

**IN THE DISTRICT COURT
AT WELLINGTON**

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

[2021] NZACC 133 ACR 195/18

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

Hearing: 21 July 2021
Heard at: Christchurch/Otautahi

Appearances: Ms K Coulston for the appellant
 Mr C Light for the respondent

Judgment: 17 August 2021

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

[1] The issue for determination is the correctness of ACC's decision dated 27 November 2017 that there was insufficient evidence for ACC to accept cover for an umbilical hernia.

Background

[2] On Saturday 23 September 2017 the appellant was engaged in clearing the remains of pinus radiata logs from trees that had been felled in a powerful storm earlier that month.

[3] When the accident occurred, he was lifting one end of a 2 metre plus length of pinus radiata log with a diameter of 250 to 300 millimetres.

[4] In a statement dated 9 June 2020 he describes what then happened:

The bottom edge of the end of the log I was supporting was resting against my stomach just above my umbilical. While I was walking sideways, I lost my footing when I stumbled on a pine cone or something similar. I then tossed the log about trying not to fall over and/or drop the heavy log onto my feet or shins. As I violently danced around, the bottom edge of the end of the log, with a great deal of force, was thrust about slid back and forth sideways and was driven into my stomach with those muscles being very tight/tense from still supporting the heavy log at the time. ...

When the accident happened and I injured myself, I felt sudden extreme severe pain just above my umbilicus. When asked to describe the level of pain on a scale of 1-10 I described it as being 11. It was horrendous. I had to stop the work I was doing immediately. In the days after the injury I was unable to do anything but lie down and rest. I also suffered from nausea, inflammation at the injury site, and a black and blue bruise developed above my umbilicus. I mistakenly believed the injury would resolve itself, but it didn't and instead the symptoms including the pain got worse.

[5] The appellant contacted his GP on 26 September and was given an appointment for 29 September.

[6] The GP, Dr Wilkinson, recorded the following:

Lifted log last w/e – pain in naval, stopped work and noted lump, inflamed that night – o/e umbilical hernia, reducible, lodge and refer mg.

[7] On the same day, Dr Wilkinson lodged an ACC45 injury claim form.

[8] The appellant saw Mr Malcolm Gordon, General Surgeon on 17 October 2017. In his report Mr Gordon said:

... examination with the aid of ultrasound shows at least a 2.5 cm defect. There is a layer of preperitoneal fat, but the hernia also contains omentum.

He has a minor diversification of the recti laying 3 cm apart.

I have explained to Jerome that upon reduction, the hernia defect may reduce enough for direct suture, but at this size, may require a mesh. ...

His umbilical hernia is clearly the result of his work accident. I have written to ACC requesting cover for repair.

[9] Mr Gordon completed an Assessment Report and Treatment Plan (ARTP) on 19 October 2017.

[10] In it he noted:

Jerome's umbilical hernia is clearly related to the injury he sustained as described above. Therefore I request ACC approval for the surgery.

[11] On 2 November 2017, ACC's medical advisor, Dr Walker, provided comment on the claim. He explained that in his clinical experience of 35 years in primary health that it was not uncommon to see individuals that have umbilical hernias of which they are unaware. The natural history however, was for the umbilical hernia to become symptomatic as time goes by. Dr Walker continued:

The client has also been identified as having a divarication of the recti. A divarication of the recti is an increase in the gap between the two sides of the rectus abdominis muscle. The increased distance is the result of the stretching of the linea alba. This is a disease condition which develops over time due to age related weakening of the connective tissue of the linea alba and other factors which may include cigarette smoking, obesity chronic cough etc.

The same weakness in the connective tissue which allows the formation of a divarication of the recti is responsible for the formation of an umbilical hernia.

The umbilicus is the scar that marks the connection between the foetus and placenta. It lies at a variable point in the midline depending on patient habitus, in the linea alba. The linea alba, a medium fibrous white line or band which divides the anterior abdominal wall into right and left halves. The linea alba is made up of the fibres of the anterior and posterior walls of the rectus sheath which interlaced in the anterior median line to form the complex tendinous raphe which is the linea alba. The linea alba lies between the two parts of the rectus abdominis muscle, the umbilicus is located just inferior to its mid point. The linea alba is narrow inferior to the umbilicus, but is wide superior to it.

