IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 162 **ACR 64/21**

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

Hearing: On the papers

Submissions: B Hinchcliff for the Appellant
F Becroft and L Hawes-Gandar for the Respondent

Judgment: 18 August 2022

JUDGMENT OF JUDGE P R SPILLER
[Leave to appeal]

Introduction

[1] This is an application for leave to appeal against a judgment of Her Honour Judge Henare, delivered on 10 May 2022.[1] On 9 November 2020, the Corporation declined Mr Folkema's claim for cover for upper incisor root resorption as a treatment injury.[2] At issue in the appeal was whether the Corporation was correct to determine that the root resorption experienced by Mr Folkema was an ordinary or necessary consequence of the treatment he received. The Court dismissed the appeal, for the reasons outlined below.

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1 *Folkema v Accident Compensation Corporation* [2022] NZACC 85.

Background

[2] Mr Folkema has an orthodontic history dating back to his teenage years.

[3] In late 2015, when travelling in Peru, Mr Folkema consulted an orthodontist for urgent treatment. He was diagnosed with a "severe class II division 1 malocclusion with severely increased overjet and palatally impinging overbite, retruded dentition, very prominent chin, and a very low anterior face height". Mr Folkema was informed that he would lose his front teeth if he did not have treatment immediately. Accordingly, he had braces fitted. The orthodontist suggested orthognathic surgery.

[4] When Mr Folkema returned to New Zealand, he consulted Dr Quick, Orthodontist. On 13 February 2016, Dr Quick noted that the treatment started in Peru and advised:

> The main issue concerning the bite were wear and trauma to the top teeth and gums from the lower teeth, increased overjet and deep bite. …
>
> **Treatment Objectives**
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> The aims of treatment are to continue with treatment in order to reduce the overjet, close the upper spaces (although leave one premolar space on the upper right), improve the deep bite, level and align the teeth and achieve the optimum bite.
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> **Treatment**
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> Levelling and aligning will continue, following which overjet reduction and space closure will commence. Thereafter, a re-assessment will be done to establish the need for jaw surgery, or whether a genioplasty on its own will suffice.
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> Treatment is expected to take approximately 24 months, depending on compliance and tissue response. Good compliance and oral hygiene can speed up treatment, whilst breakages, poor oral hygiene and compliance can slow treatment down.

[5] Mr Folkema was informed that he should seek treatment for chronic periodontal disease. In June 2016, he was referred to periodontic specialist,

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[2] Root resorption is a process in which the body breaks down and absorbs the tissue surrounding a tooth that connects the tooth to the gum. Resorption can lead to teeth falling out or becoming loose.

Dr Danesh-Meyer, who diagnosed gingivitis and recommended therapy to remove plaque and tartar.

[6] In November 2017, panoramic x-rays taken identified some root resorption of the upper incisors.

[7] On 3 December 2017, Dr Quick wrote to Mr Folkema regarding the tooth resorption issue. Dr Quick recorded that, based on a rough comparison between the x-rays, Mr Folkema's upper right central root length had reduced from an initial 14 mm to 10 mm.

[8] On 9 April 2018, Mr Folkema's braces were removed.

[9] In June 2019, Dr Quick saw Mr Folkema again and arranged further x-rays. These showed that there had been some further root resorption of the upper incisors. Dr Quick reported:

> ... the new panoramic x-ray indicates horizontal bone loss on the upper anterior teeth, which in conjunction with root resorption (which appears to have progressed despite termination of treatment) will place the longevity of his upper teeth at risk.

[10] On 25 June 2019, Mr Folkema's GP lodged a claim for upper incisor root resorption, said to have been caused by treatment provided by Dr Quick.

[11] In July 2019, Mr Folkema saw Dr Somerville for a second orthodontic opinion. Dr Somerville reviewed radiographs forwarded from Peru. He noted that Mr Folkema was concerned about root length shortening of his upper anteriors, and noted that this was likely due to several factors including the nature of the treatment and his underlying skeletal structure. Dr Somerville reported:

> The Panex taken revealed shortened root form of his upper incisors, space available (4mm) upper right premolar region, retained lower left deciduous molar, impacted lower third molars.
>
> Matthew is concerned regarding the root shortening of his upper anteriors. I advised this is likely related to several factors:
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> - The orthodontic tooth movement, as the teeth were extremely forward and proclined and were uprighted over a considerable distance.

