IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 124 **ACR 315/18**

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

Hearing: 25 May 2022
Heard at: Auckland/Tāmaki Makaurau

Appearances: Appellant in person
Mr L Hawes-Gandar and Ms F Becroft for the Respondent

Judgment: 28 June 2022

RESERVED JUDGMENT OF JUDGE C J McGUIRE
[s 32 Treatment injury - Accident Compensation Act 2001]

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[1] In June 2016, the appellant lodged a claim for cover with the Accident Compensation Corporation for complications arising from surgery undertaken on 14 December 2015. Mr Chikasha sought cover for a wound (with complications) to his left leg caused by revision surgery on 14 December 2015 being left femoral fistula surgery.

[2] There is no dispute that the left leg wound was caused by treatment received from a registered medical professional. The claim was declined on the basis that the left leg wound was an ordinary consequence of the treatment and thus excluded under s 32(1)(c) of the Accident Compensation Act 2001.

Background

[3] The respondent has summarised the appellant's medical history as follows:

5 April 1982	Mr Chikasha is born with reflux nephropathy from a congenital neurological abnormality of posterior urethral valves.
17 May 2007	Mr Chikasha is seen in the renal clinic at Waitematā DHB by Dr Kushma Nand, Nephrologist. Transplantation and pre-emptive transplantation were discussed. Mr Chikasha is referred for pre-dialysis education at Auckland DHB.
26 June 2007	Mr Chikasha is seen at home by Devin Mynett, pre-dialysis nurse specialist. Peritoneal dialysis, haemodialysis and also transplantation are discussed, including the advantages and disadvantages of each treatment as well as the risk factors associated with each type of treatment.
17 July 2007	Mr Chikasha is seen by Dr Nand who notes that Mr Chikasha is working towards a pre-emptive renal transplant with his father as the potential donor.
30 July 2007	Mr Chikasha is seen by Bridget Faire, renal transplant recipient coordinator, and provided information about potential renal transplantation and live kidney donation.
2007 – 2008	Mr Chikasha misses appointments with Dr Nand and Devin Mynett. Michael Chikasha, the appellant's father, has advised that Mr Chikasha was overseas during these two years.
18 February 2009	Mr Chikasha reaches end-stage renal failure. He presents at Waitakere Hospital and is transferred to Auckland Hospital on 19 February 2009.
June 2009	Dialysis is started.
March 2013	Femoral dialysis catheter is inserted.
July 2013	Mr Chikasha is transferred from Auckland DHB to Waitematā DHB and has his first treatment at Waitematā DHB on 18 July 2013.
28 August 2013	Mr Chikasha is seen by Dr Janak de Zoysa, clinical director and consultant Nephrologist. The option of peritoneal dialysis assisted self-care haemodialysis, or haemodialysis is discussed.
November 2013	The femoral dialysis catheter becomes infected (it requires an exchange of lines in February 2014 and is eventually removed in 2015).
2 July 2014	Mr Chikasha has a left femoral AV fistula formed.

December 2014	The fistula is angioplastied (recanalized) at surgery.
14 December 2015	Mr Chikasha undergoes repair of a superficial left femoral artery dissection at the fistula and anastomosis by a great saphenous vein patch. This is complicated by a significant blood loss.
22 January 2016	Mr Chikasha undergoes a further angioplasty of the superficial femoral artery stricture with a drug coated stent.
30 January 2016	A large fluid collection is drained.
15 April 2016	Mr Chikasha undergoes debridement of the left thigh wound. An endovascular embolization of the left thigh arteriovenous fistula is undertaken to encourage, amongst other things, left thigh wound healing.
Mar 2016 – October 2016	Mr Chikasha has peritoneal dialysis for this period.
October 2016 – June 2018	Mr Chikasha has haemodialysis and has a kidney transplant in June 2018 donated by his father.

[4] An ACC injury claim form was completed in June 2016 for a treatment injury arising from the December 2015 surgery. The claim was lodged on the basis that Mr Chikasha developed complications following the 2015 surgery.

