

**IN THE DISTRICT COURT  
AT WELLINGTON**

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

**[2023] NZACC 209**

**ACR 37/22**

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPEAL UNDER SECTION 149 OF THE ACCIDENT COMPENSATION ACT
BETWEEN	TULUI LEALAI AULOTO-SAOFAILETA Appellant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Hearing: 4 October 2023

Heard at: Christchurch / Ōtautahi

Appearances: Ms P Tucker for the Appellant  
Mr C Hlavac for the Respondent

Judgment: 18 December 2023

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**RESERVED JUDGMENT OF JUDGE C J MCGUIRE  
[Treatment Injury - s 32 Accident Compensation Act 2001]**

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[1] At issue on this appeal is whether the appellant's 2014 carpal tunnel release surgery caused a physical injury which was a treatment injury.

**Background**

[2] In approximately 1976, while in Samoa, the appellant, aged about 17, suffered a laceration to his left wrist. This likely divided his median nerve and his FPL tendon, however he denies that he had any problems with his hand following the wrist laceration.

[3] On 14 October 2013, the appellant suffered a crush injury to his left middle finger in an accident at work. ACC provided cover for this injury.

[4] On 24 October 2013, damaged tissue was removed from the tip of the appellant's finger and a skin graft was performed. After some initial bone infection (osteomyelitis), by December 2013 the finger had healed.

[5] On 20 December 2013, Dr Sanders (Registrar to Mr Creagh, Hand Surgeon) reported to the appellant's GP, Dr Hercocock:

His finger is healing very well now and he has a good range of movement and can make a fist.

[6] By 11 February 2014, the appellant had completed a work readiness programme. During 2014, the appellant attended the hand therapy clinic at the Christchurch District Health Board.

[7] On 6 June 2014, the appellant was referred to the neurology department of Christchurch Hospital for an urgent left carpal tunnel screen. The appellant was seen the same day by Mr Creagh, Plastic Reconstructive and Hand Surgeon, who noted that:

The appellant has limited movement of his fingers. This is better than it has been in the past and he is able to use his hand function a little better. However, it seems to be complicated now by a marked decrease contact of his median nerve.

[8] Mr Creagh referred the appellant for neurophysiology testing to see whether or not he had carpal tunnel syndrome.

[9] A hand written note from Linda O'Neill of the Canterbury DHB Hand Therapy Unit of the same date noted:

Able to use hand better, functioning complicating factor is what appears to be marked lack of conductivity of median nerve ...

[10] The appellant underwent nerve conduction studies on 30 July 2014 and Clinical Neurophysiologist, JG Carroll, reported:

The complete absence of both sensory and motor responses when stimulating the left median nerve makes it impossible to localise the site of the lesion or lesions affecting the nerve, but obviously the wrist is a likely possibility.

[11] The appellant was again seen by Mr Creagh on 5 August 2014. On 13 August 2014 he reported to the appellant's GP, Dr Hercock, noting:

I have reviewed his nerve conduction studies that show that it is impossible to locate the lesion, however, it could quite possibly be carpal tunnel at the wrist and I think that he should have an open carpal tunnel release at the same time as he has revision of his middle finger.

[12] Hand Clinic notes from 5 August 2014 also noted that the appellant had reduced grip strength in his left hand of 10 kg/F. It also noted that a conservative/average grip strength of a person in their early to mid-50s would be 40-50 kg/F.

[13] Notes recorded that the appellant wished to have his left middle finger amputated at the time the carpal tunnel release surgery was performed. This was subsequently scheduled to occur on 15 October 2014.

[14] On 15 October 2014, the appellant signed a consent form for "middle finger amputation, left hand, and carpal tunnel release". The consent was signed by the appellant, in which he agreed that he had received a reasonable explanation of the intent, risks and likely outcomes of the treatment.

[15] The operation was subsequently performed on 15 October 2014. Mr Creagh's surgical notes recorded:

Standard left carpal tunnel release. Nerves seemed to be flattened, but not atrophic looking. Recurrent branch intact. Thorough release.

[16] On 7 November 2014, Mr Creagh saw the appellant in clinic and reported:

He had a carpal tunnel compression performed by me and also revision of his left middle finger. These look in excellent condition today. The carpal syndromes have improved dramatically. The left middle finger is in great condition. He is happy with the results of the surgery.

[17] In March 2015, Dr Hilliard (Occupational Physician) reported that the appellant had ongoing left carpal tunnel syndrome symptoms, with a degree of pins and needles in his fingers and hands and other symptoms suggestive of complex

regional pain syndrome (CRPS). Dr Hilliard considered that the appellant may have a degree of distal upper limb sensitisation, rather than a true carpal tunnel syndrome, and had developed CRPS in his distal left upper limb.

