IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 156 ACR 24/21

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPLICATION FOR LEAVE TO APPEAL TO THE HIGH COURT UNDER SECTION 162(1) OF THE ACT
BETWEEN	DALE CHALMERS Applicant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Submissions: B Hinchcliff for the Appellant
F Becroft for the Respondent

Hearing: On the papers

Judgment: 16 August 2022

JUDGMENT OF JUDGE P R SPILLER
[Leave to appeal to the High Court]

Introduction

[1] This is an application for leave to appeal against a judgment of Her Honour Judge Henare, delivered on 5 May 2022.[1] At issue in the appeal was whether the Corporation's decision of 2 May 2018, declining Ms Chalmers' treatment injury claim on the basis her paraplegia was an ordinary consequence of the surgery, was correct. The Court dismissed the appeal, for the reasons outlined below.

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[1] *Chalmers v Accident Compensation Corporation* [2022] NZACC 79.

Background

[2] In 2000, Ms Chalmers was diagnosed with multiple sclerosis. She was 38 years old at the time. She experienced progressively limited mobility and balance problems.

[3] In November 2017, an MRI scan was taken which showed a large disc protrusion at T6/7 with severe canal narrowing secondary to the disc protrusion.

[4] On 17 November 2017, Dr Pereira, Neurologist, set out the medical case for surgical intervention for Ms Chalmers:

> Over the past 10 years she has developed episodic and subsequent progressive lower limb symptoms and immobility which were thought to be MS related. In 2010 she was able to walk 300 metres without support. She is now just able to manage 50 metres.
>
> She has had recent MRI imaging of her brain and spine to investigate this deterioration. This shows active multiple sclerosis with an inflammatory lesion in the brain. Spinal imaging shows a calcified thoracic disc at T6-7 with marked compression of the spinal thoracic cord. There is some atrophy above and below the level of that compression. The canal measures down to just 1-1.5mm at the site of this likely calcified giant thoracic disc herniation. In the lumbar region there is also disc disease with moderate spinal stenosis at the L3-4 level and mild compression of the cauda equina. There are no spinal cord MS lesions to account for her marked lower limb disability.
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> ... We do have effective treatments for multiple sclerosis in 2017 and I do think she should proceed with surgical intervention for this disc as I believe it is contributing to her immobility.

[5] On 8 December 2017, Ms Chalmers was seen by Mr Yee, Orthopaedic and Spinal Surgeon. Mr Yee noted Ms Chalmers' significant mobility issues. He discussed with Ms Chalmers surgical options and the significant risks associated with surgery, in particular the high risk of spinal cord injuries and thus paraplegia:

> On examination today she presented in an electric scooter. She has extreme difficulty walking even a very short distance of a few metres to the examination bed. There is marked gait ataxia with a clear right-sided foot drop. Neurological examination reveals patchy altered sensation in a non-dermatomal pattern in the lower limbs. She also describes a degree of hyperesthesia in the right leg. Power testing demonstrates more significant weakness in the right side in comparison to the left.
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> ... I have advised her that her thoracic spinal cord compression is amenable to surgical intervention, but unfortunately it is associated with a number of

> significant risks. Traditionally, thoracic disc removals are associated with a high risk of spinal cord injuries and thus paraplegia. If the disc is calcified it will often be completely adherent to the dura and a dural tear is very likely to occur as a result of attempting to remove it. I have advised that the other risks of surgery are inclusive but not exclusive of death, medical problems post-operatively, bleeding and requiring a blood transfusion, complications of blood transfusions, thromboembolic issues such as DVT and PE, infection, non-union, mobility from use of either autograft or allograft bone for the fusion, positioning issues including blindness and incomplete resolution of symptoms. I have advised that if the procedure is performed posteriorly, one often needs to sacrifice a thoracic nerve root which can result in some numbness around the chest wall. Alternatively, if the surgery is performed through the thoracotomy then there is some morbidity associated with the approach and also deflation of the lung. If the disc is heavily calcified and a dural tear occurs during the anterior approach this could result in a catastrophic problem of a CSF fistula into the chest. This can be a very difficult problem to solve.
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> I have advised Ms Chalmers that if we were to perform a posterior procedure to her spine it may well be appropriate to consider further imaging after the surgery to check on the adequacy of the decompression. I have also advised her that if there are any neurological problems following the surgery she may well require rehabilitation in the spinal unit.
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> Ms Chalmers informs me that she understands that she has significant problems and also that the surgery is also high risk. However, she is keen to consent to surgery to have her spine decompressed.