[5] A treatment injury claim form was completed on 1 July 2016 by Dr Ahamed. It was noted that the claim for cover was based on the 2015 revision surgery having caused post-operative wound and infection and wound dehiscence, that is the breaking open of a wound that is partly healed. Mr Chikasha's symptoms were identified as leg pain, decreased mobility, open thigh wound and recurrent infection. Underlying health conditions were identified as including end-stage renal failure and arterial thrombus (blood clot).

[6] The Corporation investigated the claim, obtaining clinical notes from the relevant DHBs as well as comments from the treating specialists.

[7] Mr Carl Muthu, Vascular Surgeon at Auckland DHB, responded, in writing to the Corporation on 26 July 2016 saying amongst other things:

> … Percy Chikasha has an extremely medically complicated situation and has end-stage renal failure due to congenital urologic abnormalities. Unfortunately,

is unable to have a fistula for dialysis in his upper limbs due to central venous obstruction therefore had AV fistula placed in left thigh. In December 2015, he needed an operation to revise this. Unfortunately following his operation had prolonged issues poor wound healing in his thigh. The multiple causes for the poor wound healing in his thigh. Firstly, is general poor wound healing due to the fact that he is renal failure. Secondary, he has lymphoedema from his leg surgery. Thirdly, he has some venous hypotension due to the fistula itself. Fourthly, infection has also played a role. I do not think management of Mr Chikasha's anti-coagulation has affected the wound healing. The delayed wound healing is the direct consequence of his surgical treatment.

Given his background, I am not surprised that he had a wound complication after the surgery. However, I am surprised at the severity of his complication and how long it has taken to resolve.

[8] Mr Dilip Naik, Vascular Surgeon, responded to ACC on 20 September 2016. After describing Mr Chikasha's history and presentation, he said:

> In my opinion, in this specific case, the large complex subcutaneous collection was an ordinary consequence of the treatment taking into account the client's underlying health, treatment provided and clinical knowledge at the time. The surgery performed on 14 December was redo surgery. There was significant bleeding at the time with a significant amount of blood loss. The patient had been on Warfarin and also had chronic renal failure and therefore had an underlying tendency to bleed. In my opinion, the risk of developing wound collection in the setting would be of the order of 5%–10% and accordingly in my opinion, the large subcutaneous collection which occurred could be regarded as an ordinary consequence of the treatment because the patient was at high risk to develop a significant wound collection.

[9] The Corporation sought independent external medial comment from Dr Nicola Hay, renal physician who prepared a report dated 7 October 2016. Dr Hay noted that she did not have the medical information for the period prior to December 2015. Notwithstanding, she stated:

> It is inconceivable that all renal replacement therapy options (haemodialysis, peritoneal dialysis, kidney transplantation, and conservative care), were not addressed.
>
> The DHB correspondence of the problem list of medical events described multiple vascular access complications. The central vessels/superior vena cava are stenosed with extensive collateral formation as a consequence of multiple central venous dialysis catheters and infective episodes. There is also a history of recurrent femoral vein dialysis line infection. Securing permanent vascular access for haemodialysis has been extremely challenging.
>
> ...
>
> In my opinion, an appropriate standard of treatment has been provided to this patient. A series of recognised complications have occurred in relation to the

> left femoral arteriovenous fistula. These began with recurrent episodes of fistula stenosis requiring angioplasty. Dissection of the vessel is a recognised complication of endovascular intervention (i.e. angioplasty). This fistula was no longer providing reliable dialysis and so a revision procedure was required (14/12/15). This surgery was technically difficult and associated with bleeding and haemodynamic instability. This was unrelated to Warfarin which had been ceased on 7/12/15. The tissues were scarred and oedematous and chronic lymphedema is a recognised complication in this setting. Pore wound healing occurs in oedematous infected tissues with compromised circulation and the uraemic state. The chronic pain in mobility problems have become significant and may well be ongoing. Vascular access revision surgery (14/12/15) was clearly indicated as Mr C's vascular access options were profoundly limited; approaching the point where haemodialysis would no longer be possible. It is unclear from the clinical notes provided as to why peritoneal dialysis had not been considered much earlier in the course of this man's illness (i.e. pre-2014/2015). The requirement for this to be a home-based therapy may well have influenced the decision making process. In hindsight, a tradition to home based peritoneal dialysis, or indeed live donor renal transplantation, would have potentially avoided this unfortunate sequence of events. However, the renal physicians involved in the care of Mr C as his disease progressed and ultimately reached in stage renal failure in 2009 can provide more appropriate comment in this regard.

