hernia repair in May 2017. Miles reports that he woke up with a new and unusual groin pain which has been a problem for his ever since. Miles describes the pain as feeling like a folded piece of cardboard which gives him pain as he hyperflexes. Heavy work is the main aggravating feature. Miles can lie on his right hip it does not disturb his sleep.
>
> …
>
> Impression: although Miles has clear evidence of low-grade CAM hip impingement, I do not think this is the cause of his current pain. In particular, the corderent test is extremely sensitive and will virtually always reproduce any intra articular hip pain.
>
> Plan: I have suggested to Miles that I do not think this current pain is coming from his hip groin. He agrees with this himself. I have suggested Miles get back to you with regard to a further investigation or management of his right inguinal pain.

[16] On 29 March 2019, Dr Hodges wrote to the Corporation and suggested that a personal injury had occurred at this as a result of surgery.

[17] The claim was reviewed internally and declined on 10 April 2019 on the basis that there was no evidence that an injury had been suffered during the inguinal hernia repair.

[18] On 23 April 2019, a further treatment injury claim form was filed listing the injury as neuralgic pain post right inguinal hernia repair. It appears that the Corporation treated the treatment injury claim form as a further claim, and notwithstanding its recent decline, investigated further.

[19] Mr Booth provided advice directly to the Corporation on 11 July 2019. Mr Booth said:

> …
>
> Whilst investigating other course for his groin pain, he had an email which demonstrate some cartilage loss in the hip groin and an interstitial tear of labrum with degeneration.
>
> He subsequently was reviewed by Mat Brick, Orthopaedic Surgeon, who felt that these changes were not consistent with the pain that Miles was experiencing. Certainly, the description that Miles gets is one of discomfort, particularly whilst squatting. He also points to the region of the external ring and around the cord, deep to this. There is certainly no evidence of hernia recurrence.

[20] In answer to the question: "What is the likelihood this patient could suffer this type of injury because of the treatment provided?", Mr Booth says:

> Chronic groin pain is a well recognised complication of inguinal hernia surgery.
>
> …
>
> He had previously had an uneventful left inguinal hernia repair so it was reasonable to assume that he would not have any issues with this repair.

[21] Mr Booth acknowledged that the incidents of chronic pain was of the order of 1 – 2%.

[22] On 25 July 2019, the Corporation issued a revised decision again declining the claim.

[23] Following an application for review, Mr Booth provided further advice on 22 November 2019. He confirmed that the mesh had not moved. He noted that the scar tissue present was a normal post-operative consequence of a surgery and could not say whether it was the cause of the appellant's symptoms, although identified it as a possibility. He confirmed that he could not identify a specific nerve injury,

although indicated that it was possible that the genitofemoral nerve had been affected.

[24] The respondent sought further advice from Dr Menzies, Surgeon, its clinical advisor. He reported on 7 February 2020 and could find no evidence of a physical injury resulting from the surgery. He noted the contemporaneous record which showed a delay in onset of symptoms of approximately five months.

[25] Following an unsuccessful review, the appellant appealed to this Court.

[26] ACC sought further advice from its internal medical advisor, Dr Phipps. In her report dated 20 October 2020, she agreed with Mr Menzies that there is no clinical evidence of any injury to the inguinal nerves in this case. She thought it was more likely than not that the appellant's symptoms were related to a degenerative right hip with associated CAM deformity.

[27] In a further report of 1 March 2021, Mr Menzies confirmed that he was unable to identify an injury caused by the 2017 surgery that had gone on to cause the pain the appellant was experiencing.

[28] Mr Pai, Orthopaedic Surgeon, undertook a paper file review on 8 April 2021. Mr Pai was of the view that the cause of the appellant's groin pain was multifactorial. He noted that groin pain following hernia repair was common but did not think that the appellant's pain could be explained on the basis of a structural injury. He concluded:

> In my opinion, on the balance of probability with the available documents and MRI, his symptoms are more than likely related to his hip pathology, and if a hip pathology was ruled out by either an intra articular corticosteroid injection or SPECT scan then possibility of non-specific pain or pain sensitisation should be considered.

[29] The appellant filed a brief report from Mr Schroeder, Surgeon, dated 16 February 2022. He said:

> Miles underwent a laparoscopic hernia repair with pro-grip mesh. This is about the safest mesh that we can use and has a very low incidents of associated chronic pain because no tacks are used. However, Miles has had such pain and

it has responded very well to two injections of steroid and local anaesthetic at the site of the mesh implantation. There has obviously been entrapment of one of the local nerves at the time of his operation because of the scar tissue. This would occasion surprise as there is a very low incidents of this. He therefore should be covered for the ensuing limitation of function by ACC. The mechanism of injury is scarring in response to the mesh, entrapping the nerve. The scarring is expected and necessary but the nerve entrapment is not.

