IN THE DISTRICT COURT
AT WELLINGTON

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

[2023] NZACC 175 **ACR 306/21**
ACR 31/22

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

Hearing: 27 July 2023
Heard at: Tauranga/Tauranga Moana

Appearances: Ms K Koloni, advocate for the Appellant
Mr P McBride for the Respondent

Judgment: 26 October 2023

RESERVED JUDGMENT OF JUDGE C J MCGUIRE
[Personal Injury, Causation s 26; Costs on Review s 148
Accident Compensation Act 2001]

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[1] In respect of appeal ACR 306/21, three issues are identified:

(a) Cover in relation to a claimed injury, namely a below knee amputation (right leg). This is claimed to the be the consequence of an insect bite, but said to have been sustained after onset of significant symptoms of substantial vascular disease;

(b) Provision of a lump sum, consequential upon cover;

(c) The advocate's claim for review costs.

[2] In respect of appeal ACR 31/22:

(a) The same claim for cover is made and entitlement to weekly compensation is sought;

(b) The advocate's claims for review costs.

Background

[3] The appellant is aged 44. On 16 April 2020, he consulted GP, Dr McGowan, via a teleconsultation due to the Covid-19 lockdown.

[4] The doctor noted what he said as follows:

> His foot has been flaring.
>
> Couldn't sleep overnight. Took some tablets overnight, which didn't help – celecoxib.
>
> Seems to be second/third toes and little toe at MTPG 5th also.
>
> His triggers seem to be gluten and sugar.
>
> Hypersensitivity sensation.
>
> Couldn't stand sheet on his foot overnight.
>
> No fevers.
>
> Has a sore on his second toenail past two months, not healing.

[5] The doctor considered it was "likely gout" and under the heading "Plan" stated:

> Start colchicine and allopurinol today, void prednisone as wound on foot and can't rule out skin infection.
>
> Repeat bloods in 1/12, under very clear instructions that he must be seen if his pain gets worse, if he develops fevers or spreading redness of his skin.

[6] Four days later, on 22 April, the appellant attended the doctor's surgery and was seen by practice nurse, Annie Gordon. She noted that he was complaining of pain in his right foot across the toes. She noted "no worse, but not getting any better".

[7] On that occasion, he was triaged by the nurse. She noted that he was taking colchicine with little relief and had not yet started alopurinol.

[8] He attended the doctor's surgery again on 30 April 2020 and was seen by Dr Tweedale, who completed an ACC injury claim form.

[9] The description of the injury was "insect bite on second toe – worsening pain and redness R foot – now spreading cellulitis". The accident date was recorded as 2 April 2020 at 2100. The diagnosis was:

> insect bite nonv-foot/toe +inf"

[10] The claim form also recorded that the appellant was unfit for work for five days.

[11] On 1 May 2020, the appellant returned to the surgery. His wound was dressed and cleaned with saline. Also, on that day his right second toe was x rayed at Bay Radiology. The finding was:

> There is diffuse soft tissue swelling of mild degree extending along the @nd toe. No focal osteolysis or periosteal reaction is identified to suggest osteomyelitis and there is no abnormality at the interphalangeal or MTP joints

[12] On 2 May 2020, there was a further consultation in surgery to review the wound and change the dressing. The notes record the following:

> **Subjective**
>
> Presents for wound review and dressing change. Wound to right second toe. Dressing removed, cleaned with saline and betadine, not oozing, still a bit swollen and ulcer seen – reviewed by DS, see notes.
>
> Simple plaster applied for review at Papamoa Monday, appointment made.
>
> **Objective**
>
> ATSP to R/V wound/xray and bloods.
>
> Xray (R 2nd toe) soft tissue swelling only, no osteomyelitis.
>
> Bloods – raised leuks/PMNs mildly only, norm urate (and norm urate late 2019 on pathlab also).
>
> …
>
> Due to see own GP on Monday for wound rv and ? change of Abx.
>
> O/E R foot – 2nd toe bit swollen, can see sie (site?) of insect bit from few wks ago.
>
> …

[13] A surgery note on 4 May includes the following:

> …
>
> Clinically – looks well with GCS 15/15.
>
> Appears uncomfortable.
>
> Limping and reduced weight bearing on the R foot.
>
> Clinically – R foot 2nd toe – ulcer approximately .8mm x .8mm in round shape.
>
> Surrounding erythema extending to R foot, with associated swelling, heat and pain ++.
>
> Pedal pulse 2+.
>
> Post tib pulse 2+.
>
> Good ROM 2nd toe, foot and ankle.
>
> Imp: cellulitis R 2nd toe extending to R foot.
>
> **Plan:**
>
> Stop oral abs.
>
> Commence IV ads via CPO – forms completed.
>
> Paracetamol and codeine for analgesia.
>
> Red flags discussed.
>
> Review tomorrow in clinic or prior if any concerns.
>
> Dressing to wound as per RN.
>
> WBAT (weight bearing as tolerated) and use of crutches – rest and elevated as instructed.
>
> Review tomorrow.
>
> …

[14] On this occasion, the appellant was prescribed codeine phosphate – 1-2 tablets every six hours.

[15] There was a telephone follow-up on the same day, 4 May 2020, from the surgery and the following was recorded:

> Still painful, took 15mg codeine and 1g paracetamol with some effect, still swollen and hot to touch, redness has not seemed to track further up towards ankle, advised to

mark with vivid erythema o/m and if starts to track further up foot, will need to go to hospital, also if develops fever above 37.5 present to hospital.

Advised to take 30mg of codeine along with paracetamol when next due analgesics.

…

[16] A further surgery note from 4 May 2020 includes the following:

Subjective:

Here for wound review to R foot, pain +++ to the verge of tears, upset that no improvement. Nil analgesics on board.

Area cleaned with chlohex, using emu oil surrounding wound, helps with pain. Cellulitis surrounding toes, and midway up foot.

Reviewed by LH, agreed IV ABS required.

ART assisted with IV ABS, given as per rx as per screening with PT consent. PT waited 20 mins post, felt slightly nauseous, experienced episode of increased pain in foot when solosite was applied to wound, area cleaned again, medihoney applied to sloughy area, covered with non-adhesive dressing, handy gauze and bandage. Given crutch to minimise wt bearing on foot, advised to elevate as much as possible, commence analgesics as per rx, take every six hours to stay on top of pain, appt booked for tomorrow for IV ABS and review …

[17] Also, on 4 May 2020, an ACC 18 Medical Certificate was completed by the nurse practitioner and the appellant was declared unfit for work until 10 May 2020.

[18] Under the heading "Diagnosis Details" is this:

Insect bite on 2nd toe – worsening pain and redness R foot – now spreading cellulitis.

[19] On 5 May 2020, the appellant returned to the surgery. The following was recorded:

Subjective:

Here for wound review to R foot, appears to have increased swelling today, but erythema subsiding slightly, still very painful, comes through in waves, barely slept last night …

ART assisted with IV ABS, given as per rx as per screening with PT consent. PT waited 20 mins post, felt fine, solosite applied to sloughy area – nil pain this time, covered with non-adhesive dressing only, found handy gauze too tight and uncomfortable, utilising crutch to minimise wt bearing on foot, advised to elevate as much as possible, continue analgesics as per rx, take every six hours to stay on top of pain, commence naproxen as per rx and take zopiclone just before bed PRN, appt for xray at 3.00pm, appt booked for tomorrow for IV ABS and review.

[20] The appellant underwent an xray on 5 May 2020. The xray report included the following:

> **Indication:**
>
> Ulcerated wound right 2nd toe, with spreading cellulitis despite antibiotics. ? foreign body.
>
> **Findings:**
>
> No radiopaque foreign bodies identified.
>
> No lytic abnormality or periosteal response associated with the 2nd toe.

[21] On 6 May 2020, the appellant attended the GP's surgery. Under the heading "Subjective", the notes included the following:

> …
>
> Weight bearing better and less pain associated with weight bearing.
>
> …
>
> R foot – significantly less swelling today, some erythema remains. Wound appears to be healing slowly, but making daily improvements.
>
> …
>
> **Plan:**
>
> IV ABS (antibiotics) day 3 today. Review tomorrow. ? continue with IV ABS for next few days prior to commencing oral ABS again.

[22] The surgery note for the following day, 7 May 2020, includes the following:

> **Subjective:**
>
> Presents for day 4 IV ABS. As charted, also viewed by LH. Looking better again, wound beginning to debride due to solosite. Wounds cleaned with chlorhex, covered with solosite and island dressing.

