IN THE DISTRICT COURT
AT WELLINGTON

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

[2024] NZACC 012 **ACR 214/22**

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

Hearing:	18 December 2023
Held at:	Auckland/Tāmaki Makaurau
Appearances:	The appellant is self-represented F Becroft for the respondent
Judgment:	25 January 2024

RESERVED JUDGMENT OF JUDGE D L HENARE
[Consequential treatment injury, s 20(2)(d) Accident Compensation Act 2001]

Introduction

[1] The appellant, Navin Chandra, challenges a review decision upholding the Corporation's decision to decline cover for a nerve injury to his right arm and hand as a consequential treatment injury.

[2] Mr Chandra claims he sustained a nerve injury and that it resulted from an unconsented nerve block procedure, administered during surgery to treat a pre-existing covered personal injury by accident.

[3] The Corporation's position is there is no evidence of an injury suffered during the treatment and therefore no basis to cover a consequential treatment injury.

Background

[4] This background is prepared in conjunction with the parties' agreed statement of facts and the Court's own review of the evidence in the appeal together with the parties' submissions.

[5] Mr Chandra has cover for a fractured fifth metacarpal bone (the little finger on the right hand), sustained in an accident on 25 March 2019 when he "fell and tripped", landing on his right hand and left shoulder. At the time, Mr Chandra was walking with crutches due to chronic regional pain syndrome (CRPS), affecting his legs and the left side of his body, resulting from an accident on 06 May 2014. Additionally, he has cover for a right-hand sprain from another injury sustained while undergoing rehabilitation for CRPS.

[6] In February 2020, Mr Chandra underwent surgery on the fifth metacarpal bone of his right hand, performed by Dr Mutu-Grigg, Orthopaedic Surgeon. During this operation, a plate with five screws was inserted to support the bone's healing process.

[7] Following the surgery, Mr Chandra reported persisting pain in the area where the plate and five screws were inserted. The surgeon recommended another surgery to remove the plate and screws after the one-year mark.

[8] In July 2020, Dr Mutu-Grigg referred Mr Chandra to the Auckland Regional Pain Service (TARPS) with a suspected diagnosis of chronic pain. The presenting complaint is noted in the clinic letter dated 3 November 2020 from Mr Hames, Physiotherapy Practice Supervisor:

> Presenting complaint
>
> Persisting hand pain and reduced function following right little finger metacarpal fracture with corrective osteotomy and subsequent CRPS…
>
> Impression
>
> Longstanding bilateral lower limb pain and now pain affecting the right hand following his 2019 injury. Activity intolerance as listed above.

[9] Assessments by Dr Tagaloa, pain specialist, a physiotherapist, and two psychologists concluded Mr Chandra would benefit from a pain management programme to help him develop coping strategies and skills. Since Mr Chandra was awaiting surgery, the programme did not then proceed. At the time, Mr Chandra

engaged in hydrotherapy with West Wave and hand therapy from a hand therapist working on hand function, as noted in Mr Hames' letter.

[10] On 23 February 2021, Dr Mutu-Grigg performed removal of metalware right fifth metacarpal surgery. During this procedure, a nerve block and general anaesthetic were administered as recorded on the operation note.

[11] In her report of 7 December 2021, Dr Hagen, Anaesthetist stated she used a nerve block after consulting with Dr Tagaloa at TARPS regarding the best approach to minimize the risk of post-surgical chronic pain. She stated her usual procedure is to contact a patient prior to surgery and she had made three attempts by phone and text without success, realising only on the day of surgery that she had been given the wrong number. She stated the usual procedure is to "thoroughly discuss both the treatments proposed by me (axillary nerve block and general anaesthesia) and the risks associated with those treatments in the pre-op situation". Dr Hagen reported:

> **What was discussed prior to the treatment and right before the treatment?**
>
> I first met Mr Chandra in the presence of a support person in the early afternoon of Tuesday 23rd February 2021. I had tried unsuccessfully to contact Mr Chandra twice by phoning him and I sent him a text message. On the day of the operation I discovered that I had the wrong or old phone number, which is why I had not been able to made contact with him.
>
> Mr Chandra's analgesic needs were challenging so I discussed his case with a chronic pain specialist colleague, Dr Nani Le-Tagaloa. I knew from hospital records that Mr Chandra was engaged with the Auckland regional Pain Service (TARPS) for ongoing pain concerns and had recently been seen by Dr Tagaloa. I documented on the anaesthetic record that a regional was suggested for pain control if possible. They also suggested daily vitamin C, so a prescription for that was provided to Mr Chandra on discharge.
>
> On the 23rd February 2021, I met Mr Chandra, introduced myself and would have proceeded with my usual discussion (outlined below) to consent him for an axillary nerve block under sedation, followed by a general anaesthetic for the operation. On reviewing the consent form, I have documented that he will receive sedation (for the axillary block) and then a general anaesthetic, but omitted to document that we discussed the nerve block.
>
> I distinctly recall meeting Mr Chandra as it is very unusual for me not to have spoken to a patient having a general anaesthetic or block before the day of surgery. I recall telling him I had been in touch with TARPS and what their recommendations was.

[12] Mr Chandra acknowledges a nerve block discussion with Dr Hagen on the day of surgery and says he did not consent to the nerve block procedure.

[13] On 15 March 2021, following a post-surgery consultation with Mr Chandra, Dr Mutu-Grigg reported:

> I saw Navin today and he has had some issues with the block. **He comments that he was completely numb and paralysed for about 3 days afterwards. His motor power is all coming back as is his sensory deficits. There is no distinct area that is more affected, it appears to be fairly global to the entire limb. Either way it is improving so I would tend to catch up with him again in another 4 weeks to reassess. He also has another meeting with TARPS in 2 weeks so hopefully we should have the clinic note as well.**
>
> (Emphasis added)

[14] On 31 March 2021, a General Clinical Letter from TARPS reports Mr Chandra noting issues with his February surgery and the recommendation of TARPS that he would benefit from "individual work for pain management" and he be referred to a psychologist in the community and "he would be agreeable to returning to either Danute Leathem or Bob Chen".