Appellant's submissions

[30] In written submissions, the appellant said:

> In 2010, Michael Booth operated a repair my left side hernia. I recovered quickly after the operation and returned to work a few weeks later with no issues whatsoever. Based on this outcome, I expected a similar result from the hernia repair operation, to the right side which again Michael performed in 15.5.17.
>
> Shortly after waking from the operation, I felt very different from the previous operation. The operation area was painful and very swollen. My wife Jill who had been a nurse for 40 years was concerned and asked Michael "If the operation had gone to plan?" He assured us that "It went well."
>
> As the days and weeks past, I just felt something wasn't right and on one of my follow up visits to Michael, I asked "If he had gone in up to his elbows?" or "If a trainee had performed the operation?" as it was so sore and there was a lot of swelling. Again he assured all had gone well but to be honest I was not convinced.
>
> I was surprised that at no stage did he physically examined me after the operation and his nurse removed the stiches.
>
> I am not a complainer and assumed the general pain and pinching feeling would pass in due course.
>
> After several months, I returned to building work but any straining or crouching caused an electric type pain which very much limited what I have previously had no issues with. This new pain was far worse than the original hernia pain and I was living on Panadols.
>
> I frequently phoned Michael Booth's room to speak with him and was referred to his nurse who said "Sometimes healing can take longer and to give it time." By now, I was all out of time and patience and sick of being "fobbed off". I stated my case that I was not at all happy with the outcome and the now almost constant pain while building.
>
> After insisting to speak with Michael, he said "Most probably the pain was from a worn hip joint." I told him "I never had a day of having a painful hip and why should my hip suddenly become painful?"
>
> I was sent off for an MRI which revealed wear and tear expected for someone of my age. I am a keen cyclist and jolly active but have never limped or noticed any hip pain at any time. Again, I felt the core issue and cause of the groin pain as a result of the hernia operation, was being avoided. Quite simply, the groin

> pain was not there prior to the operation but now it was ever present. Alternative and unrelated explanations were being offered. I just wanted the pain to go as it was becoming impossible to continue with my construction work.
>
> At my wit's end, I saw Mat Brick, whose report is filed. He studied the MRI and moved my right leg and hip through several extended removers. He is a top orthopaedic surgeon. He disagreed with Michael and as outlined, did not believe the groin pain came from hip.
>
> By now, unable to build any more due to the constant pain, I had become seriously mistrustful of Michael Booth. He "fobbed me off" and offered alternative and incorrect explanations for the groin pain. At a loss to understand his stance, I saw David Schroeder, who was a surgeon specialising in hernia repairs. I have included his latest report. Yet again another expert disagreed with Michael Booth. He is very clear "The pain is caused by nerve entrapment."
>
> …
>
> I am a builder. I absolutely loved my job doing high end renovations, but it just became impossible and by days end I was shattered with the pain. Prior to the hernia repair, although uncomfortable, at least I was able to continue building.
>
> …

[31] Mr Williams also notes that none of the ACC experts who have offered opinions as to his condition have seen or examined him

Respondent's submissions

[32] Ms Becroft acknowledges that the pain that the appellant experienced after surgery is not disputed. However, in order for cover to be granted there needs to be a physical injury caused by the surgery.

[33] The claim falls for consideration under s 20(2)(d) of the Accident Compensation Act 2001. The enquiry is whether there was a personal injury that is a consequence of treatment given to the person for another personal injury for which the person has cover.

[34] Ms Becroft refers to the decision of Justice Ellis in *Studman*[1] where the enquiry once again was whether there had been a physical injury. Her honour said:

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1 *Accident Compensation Corporation v Studman* [2013] NZHC 2598, [2013] NZAR 1347.

> [26] I agree with Mr Tuiqereqere that this requirement for "bodily harm" means that neither "pain" nor "stiffness" by and of itself constitutes a physical injury. Although both pain and stiffness may well be symptomatic of an underlying (and potentially qualifying) physical injury, that is not necessarily so. Most obviously, I suppose, pain could just as easily be caused by disease, for which (in general terms) coverage is not extended. It is for that reason that it is, in my view, necessary separately to identify the underlying physical injury with some precision.
>
> [27] The need for precise identification is, in my view, underscored by the terms of s 32. Without such identification it would not be possible, for example, to determine whether the injury concerned is "a necessary part, or ordinary consequence" of the treatment. That determination is fundamental to whether or not coverage for treatment injury exists.