[6] Mr Yee conferred with his colleagues at the hospital regarding the surgical method he proposed to adopt in the operation. On 7 February 2018, the surgery took place. In an operation note of the same date, Mr Yee recorded that the operation entailed four different surgical procedures: T5 to T9 instrumented posterolateral fusion; T6/7 decompression; T6/7 excision/removal of calcified disc; and patching and sealing of ventral dural tear. Mr Yee also reported that the massive calcified disc was severely adherent to the dura in the ventral aspect.

[7] In the evening of the day of the operation, Mr Yee commented in a separate note that the surgery was uneventful and spinal-cord monitoring gave good signals. Postoperatively, Mr Yee noted that Ms Chalmers was incoherent and he was unable to truly assess the neurological situation in her lower limbs.

[8] On 8 February 2018, a post-operative note from Mr Chan, Orthopaedic and Spinal Surgeon, recorded his concerns in the immediate post-operative period that Ms Chalmers did not appear to have "voluntary lower motor extremity power". Mr Chan stated:

> I discussed the situation with her [Ms Chalmers]. I have detailed how calcified thoracic disc prolapses and surgery for these can be associated with cord problems. This was previously outlined to her extensively by Mr Yee.

[9] On 8 February 2018, an MRI was undertaken of the spine which showed an "ill-defined focus of intramedullary T2 high signal intensity within the spinal cord at the T6/T7 level".

[10] Also, on 8 February 2018, following his ward round, Mr Yee recorded that Ms Chalmers had "significant weakness in the lower limbs along with lack of general sensation". He noted "the clinical picture today is suggestive of post-operative paraplegia which is one of my major concerns from the operation". He arranged further review by a spinal colleague. Mr Chan discussed imaging findings with the radiologist and Mr Yee. Mr Chan noted "a very satisfactory decompression of her thoracic disc prolapse has been performed", but there appeared a "high signal area to the spinal cord at this level".

[11] In a note dated 9 February 2018, Mr Yee also reported his review of the MRI scan of the spine with the radiologist. He said there had been a "good decompression at the T6/T7 level":

> However, at the level of the discectomy, there is some high signal within the spinal cord area. This could represent an area of cord infarction, residual myelomalacia or a pseudomeningocoele in the region. This is exactly the area where I had a dural tear as a result of removing the large, calcified thoracic disc and it is also the area where it has been patched...
>
> ... I have called her partner today and explained the findings. I have also explained that one of my biggest concerns was postoperative paraplegia which appears to have occurred.

[12] The diagnosis of post-operative paraplegia was confirmed. On 10 February 2018, Mr Yee referred Ms Chalmers to a Spinal Rehabilitation Unit, indicating in his referral letter:

> The patient was advised that her clinical findings could be attributed to either severe spinal cord compression from the thoracic disc or as a result of the multiple sclerosis. I advised her surgery was a possibility, but unfortunately there is a higher risk of spinal cord malfunction or paralysis following this type of surgery.

[13] On 12 February 2018, Mr Yee completed a treatment injury claim form, and a report setting out the medical history and treatment injury details. He commented:

> Technically surgery went well. Ventral dural tear occurred but this was anticipated. … The patient has been referred to the Spinal Injury Unit for Rehabilitation. I would like to make a claim for a treatment injury on behalf of the patient as the outcome of paraplegia is unexpected and devastating for all parties involved. I accept the fact she was quite weak before surgery but now has no meaningful lower limb function.

[14] On 26 February 2018, Mr Yee responded to questions from the Corporation:

