IN THE DISTRICT COURT
AT WELLINGTON

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

[2021] NZACC 149 ACR 192/18

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

Hearing:	22 June 2021
Heard at:	Nelson/Whakatu
Evidence completed:	2 September 2021
Appearances:	The appellant in person Mr H Evans for the respondent
Judgment:	30 September 2021

RESERVED JUDGMENT OF JUDGE DENESE HENARE
[Entitlement to surgery s67 and Schedule 1 of the Accident Compensation Act 2001]

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[1] The issue in this appeal is whether Mr Garside is entitled to funding for surgery to repair a left knee meniscal tear.

[2] The Corporation’s decision of 8 August 2017 declined to pay for the surgery because the condition requiring treatment was not caused by Mr Garside's accident on 3 July 1991.

Background

[3] Mr Garside has cover for a sprain or strain of his left knee caused by an accident on 3 July 1991.

[4] He also has cover for a contusion to his left knee and lower leg caused by an accident on 29 September 2002. He tripped over some driftwood while walking.

[5] In 2017 Mr Ballance, Orthopaedic Surgeon, completed an assessment report and treatment plan (ARTP) and applied to the Corporation for funding for surgery to repair a left knee meniscal tear.

[6] The Corporation obtained comment from Dr Medlicott and in reliance on his report and the radiological evidence, the Corporation issued a decision on 8 August 2017 declining to pay for his surgery as follows:

> **We're unable to pay for your surgery**
>
> Dr Julian Balance has asked us whether we'll pay for your surgery.
>
> To be able to pay for your surgery, we need to ensure it's for the injury we've agreed to cover and not for an unrelated or pre-existing health condition. In this case the injury we've approved cover for it:
>
> - Sprain Or Strain Knee – Side: Left
>
> This injury is a result of your accident on 03/07/1991.
>
> We've looked at all available information from your treatment providers and have enclosed a summary of this. This information shows that surgery is required to treat a meniscal tear of the left knee. We've determined that this condition wasn't caused by your accident on 03/07/1991, which means that we're unable to dover this condition and we're unable to approve your specialist's request to pay for your surgery.

[7] Subsequently, Mr Garside was able to access remedial surgery in the public health system.

Medical evidence

[8] Following the 2002 claim, Mr Garside was assessed by Mr Alex Rutherford, Orthopaedic Surgeon whose 13 March 2003 report noted:

> Christopher injured his left tibial tubercle when he fell on it later last year. He has had intermittent swelling and inflammation since then with an episode recently where he felt that it was infected …
>
> The tibial tubercle still remains a bit prominent and tender and he is concerned that if he kneels on it or knocks it it may flare up again.
>
> On examination today there is mild tenderness of the tibial tubercle but no inflammation or heat. The knee itself is normal.
>
> Reviewing x-rays done in Nelson and Willington are normal other than a bipartite patella which I have advised him he has had for some years.
>
> Mr Garside has had some trauma to his tibial tubercle and I suspect he has had a bursitis subsequently. There is no sign of this currently but I am sure that if he were to kneel on it or knock it significantly he may well stir it up. The treatment at this stage however conservative ensuring that he does not traumatise the area and I expect it will settle down without intervention.

[9] In September 2016 Mr Garside presented to Dr Russell at Golden Bay Community Health with pain in his left knee. Dr Russell referred him to the Orthopaedic Department at Nelson Public Hospital, noting:

> I'm concerned he may have some cruciate instability — in spite of good end points on testing. The findings also support early osteoarthritis development.

[10] An x-ray taken on 22 February 2017 showed there was mild medial compartment narrowing bilaterally, with the left slightly more so than the right; the x-ray also identified the bipartite patella, and no other abnormalities.

[11] Mr Garside presented to Dr Clark at Golden Bay Medical Centre on 2 May 2017 who noted:

> Re knee — he has considerable discomfort. I have advised that needs to use and bike to strengthen quads,, no value in further imaging as unlikely any operative intervention indicated. he would like to take furthre [sic] so will eref [sic] to Julian Ballance under ACC for consult/advice.