[35] Ms Becroft submits that in this case there is a lack of that evidence.

[36] Ms Becroft notes that post surgery there was no indication of "untoward pain".

[37] Ms Becroft refers to the notes from the GP after the operation there was "no indication of anything sinister".

[38] When eventually the MRI was undertaken, it revealed degenerative pathology around the hip. She refers to Dr Brick's report of 25 March 2019 and although Dr Brick does not think hip impingement is a cause of his current pain, he "struggles" to identify any injuries suffered as a result of medical treatment.

[39] She refers to Dr Booth's report on 11 July 2019 and says that the doctor is struggling to see any injury suffered as a result of the treatment.

[40] She refers to Dr Booth's further report of 22 November 2019 where the involvement of the surgical mesh is effectively discounted.

[41] She does acknowledge Dr Booth's statement regarding possible nerve injury:

> I cannot identify a specific nerve. It is possible that the genital branch of the genitofemoral nerve has been affected but I am not at all convinced.

[42] She refers to the report of clinical advisor Mr Menzies of 7 February 2020 where he says that there is no objective evidence tying the appellant's complaint back to the hernia repair.

[43] She refers to the paper review carried out by Surgeon Mr Pai dated 8 April 2021 and his conclusion that his clinical symptoms are more than likely related to hip pathology and that if this possibility is ruled out then the possibility of non-specific pain or pain sensitisation should be considered.

[44] On the issue of possible nerve injury, Mr Pai said this:

> Nerve injury is one of the complications of hernia repair. However, on independent assessment by Mr Menzies, there was no damage to the ilioinguinal, hypogastric or genital branch of the genitofemoral nerve on clinical basis and clinical course.

[45] Ms Becroft submits that Mr Schroeder's report of 16 February 2022 does not fit the post-operative report of pain nor the nature of the surgery. And she describes Mr Schroeder's report as "light" and not as considered as those of the other experts. Ultimately, she submits that in this case there is an absence of objective evidence of injury but that there is a very clear evidence of the degenerative hip pathology.

Appellant's reply

[46] Mr Williams said that straight after the operation there was an issue with a "huge haematoma". He said "I don't complain" and that he thought it would get better, so he quietly pushed it along. He stated categorically "I don't have a sore hip" and "I never had an ounce of pain before the operation". He reiterated that several months after the operation, the pain got worse and worse. He reiterated that the pain is down "in the groin area".

Decision

[47] On 2 March 2017, the appellant underwent a laparoscopic right inguinal hernia repair operation which was performed by Michael Booth.

[48] In 2010, the same surgeon had operated and repaired a left side hernia for the appellant. According to the appellant, in 2010, he quickly recovered after the operation and returned to his work as a builder a few weeks later with no issues.

[49] The appellant says that after the 2017 operation, the operation area was painful and very swollen. However, according to the appellant he assumed the general pain and tight pinching feeling would pass in due cause. After several months he returned to his building work but he says that any straining or crouching caused in an electric type of pain and that he was "living on Panadol".

[50] The record shows that the surgical procedure to remedy his right hernia was unremarkable. The surgeon Mr Booth noted on examination eight days after the operation:

> I saw Miles today. He has made a slightly slow recovery but is now looking great. On examination, his wounds are well healed.
>
> The appellant's GP arranged for ACC cover to be extended until his anticipated full return to work on 31 July "due to taking a while to recover from his hernia op".

[51] In a consultation on 6 July 2017, the appellant's GP noted "mild tender around umbilical surgical site, no erythema or infection evident".

[52] On 2 August 2017, Dr Miller noted:

> Has now returned to full work building. Reached up high lifting a couple of days ago and felt a bit of a sharp painful pull in the umbilical area – keen to get checked that all is still ok.
>
> The doctor found no recurrence of inguinal hernia and the appellant was advised to seek further review if ongoing problems or deterioration.

[53] In a consultation on 16 October 2017, Dr Miller recorded:

> Ongoing niggling pains at high R inguinal hernia repair site and midabdominal area post inguinal hernia repair.

[54] Dr Miller's note was that the appellant was to be referred again to Mr Booth for opinion.

[55] However, the next report on the Court file relates to ultrasound being undertaken on 10 December 2018 which noted:

> Ongoing increasing pain around tear site? Recurrence?

[56] The report also said:

> No cause for symptoms detected.