> There are two specific questions ACC have asked and they are difficult to answer. The first question relates to whether I can identify an actual physical injury to the spinal cord resulting in the paraplegia post-operatively. This unfortunately is not simple to answer as the spinal cord itself is covered by the dura and is actually not visualised at the time of surgery. She did sustain ventral dural tear which allowed egress of cerebral spinal fluid. However, the spinal cord is not visible from this small ventral lesion. At the time of surgery there was no direct trauma to the spinal cord itself. In other words there was no lacerations of the area. There was no spinal cord manipulation. However, following surgery with both the first MRI scan and subsequent MRI scan there is clear signal change within the spinal cord. This is indicative of some kind of injury to the spinal cord. Pre-operatively there was some signal change, but certainly worse afterwards. It could be related to even ischaemic changes as a result of the hypertension from having a general anaesthetic. I suspect the spinal cord injury has occurred as a result of a combination of issues. A degree of hypertension from the anaesthesia, altered cord perfusion during the decompression and secondary inflammatory issues as a result of surgery.
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> In regards to the secondary question about Ms Chalmers likelihood of sustaining the injury, the surgery is difficult. The patient was counselled pre-operatively in regards to this potential devastating outcome. As clearly documented in the clinical notes, she had progressive weakness in her lower limbs in comparison to her upper limbs. A subsequent whole spine MRI identified the severe spinal cord compression at the T6/T7 level from a massive calcified disc, Ms Chalmers reports progressive weakness in the legs and the expectation without surgical intervention is for progressive weakness to occur. However, the timeframe for this to occur is uncertain.
>
> I wish to make clear that Ms Chalmers still had some reasonable leg function prior to surgery despite her multiple sclerosis and also spinal cord compression. Following surgery to remove the massive calcified disc, she is paraplegic and there has been a definite deterioration in her neurological function.

[15] On 5 April 2018, Mr Pai, Orthopaedic Surgeon, reported to the Corporation. Mr Pai detailed the relevant medical information and noted that he had "gone through his [Mr Yee's] surgical approach of 07/02/2018 and his surgical technique was of high standard". He also noted that the MRI of 8 February 2018 was clear that

there was no evidence of surgical cause for the paraplegia and that "there was ill defined intramedullary focus of T2 high signal intensity within the decompressed cord of T6/T7 which measured about 6 mm and about 8 mm long". In response to the question whether there was a physical injury causing paraplegia, Mr Pai stated:

> ... in my opinion, the development of new neurology (complete paraplegia) is related to her surgery and is a known complication of surgery in this rare complex spinal condition and this neurological deterioration has been widely reported as being 24 to 75 percent in giant calcified disc surgeries.
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> Mrs Chalmers had impending cord compression prior to surgery and that was the indication for surgery as without surgery her likelihood of total paraplegia was quite high and there was an absolute indication for the performed surgery. Neurological deterioration is not an unknown complication following such major surgical interventions and an informed consent has been taken about this risk. …
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> These vulnerabilities [with any tumour or giant calcified disc] are not under the control of the treating surgeon and these make cord or nerve roots vulnerable after any surgery more so in the presence of a giant calcified disc which is adherent as in this case. Reference 10 suggested that the surgical treatment performed in 53 of 60 patients with trans dural spinal cord herniation and the neurological outcome was satisfactory in only 44 cases. In other words the neurological complications even in best centres is around 20% following surgery. However even considering the high rate of complication, their conclusion was that surgical treatment should be offered as without surgery the progression of neurology would be quite high.

[16] On 2 May 2018, the Corporation declined the treatment injury claim on the basis that the paraplegia was an ordinary consequence of the surgery. The Corporation identified that the new symptoms Ms Chalmers was experiencing were from progression of her underlying spinal cord impairment and multiple sclerosis following the surgery performed on 7 February 2018, and noted that literature showed that there was a very high incidence of this occurring in this particular case.

[17] A review application was lodged against that decision at the time, but it was subsequently withdrawn. A second and late review application was filed in April 2019, which eventually led to the substantive review.

[18] On 17 November 2019, Mr Pai provided a supplementary report confirming his previous opinion, that "the incidence of deterioration has been around 20% in [Ms Chalmers'] case taking into consideration pre-existing multiple sclerosis as there

is bound to be some deterioration in anyone with multiple sclerosis following surgery".

[19] On 24 May 2020, Mr Pai responded to the Corporation in an email dated:

> In my opinion she [Ms Chalmers] has undergone appropriate surgical technique. I cannot confirm any specific physical injury as casing[sic] the progression of her paraplegia considering she has had rare surgery for impending paraplegia with co-existing multiple sclerosis. In my opinion she would likely have developed the same symptoms as her condition ran its natural course.