- His skeletal pattern (extremely low mandibular plane angle and broad facial type) would be related to extremely heavy vertical forces on his anterior occlusion and possibly contribute to the traumatic forces on these teeth.

[12] Dr Somerville advised that surgery would be required to correct Mr Folkema's orthodontic issues beyond what had already been achieved.

[13] On 7 August 2019, Dr Quick stated in part:

> Root resorption is a very common side effect of orthodontic treatment (1, 3, 18, 16), and in some reports, is present in most individuals undergoing orthodontic treatment (12, 14). Lund et al have reported that approximately 90% of teeth are affected to some degree (14). Root resorption is multifactorial in origin (17, 2), and there are often conflicting reports in the literature, indicating a lack of consensus (7). The degree of root resorption encountered during orthodontic treatment is fortunately mild, and is considered an acceptable risk of treatment On average the amount of root resorption is in the region of 1.5 mm (13, 5), and it is very rare to have resorption greater than 4 mm (14). Root resorption is considered severe when the degree of root loss is greater than 30% of the root length (7) ...
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> ...root resorption appears to be present in nearly all patients undergoing orthodontic treatment to a lesser or greater degree, so the causality of root resorption with orthodontic treatment is strong. However, root resorption also occurs in individuals who have not had treatment. In this instance, root resorption is likely corelated to the orthodontic treatment, and the risk for resorption increases with duration, extraction sites and distance that teeth move. Matthew started orthodontic treatment with Dr Sax Dearing in the Hawkes Bay, but treatment was not completed. Further orthodontic treatment was started in Peru before arriving at our practice. The total duration time in orthodontic treatment is thus unknown, but would be collectively greater than the 26 months that he was with our practice. As Matthew had been in treatment for approximately a month before seeing us, treatment of an extraction adult within 26 months is considered within the normal range.
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> Matthew also has an extremely complex bite, with very deep overbite that was causing ulceration of his upper incisor teeth. There is the possibility that the traumatically deep bite was also contributing to the root resorption that has occurred, and the fact that the degree of root resorption appeared to continue after treatment had ceased would suggest that such a factor may have contributed.
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> ... Matthew ultimately met several risk factor criteria for resorption — namely extended duration of the treatment (adding the treatment duration with us and the unknown treatment duration of Dr Sax Dearing), large distance of tooth movement and extraction spaces to close. There may be other factors contributing to the occurrence of root resorption, such as his traumatic bite.

[14] On 29 October 2019, Dr Gilbert reported to the Corporation that the treatment provided by Dr Quick had been reasonable and appropriate in the circumstances, noting that:

> Regular appointments were made over the following 26 months, with the treatment provided by Dr Quick beginning with a standard approach to level and align the arches using light forces. In September 2016, Matthew reported that he had medical issues and that he could not work. A panoramic x-ray was taken which appeared to show no root resorption. Treatment continued with deterioration in Michael's oral hygiene, and with some difficulty in reducing the overbite. A further panoramic x-ray was taken in November 2017 which appeared to show some root resorption of the upper incisors and Michael was advised of this in a letter dated 3 December 2017. The letter was full and very informative and gave the options from this point. On 16 January 2018 after discussing the contents of the letter, the decision was made to continue treatment. In April 2018 the appliances were removed and retainers fitted.
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> ...
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> It is very unusual for a patient to commence treatment with one Orthodontist and then leave after one month. Most orthodontists would decide not to start any treatment if they knew this was the case, and to let the second orthodontist to formulate his own treatment plan.
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> Matthew presented to Dr Quick with an extremely severe malocclusion that was going to be very difficult to treat, and to achieve an optimal occlusion and appearance without maxillofacial surgery which Matthew was reluctant to undergo. He had also discontinued his first course of orthodontic treatment as a teenager, when it would have been a more appropriate time for treatment. He appears to have been a reluctant patient, and perhaps not accepted the extreme severity of his malocclusion and the necessity of treatment for functional reasons. The actual treatment was also compromised by Matthew's health and social issues, and his poor oral hygiene. …
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> The treatment to be provided was always going to be a compromise due to Matthew's unwillingness to accept orthognathic surgery as an integral part of the treatment. If the jaws could have been surgically repositioned and the actual orthodontic treatment to be undertaken would have been significantly different to that which would be necessary without such surgery. The tooth movement required without surgery, especially the distance and type of movement of the upper incisors, is much more difficult, and it is likely there would be a greater chance of increased root resorption. Reduction of the extreme severely increased impinging overbite is also much more difficult without surgery.
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> …
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> Root resorption occurs in almost all orthodontic treatment [1], is multifactorial [2] and there is evidence to suggest a genetic predisposition in some individuals [2, 3]. The degree of root resorption is generally mild in most treatments [4] and considered an acceptable risk of treatment. Heavy force levels increase the risk [5], and the distance and type of root movement of the upper incisors, particularly where the alveolus is narrow and the incisor roots will be in close proximity to the cortical plates [6, 7] as in this case. Matthew also had a very