[57] The appellant saw Mr Booth again on 15 January 2019. Mr Booth noted:

> In May of last year, he started to develop right groin pain, struggling to crouch which has affected his ability to work as a builder. Despite this however, he has been able to maintain his active cycling and indeed completed the tour of Aotearoa, a cycle ride the length of a country at the beginning of 2018, since then he has continued his biking. He actually finds the biking helps, as well as any back pain. The pain that he points to is actually low down in his groin, further away from the hernia repair. He has had a recent ultrasound scan that does not show any evidence of recurrence.
>
> …
>
> I am uncertain as to the cause of his symptoms, they could certainly be related to hernia repair, … I have requested an MRI of his right inguinal canal and groin …

[58] The MRI was undertaken on 21 January 2019. It found amongst other things that there was no evidence of right hip joint effusion and that the cartilage seemed reasonable over the femoral head.

[59] The MRI established extensive labral tearing and degeneration which is in keeping with age, however, it identified no abnormality/complication associated with the previous hernia repair.

[60] In a follow up report of 8 February 2019 Mr Booth said:

> "I cannot say that his pain is not due to his hernia repair, but my gut feeling is that he has significant degenerative disease affecting his right hip which is probably the cause of the pain".

[61] On 25 March 2019, Dr Brick, Orthopaedic Specialist, examined the appellant. He did not think hip impingement was the cause of the appellant's pain. He suggested further investigation of his right inguinal pain.

[62] On 11 July 2019, Mr Booth once again responded to questions from ACC. In this report and noting what Mr Brick had said, it appears that Mr Booth is again tending towards a connection with the hernia surgery. He says:

> He (the appellant) subsequently was reviewed by Mat Brick, Orthopaedic Surgeon, who felt that these changes were not consistent with the pain that Miles was experiencing. Certainly the description that Miles gets is one of discomfort, particularly while squatting. He also points to the region of the external ring and around the cord, deep to this.

[63] Mr Booth also acknowledges "chronic groin pain is a well-recognised complication of inguinal hernia surgery.

[64] In his letter of 22 November 2019, in response to questions from ACC, Mr Booth notes a question asked of him by ACC:

> In the treatment injury claim form (ACC 2152), you completed on 23/04/2019, you listed the injury as "neuralgic pain post R inguinal hernia repair". Are you able to identify a specific nerve injury responsible for Mr Williams' ongoing symptoms?

[65] Mr Booth responds:

> I cannot identify a specific nerve. It is possible that the genital branch of the genitofemoral nerve has been affected but I am not at all honestly convinced.

[66] The respondent has obtained reviews from its clinical advisor Mr Menzies and from orthopaedic surgeon Mr Pai.

[67] As the appellant points out, neither of these medical experts nor Dr Phillips, Medical Advisor, interviewed or examined the appellant. All three conclude that the appellant's presentation is more likely related to his hip pathology.

[68] Then there is the brief report obtained by the appellant from the Mr Schroeder on 16 February 2022. His conclusion is quite categorical. He says:

> However, Miles has had such pain and it has responded very well to two injections of steroid and local anaesthetic at the site of the mesh implantation. There has obviously been entrapment of one of the local nerves at the time of his operation because of the scar tissue. This would occasion surprise as there is a very low incidence of this. … The mechanism of injury is scarring in response to the mesh, entrapping the nerve.

[69] While Ms Becroft may be critical of its brevity, Mr Schroeder's professional status to give that opinion is not questioned. And his conclusion is in keeping with where the appellant says his pain is.

[70] The appellant presents as a person who gets on with life. The operation appeared to go well and the appellant did not initially complain. However, from all the information that is on the appellant's file, it is clear that the pain in his groin did not improve.

[71] On behalf of ACC, the conclusion is that the pain is related to the age-related degeneration in his hip. That conclusion runs counter to the appellant's extremely active bike riding regime. The fact that his degenerative hips do not impede this activity is not explained in the reports that the respondent has obtained.

[72] One can understand Mr Booth's reluctance to draw a conclusion that there has been a nerve impingement as a result of his laparoscopic operation. In fairness to Mr Booth, however, he does not dismiss the possibility that the appellant's presentation has a causal connection with his hernia operation.

[73] In the face of some medical uncertainty, I find that the balance is tipped in the appellant's favour on account of his own history of what has occurred and what he has experienced since the operation. Central to this too is the fact that he describes groin pain and not hip pain.

[74] Accordingly, I find on the balance of probabilities that the appellant has proven that he has suffered personal injury, namely the entrapment of one of the local nerves at the time of the operation because of the scar tissue as Mr Schroeder says. Accordingly, therefore, the appeal is allowed.

[75] Should there be any issue as to costs, the parties have leave to file memoranda in respect thereof.

Judge C J McGuire
District Court Judge

Solicitors: Medico Law Limited, Grey Lynn, Auckland