IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 66 **ACR 1/20**

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPEAL UNDER SECTION 149 OF THE ACT
BETWEEN	ESTATE OF J SANKARAN Appellant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Hearing: 19 April 2022
Held at: Auckland/Tāmaki Makaurau

Appearances: S Sankaran for the appellant
J Sumner for the respondent

Judgment: 27 April 2022

RESERVED JUDGMENT OF JUDGE P R SPILLER
[Claim for treatment injury - s 32, Accident Compensation Act 2001]

Introduction

[1] This is an appeal from the decision of a Reviewer dated 4 December 2019. The Reviewer dismissed an application for review of the Corporation's decision dated 20 August 2018, declining to accept cover for Mr Sankaran's death as a treatment injury.

Background

[2] Mr Sankaran was born in 1968. He suffered end-stage renal failure secondary to diabetic kidney disease.

[3] On 11 October 2017, Mr Sankaran was admitted to hospital for the purposes of receiving a deceased donor kidney transplant, having been stable on peritoneal dialysis at another hospital. The Department of Critical Care Medicine admission note recorded a long list of Mr Sankaran's past medical conditions and current medications. His extensive comorbidity included diabetes, hypertension, coronary artery disease, reduced left ventricular (heart) function, cataracts, C5-6 radiculopathy, asthma, previous stroke, hyperlipidaemia, and a previous cholecsystectomy (removal of the gall bladder) for cholelithiasis.

[4] On the morning of 12 October 2017, prior to surgery, Mr Sankaran was reported as stable, the only condition reported being lesions on his legs as a result of reactive perforating collagenosis (skin disorder).

[5] The first sign of complications during surgery were when it was necessary to conduct anastomosis (cross-connection) to join Mr Sankaran's external iliac blood vessel[1] with the renal blood vessel of the transplanted kidney. Mr Sankaran's venous wall was found to be very thin.

[6] The operation note of the surgery recorded, in part:

> Iliac venous tear noted which could not be salvaged so graft removed and re-perfused … Ext iliac artery sustained injury + poor quality requiring patch repair w/ donor iliac artery.

[7] Mr Sankaran was in the operating theatre for over nine hours, during which time he suffered Pulseless Electrical Activity cardiac arrest on two occasions, in turn requiring cardiopulmonary resuscitation (CPR). Mr Sankaran was kept on dialysis. Despite the surgical complications, there was reported to be reasonable perfusion in the transplanted kidney at the end of surgery and there was a small amount of urine postoperatively.

[8] On 13 October 2017, Dr Kirk Freeman, Intensivist Care Specialist, reviewed Mr Sankaran for the purposes of determining his post-operative treatment. Dr Freeman noted that the operative course had been complicated with significant venous bleeding, requiring the transplanted kidney to be removed, whilst

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[1] The iliac blood vessels provide blood to the organs in the pelvic area.

Mr Sankaran's iliac vein was repaired, before being re-implanted. It was recorded Mr Sankaran's kidney had been slow to work and this had been complicated by hyperkalaemia (increased potassium levels).

[9] On 15 October 2017, Mr Sankaran underwent a CT scan showing pneumatosis (accumulation of gas) in his intestine, which had developed as a result of dialysis. Accordingly, he was admitted to the hospital's Intensive Care Unit ("ICU") for the purpose of monitoring his kidney function.

[10] On 16 October 2017, an ICU summary update provided by Dr Les Galler, Intensivist Care Specialist, recorded that Mr Sankaran remained dialysis-dependent and anuric (without urine), and had developed abdominal distention. The update also recorded "failure of enteral feeding, some blood stained and then faeculent nasogastric aspirates and a lot of diarrhoea blood stained which was also somewhat blood stained".

[11] Also, on 16 October 2017, Dr Ian Ditter, Transplant Nephrologist, reported:

> [Mr Sankaran's] transplant procedure was very complicated, and particular problems included the recipient iliac artery dissection and assistance was needed to insert a small piece of donor artery. …
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> He was stable throughout days 1 and 2 post-transplant then developed quite a marked increase in his lactate. … it is likely that he has had some ischaemic episode in his bowel although there was no obvious macro-vascular lesion on the CT angiogram that was performed on 15 October.

[12] On 18 October 2017, Dr Sam Black, Critical Care Fellow, noted that Mr Sankaran's condition had stabilised to some degree, but that he was now experiencing abdominal pain. Dr Black recorded that Mr Sankaran had been reviewed that morning and would likely be extubateable (free of the endotracheal tube) in a day or two, on the assumption that there was nothing sinister brewing in his abdomen.

[13] On 20 October 2017, Dr Kerry Benson-Cooper, Intensivist Care Specialist, noted that Mr Sankaran had had a reasonable past 24 hours, having coped with being extubated, but that his blood platelet levels were very low.

