IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

I TE KŌTI MATUA O AOTEAROA
TE WHANGANUI-A-TARA ROHE

CIV-2018-485-208
[2018] NZHC 2848

BETWEEN	ACCIDENT COMPENSATION CORPORATION and "HK" Appellants
AND	BRENDA NG, "L" and ACCIDENT COMPENSATION CORPORATION Respondents

Hearing:	8 and 9 October 2018
Counsel:	A S Butler, S J Thomson and N J Fenton for ACC B J Peck and L J Newman for Brenda Ng and "L" E M Bransgrove for "HK"
Judgment:	2 November 2018

JUDGMENT OF CHURCHMAN J

This judgment was delivered by me on 2 November 2018 at 3:30 p.m.
pursuant to r 11.5 of the High Court Rules 2016.

Registrar/Deputy Registrar

……………………………………

Solicitors:
John Miller Law, Wellington
Russell McVeagh, Wellington

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Background

[1] In 1972, the Government of New Zealand embarked on a bold social experiment when it enacted the Accident Compensation Act 1972 (the Act).

[2] Prior to then, those who had been injured in accidents had limited options to address the consequences of the injuries they had sustained. For those in employment, there was potentially some compensation available from the Workers' Compensation Act 1956. Others were obliged to resort to the Social Security System, and for those unable to access either structure, there remained the common law action for negligence.

[3] At the heart of the action in negligence was the concept of fault. Unless a claimant could prove that the accident which occurred to them was someone else's fault, they could not succeed in obtaining compensation for their loss.

[4] A Royal Commission of Inquiry, chaired by Sir Owen Woodhouse, was set up to identify whether there was a more socially equitable method of compensating accident victims than the somewhat threadbare patchwork of existing options.

[5] The Commission's report (*The Woodhouse Report*) made a number of recommendations which formed the basis of the Act.[1] The Act has been described as a social contract or social compact.[2] It removed the fundamental right of access to the courts to sue in negligence for personal injury caused by accident in return for coverage under a scheme which provided for compensation based on the injury rather than proof of negligence.

[6] The Act, and its various subsequent iterations,[3] has always been the product of policy choices made by successive governments. It did not implement all of the recommendations of *The Woodhouse Report*, and cover was initially restricted to "earners" and those who suffered personal injury by motor vehicle accident. It did not extend to cover illness, even though the social consequences of chronic illness can be as debilitating as the consequences of accidental injury.

[7] Many of the amendments made over the years concerned whether the right to compensation should be restricted or extended.[4]

[8] One of the parts of the Act that has been the subject of amendment based on policy considerations, is that part which deals with what are now known as treatment injuries. Treatment injuries were previously described in the Act as being medical misadventure which comprised "medical error" or "medical mishap".[5]

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1 Arthur Owen Woodhouse, Herbert Bockett and Geoffrey Parsons *Compensation for Personal Injury in New Zealand: Report of the Royal Commission of Inquiry* (December 1967).

2 See Accident Compensation Act 2001, s 3; *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340 at [25]; and *Queenstown Lakes District Council v Palmer* [1999] 1 NZLR 549 (CA) at 555.

3 Accident Compensation Act 1982; Accident Rehabilitation and Compensation Insurance Act 1992; Accident Insurance Act 1998; and Injury Prevention, Rehabilitation, and Compensation Act 2001 (now renamed Accident Compensation Act 2001).

4 See Doug Tennant *Accident Compensation Law* (LexisNexis, Wellington, 2013) at [1.3.1].

5 Accident Compensation Act 2001 (then titled the Injury Prevention, Rehabilitation, and Compensation Act 2001), s 32.

[9] Originally, the concept of medical misadventure was not defined in the Act but was developed by case law. The Court of Appeal in *Childs v Hillock* said that the case law established four propositions:[6]

> (1) Medical negligence or medical error is medical misadventure.
>
> (2) A totally unforeseen adverse consequence of medical treatment is medical misadventure.
>
> (3) An adverse consequence of such treatment which is within the normal range of medical or surgical failure attendant upon such treatment is not medical misadventure.
>
> (4) An adverse consequence of such treatment which is outside the normal range of medical or surgical failure attendant upon such treatment is medical misadventure.