[10] In line Dr Hay's advice, the Corporation wrote to the DHB to obtain further information from the treating renal physician in respect of the treatment options discussed with Mr Chikasha and whether Mr Chikasha was advised of haemodialysis, peritoneal dialysis, kidney transplantation and conservative care. The DHB was also asked to provide treatment on "peritoneal dialysis was not considered before 2014/2015 in this case".

[11] An email thread was subsequently received by the Corporation beginning with Dr Swain-Williams. He forwarded the Corporation's request to the treating nephrologist, Dr de Zoysa who responded on 18 October 2016. Dr de Zoysa provided a history of the treatment advice provided to Mr Chikasha and his family from 2007 to 2016. Dr de Zoysa stated that information regarding treatment options, including peritoneal dialysis, had been provided in 2007, 2013, 2015 and 2016. Dr de Zoysa indicated that Dr Ian Dittmer from Auckland DHB would be able to comment on the advice supplied when treated at the Auckland DHB.

[12] The next comment on the email chain was from Dr de Zoysa, on 18 October 2016 when he advised:

> Mr Chikasha was initially seen in the renal clinic at Waitematā DHB 17 May 2007 by Dr Kushma Nand, nephrologist. He was seen in clinic with his mother. Transplantation and pre-emptive transplantation was discussed. He was referred for pre-dialysis education at ADHB.
>
> He had a home visit by Devin Mynett, pre-dialysis nurse specialist on 20 June 2007 where he was seen with his mother. Peritoneal dialysis and haemodialysis and also transplantation were discussed including the disadvantages and advantages of each treatment and also the risk factors associated with each type of treatment.
>
> He was reviewed 17 July 2007 by Dr Nand. It was commented that Mr Chikasha was working towards a pre-emptive renal transplant with his father as the potential donor.
>
> Mr Chikasha was seen by Bridget Faire, renal transplant recipient coordinator, 20 July 2007 and was provided information about potential renal transplantation and live kidney donation. Work up was advised and planned.
>
> He missed follow up appointments with Dr Nand Sept 2007, Nov 2007 and July 2008.
>
> He missed follow up appointments with Devin Mynett 2007/2008. I am uncertain of the exact dates but this was three appointments.
>
> He presented at Waitakere Hospital 18 February 2009 with advanced chronic kidney disease, was transferred to Auckland Hospital on 19 February 2009. A family meeting was held with Dr Michael Collins, Mr Chikasha and his mother and dialysis was discussed. It was not clear which modality of dialysis was discussed or the option of renal transplantation. Mr Chikasha was followed in clinic by the team at Auckland DHB from February 2009 and started dialysis in June 2009…

[13] The medical information was considered by the Corporation's internal complex claims panel on 27 October 2016 and the Corporation per issued its primary decision on 31 October 2016 declining the claim for cover.

[14] It was noted in the accompanying treatment injury report that the claim was initially lodged for "wound dehiscence of the left thigh arteriovenous (AV) fistula wound and left thigh collection requiring debridement. However, following discussion with Mr Chikasha's father, the Corporation was advised of additional issues, including that Mr Chikasha was not offered peritoneal dialysis and he was not provided advice about transplantation.

[15] The medical information was set out in detail in the treatment injury report which included:

> When he represented in 2009, he was in end-stage renal failure. Again the options were discussed with him and his mother and father over several meetings. There was no identified failure to provide treatment in his case. There was no physical injury identified as the end-stage renal disease was a progression of the client's underlying condition which was not medically managed in 2007/2008 due to the client not attending hospital appointments.
>
> In regards to the complications arising from the fistula formation and defunctioning, the advice on file is that these were recognised complications and would be considered in ordinary consequence of treatment. They are not related to a failure to stop warfarin therapy as this was seven days prior to surgery. Expert advice from Mr Naik, vascular surgeon was that given his underlying conditions, client had a tendency to bleed and was at risk of developing a wound collection. Expert advice from Dr Hay renal physician was that the treatment provided in this case was appropriate and that the complications experienced were recognised given the clients underlying condition and ordinary in the circumstances. Therefore the wound infection and wound dehiscence do not attract cover.