[15] On 9 April 2021 Dr Mutu-Grigg wrote to Dr Matti, Musculoskeletal Physician that:

> ... The operation itself went fairly well. We did have some local irritation and after some time, he decided that he would like to have the plate back out again. Because of his pain syndrome the anaesthetic chosen was a block. After the operation he was doing quite well and was back to activities that he had not been able to do in some years. It has however going backwards. He now has numbness and pain that is progressing proximally and is now going into has chest wall down to approximately T8 both anteriorly and posteriorly.
>
> He is currently under TARPS, but feel that you might be able to offer us some options also and would appreciate your opinion.

[16] In his letter of 9 April 2021 to Tamaki Hands, Dr Mutu Grigg reported Mr Chandra's symptoms were worsening to involve his upper limb and into his chest wall which he described:

> He has numbness and increased heat that he feels from approximately T6 on his chest wall both anteriorly and posteriorly coming right up to her(sic) shoulder to his trapezium and all the way down his arm. He will have spontaneous loss of control of the arm root feels like he did when he has a block in place where the whole arm would become paralysed and numb. He gets that every 2-3 days. He feels that his shoulder and elbow and wrist are all unstable and loose. He gets shooting pain with electricity that starts in his wrist and radiates right up into his shoulder when his limbs stay in the same position for a few minutes. It does not matter what position his arm is in he will get these symptoms. He is very weak in his hand and he cannot use a fork.

[17] Dr Mutu Grigg concluded the symptoms were indicative of central sensitisation stemming from an underlying pain syndrome due to the fact "that his symptoms are progressing more proximally would indicate this".

[18] Mr Chandra disagreed with Dr Mutu-Grigg's ability to comment on a regional pain syndrome because he lacked the qualifications to do so.

The claim

[19] On 14 April 2021, a claim was lodged for a nerve injury suffered in the surgery which Dr Shepherd, General Practitioner, described:

> Right hand surgical removal of metalware, with subclavian block persisting sensory and power weakness right arm, hand and right lateral chest wall (subclavian nerve distribution).

[20] The Corporation investigated the claim receiving extensive patient notes from Dr Shepherd including noting specialist reports from Mr Bevan, Orthopaedic Foot Specialist, Dr Ng, Musculoskeletal Physician in 2014 and 2015, occupational medicine specialist 2015, orthopaedic review in 2015 and ongoing, Dr Walker, Neurologist in 2015 and Dr Aamir, Pain Management Specialist in 2017 who noted complex regional pain syndrome. There is also reference in the patient notes to care provided by various therapists and psychological support provided by the Corporation.

[21] A Training for Independence report containing comment dated 10 May 2021 from a physiotherapist/rehab, noted Mr Chandra reporting symptoms of "complete paralysis of his arm that occurs every 2-3 days and lasting "anywhere between 90 minutes and 36 hours before it resolves" and that he feels his arm was damaged when he received the arm block. The report noted Mr Chandra's frustration with the diagnosis of clinicians who infer his upper limb symptoms were part of his overall chronic pain presentation. The report went on to note a multidisciplinary approach was necessary for recovery.

Medical reports

[22] On 18 May 2021, Dr Shepherd wrote to Dr Ng, asking him to review Mr Chandra regarding numbness, tingling and weakness in his right arm and hand "particularly in the R) C6,7 distribution. This is post R) hand surgery 23/2/21 (Mutu-Grigg) post removal of metal ware for a united 5th MC fracture, 25/2/16."

[23] Dr Shepherd attached patient notes for the period from May 2014 when Mr Chandra suffered a foot crush injury. The patient notes show Dr Ng had provided opinion on 29 October 2014 noting persistent left ankle symptoms from the foot crush injury complicated by complex regional pain syndrome. Dr Shepherd stated in her letter to Dr Ng dated 18 May 2021:

> There is a long complicated history as stated below involving multiple injuries and a diagnosis Chronic Regional Pain Syndrome.

[24] Dr Mutu-Grigg reported on 13 September 2021, explaining while the nerve conduction studies were normal, there was a chance of a nerve related issue. He thought that symptoms could represent an atypical presentation of carpal tunnel syndrome. He was unsure whether all of Mr Chandra's symptoms were consistent with a diagnosis of a pain syndrome. He recommended Mr Chandra be seen by a pain specialist to confirm diagnosis.

[25] In October 2021, Mr Chandra was seen by Dr Ng, who reported Mr Chandra left the appointment before he was able to formally examine him. However, Dr Ng noted the nerve conduction studies were normal, meaning there was no electrophysiological evidence of a peripheral nerve brachial plexus or a cervical root lesion.

[26] On 4 November 2021, Dr Mutu-Grigg reported again outlining the challenges Mr Chandra was experiencing obtaining a diagnosis and noting his concerns with the medical professionals he had seen. Commenting on a potential injury relating to the nerve block, Dr Mutu-Grigg said:

> **Looking through his case Navin feels that the block is the cause of his symptoms, and the consent was not complete. I was not present for this consenting process, but injury to the nerves being blocked would normally be discussed. Despite that I am unsure of the pathology that could be caused by a block that would cause his current array of symptoms. I do wonder if he has had a central sensitisation but that would not explain the majority of the symptoms that he has. In short, I am not sure how to explain his symptoms accurately, they are not typical for a pain syndrome.**
>
> [Emphasis added]

[27] Dr Ng, Musculoskeletal Specialist, provided an assessment on 25 November 2021, following an examination. He noted nerve conduction studies taken on 25 August 2021, were normal and diagnosis of "Comorbidities: CRPS following bilateral ankle injuries". Dr Nga commented:

> **I informed Navin that my role is to document his symptoms and current clinical signs. There are symptoms of intermittent paralysis/loss of active movement, loss of sensation and electric shock like sensations. There is constant limb paresthesia. He has signs of global right upper limb weakness and reduced sensation. These are consistent with a lower motoneuron lesion or dysfunction. There is significant disability.**
>
> **Navin's presentation is not consistent with CRPS or a pain syndrome. He does not have hyperalgesia or allodynia.**
>
> An opinion as to whether he has suffered a treatment injury is beyond my area of expertise. **I recommend that Navin undergoes assessment by a neurologist and independent anaesthetist who has expertise in nerve blocks and their possible complications.**
>
> [Emphasis added]

[28] Dr Roper, Specialist Anaesthetist reported on 5 February 2022. He considered the nerve block treatment provided by Dr Hagen was appropriate. On the question whether there should have been a different treatment path, Dr Roper noted the anaesthesia options for removal of metacarpal plate. He stated anaesthesia care involves a combination of clinical anaesthesia knowledge, surgical requirements, best practice evidence and considering patient preference. He stated:

> Where there are options available, the anaesthetist and the patient discuss these, along with the risks and benefits, and together decide on the anaesthesia care along with contingencies should there be need to change the plan.
>
> Important factors to consider for Mr Chandra include his history of chronic pain syndrome, current analgesia use, previous anaesthesia experience, surgery as a day-based procedure and the need for use of a surgical tourniquet.

[29] Dr Roper noted Dr Hagen had spoken with an anaesthetic colleague with experience in chronic pain management and the combination of axillary arm block and general anaesthetic. There was no specific clinical indication that a different treatment should have been undertaken. He noted a difference in the accounts between Dr Hagen and Mr Chandra in respect to the issue of consent. He said "if Mr Chandra made it clear he did not want an arm block, this should have been acknowledged and honoured."

[30] Dr Roper noted the arm block was performed under light sedation and Mr Chandra was communicative throughout placement of the block. He reviewed the consent documents that sedation and general anaesthesia were discussed but the regional descriptor was not annotated. He said informed consent must be obtained and

documented and in this case consent for anaesthesia was obtained but there is a difference of view around consent for the arm block.

[31] On the question whether a physical injury had been suffered, he acknowledged the range of neurological symptoms described by Mr Chandra (prolonged paralysis, altered sensation and painful sensations) since the surgery. He noted axillary arm block had the lowest risk factor for all brachial plexus blocks in their different forms. He observed it was unusual to have long lasting symptoms from an arm block procedure. He said the difficulty is identifying exactly the anatomical place of physical neurological injury. He noted review by a neurologist was sought as part of further investigation.

[32] In his letter of 9 February 2022 to the Corporation, Mr Chandra disagreed with Dr Roper's report because he had not taken into account the opinion of Dr Ng that his symptoms do not relate to chronic regional pain syndrome. Mr Chandra reiterated he had not given his written or verbal consent to the nerve block, only to the general anaesthesia.

[33] The file was then reviewed by Dr Graas, Medical Advisor, who reported on 28 February 2022, and was not satisfied that a physical injury had been established.

[34] On 4 May 2022, Associate Professor Duncan, Consultant Neurologist provided an independent review. He examined Mr Chandra and set out a detailed background to the claim. He was unable to identify a neurological mechanism by which the injection into the axillary nerve would produce tenderness to palpitation, localised to the shoulder joint superiorly. He explained the axillary block procedure:

> Injection is in the axilla and aims to block the distal part of the brachial plexus at that site. The usual effect is sensory loss over the elbow, forearm and hand. The medial upper arm is partially spared (especially medially), and you would not expect anaesthesia extending onto the shoulder of chest-this would require blocks of nerves that would require injection at multiple sites (eg. Costobrachial nerve). **Similarly, you would not expect paralysis of the muscles supplying movement to the shoulder. Thus, in the present case the weakness of the shoulder movements found on examination (see below), and the sensory loss extending on to the trunk, truncal surface of the axilla, an proximal shoulder would not be consistent with the effects of an axillary block, even allowing for grossly inaccurate placement of the injection**...
>
> It is difficult to understand or envisage a mechanism whereby all components are damaged, which would require multiple punctures, all of which by coincidence pierced neural structures....

> **There is no known mechanism relating to physical damage whereby a damaged nerve will function partially at one point in time, and not at all soon afterward.**
>
> **I unable to identify a neurological mechanism by which injection in the axilla produces tenderness to palpation local to the shoulder joint superiorly.**
>
> [Emphasis added]

[35] Dr Duncan noted the various documents provided to him including the previous complex regional pain syndrome diagnosed in October 2014, and including Dr Ng's letter of November 2021He did not think the axillary block was capable of producing the clinical syndrome exhibited by Mr Chandra. Dr Duncan concluded there is good clinical evidence against damage to nerves and the most likely caus of right hand/arm symptoms are "highly likely to be functional."

[36] On 19 May 2022, the Corporation issued a revised decision, again declining the claim which was upheld by review decision on 5 September 2022.

[37] A psychologist comment dated 25 July 2022 in a Training for Independence report noted Mr Chandra was seen by Dr Duncan for review of his intermittent paralysis and he "strongly disagreed" with Dr Duncan's opinion that the paralysis is functional in nature. It was noted there was scope for additional psychological support as Mr Chandra had experienced mental health issues and training for independence for rehabilitation purposes was encouraged to maintain recovery.