[20] On 27 October 2020, Ms Noventa, Physiotherapist, reported for Ms Chalmers. Ms Noventa stated she was unclear about certain aspects of the advice provided by Mr Yee, for example, there was no mention of possible percentages indicating risk in the preoperative letter, though these might have been discussed verbally. She thought defining element of surprise is difficult. She assessed that, while the paraplegia "was a possible outcome it was likely not an expected outcome". Ms Noventa commented further:

> MS is a progressive deteriorating neurological condition characterised by periods of exacerbation and remission. A significant number of patients eventually become wheelchair bound. This tends to happen over a long period of time as opposed to the rapid onset of complete paraplegia experienced by Mrs Chalmers post surgery ...
>
> The expert opinions including the treatment injury decision seem to be all in agreement that some aspect of the surgery is the reason for the paraplegia and not the underlying condition of multiple sclerosis.

[21] In December 2020, the review proceeded. The Reviewer noted that there was no dispute that the paraplegia was associated with the surgical procedure and focused on the ordinary consequence test. The Reviewer concluded that the adverse outcome experienced by Ms Chalmers represented an ordinary consequence of the treatment that she received and dismissed the review application.

[22] On 6 January 2021, a Notice of Appeal was filed.

Relevant law

[23] Section 162(1) of the Accident Compensation Act 2001 (the Act) provides:

A party to an appeal who is dissatisfied with the decision of a District Court as being wrong in law may, with leave of the District Court, appeal to the High Court.

[24] In *O'Neill*,[2] Judge Cadenhead stated:

> [24] The Courts have emphasised that for leave to be granted:
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> (i) The issue must arise squarely from 'the decision' challenged: ... Leave cannot for instance properly be granted in respect of *obiter* comment in a judgment …;
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> (ii) The contended point of law must be *"capable of bona fide and serious argument"* to qualify for the grant of leave …;
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> (iii) Care must be taken to avoid allowing issues of fact to be dressed up as questions of law; appeals on the former being proscribed …;
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> (iv) Where an appeal is limited to questions of law, a mixed question of law and fact is a matter of law …;
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> (v) A decision-maker's treatment of facts can amount to an error of law. There will be an error of law where there is no evidence to support the decision, the evidence is inconsistent with, and contradictory of, the decision, or the true and only reasonable conclusion on the evidence contradicts the decision …;
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> (vi) Whether or not a statutory provision has been properly construed or interpreted and applied to the facts is a question of law … .
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> [25] Even if the qualifying criteria are made out, the Court has an extensive discretion in the grant or refusal of leave so as to ensure proper use of scarce judicial resources. Leave is not to be granted as a matter of course. One factor in the grant of leave is the wider importance of any contended point of law … .

[25] Section 32 of the Accident Compensation Act 2001 ("the Act') provides:

> **32 Treatment injury**
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> (1) Treatment injury means personal injury that is—
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> (a) suffered by a person—
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> (i) seeking treatment from 1 or more registered health professionals; or
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> (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

[2] *O'Neill v Accident Compensation Corporation* [2008] NZACC 250.

(c) not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of 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 treatment did not achieve a desired result does not, of itself, constitute a treatment injury.

[26] In the High Court judgment in *Adlam*,[3] Gendall J stated:

> [39] And, the ACC's interpretation here in my view is also consistent with these definitions and the context of the provision whereby s 32(1)(c) requires that treatment injury not be a necessary part or ordinary consequence of the treatment, taking into account the clinical knowledge at the time of the treatment. The Court of Appeal in *McEnteer v Accident Compensation Corporation* has held that s 32(1)(c) requires an analysis that is rooted in the facts of particular cases, requiring expert opinion reflecting what actually occurred.

[27] In the Court of Appeal judgment in *Adlam*,[4] Cooper J stated:

> [62] Taken as a whole the provisions indicate a legislative intent to limit cover for persons who suffer injury while undergoing treatment, rather than providing cover for all those who suffer. The injury said to be a treatment injury must be the consequence of a departure from appropriate treatment choices and treatment actions. The drafting could have simply provided for cover for all injury suffered while a person undergoes treatment. But that course was not taken. Rather, boundaries were set out that have the effect of limiting the availability of cover for injury during treatment. A failure in the sense of omitting to take a step required by an objective standard is necessary.
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> …
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> [65] As is always the case, it is necessary to focus on the words Parliament has actually used. It will be apparent from our reasoning that we have discerned a legislative policy that, while not requiring a finding of negligence, still

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3 *Accident Compensation Corporation v Adlam* [2016] NZHC 1487, [2016] 3 NZLR 497 at [39].