[16] Mr Chikasha lodged a review application. However, on 27 July 2017, the Reviewer dismissed this application.

[17] A late notice of appeal was filed on or about 13 October 2018.

[18] Further evidence since filed on behalf of Mr Chikasha include a report from Dr de Zoysa dated 20 March 2019. Dr de Zoysa noted:

> Mr Chikasha is left with significant pain and has limited mobility in the left leg. Prior to this, he was mobilising independently.
>
> Between December 2014 and March 2019, he has a wound in the left thigh and left calf. This wound is now healed in March 2019 but has previously broken down and remains under surveillance by the renal team. He has previously needed regular district nurse input.
>
> ...
>
> Mr Chikasha has needed renal replacement therapy as life preserving therapy since June 2009. He required dialysis access to allow this. The angioplasty and complications from the procedure are a recognised potential complication of that therapy.

[19] In response to further questions from ACC regarding informed consent for the 14 December 2015 surgery and discussions about treatment options and alternatives, Dr de Zoysa responded on 13 September 2019:

> Mr Chikasha was seen in 2009 at Auckland DHB and had pre-dialysis education. Mr Chikasha commenced haemodialysis in June 2009 at Auckland DHB. I am unsure of what options for renal replacement therapy were discussed with him and the details of this would be best confirmed with the renal team from Auckland DHB. Mr Chikasha's care was transferred to North Shore Hospital in July 2013. Peritoneal dialysis assisted care haemodialysis and home haemodialysis was discussed with Mr Chikasha in August 2013. Peritoneal dialysis was discussed with Mr Chikasha in December 2013. Home haemodialysis was discussed with Mr Chikasha in September 2014. Home haemodialysis, assisted care haemodialysis and kidney transplantation were discussed with Mr Chikasha in February 2015. Kidney transplantation was discussed with Mr Chikasha in August 2015.

[20] ACC also obtained a report from vascular surgeon, Mr Civil, which included:

> As far as I can determine the usual peri-operative procedures were undertaken in regards to booking, consent, and operation documentation.
>
> I note that Mr Chikasha had been haemodialysis for a number of years and the form of dialysis is usually an issue resolved by the renal service. The vascular service is usually consulted for technical matters such as the formation of a fistula or for procedures to maintain patency of the fistula. This was what occurred in this circumstance and I would not normally discuss ceasing haemodialysis in a patient who had been on for a number of years in a case where the renal physicians had asked the vascular service to repair a fistula and to maintain vascular access.

[21] In a further email of 4 November 2019 to the Waitematā District Health Board, Dr de Zoysa said:

> I have reviewed the clinical records and electronic records. I discussed peritoneal dialysis with him in August 2013 and December 2013 and again in April 2016.

[22] On 18 March 2020, Mr Naik was asked to respond to the question:

> *In terms of the surgery that was responsible for the left leg wound and having regard to Mr Chikasha's underlying health at the time of the causative surgery, was a risk of a wound occurring from surgery greater than 50%? Was it more likely that not that Mr Chikasha would suffer a wound from the surgery?*
>
> In my opinion, it was highly probable that the risk of Mr Chikasha sustaining a wound would be greater than 50%. The risk of wound complications in a de novo femoral thain fistula surgery in the article referenced is 28%. In Mr Chikasha's case, it was a redo surgery with extensive scarring. Furthermore, the patient had evidence of venous hypotension and lymphedema. Accordingly, given these multiple risk factors, in my opinion, the risk of him sustaining wound complications would probably be greater than 50%.

[23] In a report dated 27 March 2020, Dr Nicola Hay, renal physician, commented on the issue of informed consent:

> There is very comprehensive documentation of detailed and informed consent concerning the angioplasty procedure on 12 December 2015.
>
> The "agreement to treatment" surgical/anesthetic consent form relating to the fistula surgery on 13 December 2015 is also very detailed with respect to risks.