[18] On 13 July 2015, ACC granted additional cover for CRPS, left upper limb, and an additional injury on the appellant's left middle finger, crush injury and amputation claim from October 2013. On 2 November 2015, the appellant attended at the Merivale Hand Clinic complaining of pain and numbness in his left arm, particularly the forearm and into the hand. He advised that he was not able to use his left hand at all because of the weakness in it. On assessment, he presented with marked weakness of the median innervated hand and forearm muscles with significantly reduced grip strength and key pinch. Grip strength was measured at 2 kg (compared with 44 kg on the right side).

[19] The appellant continued to receive treatment from the Merivale Hand Clinic, who reported on 10 March 2016 that he was now using his hand more functionally and able to carry out light function tasks with the splint on his hand. Significantly, his grip strength had increased to 9 kg. However, the weakness of the median innervated hand muscles had not changed and nerve conduction studies confirmed significant reduction in conduction of the median nerve. It recommended that the appellant return to see Mr Creagh for assessment.

[20] The appellant was seen at the Plastic Surgery Outpatient hand clinic on 22 April 2016 by Dr Andrew Davidson (Registrar), who noted:

Briefly to review his history, he had a crush injury on his dominant left hand middle finger back in 2013, eventually requiring an amputation through the middle phalanx due to osteomyelitis. Prior to this he claims he never had any trouble with the left hand in terms of weakness, pain or numbness. Since this injury, he has described deteriorating power in the hand with loss of grip strength and generalised pain that is difficult to pin point ... he claims that previously there was never any significant injury to this limb, although he did have a laceration to the wrist whilst living in Samoa. He states that the function of his hand was normal after that. He thinks that things have gradually deteriorated since this crush injury to the tip of this finger and states that he has made no improvement with the physiotherapists.

[21] The appellant returned to see Mr Creagh, who recommended that an MRI be carried out to try and identify the cause of the appellant's ongoing problems. This was carried out on 1 November 2016. The MRI of the appellant's left wrist disclosed:

Complete disruption of the median nerve just proximal to the carpal tunnel ... the location of the disruption is close to an area of fibrosis/scarring at the radial and volar aspect of the wrist which involves the skin, subcutaneous and deep soft tissues, presumably corresponding to the region of previous injury.

[22] On 13 January 2017, the appellant was seen by Dr Chen (Registrar) in the Hand Clinic, who reported:

MRI scan done 11.1.17 has shown a complete transection of the median nerve. This would have been secondary to injury that was sustained many years ago, even prior to his osteomyelitis and amputation event. He is unable to clarify a time as to when this laceration happened. I do know that he has had a previous nerve conduction study which has shown complete absence responses from the medial nerve on the left hand side.

[23] The appellant was next seen in the Hand Clinic on 10 August 2018, noting that he continued to report pain in his arm, radiating down into his left flank and into his buttocks. It was noted that the appellant had been transferred to the orthopaedic department for suspected cervical stenosis, but that in terms of his ongoing chronic pain, he required pain management.

[24] On 19 October 2018, Dr Simon Nicholson, Fellow in Plastic Surgery, sent a referral to the Pain Management Clinic at Burwood Hospital. In his letter, Mr Nicholson noted that the appellant had diffuse pain all around his left upper limb, both flanks and left back. He also noted that the appellant was awaiting an opinion from spinal surgeons about spinal stenosis which could be contributing to his symptoms.

[25] The appellant underwent assessment for his pain at the pain management clinic during 2019 and was discharged on 21 August 2019. The discharge report included the following:

Functionally he can dress independently. He walks regularly. In response to several questions about activities he finds difficult to do in and around the home. He noted that he was not able to garden (eg. digging) and not able to clean sections above his head (inside and outside his home); this is because (he explained) when he held his unaffected right arm above his head for long

periods, he experiences numbness in his left arm. He noted that he was still able to clean lower sections, including vacuum, using his right arm.

[26] The body of the report also noted that:

- (a) The appellant was suffering from degenerative spinal stenosis in his cervical spine, centred at C5/C6 and C6/C7 levels;
- (b) He was experiencing pain involving his left upper limb, left shoulder, down his left side and left lower limb;
- (c) His grip strength in his left hand was 5 kg/F, which was consistent with the MRI in 2016, which showed complete disruption of the median nerve.

[27] On 14 February 2020, the appellant's GP, Dr Vadei, lodged an ACC 18 injury claim form for a probable left hand median nerve injury suffered during the carpal tunnel release surgery performed on 15 October 2014.