[12] Dr Walker explained how a hernia develops:

A hernia is an abnormal protrusion of a viscus, or part of a viscus through a congenital or acquired defect.

In adults most umbilical hernias are in fact para-umbilical, with the defect arising just above or below the cicatrix (another name for the umbilicus which is a mark resembling a scar caused by the previous attachment of an organ, i.e. the placenta). It is more common for hernias to occur just above the umbilicus where the tissue consists of a thin layer of transversalis fascia. Inferiorly, there is slightly more reinforcement in the form of the obliterated umbilical vessels.

Adult umbilical hernias usually develop over time due to a number of factors including: the weakening of connective tissue associated with the aging process,

genetic factors, chronic cough, smoking, obesity, repeated straining, ascites, and pregnancy.

[13] Dr Walker referred to the consensus opinion of an expert advisory group representing ACC and the Royal Australian College of Surgeons. Dr Walker noted that the consensus opinion published in March 2017 concluded that the aetiology and pathogenesis of abdominal wall hernias are multifactorial and complex. In many instances a bulge protruded through an existing abdominal wall defect that enlarges with time. Such hernias were not caused by a single strenuous event but simply became apparent or increased in size after an event such as lifting. ACC could cover an abdominal wall hernia if it was established that the hernia was the result of an accident, such as direct trauma to the abdominal wall. ACC do not cover hernias that were caused wholly or substantially by disease or aging.

[14] As to then number of types of hernias, including umbilical hernias, the hernia guidelines noted:

It is unlikely that any of these types of hernias is caused by a single strenuous event. The available evidence indicated that normally these hernias develop slowly as a result of weakening of tissues in the abdominal wall, or through facial defects, and then become obvious in some people.

[15] Dr Walker concluded that Mr Larason had developed an umbilical hernia and divarication of the recti due to weakening of connective tissue associated with the aging process and the hernia was not caused by the accident event.

[16] Mr Larason provided further information to ACC including a video of him demonstrating the accident event. In it he made clear that he was not lifting the whole log but only one end and that after he stumbled there was significant poking energy from the log against his stomach.

[17] Dr Walker commented:

The large diameter of the log held against the abdominal wall is not capable of producing mechanical force sufficient to produce a traumatic rupture of the abdominal wall. This event is simply the time when the client's umbilical hernia first became symptomatic.

[18] Mr Gordon commented again on 2 March 2018:

- (i) Jerry has had annual health checks for some years. Including physical examinations. He has never been noted to have a hernia in the past and has had no suggestive symptoms preceding the event.
- (ii) Jerry has a diverification of the rectus muscles. This is a normal anatomical variation, whereby the rectus muscles lie more widely apart. The linea alba (normally narrow and thick) becomes stretched and is thinner and weaker in this situation. However this is a normal anatomical variation and is not a hernia. People with this anatomy are more prone to developing hernias.
- (iii) Jerry has recreated a video of the lifting event, I have viewed this. With the bottom edge of the angled log, supported by his central abdomen, as well as his hands, I believe that shearing force, due to a stumble could well precipitate a hernia during the events as described.
- (iv) I note the ACC medical advisor, has presented a consensus document. This includes advice that umbilical hernias are most often non traumatic in origin.

I accept entirely that this is true, however as the wording notes, this is the case most often and not exclusively. Umbilical hernias can develop with adequate force. I believe that Jerry must be given the benefit of the doubt, considering his underlying anatomy and the nature of the event.

[19] Dr Walker responded on 28 March 2018. He said:

In my opinion the large diameter of log **held** against the abdominal wall is not capable of producing mechanical force sufficient to produce a traumatic rupture of the midline of the abdominal wall.

...

There hasn't been a shearing force applied to the abdominal wall. Shearing forces occur when unaligned forces pushing one part of the body in one specific direction and another part of the body in the opposite direction.