[12] Dr Clark referred Mr Garside to Mr Ballance, Orthopaedic Surgeon, who reported on 6 June 2017. He set out the medical history but was unsure of diagnosis, recommending that a MRI scan be obtained:

> Chris has had a couple of injuries to the knee over time. He has had a mountain bike accident where he landed directly on the front it and also a further old injury to the left knee where he was kicked on the medial side. Every time he undertakes a heavy physical activity, it catches him and he gets an occasional

> sensation where it feels like something wants to move in the knee and he can click it and it loosens. It he twists his toes in, it relieves it, if he externally rotates, it is worse. He has been doing some truck driving recently and the finds the heavy clutch difficult with the knee.
>
> …
>
> On examination today, Chris has good quadriceps strength and no effusion. Ligaments are stable. The joint line is mildly tender on the medial side today. The plain AP and lateral x-rays show slight loss of joint space but is marginal otherwise unremarkable.
>
> IMPRESSION:
>
> ? medial meniscal tear left knee.
>
> PLAN:
>
> At this stage, Chris will have an MRI scan to document what is happening in his knee and I will review Chris with the result of this and we will make a decision as to whether an arthroscopy and meniscectomy will be of benefit to him or not.

[13] Dr Davison, Radiologist, reported on 26 June 2017 that:

> IMPRESSION:
> 1. Moderately extensive inferior surfacing flap tear posterior horn and body of medial meniscus confirmed. Small associated parameniscal cyst.
> 2. Mild cartilage damage medial compartment.
> 3. Mild chondropathic change patellofemoral compartment.

[14] On 27 June 2017 Mr Ballance applied for funding approval for surgery. He reported on the findings of the imaging:

> Chris was reviewed today with the results of the MRI scan of his left knee which confirms a significant tear of the medial meniscus which is predominantly horizontal in nature and there is a small associated parameniscal cyst.
>
> For Chris, the knee is a significant issue and in this circumstance, the treatment is an arthroscopy and meniscectomy to remove the torn meniscal fragment which has a 90% chance of significantly improving it for him and a 10% chance of some residual or ongoing symptoms.

[15] . When explaining the causal medical link between the proposed treatment and covered injury, Mr Ballance repeated the history of the current condition and stated:

> Direct — Chris has had a couple of injuries to the knee over time. He has had a mountain bike accident where he landed directly on the front of it and also a further old injury to the left knee where he was kicked on the medial side. Every time he undertakes a heavy physical activity, it catches him and he gets an occasional sensation where it feels like something wants to move in the knee

> and he can click it and it loosens. If he twists his toes in, it relieves it, if he externally rotates, it is worse. He has been doing some truck driving recently and he finds the heavy clutch difficult with the knee.

[16] Upon receipt of the request for funding, the Corporation sought comment from internal medical advisor, Dr Medlicott, whether Mr Garside's current injury was causally linked to his 1991 injury. Having reviewed Mr Garside's covered injuries, Dr Medlicott stated:

> There would appear to be a very significant time since the first covered claim, something over 25 years and it is unlikely therefore that the meniscal pathology now present is related to 1991. It is also less likely that medial meniscal pathology could be caused by a direct blow. Medial meniscal pathology is either associated with ligamentous and other pathology and/or anterior cruciate ligament ruptures or strains or medial ligament injuries. A direct blow is not one of the known causes of medial meniscal pathology. There is certainly is [sic] medial meniscal pathology now present. The question is whether this can be linked to 1991.
>
> I note the MRI finding of 26/06/2017. There is abnormality of the medial meniscus, both anteriorly and posteriorly and there is a parameniscal cyst which is usually related to a fairly longstanding problem. There is partial thickness cartilage loss involving the margin of the medial tibial plateau and change within the medial femoral condyle. The grading of this change is not mentioned on MRI. The lateral compartment is normal. There is some patellofemoral change and a bipartite patella (a bipartite patella is a developmental problem not caused by single episode injury).
>
> It would seem unlikely that meniscal pathology has gone unnoticed since 1991. **The present meniscal pathology is associated with some chondral changes and this usually means the meniscal pathology is age related and/or degenerative. At this stage I don't think we can draw a direct causal link to any of the previous incidents as there do not appear to be any definite notes linking these. There have been previous notes from Mr Alex Rutherford in 2003 and this is related to an infected tibial tubercle area after a fall and this is not likely to be related to meniscal pathology.**
>
> At this stage I don't think there is a direct causal link for the meniscal pathology and it is therefore more likely due to gradual process. I note an x-ray of 22/02/2017 shows medial compartment narrowing bilaterally (medial compartment narrowing is due to loss of articular surface and is a gradual process degenerative change).
>
> (Emphasis added)

The case for Mr Garside

[17] Mr Garside disputed that the need for surgery is due to gradual process or age -related deterioration. Mr Garside produced a number of documents, the operation note and photographic slides relating to his surgery in 2019.

[18] Mr Garside referred to the accidents he had sustained since he was 15 years old when he broke his wrist. He said he had learned to live with high pain tolerance in his life. He said he had also learned how to engage in a range of activities utilising particular strategies to help him cope when his knee was "unbearable".

[19] Mr Garside provided a specific narrative about his knee and the accidents he experienced:

> My left knee pain began when 21 after I was beaten up on 3/7/91 I had an x-ray while covered by ACC, F1748764001. It clearly states – Secondary 12 sprain or strain knee left.
>
> I had many injuries and visits to hospital in my early 20's and was told my knee problem couldn't be fixed and bought up my daughter.
>
> 1993 1 rode my mountain bike from Ruby Bay down the west coast to be Haast where my knee became unbearable again, so I rode less. much again
>
> Over the year I found working for my self physically bearable.
>
> By 2000 1 had had many injuries, a back inury took priority in my healing.
>
> My knee was a tollerable pain which would let me dance and do most things and suffer later and at the time.
>
> 2014 1 started full-time truck driving which after 9months again pain became intolerable,as I had to hand unload.
>
> 2015 Next I found a job that let me drive more and I would limp less.
>
> These jobs where a lot harder on my left knee but I could mostly tollerate it. But after having to use clutch every minute while being loaded clearing ditches it became to too painful.
>
> Then I found out my knee could be operated on.
>
> Other notes
>
> May 2006 1 began healing with Carolyn Simon Craniosacral therapist, natutapath, medical herbalist, where I got a lot of back work done and I told her of having my knees smashed in 2 separate incidences. And she picked up on leg blockages.
>
> 28/2/06 Tracey Smith massage therapist(deceased) wrote
>
> L knee sore
> R knee a bit better
>
> I also believe the operational notes and photos prove ACC wrong. And shows the age of injury and health of my bi patella that ACC said was the problem.

Legal framework

[20] Clause 1(1) of Schedule 1 of the Accident Compensation Act 2001 (the Act) provides the Corporation is, "Liable to pay or contribute to the cost of the claimant's treatment for personal injury for which the claimant has cover."

[21] The treatment must therefore be required to treat a personal injury for which the claimant has cover. "Personal injury" is defined so as to not include:

> (2) **Personal injury** does not include personal injury caused wholly or substantially by a gradual process, disease, or infection unless it is personal injury of a kind described in section 20(2)(e) to (h).
>
> …
>
> (4) **Personal injury** does not include:
>
> (a) Personal injury caused wholly or substantially by the ageing process; or

[22] It is for a claimant to establish causation on the balance of probabilities as the Court of Appeal held in *Accident Compensation Corporation v Ambros*:[1]