[23] At the consultation of 7 May 2020, Nurse Practitioner, Ms Hogan, noted the following under the heading "Subjective":

> 3rd dose IV ABS completed yesterday.
>
> For review today.
>
> Improving daily.

Still infected wound 2nd R toe with surrounding erythema and swelling.

Swelling and erythema less today.

Mobilising well.

Reduced levels of pain.

Plan:

Further 2-3 days IV ABS applied for through CPO.

Review tomorrow.

[24] The following day, 8 May 2020, there was a further consultation in surgery which included the following:

Subjective:

Presents for day 5 of IV ABS for infected toe/foot. Meds given as charted. Reviewed by LH (Lorraine Hogan, Nurse Practitioner). Pt to present to BF over weekend for continued IV ABS – toe ? needs surgical debridement as it seems that solosite is not sufficient. Still some necrotic tissue to toe. Also being reviewed by JWT (Dr Justice Tweedale).

[25] It appears that the doctor's surgery contacted Tauranga Hospital and the appellant was referred to the hospital. The appellant's doctor provided the following summary for his admission:

Thank you for accepting to see Brett as discussed on the phone.

Wound to R 2nd toe under ACC from bite, seen in clinic, commenced on oral ABS flucloxacillin initially, then added in probenecid. Has xray due to worsening pain symptoms on 1/5/2020 – extensive soft tissue swelling, but no evidence of osteomyelitis. Monday seen in clinic, worsening symptoms, low grade fever, generally feeling unwell, ulcerative wound in 2nd R toe, with spreading cellulitis. Pain – sharp in nature with some tingling at times, swelling and erythema over toes and foot.

Commenced on IV ADS cefazolin to GM daily + probenecid – given dose 5 today in clinic.

Had repeat xray Tuesday this week – no osteomyelitis. Bloods CRP normal and only slightly raised WBC and neutrophils. Remained with low grade temperature.

Today ongoing pain erythema, neuropathic pain, some new pustules forming, necrotic wound 2nd R toe – some improvement, but discolouration of the foot – bright red when down with some mottling in nature.

Pulses 2+ pedal and posterior tibialis CRP < 3 seconds.

[26] The hospital clinical summary included the following:

> 41yo referred in from ED with right 2nd toe infection not resolving despite AV ABS.
>
> **Background**
>
> Bipolar disorder.
>
> GORD+ prev oesophagitis.
>
> Current smoker 20 pack years.
>
> Daily marijuana use.
>
> Hx PC.
>
> Approximately 4 weeks ago had an insect bite to right 2nd toe. Then a week or so after that developed a wound at same site with some pus. Surrounding erythema developed.
>
> Has had oral flucloxacillin + probenecid course, then five days IV cefazolin with GP and still not resolved. Subjective fevers past three days. Nausea today, but still eating and drinking OK.
>
> Had been having burning pain and numbness off and on in right foot for about six months.
>
> Has had a morning cough past couple of days with some brown sputum, not uncommon for him. Nil cough during the day. No sore throat/SOB. Been to GP and supermarket, otherwise just in his bubble.
>
> **OE/Plan:**
>
> …
>
> Appears well.
>
> HS dual, chest clear.
>
> Right 2nd toe wound with black eschar and surrounding maceration. Surrounding erythema over forefoot and medially to heel. Warm to touch.
>
> **Investigations:**
>
> Bloods.
>
> Xray 5/5/20 in community. No lytic abnormality or periosteal reaction.
>
> IMP – ongoing 2nd toe wound + infection despite multiple courses ABS.
>
> **Progress:**
>
> Reviewed by orthopaedics who felt no concerns for osteomyelitis.
>
> Reviewed by surgical registrar, ABPI 1.2, no acute vascular issue, wound not needing surgical debridement.

> D/W infectious diseases. Re: antibiotic choice, recommend Augmentin plus co-trimoxazole if seawater exposure.
>
> **Plan:**
>
> Discharge home.
>
> …

[27] The appellant was discharged from the hospital and attended the doctor's surgery on 11 May 2020 for an update of his ACC medical certificate.

[28] He attended the surgery again on 13 May 2020. The medical notes included the following:

> IMP – ongoing 2nd toe wound + infection despite multiple courses ABs.
>
> **Progress:**
>
> Reviewed by orthopaedics who felt no concerns for osteomyelitis.
>
> Reviewed by surgical registrar, ABPI 1.2, no acute vascular issue, wound not needing surgical debridement.
>
> …
>
> **Plan:**
>
> Discharge home.
>
> 7/7 Augmentin and Cotrimoxazole.