> low anterior face height in which his occlusal force would be much increased and possibly causing a traumatic occlusion. This would increase the likelihood of root resorption and the difficulty in correcting the extreme overbite.
>
> Secondly, and importantly, it is difficult to measure the amount of root resorption on a panoramic x-ray, and the lengths of roots cannot be compared between different panoramic x-rays, even if they have been taken with the same machine. Normal anatomic formations can be seen as radio-opaque or radiolucent shadows, and as a result of superimposition there can be a decrease in diagnostic quality. The roots of teeth must be absolutely positioned along the focal spot of the x-ray source. This is not possible with a panoramic x-ray.

[15] On 14 November 2019, the Corporation declined cover on the basis that root resorption was an ordinary consequence of orthodontic treatment.

[16] On 27 July 2020, the Reviewer quashed the Corporation's decision declining cover and directed the Corporation to obtain further evidence in relation to whether the degree of root resorption experienced by Mr Folkema was an ordinary consequence of treatment, and then issue a further decision.

[17] On 30 October 2020, Dr Gilbert reported:

> The panoramic radiographs provided over the total course of treatment and review, have not been taken on the same x-ray machine. The type of machine referred to by Mr Hinchcliff, could only give a measure of the root lengths at the time of exposure. There could therefore be no reference to previous exposures.
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> …
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> The fact that every orthodontist, either involved in the treatment of Mr Folkema, or having reviewed his case, has stated that a successful treatment outcome would have needed to involve maxillo-facial surgery, such surgery lessening the need for such extensive tooth movement [and therefore greater risk of root resorption], indicates that the treatment outcome is likely to be sub-optimal.
>
> Such caution by orthodontist would take into account the greater risk of root resorption due to the prolonged treatment time and the extent and type of the tooth movements required.
>
> The majority of orthodontists would have been most likely to decline starting any treatment without the commitment of Mr Folkema to orthognathic surgery. There would be an expectation that root resorption would be more likely to be more extensive.
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> …

> Mr Folkema's presenting malocclusion was most unusual, and unlikely to have been seen sufficiently often for there to be a normal range of outcomes.
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> The underlying health conditions were unlikely to have been a factor, but the clinical knowledge at the time of treatment indicated that any treatment would need to involve orthognathic surgery, with the involvement of the maxilla-facial surgeon prior to the commencement of any orthodontic treatment.

[18] On 9 November 2020, after obtaining further evidence, the Corporation issued a further decision again declining cover, on the basis that the degree of root resorption experienced by Mr Folkema was an ordinary consequence of treatment.

[19] On 1 April 2021, the Corporation's decision was upheld by the Reviewer.

[20] On 10 May 2022, Judge Henare dismissed Mr Folkema's appeal.

[21] On 11 May 2022, the Corporation sought leave to appeal Judge Henare's decision.

Relevant law

[22] 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.

[23] In *O'Neill*,[3] Judge Cadenhead stated:

> [24] The Courts have emphasised that for leave to be granted:
>
> (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 …;
>
> (ii) The contended point of law must be *"capable of bona fide and serious argument"* to qualify for the grant of leave …;
>
> (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 …;
>
> (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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3 *O'Neill v Accident Compensation Corporation* [2008] NZACC 250.