[14] On 22 October 2017, Mr Sankaran received dialysis for a period of five hours and still remained anuric. Nursing notes recorded that Mr Sankaran's father had been informed that the ICU team was doing its best to keep him well but that he remained in a life-threatening situation. That evening he became increasingly hypertensive. Later that evening, he began to experience shortness of breath symptoms, and he died in ICU at 8:45 pm. A Certificate of Interim Findings from Coroner D Bell recorded his direct cause of death as "[a]cute and ongoing ischaemia of small and large intestine". The antecedent cause was recorded as "Complications of post-operative course following renal transplant procedure".

[15] On 13 November 2017, Dr Paul Morrow, Forensic Pathologist, completed a Coronial Autopsy Report. Dr Morrow noted that Mr Sankaran died approximately 10 days following renal transplant procedure. Dr Morrow assessed that the cause of death was ischaemic bowel disease with terminal sepsis complicating post-operative course (including resuscitated cardiac arrest) following renal transplant procedure due to end-stage diabetic renal disease.

[16] On 11 December 2017, Mr Sankaran's father lodged a claim for treatment injury on behalf of Mr Sankaran's estate.

[17] On 24 July 2018, the Corporation wrote to Mr Sankaran Senior declining the claim for treatment injury and enclosing a Treatment Injury Report.

[18] On 8 August 2018, Mr Motohiko Yasutomi, Transplant Surgeon, provided a specialist opinion at the request of the Corporation. The Corporation had sought answers to specific questions posed about the causal link between the "iliac blood vessel injury" suffered by Mr Sankaran and the kidney transplantation procedure. Mr Yasutomi noted that the contribution to the injury occurred because Mr Sankaran's transplanted kidney had to be removed from the first anastomosis site, due to uncontrollable bleeding from the venous anastomosis site and his atherosclerosis. The atheromatous artery condition was due to Mr Sankaran's diabetes, hyperlipidaemia, hypertension and smoking history. It took more time than usual to repair the artery and redo anastomosis at the new site, and the prolonged ischaemic time caused delayed graft function. During haemodialysis he developed

electrical activity. His cardiac instability provoked during dialysis was one of the contributions to the ischaemia of the small and large intestines.

[19] On 16 August 2018, the Corporation sought advice from its Complex Claims Panel comprising Dr Peter Jansen, Dr Chris Moughan, Ms Paula Carr (Registered Nurse), Mr Warren Maguire (Registered Nurse) and Ms Kerry Southee (Registered Nurse). On 20 August 2018, Jane Drummond, Registered Nurse, reported the Panel's findings:

> ACC acknowledge that Mr Sankaran suffered injuries while receiving treatment. The initial injury to the iliac vein during surgery was due to the poor quality of the vessels as a consequence of the diabetes, high blood pressure, smoking history, atherosclerosis and hyperlipidaemia. This resulted in dissection of the vessel with uncontrollable bleeding and need for re-do anastomosis and graft. This injury has then led to a cascade of events culminating in Mr Sankaran's death.

[20] On 20 August 2018, in light of the new clinical information received, the Corporation issued a revised claim decision upholding the earlier treatment injury decision of 24 July 2018.

[21] Mr Sankaran Senior lodged a review of the decision.

[22] On 6 November 2019, review proceedings were held. On 4 December 2019, the Reviewer upheld the Corporation's decision, concluding that it had not been established that Mr Sankaran's death met the legislative criteria of a treatment injury.

[23] On 22 December 2019, a Notice of Appeal was lodged.

[24] On 14 May 2020, Coroner Katharine Greig provided a Certificate of Findings under section 94 of the Coroner's Act 2006. Ms Greig noted that a report had been provided for the purposes of her inquiry by Dr Helen Pilmore, a Nephrologist at the hospital. Ms Greig recorded that Dr Pilmore had advised that there was no indication that any surgical error occurred during the course of Mr Sankaran's lengthy surgery, underscored by the fact that initially the kidney was making urine and that all scans subsequently showed satisfactory renal perfusion. Ms Greig also noted that Mr Sankaran Senior had asked a number of questions about the cause of death and whether his son's death was preventable. In particular, one of the matters

Mr Sankaran Senior wished to have addressed was whether his son was fit enough to undergo transplant surgery.

[25] Ms Greig ultimately concluded that Mr Sankaran was assessed thoroughly and considered fit for the surgery, albeit in a category of higher risk, but developed a post-operative complication that did on occasion occur after renal transplantation. In addition, there was no evidence that the care that Mr Sankaran was given, including the pre-transplant assessment of suitability for surgery, during surgery, or post operatively, was inappropriate.

Relevant law

[26] Section 32 of the Accident Compensation Act 2001 ("the Act') sets out:

> **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
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> (iii) referred to in subsection (7); and
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> (b) caused by treatment; and
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> (c) not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of treatment, including
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> (i) the person's underlying health condition at the time of the treatment; and
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> (ii) the clinical knowledge at the time of the treatment.
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> (2) **Treatment injury** does not include the following kinds of personal injury:
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> (a) personal injury that is wholly or substantially caused by a person's underlying health condition:
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> (b) personal injury that is solely attributable to a resource allocation decision:
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> (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.