The appeal

[38] A late appeal was filed in November 2022, with the Court granting leave to Mr Chandra to appeal out of time in January 2023.[1]

[39] New evidence was filed in the appeal from Dr Koshy, Clinical Neurophysiologist in a report dated 14 April 2023. Dr Koshy did not have access to the medical records relating to the surgery in February 2021 because his report was obtained in relation to persisting symptoms arising from a head injury and other neurological symptoms arising from a 2014 claim. Dr Koshy referred to Mr Chandra's multiple accidents, including an assault in July 2019, and a fall injuring the right shoulder and possibly the right cervical paraspinal region. Dr Koshy refers to two

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1 *Chandra v Accident Compensation Corporation* [2023] NZACC 6.

distinct episodes of head injury in February and March 2021. Mention is made "initially after the recovery from the nerve block his arm on the right would experience intermittent paralysis at a frequency of once to twice per week". Dr Koshy commented:

> My inference at the end of having gone through Navin's history was that his history suggests several falls associated with head injuries, loss of consciousness, as well as other orthopaedic injuries involving the right heel, left dorsum of foot, shoulders, as well as medial right hand. **In addition to this there is also a history of some form of nerve block that was administered to the right brachial plexus as well as upper limbs, as a requisite to surgery which, according to him, he was not informed or consented to, and has since led to a constellation of intermittent sensory and motor deficits involving this affected upper limb, producing considerable functional deficits. I was unable to ascertain or assign a specific neurological aetiology or diagnosis to the symptoms that Navin has of the right upper limb, given that it does not confirm (sic) conform to a well characterised neurological entity/diagnosis, to the best of my knowledge.**
>
> [Emphasis added]

[40] Dr Koshy provided another report on 3 July 2023, noting it followed his review relating to Mr Chandra's predominant cognitive symptoms following the accident in May 2014. Dr Koshy indicated he was arranging an MRI of the brain, cervical spine, as well as the brachial plexus together with nerve conduction studies to address the peripheral nerve functions in the right upper limb.

[41] MRI scans were undertaken on 10 August 2023. Dr Koshy reported on 3 November 2023, having reviewed the nerve conduction study completed in November together with the MRI imaging. He concluded:

> Overall my inference from the study was that while the ulnar sensory axonopathy may be explained due to the mild neuropathy at the elbow, given Navin's persistent pain, especially in the distribution of the medial ante-brachial cutaneous distribution, the relatively low MABC amplitudes and potential ulnar amplitude drop across the infra-clavicular plexus, that there may be reason to suspect a possible right lower chord brachial plexus pathology.
>
> **Given the temporal profile of onset of his symptoms** as per his reports of after receiving the brachial block for the orthopaedic surgery, there is plausible reason to suspect **if there is a non-compressive brachial plexopathy, that it may have been causally related to this particular procedure** ...
>
> **The intermittent paralysis that Navin notices of the right arm, however, seems to be atypical for a fixed brachial plexus injury, and this particular constellation of symptoms does not seem to have a plausible explanation. Focal forms of periodic paralysis have been described; however, to the best of my knowledge, I do not know if any have been described in relation to the administration of or as sequelae of brachial plexus pathology or blocks.**
>
> [Emphasis added]

[42] Dr Koshy suggested obtaining a dedicated right brachial plexus study, noting the MRI did not specifically assess this area. Dr Koshy explained the pathology of the elbow and opined "the MABC amplitudes raises the differential of right lower cord (brachial plexus) pathology" and he asked this be correlated with relevant neuroimaging. Mr Chandra sought confirmation the brachial plexus scan was undertaken. Dr Koshy subsequently provided confirmation on 28 November 2023:

> I am writing to amend an incorrect statement made in my report (dated 03/11/2023). **I have since confirmed that Mr Chandra's MRI/ study (10/08/2023) had included an imaging of the brachial plexus on both sides.**
>
> **Mr Chandra has forwarded copies of the radiology report which in the body states that there are no abnormalities noted in relation to the brachial plexus on either side.**
>
> [Emphasis added]

The submissions of Mr Chandra

[43] Mr Chandra asserts he incurred a nerve injury from an unconsented nerve injury stemming from surgery performed on 23 February 2021.

[44] Mr Chandra's submissions:

(i) referred to the events leading to the second surgery;

(ii) described his post-surgery symptoms that he says he did not experience pre-surgery and these symptoms are caused by the nerve block administered during the surgery;

(iii) described how his post-surgery symptoms affected his every-day activities; and

(iv) detailed his experiences with clinicians who seemed unwilling to commit to writing, the verbal views they had shared with him about the reasons for his symptoms.

[45] Mr Chandra submitted he did not provide informed consent for the nerve block procedure. In his written submissions dated 23 November 2023, Mr Chandra stated:

> During our conversation, Dr Hagen was explaining about localized anaesthesia by doing a nerve block. I asked Dr Hagen about the procedure and side effects. She explained that the procedure and explained that after the nerve block to the arm, "a person's arm is entirely paralyzed for up to 18 hours". I was a bit scared by this procedure, so I refused to continue with this procedure. Dr Hagen then

> expressed and shared her opinion on CPRS management. Dr Hagen advised me that after the surgical procedure she will prescribe me with Vitamin C tablets. Dr Hagen continued in our conversation that her "friend" went to a seminar and from the seminar her "friend" had found out that the intake of Vitamin C helps to reduce and manage CPRS conditions more effectively. In Dr Hagen's reports and medical notes, I believe that Dr Hagen has miscommunicated about the facts from the conversation between her and I and has provided misleading information to everyone. I agree that the procedure for localized anaesthesia (using nerve block) was discussed with me during our conversation, **but I did not agree to this procedure verbally or in writing.**
>
> [Emphasis in submission]

[46] Mr Chandra does not accept Dr Duncan's opinion that his symptoms are functional. Mr Chandra submits the appointment was not comprehensive, taking only 28 minutes, and he was not given the opportunity to discuss fully his history, the surgery, his pain symptoms and consequences of his symptoms affecting his everyday activities and his life.

[47] Mr Chandra submitted that medical professionals have not taken into account Dr Ng's view that his symptoms are not due to a chronic pain syndrome. Further, he states he has not received a diagnosis of clinical pain syndrome due to the surgery.

[48] Mr Chandra relies on the opinion of Dr Koshy whose evidence is to be preferred.

[49] Mr Chandra submits there is clear evidence of an injury caused by the nerve block procedure.

Statutory provisions

[50] This claim falls for consideration under s 20(2)(d) of the Accident Compensation Act 2002 (the Act) which provides for cover for personal injury that is a consequence of treatment provided to the person for another personal injury for which the person has cover. The Court must determine whether the claim aligns with the criteria under this provision, and whether there exists sufficient evidence indicating a personal injury resulting from the treatment received by Mr Chandra.