[20] Mr Larason applied to review the respondent's decision. He was unsuccessful at review.

[21] General surgeon, Mr Sexton, provided comment on 23 August 2018. He said:

The exhaustive analysis outlined by Dr Walker will not be repeated here, but the salient points in this case relate to the presence of central obesity, which in males is combination of subcutaneous and intraperitoneal fat, rectus divarication which both Dr Walker and Dr Gordon have acknowledged to have an association with an increased incidence of umbilical herniation and the nature of the described activity which of itself does not contain the mechanistic intensity to produce a rupture of the abdominal wall midline.

...

The resting of the end of the log against the abdominal wall is not a cause of traumatic hernia. This type of hernia is due to a high energy crushing injury to the abdominal wall, which is seen in high speed crashes involving individuals restrained with a lap belt or in high injury impacts with items with a small surface area which may penetrate and crush the abdominal wall layers leading to a defect. Leaning on the end of a log, whether the client tripped or not, particularly with a diameter of 300 millimetres as described, is an implausible mechanism for producing a 2.5 cm defect in the paraumbilical area.

As has been explained, a symptomatic aggravation of a paraumbilical hernia may occur where the abdominal content, in this case the omentum, is pushed into the hernia bulge which is made up of the peritoneal lining of the abdominal wall and produces pain by stretching the sac. This is undoubtedly the mechanism in this case and there are no features to support the suggestion that the described activity has caused a central rupture of the anterior abdominal wall.

I am a general surgeon whose practice has included the surgical management of abdominal wall hernias and am part of the expert advisory group which drew up the original hernia guidelines in 2001 and the recent revision currently used.

[22] On 21 March 2019, Mr Gordon reported further:

- i. At the time of surgery I found a small transverse orientated hernia defect immediately above the umbilical cicatrix. I found no other weaknesses. I stated that one cannot tell with any certainty the cause of the hernia (traumatic versus congenital) from examination at the time of surgery. However the transverse orientation and the fact that it lay immediately above the umbilical cicatrix (thickened scar, where the umbilicus “heals after birth”) would be where I expect a hernia to be were it traumatic in origin and with the mechanism that you described, with the log resting against the top of the umbilicus.
- ii. This is not a common site for hernia. Most hernias are through the umbilical defect itself due to the cicatrix having not fully fibrosed. Most congenital hernias lie further above or inferior to the umbilicus if they do not pass through the umbilicus itself. Again, I can’t state with absolute certainty that the hernia is traumatic in origin but again where your hernia was, would be the most likely site in the event of the trauma that you described.
- iii. ... some hernias will be essentially a round hole, some are more transversely orientated. I believe a traumatic hernia caused by the mechanism you described, would be more likely to give a transverse oriented tear in the linea alba. Congenital hernias are more likely to be more round. Unfortunately this is not an absolute.
- iv. On ultrasound, when you stand erect, your rectus muscles do lie about 3 cm apart. This means that the tough layer down the midline between the rectus muscles is generally more thinned and not as strong. This may make you more prone to developing a traumatic hernia.

[23] The appellant's solicitors obtained a further report from Mr Roberts, gastrointestinal surgeon and endoscopist, dated 7 October 2019. Mr Roberts had met with the appellant and examined him.

[24] Amongst other things, Mr Roberts said:

It does not appear that he has in fact had a right sided hernia and on the basis of the history provided it does seem more probable than not that his abdominal hernia at the level of the umbilicus was a result of the injury sustained on 27 September 2017.

[25] As to the mechanism of injury demonstrated by Mr Larason using the model that he had brought with him, Mr Roberts said:

Given the weight of this log it was resting against his abdominal wall at approximately the level of the umbilicus. As the opposite end was resting on the ground only the bottom edge of the end of the log was in contact with his abdominal wall with the gap calculated at approximately 100 millimetres between the top edge of the log and his abdominal wall. This resulted in concentration of pressure at the site of his injury.