[28] On 5 March 2020, Dr Vadei completed an ACC 2152 Treatment Injury claim form noting that it was not clear whether the appellant's left median nerve injury was due to his carpal tunnel release operation or was part of his initial injury.

[29] On 17 March 2020, ACC issued a decision declining cover, noting that the appellant's left median nerve injury had been noted prior to his treatment and had been identified as related to a laceration injury (to his left wrist) whilst being overseas.

[30] The appellant subsequently applied to review that decision. During the course of that review, an issue was raised as to whether the appellant had provided consent for the carpal tunnel release surgery that had been performed on 15 October 2014. The reviewer therefore quashed ACC's decision and directed that ACC issue a new decision, having considered the issue of informed consent.

[31] ACC subsequently sought a report from Mr Creagh, who reported on 16 April 2021. The report includes the following:

1. A letter dated 5/08/2014 discussed the nerve conduction study's findings and the plan to have an open carpal tunnel release. How was this decision made and what was discussed with the client?

Your first question refers to a letter dated 15 August 2014 about nerve conduction study's findings and the plan to have an open carpal tunnel

release. I think it important here that the original nerve conduction study's report is reviewed by yourself. This report was conducted by Mr G J Carroll, Clinical Neurophysiologist, on 30 July 2014, concludes that:

There is complete absence of both sensory and motor responses when stimulating the left median nerve makes it impossible to localise the site of the lesion or lesions affecting the nerve, but obviously the wrist is a likely possibility.

What this is referring to is that when the carpal tunnel was studied, there was no activity in the median nerve whatsoever and this report pre-dated his surgery. This, therefore, reinforces the fact that this gentleman's injury was a long-standing pre-existing injury, which again is referred to on multiple occasions in the timeline that we have provided.

2. Please discuss what was explained to the client before the surgery and discuss what is explained in general for this kind of surgery, carpal tunnel release.
3. Please describe in detail if the carpal tunnel release involving any physical incision/manipulation including necessary incision to the left hand.

The consent in regard to this was a verbal discussion with the patient before surgery and multiple occasions in clinic prior to this, explaining the risks, benefits and potential complications of the procedure including, but not limited to, general anaesthetic, bleeding, infection, poor scarring, recurrence, nerve injury, wound healing problems and the inability to guarantee a good functional result.

The carpal tunnel release itself was very straightforward and the nerve seen within the carpal tunnel was noted to be very flattened, dull and atrophic looking.

4. What is the cause of the client presenting deterioration in left hand function following his surgery on 15/10/2014?

Your question is if there is any cause of the client presenting deterioration of left hand function prior to his surgery on 15 October 2014. This gentleman has had a long standing left median nerve injury that has been alluded to multiple times in our previous notes. He had a pre-operative neurophysiological finding of complete absence of the median nerve at the level of the wrist. There is an MRI concordant with complete division of the median nerve in the distal forearm, along with hand therapy and clinical notes pre-dating his surgery that also show an absence of median nerve function.

All this is consistent with this gentleman having suffered a median nerve injury a long time ago. It is unfortunate that he cannot recall the dates or time of this, but in no way was this related to his surgery on 15 October 2014.

I am happy to answer any further information required or provide any further medical evidence of the aforementioned notes.

[32] On 8 April 2021, ACC issued a new decision declining the appellant's claim for a treatment injury, including an injury caused by a failure to obtain informed consent to treatment. ACC's letter included an ACC Treatment Injury Report which noted that the left median nerve injury had not been caused by the left carpal tunnel release surgery. It had been noted earlier and was identified to be related to a laceration injury to the left wrist whilst living overseas.

[33] On 24 May 2021, Catrina Logan of Patient Information at Canterbury District Health Board wrote to ACC attaching a statement which advised:

The consent process that was followed at the time is outlined in the attached policy document. Mr Lealaialoto attended a series of outpatient clinics with a surgeon where the plan for surgery was discussed (see letter of 5 August 2014) where the letter to the GP mentions the need for an open carpal tunnel release at the same time as the finger surgery (middle finger amputation). A follow-up after the surgery occurred on 7 November.

...

This form as sent out only included the middle finger amputation. On the day when he saw the surgeon, the second procedure, as was planned, was added and the surgeon has added their signature at the time. This section is also where the patient has signed using the same pen.