[51] A consequential treatment injury differs from a treatment injury, under s 20(2)(b), because the general treatment injury provisions, and exclusions, under ss 32 and 33 of the Act, do not apply.

Discussion

[52] In the agreed statement of issues, the parties agree the focal point in the appeal relates to the decision of the Corporation on 3 August 2021 to decline cover for a consequential treatment-related injury, specifically a nerve injury affecting the right arm and hand.

[53] Accordingly, the Court must determine whether there is sufficient evidence, on a balance of probabilities to support:

(a) a physical injury; and if so

(b) whether there is sufficient evidence that any such injury was caused by the treatment.

[54] If a physical injury caused by treatment can be established, the injury will be covered, even if it is an ordinary consequence of the treatment.

Consent

[55] Before I turn to consider the issue whether the nerve block treatment caused a physical injury, I discuss the submission by Mr Chandra that he did not consent to the nerve block procedure.

[56] The model of medical paternalism when obtaining informed consent has changed. Patients are now to be treated as adults capable of understanding that medical treatment may involve risks, accepting responsibility for taking risks affecting their own lives, and living with the consequences of their choices.[2]

[57] Dr Hagen's evidence of the timeline of actions is:

> - 9th February 2021 I received the assessment form for Mr Chandra. Around this time, I also received the operating list for the whole session for Mr Mutu-Grigg's list on 23 February 2021 which is where I recall getting Mr Chandra's phone number from. I looked Mr Chandra up on our regional clinical portal and reviewed his clinic letters, with particular attention to his TARPS letter from 3rd November 2020. I liaised with Dr Tagaloa about the best approach to Mr Chandra's anaesthesia in order to decrease the chance of him developing another chronic pain syndrome in his right arm.

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2 *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 approved by the High Court in *Shand v Accident Compensation Corporation*, [2020] NZHC 2743.

- I attempted to call him and then texted Mr Chandra to the phone number I had originally been given and did not realise there was another number.

- 23rd February 2021-I met Mr Chandra in the pre assessment room at North Shore Surgical Centre in the company of a support person.

[58] In response to the question, what did Mr Chandra consent to? Dr Hagen stated she documented on the consent form that Mr Chandra consented to sedation which is ticked Yes on the anaesthesia plan and consent form (for the axillary block) and ticked Yes for general anaesthetic. The consent form shows Dr Hagen ticked General under anaesthesia, but she did not tick Regional. She recalls informing Mr Chandra she had been in touch with TARPS about their recommendation for a nerve block, but she acknowledged she omitted to record the nerve block discussion. She ticked the risk discussion for sore throat, nausea/vomiting, dental damage, allergic reaction, rare serious events and pain.

[59] She said she discussed the recommendation from TARPS that an axillary nerve block and post operative vitamin C to prevent the development of a chronic regional pain syndrome, given Mr Chandra's pain history in his legs and hand. She stated, "Mr Chandra verbally agreed with this plan".

[60] Dr Hagen outlined the elements of the axillary nerve block together with the general anaesthetic. She outlined why the option of a combination of regional anaesthesia under sedation for pain relief after general anaesthetic was recommended. She said it constituted best practice to avoid chronic pain which was "a major concern" for herself, the TARPS specialist and Mr Chandra. Dr Hagen noted Mr Chandra's previous episode of post-operative nausea and vomiting which occurs because of the volatile agents and significant doses of opioids. She said using "a propofol or volatile based" infusion for the anaesthesia and a regional block for the analgesia is the best way of minimising the chance of nausea and vomiting again.

[61] Dr Hagen described the possible side effects include tingling or paraesthesia in the fingers or a patch of numbness might last for weeks instead of days. She described the 'dead' feeling of the insensate limb noting it is annoying to some but most people like the pain free aspect. She opined that long term nerve damage or life-threatening issues like accidentally injecting the local into a blood vessel is extremely unlikely as the ultra-sound guidance means "we can see what we are doing in real time". She said the block usually lasts between 18-36 hours.

[62] The anaesthetic record confirms the nerve block was administered following the general anaesthesia and the nerve block procedure was straightforward with no concerns recorded on the anaesthesia chart. Dr Hagen does record on the anaesthetic record, her discussion with a pain specialist from TARPS of a chronic regional pain syndrome in his legs and hand. She recorded Dr Tagaloa's suggestion "regional if possible".

[63] In summary, Dr Hagen's evidence is Mr Chandra consented to sedation and general anaesthetic. Further, that Mr Chandra agreed with the plan recommended by TARPS pain specialist that an axillary nerve block and post-operative vitamin C to prevent chronic regional pain syndrome, noting his medical history.

[64] Both Mr Chandra and Dr Hagen agree there was a discussion on the day of surgery about axillary nerve block and post operative vitamin C to prevent the development of a chronic regional pain syndrome. Dr Hagen concedes she omitted to document the discussion on the consent form other than noting Mr Chandra will receive sedation. It appears following her discussion with Mr Chandra, Dr Hagen believed she had obtained his implied consent.

[65] At hearing, Mr Chandra acknowledged the discussion with Dr Hagen about the nerve block procedure and says he did not give his consent.

[66] The evidence of Mr Chandra from the transcript of hearing is:

> **Mr Chandra**
>
> ... There was a discussion of nerve block. But not on me, the discussion was, she was there with me, my fiancée. Dr Hagen in, right in the conference room or like the meeting room, she started talking about the chronic regional pain. **She said we believe you actually are suffering from chronic regional pain. I said yes I do.** And she said to me her friend went to a conference whereby, her friend learnt that nerve blocks and consumption of vitamin C helps people with the nerve block. I said okay and **there was no particular question asked to me whether I should actually get a nerve block.** I did actually ask her because she was talking about nerve blocks because I have never actually heard of the nerve block procedure. **I said what are the side effects of, of it**. She said apart from the like, apart from the area being, or arm of the area I can't actually – she said it's usually paralysed for 18 hours. After 18 hours people usually get you know, back to normal. And I said why do people actually get the nerve block. She said because it helps actually cure, or it helps you, it helps people who have had surgeries deal with the pain temporarily, meaning you know after the surgery when you get the pain, instead of taking oral medication, that will actually help like you know like ... administer pain.