[27] In *Ambros*,[2] the Court of Appeal envisaged the Court taking, if necessary, a robust and generous view of the evidence as to causation:

> [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 …
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> …
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> [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 ... 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 …

[28] In *Sam*,[3] Mallon J stated:

> [24] Having assessed what are the range of possible causes on the evidence, I reject the submission that, if any of the possible causes would be covered, it is for ACC to disprove that cause. I agree with ACC that *Accident Compensation Corporation v Ambros* [2008] 1 NZLR 340 does not support such an approach. Rather *Ambros* upheld the position previously taken in an earlier case that the legal burden of establishing causation on the balance of probabilities remains on the claimant.

[29] In the Court of Appeal judgment in *Adlam v Accident Compensation Corporation* Cooper J stated:[4]

> [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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2 *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.

3 *Sam v Accident Compensation Corporation*, [2009] 1 NZLR 132, CIV 2008-485-829, High Court, Wellington, 31/10/2008.

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

> …
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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.

[30] In *Accident Compensation Corporation v Ng* the Court of Appeal, in relation to the phrase "not [an] ordinary consequence", stated the following:[5]

> [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.

Discussion

[31] The issue for determination in this appeal is whether the damage to Mr Sankaran's iliac artery was caused wholly or substantially by his underlying health condition. Legislative boundaries have been set around entitlement to cover for injury suffered by a person seeking treatment from a registered health professional.[6] In particular, treatment injury does not include personal injury that is wholly or substantially caused by a person's underlying health condition.[7] The fact that treatment did not achieve a desired result does not, of itself, constitute a treatment injury.[8] The injury said to be a treatment injury must be the consequence of a departure from appropriate treatment choices and treatment actions, objectively assessed.[9]

[32] The Estate of Mr Sankaran submits Mr Sankaran's death was due to treatment injury, arising from his surgery and treatment. Prior to his surgery, he was as well as he could be on home dialysis, was fully self-managing, and was assessed by medical

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5 *Accident Compensation Corporation v Ng* [2020] NZCA 274, [2020] 2 NZLR 683, at [68].
6 See *Adlam* n4 above.
7 Section 32(2)(a).
8 Section 32(3).
9 See *Adlam* n4 above.

specialists as fit for kidney transplant. His untimely, premature and unexpected death was directly and unequivocally linked to the treatment injury he sustained as a result of the invasive surgery. He would not have died when he did if he had not had the surgery.

[33] This Court acknowledges the submissions made by the Estate of Mr Sankaran and extends its condolences on the tragic passing of Mr Sankaran. However, the Court has to make its decision in terms of the Accident Compensation Act 2001, as interpreted by the higher courts. The Court refers to the following considerations.

[34] First, the sad reality is that, according to medical reports, Mr Sankaran was in very poor health leading up to his surgery. He suffered end-stage renal failure secondary to diabetic kidney disease. In addition, the Department of Critical Care Medicine records, on the day of Mr Sankaran's admission to hospital, a long list of past medical conditions and current medications. His extensive comorbidity included the effects of diabetes, hypertension, coronary artery disease, reduced left ventricular (heart) function, cataracts, C5-6 radiculopathy, asthma, previous stroke, hyperlipidaemia, and a previous cholecsystectomy (removal of the gall bladder) for cholelithiasis.

[35] Second, contemporaneous medical records note that complications in the surgery ensued when Mr Sankaran's venous wall was found to be very thin. The operation note of the surgery recorded, in part, that the poor quality of the iliac artery required patch repair with the donor iliac artery.

[36] Third, Mr Motohiko Yasutomi, Transplant Surgeon, assessed that Mr Sankaran's atheromatous (abnormal) artery condition was due to his diabetes, hyperlipidaemia, hypertension and smoking history.

[37] Fourth, the Corporation's Complex Claims Panel assessed that the initial injury to Mr Sankaran's iliac vein during surgery was due to the poor quality of the vessels as a consequence of Mr Sankaran's diabetes, high blood pressure, smoking history, atherosclerosis and hyperlipidaemia. The Panel advised that his condition resulted in dissection of the vessel with uncontrollable bleeding and the need for re-do

anastomosis and graft, which then led to a cascade of events, culminating in Mr Sankaran's death.

[38] Fifth, Coroner Katherine Greig found no evidence that the care that Mr Sankaran was given, including the pre-transplant assessment of suitability for surgery, during surgery, or post operatively, was inappropriate. Ms Greig referred in her report to the assessment of Dr Helen Pilmore, a Nephrologist at the hospital where the surgery was performed. Dr Pilmore advised that there was no indication that any surgical error occurred during the course of Mr Sankaran's surgery.

Conclusion

[39] In light of the above considerations, the Court finds that Mr Sankaran's personal injury was wholly or substantially caused by his underlying health condition, and, as such, did not qualify as a treatment injury in terms of the Act.

[40] The decision of the Reviewer dated 18 August 2020 is therefore upheld. This appeal is dismissed.

[41] I make no order as to costs.

P R Spiller
District Court Judge

Solicitors: Ford Sumner, Wellington, for the respondent.