### **Further medical evidence**

[34] On 6 December 2022, a medical report was obtained from another specialist surgeon, whose identity, by consent of the parties, is not disclosed. This specialist report of 6 December 2022, as summarised by Mr Hlavac, included the following:

- (a) The appellant had an unrepaired complete division of his medial nerve at the level of DRUJ, consistent with the laceration to his distal forearm in the mid-1970s.
- (b) Despite this, the appellant had a high level of function in his left hand until the injury to his left middle finger in October 2013. After that, he was still able to use his left hand, but with decreased function.
- (c) Following carpal tunnel release procedure on 15 October 2014, his overall left hand function became worse with decreased grip strength and pain over time became more widespread.
- (d) It is possible for a patient with long-standing median nerve injury to have very reasonable hand function and grip strength on the basis that lack of sensation is compensated for by an increase in grip strength which comes from the muscles in the forearm. Because of this, the carpal tunnel decompression procedure would have suddenly caused an



additional decline in overall hand function, much more than would have been expected normally.

- (e) Because the appellant was relying on his grip strength to compensate for his lack of median nerve sensation and proprioception, the carpal tunnel decompression procedure would have suddenly caused an additional decline in overall hand function, much more than would have been expected normally
- (f) The reduction in grip strength would have a proportionately greater effect on the appellant than someone without a median nerve injury. The grip strength gradually returns as the healing process occurs, although this is not always complete. The appellant then developed complex regional pain syndrome with widespread pain, swelling and stiffness; all symptoms that will be proportionately worse in a patient with pre-existing median nerve injury.
- (g) Full imaging of the median nerve prior to the October 2014 procedure and appreciation of the pre-existing damage to the nerve may have prevented the carpal tunnel decompression or allowed a more nuanced conversation with the appellant about the expected outcome of surgery.

[35] Mr Creagh responded on 15 May 2023. For convenience, I again adopt Mr Hlavac's summary:

- (a) He agrees that following the crush injury to the appellant's left middle finger and the osteomyelitis, the appellant would have had decreased functional ability to use his left hand.
- (b) He disagrees that following the carpal tunnel release procedure of 15 October 2014, the appellant's overall left hand function became worse with decreased grip strength and pain. Mr Creagh referred to his clinical note from 7 November 2014, which recorded that the carpal tunnel decompression and revision of the left middle finger was in excellent condition and that his carpal tunnel syndromes had improved dramatically. During a review in Mr Creagh's hand clinic in June 2015, there was no mention of any problem with the appellant's left hand.
- (c) On 5 August 2014 (prior to his carpal tunnel release surgery), the appellant had a grip strength measuring at 10 kgs. 18 months post-operatively, on 10 March 2016, his grip strength in his left hand was re-measured at 9 kgs, which is within 1 kg of his pre-operative grip

strength and therefore shows there was no loss of grip strength as a result of the carpal tunnel release surgery.

- (d) There has been multiple documented information about MRI scans further up the appellant's spinal column and his upper arms, where he has significant spinal stenosis and possibly a higher lesion, causing what is known as double crush syndrome, which may have been the cause of his increasing discomfort in all of his upper left limb and extending down to his left flank.
- (e) Mr Creagh disagrees with the suggestion that full imaging of the median nerve prior to the October 2014 procedure may have prevented the carpal tunnel decompression. Mr Creagh advises that there were significant signs and symptomology of carpal tunnel in all of his clinical notes, which was confirmed by the nerve conduction studies showing that there was a lack of median nerve function distal to the wrist and his working diagnosis at this point in time is that this has been caused by carpal tunnel syndrome. It was Mr Creagh's standard practice in this type of patient to offer a carpal tunnel release, with the signs and symptoms of the nerve conduction study. MRI is not a standard investigation in pre-operative carpal tunnel.
- (f) While Mr Creagh accepts that there is a possibility that there can be a change in hand function with a carpal tunnel release, pre-operatively, the appellant had a grip strength that was only 10 kgs, and his pre-operative hand function as noted in the Hand Therapy Unit notes shows that he did not have a normally functioning hand and that there was a lack of sensory return. Mr Creagh therefore does not agree that the appellant suffered an additional decline in overall hand function as a result of his carpal tunnel procedure.
- (g) Mr Creagh agrees that if an MRI had been performed prior to October 2014, it would have identified the pre-existing median nerve injury. The hand therapy note from June 2014 shows that the appellant

was able to use his left hand better functionally, but the complicating factor was the apparent marked decreased conductivity of the median nerve, wasting of the thenar eminence and decreased sensation protectively from his median nerve. This appears to be a pre-existing injury.

- (h) The hand surgeon who provided the 6 December 2022 report provided a further report on 30 June 2023. The surgeon sought to clarify a number of matters arising from the earlier report in light of Mr Creagh's report of 15 March 2023. Some opinions contained in the 6 December 2022 report were revised. Also, there was agreement with a number of matters raised by Mr Creagh.