[29] The appellant attended the doctor's surgery again the following day, 14 May 2020. Under the heading "Subjective" is this:

> …
>
> Unfortunately his foot has not improved and he has developed increased swelling and pain in his foot. He has an ulcer on his second toe, which has expanded. He has been feeling hot and cold, suggestive of ongoing fever. I discussed with Dr Hanfelt-Goade, who felt he needed further investigation.
>
> Referral orthopaedics.

[30] The same day, 14 May 2020, his right foot was xrayed at Tauranga Hospital. The report noted:

> No fracture or dislocation. Bone density is normal. No osteolytic or sclerotic bone lesions.

> Please note, the early changes of osteomyelitis may not be evident radiographically. If there is ongoing clinical concern for osteomyelitis, a targeted MRI of the area of interest is recommended.

[31] On 20 May 2020, a lower limb peripheral runoff angiogram with contra was undertaken. The angiogram was undertaken because of an indication of right second and third toe gangrene.

[32] Under the heading "Comment" is this:

> Very poor below knee contrast enhancement, particularly within the right leg.
>
> Allowing for this, there is flow within the anterior tibial artery, but no comment can be made on any other underlying crural vessel disease. The appearances are suspicious for complete occlusion of the right posterior tibial proximally.
>
> There is no occlusive disease or inflow stenosis within the above knee vasculature.

[33] On 22 May 2020, a further right femoral angiogram was undertaken. The report includes the following:

> CLINICAL:
>
> Foot ischaemia with gangrene second and third toes. Smoking history. Brett gives a history today of onset of symptoms about six months ago when walking down a hill, when he developed numbness and discomfort in the foot. Further new symptoms 4-6 weeks ago.
>
> Right groin downstream puncture performed. Multiple runs show intact common femoral, surficial and profunda femoris arteries. The popliteal artery is satisfactory. There is a good anterior tibial artery; however this stops abruptly at the ankle. The tibioperoneal trunk proximally is identified; however neither posterior tibial nor peroneal artery is shown.
>
> Attempts to probe the posterior tibial and peroneal arteries have been made with an 014 command wire and associated CXI(R) catheter without success.
>
> Following this, the distal anterior tibial has been probed at the ankle in order to attempt to get through into dorsalis pedis; however this has not been successful. The procedure has been terminated.
>
> An attempt to insert a place of Star Close device has been made but the wire unfortunately has come out with manual compression then used.
>
> **Summary:**
>
> Single anterior tibial crural vessel to the ankle, which stops abruptly. Occluded posterior tibial and peroneal arteries with poor runoff through the foot. Multiple small collaterals are developing in the calf. While not diagnostic, Buergers' Disease is to be considered.

Dr Gerard Eagar
Consulting Radiologist

[34] The appellant was discharged on 2 June 2020. The discharge notes included strong advice for the appellant to quit smoking.

[35] The appellant continued to be treated by his GP. The GP noted on 11 June 2020:

> …
>
> No real progress. Pain increased in severity and ++
>
> Pt struggling.

[36] On 26 June 2020, the appellant had a consultation with specialist podiatrist, Sophronia Kear. She noted:

> He was still under investigation for Buergers' Disease and "continues to take pain medication for foot pain. He continues to have necrosis to his toes and healthy tissue forming. His necrosis particularly to the right second toe is stable and dry. He has lifting of his toenails to the first, second and third toes, but these are not ready to be removed. He also has a superficial wound overlying the fifth MPJ.

[37] On 14 July 2020, the appellant's GP notes that codeine is ineffective; that tramadol is ineffective, but that Severdol worked well.

[38] On 15 July 2020, the appellant consulted vascular surgeon and endovascular surgeon, Mr Holdaway.

[39] In his report, Mr Holdaway noted:

> …
>
> However, the crural arteries were diseased and there was severe reduction in size of the digital vessels and mid-foot vessels. Indeed, this has all the appearances of Buergers' Disease and I would agree with Phil's diagnosis in this regard.
>
> …
>
> Brett is a smoker of both tobacco and marijuana. He has been counselled about smoking cessation, particularly with the presumptive diagnosis of Buergers' Disease. He has reduced his smoking, but has not yet completely quit.
>
> …

> Vascular examination showed femoral and popliteal pulses were easily palpable bilaterally. However, digital pulses were absent. His right second toe has distal tip dry gangrene. There is also a spot of gangrene on his right big toe. There are some ischaemic looking blood blister areas developing on this heel.