[26] As to causation, Mr Roberts said:

The history as described above is consistent with a significant force applied to the mid abdominal wall with a concentration of the pressure due to the edge of the log resting in contact with the abdomen. Clearly Mr Larason sustained a significant injury as he was unable to continue working and remained in significant pain to the extent that he requested a consultation with his own doctor three days later. On balance therefore this is consistent with a direct causal link between the events that occurred on 23 September 2017 and the hernia that was subsequently diagnosed on 29 September 2017.

[27] Mr Roberts was also of the opinion that the appellant's injury met the hernia criteria guidelines as published by ACC in 2017.

[28] Mr Roberts also noted:

You ask if Dr Walker is correct in suggesting that divarication in the rectus muscle is a result of age, obesity, smoking and chronic cough. It is important to note that Mr Larason does not smoke, he is not obese and does not have a chronic cough. ...

[29] Mr Roberts also added:

I feel it is important to clarify that Mr Larason was not in contact with the full 300 millimetre surface of the cut end of the log but merely the sharp inferior margin as the opposite end was still supported by the ground. It is also important to note that traumatic rupture of the umbilical area is not the same as “general rupture of the anterior abdominal wall” which would take a far more violent force to develop. ...

The umbilicus is a natural point of weakness in the human body and the force required to disrupt this area is of course less than required to cause a “general rupture of the anterior abdominal wall”. It appears that ACC has perhaps inadvertently overlooked this fact.

[30] Following Mr Roberts’ report, Dr Sexton commented further on 11 November 2019:

... in this case it is far more likely that pressing the umbilicus against the end of the log as described by the client is likely to put pressure on an existing asymptomatic bulge rather than causing a 2.5 cm defect in the midline of the abdomen wall and a hernia which was reported to be readily reducible less than a week later.

An acute traumatic disruption leading to a 2.5 cm defect through the linea alba is most unlikely to progress to a mature reducible paraumbilical hernia a few days later. Otherwise there is general agreement that the umbilicus is a weak area in the abdominal midline and rectus divarication may be a contributor to the development of a paraumbilical hernia.

[31] Mr Roberts commented further on 19 November 2019, on Mr Sexton’s further comments. He said:

The critical aspect of this issue of course is whether the patient (Mr Larason) had previously noted a hernia or not. the umbilicus is part of the anatomy which is easily observed and it would be worth confirming with Mr Larason whether he was aware of any deformity at that area or not. In the absence of any observed deformity prior to the injury it remains more likely that the hernia developed as a consequence of the injury rather than spontaneously.

Further Evidence at Appeal Hearing

[32] Mr Larason was permitted to give evidence at the appeal hearing and again to demonstrate the mechanism of injury using a prop that had two round slices of timber of approximately 300 millimetres in diameter attached to each end of a slender pole to represent both the diameter and the length of log involved in his accident. He demonstrated how, when he lost his footing and stumbled, the log was,

“thrust about, slid back and forth sideways” and how the bottom edge of the log was driven into his stomach.

[33] Mr Larason said he lost a tremendous amount of fitness following the accident and that the video he recorded of the mechanism of the accident was done a long time after the event.

[34] He also made the point that Dr Sexton did not examine him.

[35] At the time of the accident his daily routine was gym activity from 6 am followed by a long day as a lumberjack cutting firewood and cleaning up the mess left after the storm. He said that prior to the injury “I was very fit” and that for his age he was in the top 2%. He said that for his age, his arms and legs were in “phenomenal shape” and that “life was good”.

[36] The video demonstration of how the accident occurred was played with the appellant commenting that ACC appeared to wrongly assume that the whole circle of the end of the log was distributed over the area of his stomach whereas in fact only 80 millimetres of the bottom edge of the log was against his stomach.

The Appellant’s Submissions

[37] Ms Coulston submitted that ACC’s advisor, Dr Walker, predetermined the issue; that he did not look at what happened, and he seemed to fail to understand the mechanism of the accident.

[38] She also draws attention to other aspects of the appellant’s fitness regime, in that prior to his accident the appellant had swum in the Canterbury Swim School lap pool two or three times a week.

[39] She also refers to the appellant’s GP, Dr Wilkinson, who in his report dated 16 March 2018 says:

This certifies that the patient named above has been examined by me on regular occasions in the 20 years we have cared for him and at no time has he had any herniae or abdominal wall issues to predispose him to umbilical hernia.