[36] The hand surgeon who provided the 6 December 2022 report provided a further report on 30 June 2023. The surgeon sought to clarify a number of matters arising from the earlier report in light of Mr Creagh's report of 15 March 2023. Some opinions contained in the 6 December 2022 report were revised. Also, there was agreement with a number of matters raised by Mr Creagh.

[37] The 30 June 2023 report included the following:

- (a) Following treatment for the crush injury and bone infection in October 2013, the appellant had a shortened middle finger and reduced flexion of his middle finger. He was not able to return to work and had a grip strength of 10 kg/F (average would be at least 45 kg/F). As the appellant's recovery stalled, it became apparent he had profound lack of function in his medial nerve. Hand therapy reports note the appellant's low grip strength and stiffness of the middle finger. This lack of tight flexion in the middle finger would have reduced his grip strength.
- (b) The appellant's post-injury function was very poor. This surgeon's earlier report of 6 December 2022 raised several questions about carpal tunnel decompression as a cause of diminished function. This surgeon now considered that most of the appellant's functional loss occurred after his original accident (ie. before his carpal tunnel release surgery).

- (c) Signs of advanced median nerve compression were noted during the appellant's follow-up to his October 2013 injury. It was reasonable to assume, given the appellant's pre-injury function, clinical picture and nerve conduction studies, that this median nerve compression was new. While in hindsight, imaging of the forearm would have allowed for a more nuanced consent process, the clinical picture and evidence for a severe and new median nerve compression was strong, and so a carpal tunnel decompression was reasonable. The expectation would have been an improvement in the symptoms of nerve decompression, although a full recovery of median nerve would have been unlikely.
- (d) There is a discrepancy between the appellant's recollection of the function of his hand post-carpal tunnel decompression surgery in October 2014 and Mr Creagh's documentation. In particular, the appellant's record made eight years after the operation, in which he stated that his hand "stopped working straight away after the operation" is at odds with Mr Creagh's contemporaneous note from an outpatient clinic on 7 November 2014 where he describes an improvement in the appellant's symptoms and good healing.
- (e) By November 2015, the appellant's hand function was very poor, with very poor grip strength and symptoms and widespread pain and loss of function. However, by March 2016, his grip strength had restored to 9 kg/F. If grip strength is the only measure of function, then the appellant's hand had been returned to the level of function pre-carpal tunnel decompression.
- (f) It is likely that there is concurrent pathology at issue. The outstanding issue is the nerve decompression within the cervical spine, which remains an unanswered question. Alternatively, longer term complications of carpal tunnel decompression, such as complex regional pain, scar tissue, pillar pain or reduced grip strength could be contributory.

- (g) Carpal tunnel decompression is usually an operation with a straightforward recovery (with success rates at between 75 to 90 per cent). Common complications can arise when the carpal tunnel operation is performed without technical errors, including infection, painful scars due to injury to small nerve branches, pillar pain, complex regional pain syndrome and tendon issues such as exacerbation or causation or triggering, tenosynovitis or scar tissue around the nerve or between the nerve and tendon. Reduction in grip strength usually resolves and this is more of an issue for heavy manual workers. A patient who is a heavy manual worker with failure to return to work 12 months following a crush injury of the tip of his finger and concurrent severe median nerve pathology would be more likely to have a modest result after carpal tunnel decompression surgery and could be at increased risk of increased stiffness, more persistent reduction in grip strength and complex regional pain syndrome.
- (h) As time progressed, it seemed that the appellant's hand function deteriorated further and this slow ongoing decline "cannot be attributed to the carpal tunnel decompression". It could result from chronic neuropathic pain as a complication of the surgery, or cervical spine stenosis or nerve root decompression.

[38] The appellant has provided two briefs of evidence – one from himself and another from Robert Auimataigi, both dated 19 August 2022. In those briefs:

- (a) At paragraph 16, the appellant refers to his appointment with Mr Creagh at the Plastic Surgery Outpatient Clinic on 13 August 2014 and says:

I do not recall a discussion about the carpal tunnel surgery going to happen, but rather it was unclear what was going on. The fingers were the main focus when I went there. The wrist was fine as far as I was aware. The surgeon's note reads as if he had made up his mind afterwards, which is what I think happened.

- (b) Regarding the signing of the consent form, the appellant says:

25. Regarding the consent form, I signed a consent form on 15 October 2014 with the very clear view that it was for my finger only. Robert, my support person, helped fill out the forms for me. We talked a lot about what happened and I do not recall any discussion about my wrist.
26. Looking at the consent form attached ... I am clear the carpal tunnel aspect was written down afterwards. Robert was in the room with me, but had to step outside for a phone call so was not 100 per cent sure he heard everything. ... I signed the back of the form, but I did not sign the front where it says "Patient's signature". I did not sign the consent part – it is not my signature.