> I've done my own research and I found the same thing it it's, it's available like you know, it's openly available on the internet that nerve blocks only work like temporarily in scenarios whereby you know, people who can't actually take oral medication or have problem with it because I do actually have problem with actually taking tramadol and that, that actually eases the pain. But then I explained to Dr Hagen, I said I will never be in favour of actually getting a nerve block for my surgery first of all, my first surgery was more complicated, I was not actually given a nerve block. **Second surgery I wouldn't actually like, prefer a nerve block. We were only having a discussion.** I said I wouldn't actually prefer having a nerve block because my father had had like paralysis, who has recovered a while ago, maybe 35 years ago. He's recovered 90%, I've seen him struggle. I said I don't want the trauma actually like, you know, like I mean getting back in my life personally. **That was the only sort of discussion. We never agreed,** ... so I saw her actually tick 'cos I was sitting right next to her, she ticked General Anaesthesia and she signed for it. She didn't actually explain to me that you will actually get a nerve block as well.
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> [Emphasis added]

[67] Ms Becroft acknowledged the consenting process was not gold standard.

[68] Taking into account the available evidence of Mr Chandra and Dr Hagen, together with the opinion of Dr Roper, the Court is able to find:

- Mr Chandra raised the issue of lack of informed consent soon after the surgery and has been consistent in his views expressed to specialists that he gave consent to the general anaesthesia in the surgery, but not to the nerve block procedure;

- Dr Hagen reviewed Mr Chandra's records, noted the opinion of Dr Tagaloa of TARPS that Mr Chandra had a chronic regional pain syndrome and her recommendation for nerve block. There is no reason not to accept Dr Hagen's evidence that she then made attempts to contact Mr Chandra prior to the date of surgery. An administrative error occurred when Dr Hagen was not given the correct phone number for Mr Chandra;

- Mr Chandra acknowledges there was a discussion on the day of surgery about the nerve block;

- Dr Hagen discussed with Mr Chandra the reasons why the nerve block was recommended by Dr Tagaloa, its benefits and the side effects;

- Dr Hagen believed Mr Chandra had consented to the plan to provide the nerve block procedure and post operative vitamin C to prevent chronic pain syndrome;

- Dr Hagen acknowledged the anaesthetic consent form was not fully completed;

- Dr Roper, independent anaesthetist states informed consent must be documented; and

- Dr Roper notes while consent for the general anaesthesia was obtained, there is a difference of opinion around obtaining consent for the use of the nerve block.

[69] Reviewing the transcript of Mr Chandra's evidence and the signed statement of Dr Hagen, I have no doubt there has been a miscommunication between Mr Chandra and Dr Hagen. There is no corollary evidence available. It is the case there is some contradiction in Mr Chandra's evidence at hearing. On the one hand, Mr Chandra stated he was not expressly asked for his consent. On the other, Mr Chandra stated he made it clear to Dr Hagen he would prefer not to have the nerve block. However, there is no doubt, Mr Chandra's consent, even if impliedly obtained, has not been fully documented.

[70] In determining how to proceed, the Court must consider whether the issue of consent is material. Section 33(1)(e) of the Act, provides that obtaining, or failing to obtain a person's consent to enable the person to make an informed decision, amounts to treatment when considering a treatment injury. This means that, as discussed by the Court in *Maloney*,[3] in the absence of informed consent, even an essential part of a treatment would become a treatment injury, if it caused harm to the person.

[71] In consequence, a finding of a lack of informed consent would not remove the need for the Court to be satisfied any part of the surgery was causative of the injury for a claim to succeed. In this case it means there must be a sufficient basis for

[3] *Maloney v Accident Compensation Corporation* [2016] NZACC 182.

concluding the nerve block caused a nerve injury or any other physical injury. As noted in *Ambros*:[4]

> ...Causation remains a separate, and essential ingredient to prove a treatment injury.

[72] In the appeal, Mr Chandra seeks cover for a nerve block injury. For this reason, the issue of consent is material in this appeal if a discernible physical injury is caused by the nerve block procedure.

Causation

[73] I now turn to consider the evidence on the agreed issue whether a nerve injury or any other physical injury was caused by the nerve block procedure.

[74] The Court of Appeal in *Ambros*[5] outlined the guiding principles regarding causation:

> [68] Spigelman CJ in *Seltsam* said that the only time that a Judge is not able to draw a robust inference of causation are cases where medical science says that there is no possible connection between the events and the injury or death — see at 275. If the facts stand outside an area in which common experience can be the touchstone, then the Judge cannot act as if there were a connection. However, if medical science is prepared to say that there is a possible connection, a Judge may, after examining all the evidence, decide that causation is probable ...
>
> [69] We agree that the question of causation is one for the courts to decide and that it could in some cases be decided in favour of a plaintiff even where the medical evidence is only prepared to acknowledge a possible connection ...
>
> [70] Finally on this topic, we note that the generous and unniggardly approach advocated in *Harrild v Director of Proceedings* [2003] 3 NZLR 289 at [19] (CA) per Elias CJ, at [39] per Keith J and at [130] per McGrath J was used by the High Court in this case to modify the causation test. This, in our opinion, is not an appropriate application of the principle, given the plain words of the 1998 Act and the rejection of the increased risk test in Atkinson. The generous and unniggardly approach referred to in *Harrild* may, however, support the drawing of "robust" inferences in individual cases. It must, however, always be borne in mind that there must be sufficient material pointing to proof of causation on the balance of probabilities for a court to draw even a robust inference on causation. Risk of causation does not suffice.