[40] At a consultation with his GP on 24 July 2020, it was noted:

> …
>
> Wounds worse today.
>
> Spreading over the foot, now has wound on the heel, and spreading up the back of the leg – pustules over the posterior lower leg around achilles. Presently on flucloxacillin …

[41] The appellant was admitted to Tauranga Hospital again on 24 July 2020.

[42] On 29 July, Mr Holdaway reported again, noting:

> …
>
> There is reasonable arterial inflow in Brett's lower leg down to the level of the ankle. Thereafter, none of the three calf arteries are seen into the foot. It is no surprise his foot is in so much trouble.

[43] A balloon angioplasty was mentioned, however Mr Holdaway went on to say:

> …
>
> This is in no way certain and at best there would be a 50 per cent chance of success. If this is not successful, then Brett may well need to consider some of amputation.

[44] Mr MacDonald was discharged from hospital on 31 July 2020. In the discharge notes, Dr Thwaite noted the following:

> …
>
> R foot wound swab: staph aureus sens. to flucloxacillin and erythromycin.

[45] Following this appeal hearing, advice was sought from Dr Thwaite as to what this entry meant.

[46] In a letter to the service manager dated 10 August 2023, Dr Thwaite said this:

> With regard to your letter of 2 August, the answer to your question is as follows:
>
> (b) Able to be treated with flucloxacillin.

[47] The appellant was admitted to Hamilton Hospital on 18 August 2020.

[48] Under the heading of "Clinical Information" contained in his discharge summary is this:

> Mr MacDonald is a 41 year old male who was admitted under the care of Mr Holdaway, consultant vascular surgeon, for an elective right forefoot amputation.
>
> Mr MacDonald is known to our service as he previously was transferred from Tauranga following a failed attempt at angioplasty. Unfortunately after his AT angioplasty in Waikato Hospital, no flow was demonstrated to the toes. He was discharged home in view of readmitting at a later date for an elective amputation.
>
> …
>
> Mr MacDonald was admitted through DOSA and proceeded to theatre on the same day 18/8/20.
>
> **Procedure:**
>
> Right trans metatarsal forefoot amputation.
>
> Surgeon: Mr Holdaway/S French
>
> Discharged to ward post-operatively. Reviewed by anaesthetics and pain team due to uncontrolled pain post-operatively. Initially managed with morphine PCA, however this was changed to a ketamine infusion. Due to increasing inflammatory markers and ongoing pain, Mr MacDonald's wound was reviewed on 21/08/20: wound marginal, some areas of slough on dorsum of the foot. Septic screen sent to rule out other source.
>
> Unfortunately Mr MacDonald's wound was reviewed again on 24/08/20 and was found to be unsalvageable. The option of BKA (below knee amputation) vs attempting to manage conservatively was discussed at length with Mr MacDonald and he decided on the option of BKA.

[49] This procedure occurred on 26 August 2020.

Appellant's Submissions

[50] Ms Koloni submits that at the heart of this case is an insect bite to the second toe of the appellant's right foot from about the end of March or beginning of April 2020.

[51] She reminds the Court that this occurred during lockdown and that the appellant's initial consultations had to be via telephone.

[52] She took the Court through the GP consultations that occurred during May and the months that followed as set out in the background section of this judgment.

[53] She noted that the appellant was a very active man, with three young children, who had no problem with circulation prior to the insect bite.

[54] She points to the fact that the appellant improved while he was receiving intravenous antibiotics.

[55] She submitted that a possible cause of the condition that led to amputation was the "superbug – staph aureus" mentioned in Dr Thwaite's discharge summary of 31 July 2022.

[56] As referred to in the background section of this judgment, Mr Thwaite has cleared up that issue in his letter of 10 August, noting that the staph aureus infection that the appellant had was able to be treated with flucloxacillin.

[57] Ms Koloni also seeks lump sum compensation because ACC, in her submission, wrongly declined cover for below knee amputation.