(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 …;

(vi) Whether or not a statutory provision has been properly construed or interpreted and applied to the facts is a question of law … .

[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 … .

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

32 Treatment injury

(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 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.

[25] In the High Court judgment in *Adlam*,[4] 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

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

> 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.

[26] In the Court of Appeal judgment in *Adlam*,[5] 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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> …
>
> [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 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.

[27] In *Ng*, the Court of Appeal stated the following in relation to the phrase "not [an] ordinary consequence":[6]

> [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

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5 *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].

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

> 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.

[28] In *Ambros*,[7] the Court of Appeal commented on the issue of difficulty in establishing a causal link between medical error and personal injury because of scientific uncertainty over the causal mechanism:

> [53] Uncertainty can arise because of the objective limitations of scientific medical knowledge about a particular biological process (particularly where there may be multiple possible causes) or from the difficulty of providing a scientific explanation for the sequence in a particular case.
>
> [54] We propose to deal in this section with the ways in which courts have traditionally dealt with uncertainty under the following headings: evidential onus, inferences, statistics and proximity. …
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> [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 of common sense …
>
> [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 para [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 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 …

The Court's judgment of 10 May 2022

[29] Judge Henare outlined the relevant facts and the law of the case. Her Honour noted that there was no dispute that, for the purposes of section 32 of the Act, Mr Folkema's root resorption was caused by orthodontic treatment. Her Honour stated that the key issue was whether the Corporation was correct to determine that the root resorption experienced by Mr Folkema was an ordinary or necessary consequence of the treatment he received.

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7 *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.

[30] Judge Henare noted that, in assessing whether Mr Folkema's root resorption was an ordinary consequence of his orthodontic treatment, it was first necessary to consider the nature, duration and severity of his condition. Based on Dr Quick's report and the analysis of Brezniak and Wasserstein, Her Honour concluded that the ordinary range of consequences for orthodontic treatment included some measure of root resorption.

[31] Judge Henare then turned to consider Mr Folkema's susceptibility to root resorption in light of the medical literature. Based on the evidence of Dr Quick and Dr Gilbert, together with the orthodontic literature cited to support their views, Judge Henare concluded that Mr Folkema had increased susceptibility to root resorption from his orthodontic treatment.

[32] Judge Henare considered Mr Hinchcliff's submission that treatment should have been suspended in December 2017 after root resorption had been diagnosed. Her Honour noted that, in December 2017, Dr Quick indicated three options for treatment. His report of June 2019 provided that treatment be continued with caution and the appliances removed in April 2018. Dr Gilbert was informed of the basis on which the treatment continued, and there was no view from him or evidence from any other specialist that treatment should have been suspended in December 2017.

[33] Judge Henare also considered Mr Hinchcliff's submission that the Corporation did not follow the directions of the Reviewer and obtain radiographs from a dental specialist to determine the amount of root resorption. Having perused the Review directions, Judge Henare observed that the Reviewer directed the Corporation to obtain expert advice on the extent of resorption and consider whether this was within the normal range of expected outcomes. This expert advice was obtained from Dr Gilbert who assessed that it was not possible to determine the extent of resorption.

[34] Judge Henare summarised that, taken together, the evidence before her showed that it was not possible to determine the degree of root resorption which occurred in this case. Further, there was no suggestion in the available reports that

the root resorption which occurred was outside the normal range, taking into account the circumstances of treatment and Mr Folkema's circumstances.

[35] Judge Henare concluded that the evidence showed that Mr Folkema was at a greater risk of root resorption. In particular, the following factors were relevant: treatment duration, extensive tooth movement during treatment, Mr Folkema's bite, three premolar extractions, and susceptibility of incisors. Having regard to all the available evidence, Her Honour concluded that the root resorption suffered by Mr Folkema was within the normal range of outcomes having regard to his circumstances and the treatment. Accordingly, Judge Henare found that the root resorption suffered by Mr Folkema was an ordinary consequence of the orthodontic treatment received by him.