Appellant's submissions

[24] Mr Chikasha recalled what occurred on 14 December 2015 from his perspective. He said it was supposed to be a 30-minute procedure. He said he woke from the anesthesia to find that he needed to be taken to Auckland Hospital on account of a "complication with your leg". He said that everything changed for the worst from that time. He stayed in hospital for 30 days and had to return three times.

[25] He said that he had an argument with the vascular surgeon Mr Muthu who said that everything was going to be fine. After the 30 days in hospital, he was then on crutches and in a wheelchair.

[26] He spoke of what followed and the eventual kidney transplant from his father in June 2018. Both his father and his three siblings had offered to donate a kidney.

[27] He confirmed that after the operation in December 2015, he was left with two wounds on his left leg that would not heal and they ended up becoming one large wound.

[28] He said that, a month later, the wounds closed up and he was left with a big scar. He is left in a position where he cannot do simple exercise, he cannot run and all weight is now on his right leg with his left leg still swollen.

[29] He said that he came out from an operation "messed up" and that it was not fair.

[30] He said that so far as his leg was concerned serious mistakes had been made and that it was only because of someone's quick thinking while he was on the operating table that he came out alive.

[31] He said he had to sign things as he was going into theatre and that he had no time to think about them or what they were for. He said that when taken to Auckland Hospital, he was on palliative care and that it was only through his mother's strong intervention when she demanded answers from those caring for him that things changed. He stated that, for ten years, he had been frustrated over the issue.

[32] He told the Court that he cannot get a proper job and that he is only three quarters functional.

[33] He said that when he started dialysis in 2009, family members were prepared to donate a kidney, but Dr Dittemer and others declined it.

[34] He said that if a transplant had occurred then, none of the matters arising from the 2015 surgery would have occurred.

[35] He reiterated that in 2015, the only education he had about the operation was "just outside the theatre". He reiterated that he was asked to sign a form just few minutes before he went into theatre. He said this happened every time he had an operation.

[36] He said that transplant had been the only solution for more than ten years and that it was the best solution. However, "the longer you are on dialysis, the more chance of complication".

[37] He reiterated that the hospital team did not want to do a transplant even though family members were willing to donate a kidney. He says Dr Dittmer "was blocking us from day one".

Respondent's submission

[38] Ms Becroft acknowledged that for Mr Chikasha, life was not fair having been born with this serious congenital condition. She acknowledges from 2009 he was at end-stage renal failure. It was at that time that he started haemodialysis and that this occurred three to four times a week for a number of years during which time there was discussion regarding possible transplant. She says that in 2013, the dialysis was not working properly, and that stenosis occurred (vein narrowing) with the fistula in his thigh. He underwent angioplasty procedure in 2014 for this.

[39] She notes that surgery occurred on 13 December 2015, not 14 December 2015 as is recorded in many of the documents. In this regard, she refers to the clinical summary of Auckland City Hospital noting the surgery commencing at 8.51 am on 13 December 2015.

[40] She notes that unfortunately a significant wound injury occurred and did not heal. There were problems with infections. There was further angioplasty. There was debridement in April 2016, and he was admitted as an inpatient in June 2016.

[41] She notes that he was on peritoneal dialysis for a period in 2016 and then went back to renal dialysis.

[42] She acknowledges and accepts that the injury was caused by treatment. However, the issue here is whether or not the injury was an ordinary consequence of the procedure.

[43] She submits there is a clear consensus from Dr de Zoysa, Dr Naik and Dr Hay that accepting the appellant's wound was caused by the treatment, it was an ordinary consequence of the procedure.

[44] She refers to the Court of Appeal decision in *ACC v Ng and L*[1] where the Court said, regarding the interpretation of the words "not an ordinary consequence?":

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1 *Accident Compensation Corporation v Ng* [2020] NZCA 274, [2020] 2 NZLR 683.

> [68] In our view, it should be interpreted as meaning an outcome that is outside of the normal range of outcomes, something out of the ordinary which occasions a measure of surprise. That is an interpretation that we consider, as did the Court in Childs v Hillock, best captures Parliament's intent in the context of a scheme which is underpinned by the concept of "personal injury by accident" and which does not provide universal compensation for sickness or ill-health …
>
> [69] Whether an adverse consequence is inside or outside the normal range of consequences of the medical treatment given to a particular claimant is ultimately a matter of judgment for the decision maker. It is to be exercised on a case-specific basis taking into account all the circumstances of the treatment and the particular claimant. Thus, relevant circumstances will include not only the nature of the harm suffered but also its duration and severity as well as any other circumstances pertaining to the patient which may have rendered them more or less susceptible to the adverse consequence. The decision may be informed by medical studies including relevant statistical analysis … as well as the clinical experience of the treating physician(s) and other specialists.