[40] In similar vein she refers to a letter from the appellant's osteopath, Mr Taborski, dated 13 February 2019. Mr Taborski says:

Prior to the stumbling incident while cutting wood in September 2017, I had assessed Jerry for both inguinal and abdominal hernias, which I need to exclude for the manipulation techniques I was performing on his lumbar spine. I did not find any signs of hernias at the time, and Jerry responded well to the techniques.

[41] Ms Coulston also refers to a further report from Dr Wilkinson, dated 14 September 2018, in which he says:

This certifies that the patient named above has been examined by me, as stated previously, regularly and I confirm that he has had abdominal examinations which specifically excluded any suggestion of abdominal herniae, and given his BMI of 30, there is no reason to believe body mass has any bearing on the development of his umbilical hernia.

[42] Ms Coulston refers to the case of *Hopkins v ACC*¹ where the Court said:

... It is also well settled that, when the Court is presented with evidence from a specialist who has carried out surgery on a particular injury, it would take significant reasoning for the assessment of that surgeon to be put to one side in favour of the evidence of persons who make informed opinions based on general medical reasoning.

[43] Ms Coulston submits that Mr Gordon's evidence should be preferred over the opposing evidence for the above reason.

[44] She also refers to Mr Roberts' evidence and in particular his comment:

The umbilicus is a natural point of weakness in the human body and the force required to disrupt this area is of course less than that required to cause a general rupture of the anterior abdominal wall. It appears that ACC has perhaps inadvertently overlooked this fact.

[45] She is critical of Dr Walker's evidence. At page 2 of Dr Walker's report of 28 March 2018 he says:

If there had been an acute abdominal wall injury there would have been signs of an acute soft tissue injury such as local tenderness and bruising.

¹ *Hopkins v Accident Compensation Corporation* [2013] NZACC 195 at [35].

[46] Ms Coulston points out that the GP's notes from 29 September 2017 record "pain in navel, stopped work and noted lump, inflamed at night" and that the appellant's evidence is that at the injury site there was a black and blue bruise.

[47] She submits that Dr Walker effectively predetermined the issue by not looking at what actually happened and failing to understand the actual mechanism of injury with his assumption of a flat log end against the appellant's stomach.

[48] She refers to Mr Taborski's report of 23 April 2020, where he says:

In the period of my treating Jerry in the months immediately prior to September 23rd 2017 he did not have central obesity or protruding stomach.

Osteopaths rely on the visual and palpatory examination before and after each treatment. Further, osteopathic treatments involve hands on techniques, which would give me several opportunities to notice the presence of subcutaneous adipose tissue. I can also confirm that during that time Jerry's waist to hip ration did not indicate obesity.

[49] Ms Coulston refers to Mr Sexton's report and submits that the description of the mechanism of the accident is flawed as well as the conclusion reached about the appellant's body condition.

[50] Ms Coulston also points out that although Dr Gordon was concerned that surgical mesh might be needed to repair the hernia, it was not in fact needed and that this too argues against an obese or unfit condition.

[51] She submits that while Dr Walker says the ACC guidelines for cover are not met, Mr Roberts, in his report of 7 October 2019, is of the opinion that the appellant's injury does meet the criteria of the ACC guidelines. He notes that the appellant sustained an injury from a significant force applied at the level of the umbilicus and that this developed into an umbilical hernia within a few days.

[52] She seeks that the review decision of 22 May 2018 be quashed, the appeal upheld, and the appellant awarded cover. She also seeks costs.

The Respondent's Submissions

[53] Mr Light draws attention to Dr Walker's first report where he notes that the appellant has been identified as having a divarication of the recti and that the same weakness in the connective tissue that allows the formation of the divarication of the recti is responsible for the formation of an umbilical hernia.

[54] He notes that the appellant had just turned 67 at the time of the accident.

[55] Mr Light reminds the Court that there is no cover under the Act for issues arising from the process of aging.