[75] The evidential threshold required to establish causation must be robust. Risk of causation does not suffice. The following principles have emerged in the case law:

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[4] *Accident Compensation Corporation v Ambros* [2007] NZCA 304 at [46], [2008] 1 NZLR 340.
[5] *Accident Compensation Corporation v Ambros,* above n 4.

(a) A temporal connection will often be a feature of claims for injuries said to have been caused by a single incident. However, a temporal connection alone is not sufficient.[6]

(b) Causation is essentially a medical question and will turn on the advice of those medically qualified to comment.[7]

(c) Additional weight will be given to a medical opinion which provides an injury mechanism and justifies why that mechanism best explains the injury.[8]

(d) Where there are competing specialist opinions, preference is often given to the commentator whose opinion is most consistent with the contemporaneous medical records (initial presentation, early imaging, early examination findings and the timeline for the resolution or worsening of symptoms).[9]

[76] Mr Chandra submits there is clear evidence of a nerve injury caused by the nerve block.

[77] Ms Becroft counters that no evidence has surfaced to indicate any injury occurred during the treatment or was caused by the nerve block. Consequently, Ms Becroft submits there is no evidential basis to support the grant of cover for a consequential treatment injury.

[78] The starting point is the evidence concerning the nerve block procedure. Dr Hagen's statement described the nerve block procedure as an axillary nerve block under sedation. She explained "one tablespoon of local anaesthetic (the same medicine the dentist uses when making gums numb)" is "placed around the nerves that supply the wrist and arm with movement and sensation," which "will turn them off for several hours". The anaesthetic record notes "a brachial plexus axillary right". Dr Roper reviewed the operative documents in the context of the anaesthesia treatment. He did

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6 *Bloomfield v Accident Compensation Corporation* [2014] NZACC 1 at [18].

7 *Stewart v Accident Compensation Corporation* [2003] NZACC 209. This case was referred to in *Ambros* and has been repeatedly upheld. For example, it was applied in *Taiapa v Accident Compensation Corporation* [2022] NZACC 65.

8 For example, *Howard v Accident Compensation Corporation* [2022] NZACC 25 at [42] and [43].

9 For recent examples: *Taiapa v ACC* [2022] NZACC 65; *Prater v ACC* [2022] NZACC 65 and *Herbst v ACC* [2020] NZACC 112.

not consider there were clinical indications that a different treatment path should have been taken. He noted that an axillary arm block has the lowest neurological risk of all the brachial plexus blocks in all their different forms. He noted Mr Chandra's symptoms and the difficulty of identifying exactly the anatomical place for a physical injury as against the documents he reviewed, including the anaesthetic record.

[79] Dr Mutu-Grigg's first follow up report about 3 weeks after surgery, noted Mr Chandra described his symptoms as numbness and paralysis for about 3 days. Dr Mutu-Grigg noted "his motor power was all coming back as is his sensory deficits". Dr Mutu-Grigg noted no distinct area affected and pain symptoms appeared "fairly global to the entire limb". Six weeks later, Dr Mutu-Grigg recorded Mr Chandra was doing well and "back to his activities that he had not been able to do in some years but he had gone backwards. Symptoms were now numbness and pain progressing proximally and into his chest wall down to approximately T8 both anteriorly and posteriorly".

[80] Dr Mutu-Grigg provided more detail regarding the symptoms he took from Mr Chandra, in his report about 8 months later. He identified the paralysis starts around the shoulder girdle, travels down to the hand with a complete paralysis, which occurs two to three times a week. Secondly, the pins and needles and shocks occur in the hand up to the elbow and Mr Chandra feels he is being electrocuted. Thirdly, there is a burning sensation that starts around the shoulders and goes all the way down to the fingers. Mr Chandra feels it warms up and is very painful. Dr Mutu-Grigg wondered whether there had been a central sensitisation, but that would not wholly explain these symptoms.

[81] The Court accepts there appears a temporal connection between the February 2021 surgery and these symptoms. However, the evidence shows a pre-surgery picture of chronic pain. The November 2020 TARPS report from Dr Tagaloa, Anaesthetist and Pain Specialist, noted multiple accidents and injuries since 2014 culminating in severe pain affecting Mr Chandra's right and left foot and his right hand around the plating of the fracture. Numbness, pain and swelling of the shoulder were also recorded. Dr Tagaloa noted a chronic musculoskeletal pain secondary to trauma with central sensitisation which she discussed with Dr Hagen.

[82] Dr Mutu-Grigg's reports confirm the surgery itself was uneventful. The Court observes Dr Mutu-Grigg's letter to Dr Matti some 5 weeks after the surgery notes Mr Chandra was doing well after the operation and he recommenced activities he had not been able to do in some years, but then he had gone backwards with the pain symptoms progressing into the chest wall. The pain was not limited to the arm but moved across to the top of the thoracic area. Dr Mutu-Grigg's letter to Tamaki Hands on the same date as his letter to Dr Matti, acknowledged Mr Chandra's symptoms were related to central sensitisation caused by a pain syndrome. Dr Mutu-Grigg could not identify any nerve injury suffered in the surgery. Mr Chandra submits Dr Mutu-Grigg is not qualified to give an opinion on chronic pain syndrome, and it is unfair to classify his pain as a pain syndrome. The Court observes Dr Mutu-Grigg had Dr Tagaloa's clinical opinion of a pain syndrome. Dr Mutu-Grigg did not know what was causing the pain symptoms, hence his referral to a musculoskeletal specialist.

[83] Dr Shepherd's letter to Dr Ng seeking a second opinion, refers to the symptoms of intermittent paraesthesia and sensations. Notwithstanding Dr Shepherd filed the injury claim, she was uncertain as to the clinical position and raised a couple of differential diagnoses with Dr Ng of "CRPS v nerve palsy secondary to nerve block injury". The fact of differential diagnoses suggests she was grappling with diagnosis.

[84] Dr Ng arranged the nerve conduction studies some 6 months after the surgery which he found were normal, showing no electro-physiological evidence for a nerve, brachial plexus or cervical root lesion.