[45] Ms Becroft submits that the criteria set out in *Ng*'s case is not met.

[46] She submits the appellant gave informed consent and that this is supported the reports of Dr de Zoysa and Dr Dittmer.

[47] She notes that the issue was reviewed by Mr Civil, Dr Naik and Dr Hay. Their conclusion was the usual perioperative procedures had been undertaken and that there was informed consent.

Decision

[48] Section 32(1) to (3) of the Accident Compensation Act 2001 reads:

> (1) **Treatment injury** means personal injury that is—
>
> (a) suffered by a person—
>
> (i) seeking treatment from 1 or more registered health professionals; or
> (ii) receiving treatment from, or at the direction of, 1 or more registered health professionals; or
> (iii) referred to in subsection (7); and
>
> (b) caused by treatment; and
>
> (c) not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment, including—
>
> (i) the person's underlying health condition at the time of the treatment; and
> (ii) the clinical knowledge at the time of the treatment.

(2) **Treatment injury** does not include the following kinds of personal injury:

(a) personal injury that is wholly or substantially caused by a person's underlying health condition:

(b) personal injury that is solely attributable to a resource allocation decision:

(c) personal injury that is a result of a person unreasonably withholding or delaying their consent to undergo treatment.

(3) The fact that the treatment did not achieve a desired result does not, of itself, constitute **treatment injury**.

...

[49] The term "treatment" is defined in s 33 as including, amongst other things:

(a) the giving of treatment:

(b) a diagnosis of a person's medical condition:

(c) a decision on the treatment to be provided (including a decision not to provide treatment):

(d) a failure to provide treatment, or to provide treatment in a timely manner:

(e) obtaining, or failing to obtain, a person's consent to undergo treatment, including any information provided to the person (or other person legally entitled to consent on their behalf if the person does not have legal capacity) to enable the person to make an informed decision on whether to accept treatment:

[50] One cannot help but have great sympathy for the position Mr Chikasha found himself in after the operation on 13 December 2015 and the massive challenges he has had to face since that time on account of substantial incapacity with his left leg.

[51] As the issue of informed consent, amongst the papers before the Court is an "agreement to treatment" form that appears on its face to have been generated on 11 December 2015 by the Auckland District Health Board. At the time of the document, there appears to be a sticker which has Mr Chikasha's full name, date of birth and address and then "11/12/2015 vascular service". The document proceeds with appropriate portions completed in handwriting. It reads:

> I, Percy Christopher Chikasha, agree to left femoral fistula revision – femoral patch angioplasty.
>
> Risks: Bleeding, infection, trauma to surrounding structures – bruising, oedema, nerve impairment, numbness, distal embolic heart attack, stroke, death.

> Be performed on me …
>
> I have been able to discuss this with Gym Richardson, nurse specialist.
>
> He/she has explained the reasons and expected risks to me of the procedure relating to my clinical history and condition and I agree to this treatment/procedure. I have had adequate opportunity to ask questions and these have been answered to my satisfaction. I understand that during this procedure, images or pictures may be captured if relevant to my care. These images will be incorporated into my clinical record. I understand that I am welcome to ask for more information if I wish.

[52] The document then appears to be signed by the appellant and Mr Richardson; and dated 11/12/15. Mr Richardson's designation is "nurse specialist vascular". This portion of the document is dated 11/12/15. Then below this:

> I have read or had explained to me the anaesthetic information left it. I have had adequate opportunity to ask questions about the anaesthetic for the above procedure and these have been answered to my satisfaction …

[53] What follows is the signature of the clinician with the designation "specialist" then follows this:

> I agree to this anaesthetic being given. I acknowledge that I should not drive a motor vehicle nor operate machinery or potentially dangerous appliances, drink alcoholic beverages, or make important decisions for 24 hours after the operation having had a general anaesthetic and or narcotic or sedative agent administered.