[56] Mr Light does not accept that the respondent's experts misunderstood the mechanism of the accident on 23 September 2017 as Dr Walker had the appellant's video available to him.

[57] Mr Light points out that Mr Sexton, was involved in the preparation of ACC's hernia guidelines and both he and Dr Walker conclude that the nature of the described activity does not contain the mechanistic intensity required to produce a rupture of the abdominal wall midline.

[58] He notes that the guidelines state that it is most unlikely that an umbilical hernia is caused by a single strenuous event.

[59] He also notes that Mr Larason's admitted weight prior to the accident of 94 kgs and his height of approximately 187 centimetres gives him a body mass index of 26.88 which is classified as overweight. He notes that overweight males with rectus divarication increase the incidence of umbilical herniation.

[60] He submits that the appellant has not established that the accident was causative of the hernia.

The Appellant's Reply

[61] In reply Ms Coulston acknowledges that s 26 excludes cover for personal injury caused wholly or substantially by the aging process. However, she submits

that the evidence is that although he may have had a slightly weakened linea alba, he did not have a hernia prior to the accident. Therefore, the weakness was not a substantial cause of his injury.

[62] She submits that Mr Sexton and Dr Walker premise their opinions on the fact that the appellant was obese when he was not.

Decision

[63] On 23 September 2017 the appellant was clearing his property of debris of fallen trees following a storm. As he was pivoting a 2 metre long approximately 300 millimetre diameter pinus radiata log with him holding one end of the log and the other end being on the ground, he lost his footing and stumbled. He said:

As I danced violently round the round bottom edge of the end of the log, with a great deal of force was thrust about, slid back and forth sideways, and was driven into my stomach with those muscles being very tight/tense from still supporting the heavy log at the time. I felt extreme and sudden pain just above my umbilicus.

[64] He hoped the injury would settle. It did not and after four days made an appointment with his doctor which occurred on 29 September 2017.

[65] The doctor noted:

Lifted log last w/e – pain in naval, stopped work and noted lump, inflamed that night – o/e umbilical hernia.

[66] The appellant's doctor, Mr Gordon, the surgeon who repaired the hernia and Mr Roberts who reviewed the case are of the opinion that the accident of 23 September 2017 caused the hernia injury. The respondent's experts notably Dr Walker and Dr Sexton – general surgeon, are of the view that this injury was caused wholly or substantially by the aging process and accordingly is not covered under the Accident Compensation Act.

[67] The appellant has been concerned that Drs Walker and Sexton have misunderstood the mechanism of injury, wrongly believing that effectively the flat end of the log was resting against the appellant's stomach when he stumbled and that

therefore the violent mechanism required to cause a hernia in an otherwise healthy person was not present.

[68] In his report of 24 November 2017 Dr Walker notes:

The client describes lifting a heavy log with a diameter of between 250 and 300 cm which he rested against his abdominal wall as he “walked” the log around, he stumbled, and did a little dance, and felt pain in his abdomen. He lowered the log to the ground. The large diameter of log held against the abdominal wall is not capable of producing mechanical force sufficient to produce a traumatic rupture of the abdominal wall. This event is simply the time when the client’s umbilical hernia first became symptomatic.

[69] I find that this description of the mechanism of the accident is not an accurate recounting of what actually occurred. What I accept really happened, as described by the appellant is that it was not the flat log end that was against his stomach but 60-80 millimetres of the bottom rim of the log that was against his stomach when he stumbled which the appellant described as a “concentrated tremendous force against my body mass bouncing and slicing against an immovable object.”

[70] I note that such description allows Mr Roberts to conclude that this resulted in concentration of the pressure at the site of his injury and that it was “from a significant force applied to the level of the umbilicus which resulted in pain to the extent that he could not continue his activities” and that this was followed by the development of the umbilical hernia within a few days of that injury. Mr Roberts also notes that the appellant had no preceding herniation that may have precipitated this hernia.