4 *Adlam v Accident Compensation Corporation* [2017] NZCA 457, [2018] 2 NZLR 102 at [62] and [65]; see also *McEnteer v Accident Compensation Corporation* [2010] NZCA 126, [2010] NZAR 301 at [20].

> operates on the basis that a treatment injury will only have occurred where there has been some departure from a standard and that departure has caused a personal injury.

[28] In *Ng*,[5] the Court of Appeal, in relation to the phrase "not [an] ordinary consequence", stated:

> [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. So, for example, side effects of chemotherapy of a nature and severity that are encountered reasonably often and occasion no surprise are ordinary consequences of that chemotherapy even if (as will often be the case) such side effects are not encountered in more than 50 per cent of cases.
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> [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 decisionmaker. It is to be exercised on a case specific basis taking into account all of the circumstances of the treatment and the particular claimant. Thus, relevant considerations 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.

Judge Henare's judgment of 5 May 2022

[29] Judge Henare analysed the submissions and facts presented in light of the above law. Her Honour noted that Ms Chalmers' evidence at review confirmed that she faced stark choices when informed of the seriousness of the giant calcified disc herniation compressing her spinal cord, and that the decision for surgical treatment was undertaken because of the chance it offered to stem the rapid decline of her mobility. Judge Henare noted that, in the period immediately prior to the surgery, Ms Chalmers' functional ability was declining rapidly. Mr Yee told her that, if she did not have surgery, her condition would most likely lead to paraplegia. The evidence also confirmed that Ms Chalmers was warned about the risks involved in the operation.

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

[30] Judge Henare noted that the specialist evidence was that the surgical procedure itself went smoothly with no obvious signs of injury. Her Honour concluded that there was no evidence to suggest a breach of an appropriate standard of care. Judge Henare concluded:

> [77] … Taking into account all of the circumstances both of the treatment and those relating to Ms Chalmers, whilst the paraplegia was certainly neither expected nor desirable, it was not surprising. This is manifest from the clinical reporting of Mr Yee before the surgery and upon discovering the fact of the post-surgery paraplegia, taken together with the reporting of Mr Chan.

[31] Judge Henare accepted that, while statistics would not be determinative, they were a relevant consideration, and considered the statistical evidence provided by Mr Pai. Her Honour noted that, standing back and considering all the evidence objectively, Ms Chalmers was facing a high risk of paraplegia without surgery. Surgery offered an opportunity to decrease the risk of paraplegia, but there was still a high risk of paraplegia.

[32] Judge Henare then summarised her analysis as follows:

(a) The nature of the harm suffered is paraplegia. It is a severe condition that will prevent Ms Chalmers from walking for the rest of her life.

(b) Ms Chalmers' multiple sclerosis may have made her more susceptible to post-operative paraplegia since, in the view of Dr Pereira, it was contributing to her immobility.

(c) Mr Pai's analysis of medical statistics indicates there is in general a 4 to 10% chance of post-operative paraplegia after the type of surgery undertaken by Ms Chalmers.

(d) Mr Yee indicated before the operation was performed there was a high risk of post-operative paraplegia.

[33] Judge Henare concluded that, while Ms Chalmers' paraplegia was devastating, her post-operative paraplegia was within the normal range of consequences of the surgical treatment, and thus an ordinary consequence of the surgery. Her Honour therefore dismissed the appeal.

The appellant's submissions

[34] The advocate for Ms Chalmers framed two questions of law:

(a) Did the Judge err when making findings of fact and law related to the statistical outcome?

(b) Did the Judge err when deciding that, when a chance of the injury occurring is 4-10%, and the use of the word "unexpected" does not create a level of surprise?

[35] The advocate submitted that:

(a) Multiple sclerosis (referred to by the Court) is an irrelevant consideration: the evidence is that the surgery caused the paraplegia and not multiple sclerosis.

(b) The Court incorrectly relied heavily upon the opinion of Dr Pai: he is not a neurosurgeon, and his percentages of the chance that the injury would occur were incorrect.

(c) The Court found that a 4%-10% chance of an injury does not occasion a measure of surprise, whereas, in the decision in *Accident Compensation v Ng and L*, the Court of Appeal found that Ms Ng's 16-22% and Ms L's 10-38% chances occasioned a measure of surprise.