[39] Mr Auimatagi says:

10. I have been provided with a copy of the consent form now to consider – my recollection is we saw Mr Creagh before the surgery and he said "I'll get the papers". We saw it briefly. He said he would prepare for the operation very shortly. I find it hard to recall exactly what was on the paperwork, but in my view, I do not recall carpal tunnel being discussed. I believe Tului signed the back before he was discharged after the operation.

[40] At paragraph 29 of his brief, the appellant says:

I do not believe I consented. I do not believe I was aware that one of the possibilities of the carpal tunnel operation would be loss of function of my left hand. This is not an anticipated consequence for me of an operation. I would not have agreed had I known that there was a risk I would lose the remaining function in my hand.

[41] Mr Creagh responded to those briefs of evidence in his report of 15 May 2023. He refutes the suggestion that he did not discuss the carpal tunnel surgery with the appellant which included the risks, benefits and potential complications. He also disputes the appellant's suggestion that the appellant did not sign the consent form prior to his operation. Regarding the consultation of 5 August 2014, he says:

I reviewed Mr Lealaiauloto-Saofaileta on the 5<sup>th</sup> of August 2014 in my clinic. That was typed on the 13<sup>th</sup> of August 2014 and this clinical notes shows that I reviewed his nerve conduction studies, that showed it was impossible to localise where the lesion of his median nerve was, however it could quite possibly be at the carpal tunnel and I have indicated that at that point I think it should have an open carpal tunnel release, at the same time of revising his middle finger stump and I applied for ACC funding for both of these procedures. I explained this to Mr Lealaiauloto-Saofaileta, given that I had completed his ACC form and his waitlist form for a left carpal tunnel release and middle finger amputation, I would have discussed this in full with Mr Lealaiauloto-Saofaileta and this is my standard practice when discussing any potential operation and booking a patient for a general anaesthetic

procedure, we discuss the operation that I am booking him for and I go through the risks, benefits and potential complications.

[42] Following that consultation, Mr Creagh applied to ACC to fund the carpal tunnel release surgery and information relating to that was provided to the appellant's GP.

[43] As to the issue of consent, Mr Creagh says this in the same letter of 15 May 2023:

I note the evidence around informed consent that if Mr Lealaiauloto-Saofaileta states that he did not sign the consent form and this is not his signature. Mr Auimatagi states that he does not recall carpal tunnel being discussed and it then goes on to state that the form would have to be signed when he was discharged after the operation. This is indeed not correct under standard operating protocol, the consent form must be signed prior to the procedure and is checked along with marking of the patient before the procedure takes place. I am somewhat taken aback by this accusation around lack of informed consent. I clearly discussed the investigation of his carpal tunnel at several clinic visits. In my application to ACC and in the information back to his GP and his solicitor, this was part of the discussion and certainly at all times I would have kept Mr Lealaiauloto-Saofaileta updated with my planned investigation and treatment. I therefore absolutely disagree with the statement briefs of evidence around informed consent that have been provided ...

### **Appellant's submissions**

[44] The ACC 45 treatment injury claim form dated 14 February 2020 alleged medical misadventure relating to carpal tunnel surgery and median nerve injury. The claim form was completed by the appellant's GP, Dr Vadei. The purpose of the operation was to improve the appellant's hand functionality. It failed from that perspective.

[45] Ms Tucker took the Court through the chronology of events. She highlights the fact that a year after the operation, there was a decline in function in the appellant's left hand grip with it reduced to 2 kg/F and that the appellant was beset with chronic pain.

[46] She submits that what had occurred years earlier in Samoa, she describes as "little or no accident".

[47] She acknowledges that after the operation, the appellant's grip strength had gone up and down, but was trending down.

[48] She conceded that the issue of informed consent is not an aspect of the case that the appellant is now appealing. However, she says that the appellant did not know the risks of losing hand function as a result of the operation. She says nevertheless that the appellant should have been made aware that the failure rate of such an operation was between 10 and 25 per cent.

[49] She submits that the surgery did result in the appellant having chronic pain.

### **Respondent's submissions**

[50] Mr Hlavac notes that the appellant had a very significant crush injury to his finger in October 2013 and the effects of this are documented by ACC, who granted cover and entitlements. The appellant's grip strength was reduced and he was subject to chronic pain. He submits that both these resulted from the crush injury, which reduced his grip to 10 kg.