> [65] The requirement for a plaintiff to prove causation on the balance of probabilities means that the plaintiff must show that the probability of causation is higher than 50 per cent. However, courts do not usually undertake accurate probabilistic calculations when evaluating whether causation has been proved. They proceed on their general impression of the sufficiency of the lay and scientific evidence to meet the required standard of proof ... The legal method looks to the presumptive inference which a sequence of events inspires in a person with common sense ...
>
> [66] The legal approach to causation is different from the medical or scientific approach. In *March v Stramare*, Mason CJ at 509 in the High Court explained that the scientific concept of causation has been developed in the context of explaining phenomena by reference to the relationship between conditions and occurrences whereas in law problems of causation arise in the context of ascertaining or apportioning legal responsibility for a given occurrence. At law the cause is not the sum of the conditions which are jointly sufficient to produce the occurrence ...
>
> [67] The different methodology used under the legal method means that a court's assessment of causation can differ from the expert opinion and courts can infer causation in circumstances where the experts cannot. This has allowed the court to draw robust inferences of causation in some cases of uncertainty — see at [32] above. However, a court may only draw a valid inference based on facts supported by the evidence and not on the basis of supposition or

[1] *Accident compensation Corporation v Ambros* [2008] 1 NZLR 340.

> conjecture Judges should ground their assessment of causation on their view of what constitutes the normal course of events, which should be based on the whole of the lay, medical, and statistical evidence, and not be limited to expert witness evidence …

[23] In *Johnston v Accident Compensation Corporation*,[2] Simon France J, with reference to *McDonald, Cochrane v Accident Compensation Corporation*[3] and *Accident Compensation Corporation v Ambros*[4] rejected an argument on behalf of the appellant that it was sufficient to link the incapacity to the accident.

[24] In *Mehrtens v Accident Compensation Corporation*,[5] Judge Ongley referred to the following factors that determine whether an injury is caused by an accident:

- The nature of the injury - as initially identified since it is generally reasonable to expect that an initial diagnosis, primarily directed at treatment rather than any issue of ACC coverage or entitlements - will represent an unvarnished assessment of "the injury", which may later require closer analysis in terms of any ACC issue.
- Any further or revised diagnosis of the injury having regard to the observations above.
- The significance and seriousness of the accident, and in particular the mechanism of injury. In other words, is the injury which has been diagnosed plausibly or reasonably likely to have been caused by the event, or equally explicable by non injury causes.
- The development of symptoms, and any change in those symptoms, following the accident the onset (whether immediate or gradual), magnitude, and nature of those symptoms.
- The extent of any pre-existing condition and whether there had been prior symptoms consistent with that condition (as might be revealed by claimant history, or prior medical interventions and the results of x-rays, MRI scans, and the like).
- Whether any change in the presentation of symptoms is consistent with the natural course of the identified/diagnosed condition, or injury.
- The objective signs or indicia of injury. This may be simple where the injury is obvious - such as a laceration. It may be less obvious where the symptoms are explicable in different ways i.e., where the symptoms may be explained by reference of pre-existing conditions, which the injury has merely rendered symptomatic, but may equally be explained as having stemmed substantially from the accidental injury.

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2 *Johnston v Accident Compensation Corporation* [2010] NZAR 673.
3 *McDonald, Cochrane v Accident Compensation Corporation* [2005] NZAR 193 (HC).
4 *Accident Compensation Corporation v Ambros* [2007] NZCA 304; [2008] 1 NZLR 340 (CA).
5 *Mehrtens v Accident Compensation Corporation* [2012] NZACC 25.

- The nature and quality of the evidence, both medical and factual. In relation to the medical evidence, particularly in an area where an opinion is relied upon, the Court will be influenced by the extent to which the medical opinion proceeds logically from as clear or settled a basis of fact as is possible (including the possible need for caution when significant reliance is based on a claimant's self report); appropriate level of regard for and consideration of medical research and studies bearing on the issue at hand applied to the particular facts of the case; and a logically reasoned conclusion which takes account of any differing views or factors which might contra indicate the opinion being presented. In this respect, an opinion which is seen to absorb and respond to matters (whether matters of fact or opinion) which challenge the view offered, will often be regarded as more persuasive.