Discussion

[36] As noted above, Ms Chalmers must establish that the decision of Judge Henare was wrong in law. A decision-maker's treatment of facts can amount to an error of law where there is no evidence to support the decision, the evidence is inconsistent with, and contradictory of, the decision, or the true and only reasonable conclusion on the evidence contradicts the decision.

[37] This Court can discern no errors of law made by Judge Henare. Her Honour framed her judgment correctly with reference to the terms of section 32 of the Act and the leading judgments in *Adlam* and *Ng*. The focus thus turns to whether Judge

Henare's treatment of the facts amounted to an error of law, to the extent outlined above, for the reasons advanced on behalf of Ms Chalmers.

[38] First, this Court finds that Judge Henare did not make a mistake of fact in her reference to multiple sclerosis. Judge Henare explicitly stated throughout her judgment that the nature of the harm suffered by Ms Chalmers was paraplegia. Judge Henare's reference to multiple sclerosis simply highlighted the possibility that this may have made her more susceptible to post-operative paraplegia, since, in the view of Dr Pereira, it was contributing to her immobility. The Court of Appeal in *Ng* noted that a relevant consideration for deciding whether an adverse consequence was inside or outside the normal range of consequences of medical treatment was a circumstance pertaining to the patient which may have rendered her more or less susceptible to the adverse consequence.[6]

[39] Second, this Court finds that Judge Henare did not make a mistake of fact in referring in support, to the opinion of Dr Pai, an Orthopaedic Surgeon. In view of the fact that the operation in question was conducted by an Orthopaedic Surgeon, Dr Pai's views were entitled to some weight. As to the statistics cited by Dr Pai, Judge Henare noted that the risk of paraplegia changed in Dr Pai's two reports from 24% to 75% in his first report, to between 4% and 10% in general and 20% in respect of Ms Chalmers. Judge Henare preferred Mr Pai's second report as it developed the medical reasoning from his first report with reference to evidence, including medical literature, and Judge Henare observed that the 4%-10% statistic was supported by a 2018 study provided in evidence. Judge Henare noted that statistics would not be determinative, but that they were a relevant consideration, as has been confirmed by the Court of Appeal in *Ng*.[7] Judge Henare's reference to Dr Pai's reports should also be seen in the context of the rest of her analysis, which included reference to the circumstances Ms Chalmers and her treatment, and the clinical reporting of Mr Yee and Mr Chan. Judge Henare was entitled to include, in her judgment, reference to the opinion and supporting statistics of Dr Pai, and did not err in doing so.

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6 See n5 *Ng*, at [69].

7 Supra.

[40] Third, this Court finds that Judge Henare did not make a mistake of fact in finding that Ms Chalmers' chance of an injury did not occasion a measure of surprise. The Court of Appeal in *Ng* stressed that, 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. The Court of Appeal noted that this judgment was to be exercised on a case-specific basis taking into account all of the circumstances of the treatment and the particular claimant.[8] Judge Henare's finding that, while Ms Chalmers' paraplegia was certainly neither expected nor desirable, it was not surprising, was not based simply on Dr Pai's statistics. As noted in Her Honour's judgment,[9] her finding was made after taking into account all of the circumstances both of the treatment itself and those relating to Ms Chalmers. Judge Henare remarked that the paraplegia not being surprising was manifest from the clinical reporting of Mr Yee before the surgery and upon discovering the fact of the post-surgery paraplegia, taken together with the reporting from Mr Chan. Judge Henare's finding was one that she was entitled to make on the available evidence.

The Decision

[41] In light of the above considerations, the Court finds that Ms Chalmers has not established sufficient grounds, as a matter of law, to sustain her application for leave to appeal, which is accordingly dismissed. Even if the qualifying criteria had been made out, this Court would not have exercised its discretion to grant leave, so as to ensure the proper use of scarce judicial resources. This is because this Court is not satisfied as to the wider importance of any contended point of law.

[42] Costs are reserved.

Judge P R Spiller
District Court Judge

Solicitors: ACC Employment Law, Auckland for the appellant
Medico Law, Auckland for the respondent

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8 See n5 *Ng* [2020] 2 NZLR 683, at [69].
9 See n1 *Chalmers*, at [77].