Respondent's Submissions

[58] Mr McBride notes that in its letter of 16 March 2021, ACC declined cover for right below knee amputation as a consequence of the insect bite sustained on 2 April 2020 because:

> The medical evidence, including information supplied by your vascular surgeon, supports that the need for the amputation surgery was ischaemia (restriction of blood supply to tissues) and dry gangrene at several places in the foot. Dry gangrene is a well known effect of conditions that reduce or block arterial blood flow.
>
> After carefully assessing all the medical information available, we are unable to continue with your entitlements. We have now suspended your entitlement to weekly compensation, and we are providing you with 14 days notice from the date of this letter. Your weekly compensation entitlement will cease on 29 March 2021.

[59] Mr McBride acknowledges that the appellant and his family have been through a harrowing and life changing experience, but the question is whether there is medical evidence that proves the below knee amputation is causally related to the insect bite.

[60] He submits that the answer, on the medical evidence, is absolutely plain that it was not.

[61] He accepts that the appellant had issues with his foot, that he attributed to the insect bite. However, the medical evidence supports the diagnosis of Buergers' Disease and not the insect bite.

Appellant's Reply

[62] In her reply, Ms Koloni was critical of ACC's decision making, claiming that ACC had not sought medical information prior to making its decision.

[63] She also submits that if the appellant does not have cover under s 20(1), then he should have cover under s 20(2)(f), (g) and (h) relating to personal injury caused by a gradual process, disease or infection, or injury caused by gradual process consequential on personal injury suffered by the person, or such injury consequential on treatment given to the person for personal injury for which the person has cover.

Decision

[64] As the background section of this judgment records, the appellant did indeed have an insect bite on the second toe of his right foot at approximately the beginning of April 2020.

[65] This is documented in the ACC injury claim form completed by the appellant's doctor on 30 April 2020.

[66] The medical records also show that the appellant reported the insect bite to his GP on 24 April 2020 and again on 2 May 2020.The record of 2 May 2020 notes that the examining nurse can see the site of the insect bite.

[67] It should be noted that at the time the appellant provided this information to his GP, the expectation was that it would heal.

[68] As the background section of this judgment shows, the medical centre that he attended was very responsive to him and this can be seen in the medical centre notes in early May of 2020.

[69] An x ray was taken on 1 May 2020, but this revealed soft tissue swelling only.

[70] It is noted that on 4 May 2020, the medical centre followed up with a phone call to the appellant and the potential need for him to go to hospital was discussed.

[71] A further x ray was carried out on 5 May 2020. It was aimed at establishing whether there was any foreign body in the appellant's wound. None were identified.

[72] On 20 May 2020, the appellant underwent a lower limb peripheral runoff angiogram.

[73] This noted:

> Very poor below knee contrast enhancement, particularly within the right leg.
>
> Allowing for this, there is flow within the anterior tibial artery, but no comment can be made on any other underlying crural vessel disease. The appearances are suspicious for complete occlusion of the right posterior tibial proximally.
>
> There is no occlusive disease or inflow stenosis within the above knee vasculature.
>
> If required, a repeat targeted and limited below knee CTA could be performed to better visualise the crural vessels.

[74] Given this result, a further right femoral angiogram was carried out two days later. Under the heading "Clinical" is this:

> Foot ischaemia with gangrene second and third toes. Smoking history. Brett gives a history today of onset of symptoms about six months ago when walking down a hill, when he developed numbness and discomfort in the foot. Further new symptoms 4-6 weeks ago.
>
> …
>
> **Summary:**
>
> Single anterior tibial crural vessel to the ankle, which stops abruptly. Occluded posterior tibial and peroneal arteries with poor runoff through the foot. Multiple small collaterals are developing in the calf. While not diagnostic, Buergers' Disease is to be considered.

[75] In the hospital discharge summary of 2 June 2020, after the reports on the angiograms had been obtained, the report noted:

> While not diagnostic, Buergers' Disease is to be considered.

[76] What then followed was appropriate conservative treatment, but it was plain that the condition of the appellant's right foot was worsening as time went by. On 24 July 2020, he was again referred to hospital for assessment.

[77] On 29 July 2020, vascular and endovascular surgeon, Mr Holdaway noted:

> There is reasonable arterial inflow in Brett's lower leg down to the level of the ankle. Thereafter, none of the three calf arteries are seen into the foot. It is no surprise his foot is in so much trouble.

[78] Regrettably, from there the condition of the appellant's right foot worsened. On 31 July 2020 there was a failed attempt at angioplasty in Waikato Hospital and the report says that no flow was demonstrated into his toes and he was discharged home with a view to being readmitted at a later date for an elective amputation.