The appellant's submissions

[36] Mr Hinchcliff, for Mr Folkema, submits as follows. The Court's decision to deny cover, based on the inability to obtain precise measurement of root resorption, contradicts the law set out in *Ambros*. In this case, the Court of Appeal noted that the Courts have traditionally dealt with uncertainty under the headings of evidential onus (probability of causation is higher than 50 per cent), inferences (robust inferences of causation can be drawn in some cases of uncertainty), statistics and proximity (this is sometimes sufficient to prove causation). The evidence is that Mr Folkema had crooked teeth, had treatment, and ended up with incisors with a guarded prognosis due to loosening. The inference can be drawn that the incisor roots were resorbed because the teeth were loose and have a guarded prognosis; the statistics show that it is very rare to have root resorption in the range of four millimetres or to the point where they are loose; and proximity shows that the orthodontic treatment caused the teeth loosening, or at least materially contributed to it. The Court's judgment is incorrect because the facts were not applied to the law created in *Ambros*; and the Court's judgment erred because of its apparent need for conclusive evidence to make a finding on fact.

[37] Mr Hinchcliff proposes the following questions of law:

(a) Did the judgment err by requiring precise evidence of the injury instead of considering the elements stated within *Ambros*?

(b) Did the judgment err by overlooking the usual standard of determining the matter on the balance of probabilities?

(c) Did the judgment err by overlooking the beginning and result of the treatment? Was it too narrowly focused on the exact extent of the injury?

(d) Did the judgment place too much emphasis on known risk factors as the cause of the injury?

Discussion

[38] This Court notes that the submissions made by Mr Folkema's advocate are primarily based on an alleged contradiction between Judge Henare's judgment and the Court of Appeal's judgment in *Ambros.* This Court notes that the Court of Appeal in *Ambros* addressed whether there was a causal link between medical error and personal injury. In this context, the Court of Appeal in *Ambros* commented on the issue of difficulty in establishing such a causal link because of scientific uncertainty over the causal mechanism. However, in Mr Folkema's case, as noted by Judge Henare, there was no dispute that, for the purposes of section 32 of the Act, Mr Folkema's root resorption was caused by orthodontic treatment.

[39] Instead, as noted by Judge Henare, the key issue in Mr Folkema's case was whether the Corporation was correct to determine that the root resorption experienced by Mr Folkema was an ordinary or necessary consequence of the treatment he received. Judge Henare was thus required to analyse the facts of Mr Folkema's case in light of section 32(1)(c) as interpreted by higher Court authority. Section 32(1)(c) requires the Court to take into account the person's underlying health condition at the time of the treatment, and the clinical knowledge at the time of the treatment. The Court of Appeal in *Ng*[8] noted that, whether an

[8] *Ng*, See n6 above, at [69].

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. The Court of Appeal said that the inquiry was to be exercised on a case specific basis, taking into account all of the circumstances of the treatment and the particular claimant. The Court noted that 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 him more or less susceptible to the adverse consequence.

[40] In the event, Judge Henare conducted an orthodox analysis of Mr Folkema's case as directed by the Court of Appeal in *Ng*. Her Honour found, in light of medical evidence, that the ordinary range of consequences for orthodontic treatment included some measure of root resorption. Her Honour further found that Mr Folkema had increased susceptibility to root resorption from his orthodontic treatment, having regard to his bite, three premolar extractions, and susceptibility of incisors. Her Honour further found, in light of the evidence, that, while it was not possible to determine the degree of root resorption which occurred in this case, there was no suggestion in the available reports that the root resorption which occurred was outside the normal range, taking into account the circumstances of treatment and Mr Folkema's circumstances. In light of these findings, Judge Henare concluded that the root resorption suffered by Mr Folkema was an ordinary consequence of the orthodontic treatment received by him.

[41] In that Judge Henare's analysis was in accordance with the requirements of the Act, as interpreted by higher authority, this Court can find no error of law in Her Honour's judgment.

The Decision

[42] In light of the above considerations, the Court finds that Mr Folkema has not established sufficient grounds, as a matter of law, to sustain his 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 Court is not satisfied as to the wider importance of any contended point of law.

[43] There is no issue as to costs.

P R Spiller
District Court Judge