[54] The document is then signed again by the patient and the clinician and dated 13/12/15.

[55] On its face therefore, this agreement to treatment document appears to have been put to the appellant on two occasions. Firstly, on 11 December 2015 when on its face, the appellant agreed that there were wide ranging risks with the operation including bleeding and death and then two days later, on 13 December 2015, the appellant again signs the document agreeing to anaesthesia.

[56] The letter completion regarding anaesthesia is consistent with the appellant's recollection that he signed consent just before the operation on the day of the operation.

[57] However, there is nothing before me that would indicate the first part of the document the appellant signed was incorrectly dated 11 December 2015, two days before the operation, where the stark risks of the operation were set out.

[58] Accordingly, I conclude that the appellant is mistaken and his recollection that he effectively had no time to consider the risks of the operation.

[59] Dr de Zoysa, consultant nephrologist, says in his report of 20/03/2019:

> Mr Chikasha has needed renal replacement therapy as life preserving therapy since 2009. He required dialysis access to allow this. The angioplasty in complications from the procedure (of 13/12/2015) are a recognised potential complication of that therapy.

[60] Mr Muthu, vascular surgeon at Auckland DHB, said in his response of 26 July 2016:

> The delayed wound healing is the direct consequence of his surgical treatment. Given his background, I'm not surprised that he had a wound complication after the surgery. However, I am surprised at the severity of his complication and how long it has taken to resolve.

[61] Mr Naik, vascular surgeon, said in his report of 20 September 2016:

> In my opinion, in this specific case, the large complex subcutaneous collection was an ordinary consequence of the treatment taking into account that the clients' underlying health, treatment provided and clinical knowledge at the time. The surgery performed on 14 December (sic) was redo surgery. There was significant bleeding at the time with a significant amount of blood loss.
>
> ...
>
> Accordingly, in my opinion, the large subcutaneous collection which occurred can be regarded as an ordinary consequence of the treatment because the patient was at high risk to develop a significant wound collection.

[62] Renal surgeon, Nicola Hay, said in her report of 7 October 2016:

> In my opinion, an appropriate standard of treatment has been provided to this patient. A series of recognised complications have occurred in relation to the left femoral arteriovenous fistula. These began with recurrent episodes of fistula stenosis requiring angioplasty. Dissection of the vessel is a recognised complication of endovascular intervention (i.e. angioplasty). This fistula was no longer providing reliable dialysis and so a revision procedure was required (14/12/15). This surgery was technically difficult and associated with bleeding and haemodynamic instability.

[63] And in her later report of 27 March 2020, she said:

> Noting the extensive history of previous vascular surgery and other interventions (placement of temporary and tunnel dialysis catheters, thrombolysis and angioplasties, and multiple prior infections) with resultant central venous stenosis and extreme challenges in securing dialysis access to any part of Mr Chikasha's vasculature, my personal opinion is that there was at least a 50% likelihood that Mr Chikasha would experience wound healing complications as indeed eventuated.

[64] Clinical director and consultant nephrologist, Dr de Zoysa, said this in his report of 20 March 2019:

> Was the injury a necessary or ordinary consequence of that treatment?
>
> Mr Chikasha has needed renal replacement therapy as life preserving therapy since June 2009. He required dialysis access to allow this. The angioplasty and complications from the procedure are a recognised potential complication of that therapy.

[65] Regrettably, from Mr Chikasha's standpoint, the weight of medical opinion in this case falls short of establishing on the balance of probabilities that a treatment injury as described in s 32 of the Act occurred. I conclude in terms of what the Court of Appeal said in *Ng,* that in this case the outcome was not outside of the normal range of outcomes, given Mr Chikasha's presenting condition at the time of surgery. What occurred was indeed unfortunate and unwanted but, in my conclusion, not outside the normal range of outcomes, not something out of the ordinary which occasions a measure of surprise, to use the Court of Appeal's words in *Ng.* Accordingly, therefore, I must dismiss this appeal.

[66] There is no issue as to costs.

Judge C J McGuire
District Court Judge

Solicitors: Medico Law Limited, Grey Lynn.