[79] On 12 August 2020 the appellant was again seen by Mr Holloway and surgical options addressed.

[80] On 18 August 2020, he underwent a right trans metatarsal forefoot amputation. This was followed by a below right knee amputation on 26 August 2020.

[81] The sequence is conveniently summarised in Mr Holdaway's Discharge Summary of 31 August 2020:

> Mr MacDonald is known to our service as he previously was transferred from Tauranga following a failed attempt at angioplasty. Unfortunately after his AT angioplasty in Waikato Hospital no flow was demonstrated to the toes. He was discharged home in view of readmitting at a later date for an elective amputation.
>
> ……
>
> Mr MacDonald was admitted through DOSA and proceeded to theatre on the same day 18/8/20.
>
> Procedure: Right Transmetatarsal Forefoot Amputation
>
> ….
>
> Discharged to ward post-operatively. Reviewed by anaesthetics and pain team due to uncontrolled pain post-operatively. Initially managed with morphine PCA, however this was changed to a ketamine infusion. Due to increasing inflammatory markers and ongoing pain, Mr MacDonald's wound was reviewed on 21/08/20: wound marginal,

> some areas of slough on dorsum of the foot. Septic screen sent to rule out other source.
>
> Unfortunately Mr MacDonald's wound was reviewed again on 24/08/20 and was found to be unsalvageable. The option of BKA (below knee amputation) vs attempting to manage conservatively was discussed at length with Mr MacDonald and he decided on the option of BKA.
>
> …
>
> Mr MacDonald returned to theatre on the 26 /08/20
>
> Procedure : Right below knee amputation.
>
> …
>
> Good progress post surgery...

[82] What this history shows is that those in charge of the appellant's care carried out appropriate tests and procedures at appropriate times.

[83] Regrettably from the appellant's standpoint, the evidence that tells most against the insect bite being causative of an injury ultimately requiring below knee amputation is the two angiograms of his lower limbs carried out on 20 May 2020 and 22 May 2020. What the angiograms prove is that the appellant had extremely restricted blood flow to his right foot, the summary of the latter angiogram noting:

> Single anterior tibial crural vessel to the ankle, which stops abruptly. Occluded posterior tibial and peroneal arteries with poor runoff through the foot. Multiple small collaterals are developing in the calf. While not diagnostic, Buergers' Disease is to be considered.

[84] This is confirmed in Mr Holdaway's report of 29 July 2020 with the attempts to improve blood flow to his right foot being unsuccessful.

[85] Mr Holdaway reported again on 12 August:

> As you are aware, we organised for Brett to be urgently transferred from Tauranga Hospital on 31 July 2020 to perform a desperate very distal angioplasty of his posterior tibial artery for treatment of his Buergers Disease.
>
> At the time of his admission, he already had dry gangrene of his right 1st and 2nd toe.
>
> I attended the angioplasty and Dr Zaman worked very hard to try and get the micro catheters down into the foot. In the end we could open up the posterior artery down to the level of the

> ankle. However, there was no main vessel flow, below this, and he has a typical pattern of severe small vessel and capillary type occlusion seen in Buergers disease.

[86] Also, there is his revelation to Dr Thwaite at Tauranga Hospital on 22 May 2020 while undergoing a Right Femoral Angiogram, that he developed numbness and discomfort in his right foot when walking down a hill some six months earlier.

[87] What is clear is that the medical professionals involved did their best to provide the appellant with an optimum outcome. I am satisfied that in this regard, their efforts and their professionalism cannot be questioned.

[88] In essence, the blood flow to the appellant's right foot was so compromised that ultimately the below knee amputation was frankly inevitable.

[89] Accordingly, I find that the insect bite played no role in a causative sense in respect of the below knee amputation. The cause was the underlying and already substantially symptomatic vascular disease identified by the angiograms.

[90] As I have found that cover does not extend to the appellant's condition that required the amputation, appeal ACR 306/21 must be dismissed.

[91] It follows that in respect of appeal ACR 31/22, as cover is not available to the appellant, this appeal too must be dismissed and his claim for weekly compensation refused.

[92] Under ACR 31/22, Ms Koloni has made a claim for review costs.