[71] Significantly in his comment of 23 August 2018, Dr Sexton says:

The exhaustive analysis outlined by Dr Walker will not be repeated here, but the salient points in this case relate to the presence of central obesity, which in males is a combination of subcutaneous and intraperitoneal fat, rectus divarication which both Dr Walker and Dr Gordon have acknowledged to have an association with an increased incidence of umbilical herniation and the nature of the described activity which of itself does not contain the mechanistic intensity to produce a rupture of the abdominal wall midline.

[72] Dr Sexton goes on to contrast “the resting of the end of the log against the abdominal wall” with a recognised traumatic cause of hernias of this kind namely

high speed motor vehicle crashes involving individuals restrained by lap belts or in high injury impacts with items with a small surface area which may penetrate or crush the abdominal wall layers leading to a defect.

[73] Dr Sexton goes on to say:

Leaning on the end of a log, whether the client tripped or not, particularly with a diameter of 300 millimetres as described, is an implausible mechanism for producing a 2.5 centimetre defect in the paraumbilical area.

[74] From the outset therefore it seems that both Dr Walker and Dr Sexton had been considering a mechanism of injury somewhat different from what had in fact occurred.

[75] However, neither Dr Sexton nor Dr Walker rule out hernia causation from a single strenuous event with Dr Walker saying that the expert advisory group representing ACC and the Royal Australasian College of Surgeons in the publication in March 2017 “noted limited research evidence relating to hernia causation from a single strenuous event”.

[76] Mr Roberts is of the view that the injury in this case does meet the criteria of the ACC 2017 guidelines.

[77] A further matter relates to the appellant’s overall health status and whether or not he was obese at the time of the accident.

[78] Mr Light properly acknowledges that with a pre-accident weight of 94 kilograms and a height of 187 centimetres the appellant has a body mass index of 26.88 which places him in the “overweight” category, but not obese.

[79] Again, Dr Sexton appears to be in error when in his comment of 23 August 2018 he says:

The salient points in this case relate to the presence of central obesity ... rectus divarication and the nature of the described activity which of itself does not have the mechanistic intensity to produce a rupture of the abdominal wall midline.

[80] While the appellant was overweight at 94 kgs he plainly kept himself fit and active. His swimming routines, his daily exercise routines, his yoga and his recourse to osteopathy to treat injuries and sprains is eloquent evidence of his goal to stay fit and active.

[81] It is accepted that he had divarication of the recti. And for our purposes, that was a genetic predisposition to developing an umbilical hernia, but as Ms Coulston submits, it does not disqualify him from cover simply on account of that susceptibility.

[82] Likewise, I agree with what the District Court said in *Hopkins*² quoted earlier in this Judgment at paragraph 42, regarding the weight to be attached to the evidence of the operating surgeon.

[83] In this regard, Mr Gordon's views are measured. He says in his report of 21 March 2019:

- i. I stated that one cannot tell with any certainty the cause of the hernia (traumatic versus congenital) from examination at the time of surgery. However the transverse orientation and the fact that it lay immediately above the umbilical cicatrix (thickening scar, where the umbilicus "heals after birth") would be where I would expect a hernia to be, were it traumatic in origin and with the mechanism that you described, with the log resting against the top of the umbilicus.
- ii. This is not a common site for hernia. ... again, I can't state with absolute certainty that the hernia is traumatic in origin but again where your hernia was, would be the most likely site in the event of the trauma that you described.
- iii. ... some hernias will be essentially a round hole, some are more transversely orientated. I believe a traumatic hernia caused by the mechanism you described, would be more likely to give a transverse orientated tear in the linea alba. Congenital hernias are more likely to be more round. Unfortunately this is not an absolute.

[84] After considering all the evidence, I find that the appellant has proved on the balance of probabilities that the umbilical hernia he suffered was caused by the accident of 23 September 2017. Accordingly, the respondent's decision of

² See n1.

27 November 2017 is quashed, and the appellant is granted cover for his umbilical hernia.

[85] The appellant is entitled to costs. Should there be any issue in that regard counsel have leave to file memoranda in respect thereof.



Judge C J McGuire
District Court Judge

Solicitors: Karina Coulston, barrister, Christchurch for the appellant
Young Hunter, Solicitors, Christchurch for the respondent