[51] He notes that cover for complex regional pain syndrome was granted in July 2015 as a consequence of the finger crush injury. He submits therefore that the two main effects of the crush injury resulted in cover and entitlements. He submits therefore it is not clear why cover is sought as arising from the carpal tunnel operation.

[52] He notes that the reviewing hand surgeon's report of 30 June 2023 said:

The clinical picture and evidence for a severe and new median nerve compression was strong, and so a carpal tunnel decompression was reasonable. The expectation would have been an improvement in the symptoms of nerve compression, although a full recovery of median nerve would have been unlikely.

[53] He refers to the nerve conduction studies carried out before the carpal tunnel surgery and the conclusion of the neurophysiologist of 30 July 2014:

The complete absence of both sensory and motor responses when stimulating the left median nerve makes it impossible to localise the site of the lesion or lesions affecting the nerve, but obviously the wrist is a highly likely possibility.



[54] Accordingly, he submits that the studies did not show that the nerve was cut.

[55] He submits therefore that the conclusion of the reviewing hand surgeon was that Dr Creagh was right in his assessment.

[56] He notes again that the appellant has cover for chronic pain and finger crush.

[57] He refers again to the hand surgeon's report of 30 June 2023 where in the summary portion she also notes that the cervical spine stenosis and nerve root decompression remain a significant and unknown possible contributory factor.

[58] He submits that the issue of informed consent is only relevant if there is shown to be a treatment injury.

[59] In this regard, he says there are three possibilities:

- (a) First, that there was a transection of the nerve during the carpal tunnel operation. He says that there is no evidence of this.
- (b) Secondly, there is the proposition that reduced grip strength was caused by the surgery. It is accepted that until the crush injury, the appellant had good grip strength at 40 kg/F until the crush injury, but it fell then to 10 kg/F. Mr Hlavac says however that this is covered under the finger crush injury claim. However, by March 2016, his grip strength was back to its pre-operative level.
- (c) The third possibility of injury was the commencement of chronic pain for which there is cover.

[60] He submits that in any event, ups and downs in grip strength was an expected result of carpal tunnel surgery, more so because of the appellant's pre-existing condition. Therefore, he submits that in terms of s 32(1)(c) it was an ordinary consequence of the operation.

[61] Finally, Mr Hlavac submits that for there to be cover, there needs to be a physical injury and aside from what is presently covered for the appellant, the medical evidence does not identify any injury from the carpal tunnel operation.

[62] In reply, Ms Tucker refers to Mr Creagh's report of 15 May 2023, where at page 5 he says:

The loss of function in a hand from a carpal tunnel procedure would be exquisitely rare, in fact I can never recall a case where there has been loss of function of hand in my operating experience, where there has been complete loss of function following a carpal tunnel operation.

[63] She submits that the appellant had an operation. He did not know he was having 25 per cent hand function loss and now has a permanent chronic problem.

[64] Ms Tucker seeks costs. The appellant is legally aided.

## **Decision**

[65] The two issues to be determined are whether the appellant's 2014 carpal tunnel release surgery caused a physical injury which was a treatment injury and whether the appellant gave informed consent to the surgery.

[66] Dealing with the latter question, the reviewer found that there was a failure to obtain informed consent. He said:

I consider the consent form is documentary evidence that no person obtained informed consent to either of the surgeries on 15 October 2014, noting that the part of the form that would obtain such consent to particular treatment was not filled in for either of the surgeries.

[67] Mr Creagh responds in his report of 15 May 2023, saying:

I note the evidence around informed consent, that Mr Lealaiauloto-Saofaileta states that he did not sign the consent form and this is not his signature. Mr Auimatagi states that he does not recall carpal tunnel being discussed and it then goes on to state that the form would have been signed when he was discharged after the operation. This is indeed not correct under standard operating protocol, the consent must be signed prior to the procedure and is checked along with marking of the patient before the procedure takes place. I am somewhat taken aback by this accusation around lack of informed consent. I clearly discussed the investigation of his carpal tunnel at several clinic visits, in my application to ACC and in the information pack to his GP and his solicitor, this was part of the discussion and certainly at all times I would have

kept Mr Lealaiauloto-Saofaileta up to date with my planned investigation and treatment. I therefore absolutely disagree with the statement briefs of evidence around informed consent which have been provided ...

[68] In his statement of 19 August 2022, the appellant says:

I do not believe I consented. I do not believe I was aware that one of the possibilities of the carpal tunnel operation would be loss of function of my left hand. This is not an anticipated consequence for me of an operation. I would not have agreed had I known there was a risk I would lose the remaining function in my hand.