[93] Mr McBride opposes the award of review costs and refers to s 148(2)(b), which provides that the reviewer "may award an applicant costs and expenses, if the reviewer does not make a review decision in favour of the applicant, but considers that the applicant acted reasonably in applying for the review".

[94] With respect to costs and expenses, in the Review Decision dated 10 December 2021 the reviewer said at paragraph 111 of her decision:

> Mr MacDonald has been unsuccessful in this review application. While there is a discretion to award costs even where an applicant is not successful, I am not satisfied

that Mr MacDonald has acted reasonably in applying for the review for the following reasons:

(a) It was made clear in the documentation provided and during the case management conference of 10 September 2021 that the burden lay with Mr MacDonald to show on the balance of probabilities that Mr MacDonald's below knee amputation was a consequence of the personal injury insect bite he sustained on 2 April 2020.

(b) Ms Koloni was advised that Mr MacDonald must provide further evidence and written submissions on or before 5 November 2021. It was explained to Ms Koloni that evidence to support Mr MacDonald's application for a review was required.

(c) No written submissions or medical evidence was provided prior to the hearing. However, Ms Koloni did enter into extensive derogatory email correspondence with ACC's representative, Mr Lister.

(d) For costs to be awarded, I need to be persuaded that an applicant has acted reasonably in mounting a review notwithstanding that they have been unsuccessful in the review outcome. In this case, the only claim for costs incurred are those incurred under Ms Koloni's representations. I am not persuaded it is reasonable that these costs be paid in this instance.

[95] With respect to costs, in the Review Decision dated 17 February 2022 the reviewer said:

Costs

Although Mr Macdonald was not successful with his review application, under s148 of the Act I may award costs if I consider that Mr MacDonald has acted reasonably in applying for the review.

Ms Koloni sought review costs on behalf of Mr MacDonald. ACC were opposed to an award of costs. In essence ACC submitted that there was no merit in lodging a review application against ACC decision to suspend Mr MacDonald's weekly compensation. ACC submitted that the review in relation to the decision declining to approve cover for the right below knee amputation would have been determinative of the suspension decision.

I agree with ACC's submission and in addition note that at the time that Ms Koloni lodged the review application on instructions from Mr MacDonald, he only had cover for an insect bite to his right second toe and due to the surgery it was clear that the injury to his right second toe was not the cause of his ongoing incapacity. Ms Koloni did not provide any medical evidence to establish that it was. Overall, I find that Mr Macdonald has not acted reasonably in instructing Ms Koloni to lodge the review application on his behalf, and I decline to award costs.

[96] Ms Koloni submits:

- The reviews themselves were reasonable to lodge, given the impact of each decision of ACC, all of the circumstances, and the right to lodge reviews.

- There was most certainly failure by ACC to disclose relevant information to the reviewer, and the dialogue that followed was less than desirable and quite disturbing

- These reviews required an immense amount of time and effort and were adjourned while all medical files were sought from BOP Tauranga and Waikato DHB's (as it was clear ACC had not sought this information prior to making their decisions).

[97] For the hearing of these appeals Ms Koloni has placed before the Court a number of documents omitted from the Bundle of Documents filed on behalf of ACC.

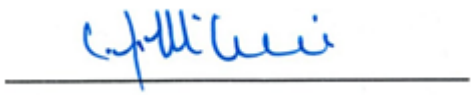
[98] In particular there are medical records of various consultations by the appellant, particularly but not exclusively with his GP, from May to August 2020. I have found these documents, provided by Ms Koloni, to be helpful in the determination of these appeals in respect of the two reviews. Without them, a full appreciation of what had transpired from the time the appellant first presented to his GP on 16 April 2000 would not have been possible. I note what the reviewers have said in respect of costs and that in respect of the first review it is noted that Ms Koloni had provided no written submissions or medical evidence prior to that review hearing.

[99] I infer that that had been remedied by the time of the second review hearing.

[100] Accordingly, I rule that in respect of the second review hearing Ms Koloni is entitled to half scale costs. I expect the figure to be agreed between Mr McBride and Ms Koloni without the need for further involvement by the court

[101] The result of this appeal therefore is that both appeals ACR 306/21 and ACR 31/22 are dismissed save for costs at review in respect of ACR 31/22.

[102] Costs on the appeals, ACR 306/21 and ACR 31/22 are reserved.



C J McGuire
District Court Judge

Solicitors: McBride Davenport James, Wellington