[85] The point is made by Dr Mutu-Grigg writing to Dr Shelford, that he was unable to fully explain Mr Chandra's symptoms anatomically. In his November 2021 report, Dr Mutu-Grigg did not consider any further surgery could improve these symptoms and the best way forward was pain management.

[86] In his second report, Dr Ng noted the range of symptoms and thought they were consistent with a lower motoneuron dysfunction and not CRPS or a pain syndrome. However, Dr Ng noted there should be an assessment by a neurologist.

[87] Dr Roper provided independent opinion, explaining the axillary nerve block procedure, the reasons supporting the decision to utilise the nerve block procedure and noting no complications during the surgery. There is no suggestion in his report he

thought the use of the nerve block was inappropriate or that a different treatment path should have been undertaken. He, like Dr Mutu-Grigg, described the range of symptoms experienced since the surgery, noting the numbness and paralysis in the right arm which lasted 3-5 days, then normal arm function followed by fluctuating and intermittent weakness and altered sensations in the right arm. Dr Roper recorded pins and needles sensations with warmth and burning persisting. Dr Roper acknowledged that brachial plexus blocks have a small risk of neurological complications. However, as a specialist anaesthetist, Dr Roper noted the specific symptoms of Mr Chandra are unusual and unlikely related to a nerve block. The Court observes both Dr Mutu-Grigg and Dr Roper agree the difficulty in identifying a physical neurological injury resulting from the nerve block. However, they agreed to defer to the opinion of a neurologist.

[88] At hearing, Ms Becroft explained the Corporation had myriad problems trying to arrange an appointment with a neurologist, hence the reason for flying Mr Chandra and his fiancée to Christchurch to see Associate Professor Duncan.

[89] Dr Duncan took a comprehensive history from the documents he identified. He noted the site of the axillary block being injection into the axilla (armpit). Dr Duncan noted the usual effects of sensory loss over the elbow, forearm, and hand. He agreed with Dr Roper that the medial upper arm is partially spared, and it would not be expected that anaesthesia would extend onto the shoulder and chest. Such extension would require nerve block injections at multiple sites, for example into the costobrachial nerve. Similarly, paralysis of muscles supplying movement to the shoulder is not expected. Dr Duncan detailed a full picture of Mr Chandra's symptoms in the documents before him and which he found on examination. Dr Duncan explained the mechanisms which would cause persisting effects of axillary block and the pathophysiology of nerve damage noting "no known mechanism relating to physical damage whereby a damaged nerve will function partially at one point in time, and not at all soon afterward". The significance of Dr Duncan's report is that the neurologist was unable to identify any physical or neural injury caused by the nerve block.

[90] The Court notes Mr Chandra's concerns about his appointment with Dr Duncan. However, the Court finds Duncan's evidence is crucial not only because of his qualifications and experience as a consultant neurologist, but also he has provided

clear reasoning for his opinion. Moreover, there is no medical evidence challenging Dr Duncan's opinion.

[91] Finally, the Court considers the opinion of Dr Koshy. Although Dr Koshy's reports primarily relate to other claims, he has provided a thorough assessment following the reporting from Mr Chandra about his symptoms and his beliefs around causation. Like Dr Duncan, Dr Koshy opined he could not assign any neurological pathology to Mr Chandra's symptoms, and it was likely he suffered some form of chronic pain syndrome, though there were some atypical features to support a pain syndrome. Dr Koshy's report in November 2023 shows the nerve study he arranged was detailed because more areas were tested in comparison with the first nerve study. Dr Koshy posits differential diagnoses being his theory of what may be potentially causing the symptoms including ulna neuropathy at the elbow and the possibility, not probability, of some pathology in the brachial plexus. He says the ulnar axonopathy may be explained by mild neuropathy at the elbow, but this is not related to the brachial plexus.

[92] Dr Koshy is frank regarding the range of possibilities. However, Dr Koshy does not identify any one theory being more likely than the other. However, he does make plain that the intermittent paralysis experienced by Mr Chandra is atypical for a brachial plexus injury. Following the MRI of the brachial plexus being brought to his attention, he confirmed there were no abnormalities noted in relation to the brachial plexus. This Court finds Dr Koshy has left no stone unturned in considering different theories or possibilities whether a nerve injury has been caused by the nerve block.

[93] The difficulty in the case is even if all other specialist evidence were to be set to one side, the opinion of Dr Koshy is plain that there is a disconnect between Mr Chandra's symptoms and any discernible physical injury caused by the nerve block. On causation, Dr Koshy goes no further than noting a range of possibilities.

[94] The Court finds the weight of the objective evidence does not support a nerve injury or any other physical injury caused by the axillary nerve block procedure. In *Ambros* terms, there is insufficient evidence to enable this Court to draw a robust inference of causation.

[95] On the balance of probabilities, this Court finds there is no clear evidence of a nerve injury, or any other physical injury caused by the axillary nerve block procedure. Instead, Mr Chandra's symptoms appear to have arisen independent of any discernible physical injury, with, at best, a temporal link between the on-set of symptoms following the second removal of metalware surgery. This link does not provide any clear cause to explain Mr Chandra's ongoing symptoms.

[96] For the sake of completion, the Court notes at review there was discussion regarding the operative decision, whether the second decline decision of the Corporation overtook the first decline decision dated 3 August 2021, and whether there were any jurisdictional issues arising. This Court agrees with the Reviewer that the Corporation's second decision, dated 19 May 2022, simply confirms the original decline decision which is the operative decision before the Court.

Result

[97] On balance, the Court finds the available medical evidence does not reach the evidential threshold on a balance of probabilities basis, required to establish a consequential treatment-related injury, being a nerve injury or any other physical injury caused by the nerve block procedure administered in the surgery on 23 February 2021.

[98] Accordingly, the appeal is dismissed.

[99] There is no issue as to costs.

Judge D L Henare
District Court Judge

Solicitor for the respondent: Medico Law Limited, Auckland