[25] The approach discussed by Judge Ongley in Mehrtens was applied in *Lucas v Accident Compensation Corporation*[6] (a surgery case) where Judge Powell accepted the factors as an outline of considerations that are applicable to many of the issues that come before the Court, including the issues that arise in the present appeal.

Discussion

[26] At the outset, there is no dispute with Mr Garside's evidence regarding the accidents he suffered and the functional limitations and pain he has experienced. As a result of his accidents, Mr Garside received cover for a sprain to the left knee in 1991 and contusion or bruising to his left knee and lower knee in 2002.

[27] In response to questioning from Mr Evans, Mr Garside confirmed he was knocked out in the assault on him in 1991 and when he came to his knee was sore. However, Mr Garside confirmed his evidence at review that his assailant knocked him out but he could not recollect the details "whether he kicked me or jumped on me I don't know". It is clear Mr Garside's evidence at review is consistent with his responses to Mr Evans.

[28] Mr Garside also mentioned the knee problems he suffered from a mountain bike crash and, at hearing, another crash in a motor vehicle. However, there is no available evidence of the claims made for these accidents.

[29] Causation is the issue in this appeal. Whether the need for surgery, that is the meniscal tear is causally linked to covered injuries in 1991 or potentially 2002. The

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6 *Lucas v Accident Compensation Corporation* [2015] NZACC 216 at [14].

guiding principles are set out by the Court of Appeal in *Ambros*. A claimant must establish the accident caused a new physical injury. A condition that has become symptomatic because of an accident or was aggravated by accident will not suffice. There must be robust evidence to enable the Court to draw inference on causation. The Court is unable to draw an inference as to causation in the absence of medical explanation.

[30] I agree with the Reviewer the difficulty in this case lies in Mr Balance's request for surgery funding. Mr Balance failed to provide any explanation on causation, that is of a direct causal link between any of the covered injuries and the need for surgery. Beyond noting Mr Garside had suffered injuries to his left knee over time, Mr Balance does not provide any medical reasoning how those injuries are causally linked to the meniscal tear.

[31] There is no evidence of a meniscal tear seen in Mr Garside's knee prior to 2017. An x-ray taken in 1991, following his first injury, did not uncover any bony injury, and no abnormality was found but for a bipartite patella which was noted as likely to be congenital in nature.

[32] Dr Medlicott explained that a direct blow to the knee is not a known cause of medial meniscal pathology. When Mr Garside was treated for his 2002 injury, Mr Rutherford noted an infected tibial tubercle; Dr Medlicott noted that this is unlikely to be related to the meniscal tear.

[33] Dr Medlicott opined that it would be unlikely for a meniscal tear to have gone unnoticed since 1991, and that the meniscal pathology was associated with some chondral changes which usually means the meniscal pathology is degenerative.

[34] At hearing, Mr Garside produced a copy of the operation note together with photographic slides of his knee that were taken at surgery. He confirmed surgery was performed in the public system. Mr Garside said that following his surgery, "the meniscal tear had been fixed and his knee fixed." Mr Garside said that it took him approximately a year after surgery to return to truck driving.

[35] Mr Garside submitted the Corporation had not proved its case. He said he was knocked out in 1991 and he has had "smashed knees" in two other accidents arising from mountain bike and motor vehicle crashes. All of these accidents caused blows to his knee caps. He said he had to put up with pain over many years. He queried why it was the Corporation continued to state his need for surgery was not caused by his covered injuries. The issue of causation relies on medical evidence.

[36] Following discussion at hearing, Mr Evans agreed to put the operation note and the slides to Dr Medlicott for consideration by the full Clinical Advisory Panel (CAP) to explain why, given the covered knee injuries, Mr Garside could not have developed a meniscal tear. The CAP provided a detailed report dated 26 August 2021 following their meeting on 24 August 2021.