[69] His support person, Mr Auimatagi, in his statement of 19 July 2022 says:

I have been provided with a copy of the consent form now to consider – my recollection is we saw Mr Creagh before the operation and he said “I’ll get the papers”. We saw it briefly. He said he would prepare for the operation very shortly. I find it hard to recall exactly what was on the paperwork, but in my view I do not recall carpal tunnel being discussed. I believe Tului signed the back before he was discharged after the operation.

[70] I disagree with the reviewer’s finding in this regard and conclude that what Mr Creagh says is correct. There were numerous interactions with Mr Creagh from the time of his fingertip surgery on 25 October 2013 through to the time of the surgery for left carpal tunnel release and middle finger amputation on 15 October 2014. I find that informed consent was given by the appellant and I note and thank Ms Tucker for advising that the appellant no longer pursues that issue.

[71] The other question to be determined is whether the appellant’s carpal tunnel release surgery and middle finger amputation of 15 October 2014 was a treatment injury.

[72] Following that surgery, there was a reduction in grip strength in the appellant’s left hand, down to 2 kg/F. However, by March 2016, that had improved and the appellant’s grip strength had returned to the approximate level that it was prior to the carpal tunnel surgery at about 9 kg/F. The consultant hand surgeon’s report of 30 June 2023 notes that reduction in grip strength is common following a carpal tunnel operation and the subsequent slow ongoing decline since 2016 cannot be attributed to the carpal tunnel decompression. The surgeon’s view was that it could result from either chronic neuropathic pain, as a complication of the surgery, or cervical spinal stenosis, or nerve root compression.

[73] I accept Mr Hlavac's submission that while the purpose of the carpal tunnel release surgery was to improve the appellant's hand function, the fact that it did not does not of itself provide a basis for cover for a treatment injury, given that s 32(3) states:

The fact that the treatment did not achieve a desired result does not of itself constitute treatment injury.

[74] It is noted that the appellant was granted cover for complex regional pain syndrome in July 2015 as an additional injury on his left middle finger crush injury and amputation claim.

[75] It is acknowledged that the surgery of 15 October 2014 did not have a long term optimum outcome. One of the unknowns in this case is just what the injury to the appellant was that he sustained to his left hand in Samoa, about 1976 before he came to New Zealand. However, what we do know is that in July 2014, before the surgery, Neurophysiologist J G Carroll noted a complete absence of both motor and sensory responses when stimulating the median nerve.

[76] The documents before the Court show that in the lead up to the surgery of 15 October 2014, the appellant received appropriate medical care. The carpal tunnel decompression operation appears to have been one that, in respect of the appellant, did not raise any particular medical issues or challenges.

[77] After the operation, on 7 November 2014, Mr Creagh noted that:

These look excellent today.

and

He is very happy with the results.

[78] It was only in the month after that issues with the appellant's left had manifested themselves and in Dr Cox's assessment on 2 November 2015, his grip strength of his left hand was 2 kg.

[79] However, this improved and by 10 March 2016, his grip strength was 9 kg, which was approximately what it was prior to the operation.

[80] Looked at overall, on the basis of all the evidence before me, I am bound to conclude that the treatment the appellant received was appropriate and while the appellant's grip strength dropped after the operation, as mentioned when he was assessed on 10 March 2016, his grip strength had returned to its approximate pre-operative level.

[81] In terms of the s 32 criteria therefore, I must conclude that a treatment injury has not been proven.

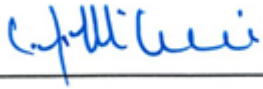
[82] I note that s 32(2) provides that a treatment injury does not include personal injury that is wholly or substantially caused by a person's underlying health condition. In this case that underlying health condition includes the appellant's accident before he came to New Zealand.

[83] Section 32 is drafted to yield sensible answers to claims for treatment injuries. Plainly, there are a range of outcomes that are not optimal but which would on the balance of probabilities be an ordinary consequence of the treatment, taking into account all the circumstances of the treatment, including the person's underlying health condition and the clinical knowledge at the time of the treatment. Ultimately, I find that what occurred here was that the appellant's recovery to his pre-treatment grip strength was slow. However, as subsection 3 says, the fact that the treatment did not achieve a desirable result, which I understand in this case to be greater grip strength after the operation, that does not of itself constitute treatment injury.

[84] Because I cannot otherwise fault the care that the appellant received, and because the final result left him effectively no worse than he was prior to treatment, I must find that there was no treatment injury here. Accordingly, the appeal is dismissed.

[85] For the sake of completeness, I simply note that the appellant's cover for complex regional pain syndrome is unaffected by this decision.

[86] Costs are reserved.



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CJ McGuire  
District Court Judge

Solicitors: Young Hunter, Christchurch  
Joynt Andrews Solicitors, Christchurch