[37] In respect to the claims in 1991 and 2002, CAP opined:

> **CAP Review of 03/07/1991 claim:**
>
> There are two claims on the same date which appear to be "duplicate" claims.
>
> The CAP noted that there were no contemporary clinical records. There was a normal left knee X-ray report dated 08/07/1991 (except for a bipartite patella, which is a developmental variation). There was no evidence of fractures, subluxations, dislocations, soft tissue swelling, hemarthrosis or any other acute injuries on that X-ray report.
>
> The ACC physical file was apparently destroyed, and no further information was available. The first possible mention of this event was in Dr Russell General Practitioner's 16/09/2016 referral to the Orthopaedic Department in which he noted "PHX2 of mountain bike accident that "wrecked" his left knee".
>
> The CAP concluded that, based on the evidence provided, there is no objective evidence of internal, traumatic damage to Mr Garside's left knee on 08/08/1991. The CAP would be happy to review any contemporary clinical information regarding this event if that becomes available.
>
> **CAP review of 29/02/2002 claim:**
>
> There are two claims on the same date which appear to be "duplicate" claims.
>
> The CAP noted the mechanism of injury on 29/02/2002 was that Mr Garside's left knee - the area just under the kneecap (the tibial tuberosity) - impacted a rock when he tripped and fell when carrying rocks and driftwood.

[38] CAP went on to review other injuries referred to by Mr Garside in his evidence that:

> The clinical records indicated that Mr Garside reported other injuries to his left knee, including an assault during a pub fight, being hit on the side of his left knee and possibly another mountain bike accident. There were no ACC claims associated with these. **The CAP would be happy to review the contemporary medical records regarding any other injuries, if they related to an ACC-covered accident, at any time.**
>
> (Emphasis added)

[39] Imaging was also considered by CAP:

> Mr Garside's 05/10/2002 left knee X-ray again showed a bipartite patella with no bony injury. Subsequent medical notes on 08/10/2003 recorded that the left knee tibial tuberosity became infected and inflamed. Mr Garside apparently received one dose of intravenous antibiotics and 7 days of oral flucloxacillin antibiotics which settled the infection. As Mr Garside "was convinced that there is a problem requiring surgery" Dr Mike Kaw General Practitioner Locum referred Mr Garside for Orthopaedic review.

[40] The Court particularly observes that CAP considered the report from Mr Rutherford, orthopaedic surgeon who saw Mr Garside in 2003 and noted no evidence of meniscal tear. CAP stated:

> On 13/03/2003 Mr Alex Rutherford Orthopaedic Surgeon noted intermittent swelling and inflammation of Mr Garside's left knee tibial tuberosity which was probably a bursitis which would settle. He noted on physical examination "the knee itself is normal". There was no evidence of a meniscal tear or any internal derangement of Mr Garside's left knee. The CAP commented that this was a minor injury to the tibial tuberosity.

[41] The CAP reviewed Mr Garside's left knee imaging available– the X-ray on 22/02/2017 and the MRI scan on 26/06/2017. The CAP noted that Mr Garside had signs of gradual onset left knee joint deterioration:

- On the 22/02/2017 weight-bearing X-rays there was medial joint space narrowing.

- On the 26/06/2017 MRI scan, particularly the coronal T2 images, there was significant thinning of the cartilage over the tibia in the medical compartment and a partly extruded, chronic medial meniscus with fragments indicating longstanding wear.

[42] Other points made by CAP in reaching a conclusion on age related deterioration are as follows:

- that symptomatic knee pain and radiographic knee joint deterioration gets more common in the general population as we get older. This is known to develop slowly over a long time. Mr Garside's recorded symptoms of worsening left knee pain are consistent with his gradually progressive left knee deterioration which had eventually became bothersome and symptomatic by around 2016 when he sought medical assistance.

- Referring to medical literature, left knee pain is very common, up to 50% of people aged 50 years and over (like Mr Garside) report knee pain during the course of one year, and around 25% report severe and disabling pain.

- Changes such as those seen on Mr Garside's imaging are not the result of a single episode of trauma, but rather, are part of a disorder of the entire knee joint. All the structures in the knee joint work together to provide knee bending, twisting and all the other complex leg functions, so, when one part starts to deteriorate, it follows that other parts worsen too.

- Cartilage loss like that seen on Mr Garside's imaging is the hallmark of gradual deterioration. This can be associated with changes to the subchondral bone, synovial membrane, menisci, ligaments, tendons and muscles. Everyone's knees deteriorate differently, and it is not possible to estimate with any degree of accuracy when Mr Garside's left knee started to deteriorate. It was probably sometime between the 2002 imaging (which was reported as normal) and the 2017 imaging, and it probably took some years to get to the point where it became symptomatic and required surgery.

[43] The CAP concluded:

> "The CAP noted that the most likely explanation for Mr Garside's left knee problems and symptoms is a gradual onset, constitutional condition rather than reported trauma from some decades ago. Mr Garside's left knee meniscal tearing and cartilage thinning is part of the age-related deterioration of his left knee joint, which is commonly found in the general population in the absence of trauma. A causal link between this and/or his 26/07/2019 surgery and/or his 03/07/1991 and/or 29/09/2002 ACC claims and/or any other reported injuries and/or any combination of these seems most unlikely, based on the information provided."

[44] For the sake of completeness, the Court observes in September 2016, Mr Garside's GP Dr Russell noted in his assessment that early osteoarthritis was developing in Mr Garside's knee.

[45] I adopt Judge Powell's approach in *Lucas* that when the Court assesses competing medical reports, clarity and logic is looked for together with medical reasoning. Here, the Court does not find any medical reasoning on causation in Mr Balance's report. Dr Medlicott explained after some 30 years it is less likely a medial meniscal tear was caused by a direct blow. The Court prefers the opinion of the CAP because of the detailed analysis and reasoning leading to the conclusion of no causal link between the need for surgery indicated in the operation note and photographs in 2019, and any of the covered injuries.

Decision

[46] There must be a causal link between any of the covered injuries in 1991 or 2002 and the need for surgery in order for Mr Garside to access entitlement to funding for surgery under the Act.

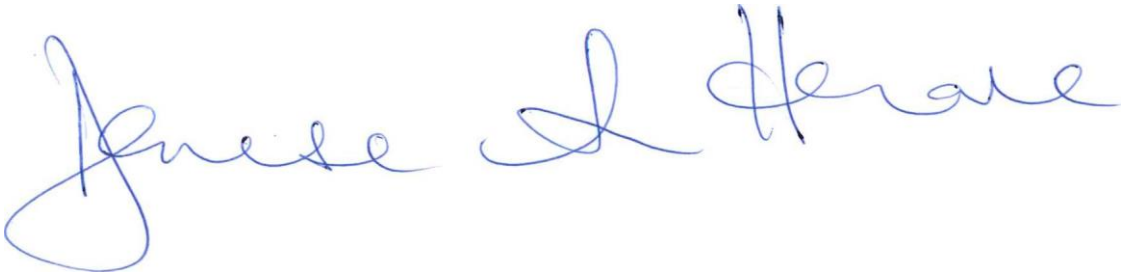
[47] Taken together, the Court finds on balance that the weight of the medical evidence particularly from Dr Russell, Dr Medlicott and the CAP is overwhelming on the issue of causation.

[48] Since the weight of the medical evidence on causation shows no causal link between the meniscal tear and any of the covered injuries in question, the need for funding for surgery is not made out.

[49] For this reason, the appeal is unsuccessful.

[50] Accordingly, the appeal is dismissed.

[51] There is no issue as to costs.



Judge Denese Henare
District Court Judge

Solicitors: Hamish Evans, Barrister, Christchurch for the respondent