[10] The approach developed by the courts led to the inclusion in s 5 of the Accident Rehabilitation and Compensation Insurance Act 1992 of a definition of medical misadventure as meaning personal injury resulting from medical error or medical mishap. Medical error was defined as:

> "Medical error" means the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances. It is not medical error solely because desired results are not achieved or because subsequent events show that different decisions might have produced better results.

[11] "Medical mishap" was defined as an adverse consequence of treatment properly given if the likelihood of the adverse consequence of the treatment occurring was rare and the adverse consequence of the treatment was severe.

[12] These definitions were incorporated into the Accident Insurance Act 1998 and the Injury Prevention, Rehabilitation, and Compensation Act 2001 which applied until 30 June 2005, with the current version of the Act coming into effect on 1 July 2005 as

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6 *Childs v Hillock* [1994] 2 NZLR 65, [1994] NZAR 97 at 72, citing *Bridgeman v ACC* [1993] NZAR 199 at 210.

a result of the Injury Prevention, Rehabilitation, and Compensation Amendment Act (No 2) 2005.

[13] The definitions in effect immediately prior to 1 July 2005 represented an anomaly in that they were at odds with the "no fault" ethos that underpinned the scheme. In order to obtain cover, "fault" on the part of the registered health professional had to be established. That was often as difficult and complicated a process as the establishment of fault had been under the common law in relation to a negligence action.

[14] The concept of rarity that was a precondition for the finding of a medical mishap was defined by statistical probability as an outcome occurring in one per cent of the cases in question.[7]

[15] In order to establish the rarity and severity of the consequence of a treatment injury, it was invariably necessary for specialist reports to be obtained. This led to both delays and cost. Widespread dissatisfaction with these consequences was behind the amendments that led to the present form of s 32.

Current wording of s 32

[16] The current wording of s 32 provides:

> (1) **Treatment injury** means personal injury that is—
>
> (a) suffered by a person—
>
> (i) seeking treatment from 1 or more registered health professionals; or
>
> (ii) receiving treatment from, or at the direction of, 1 or more registered health professionals; or
>
> (iii) referred to in subsection (7); and
>
> (b) caused by treatment; and

7 Accident Compensation Act 2001 (then titled the Injury Prevention, Rehabilitation, and Compensation Act 2001), s 34(3).

(c) not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment, including—

(i) the person's underlying health condition at the time of the treatment; and

(ii) the clinical knowledge at the time of the treatment.

(2) **Treatment injury** does not include the following kinds of personal injury:

(a) personal injury that is wholly or substantially caused by a person's underlying health condition:

(b) personal injury that is solely attributable to a resource allocation decision:

(c) personal injury that is a result of a person unreasonably withholding or delaying their consent to undergo treatment.

(3) The fact that the treatment did not achieve a desired result does not, of itself, constitute **treatment injury**.

(4) **Treatment injury** includes personal injury suffered by a person as a result of treatment given as part of a clinical trial, in the circumstances described in subsection (5) or subsection (6).

(5) One of the circumstances referred to in subsection (4) is where the claimant did not agree, in writing, to participate in the trial.

(6) The other circumstance referred to in subsection (4) is where—

(a) an ethics committee—

(i) approved the trial; and

(ii) was satisfied that the trial was not to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled; and

(b) the ethics committee was approved by the Health Research Council of New Zealand or the Director-General of Health at the time it gave its approval.

(7) If a person (**person A**) suffers an infection that is a treatment injury, cover for that personal injury extends to—

(a) person A's spouse or partner, if person A has passed the infection on directly to the spouse or partner:

(b) person A's child, if person A has passed the infection on directly to the child:

(c) any other third party, if person A has passed the infection on directly to that third party:

(d) person A's child or any other third party, if—

(i) person A has passed the infection directly to his or her spouse or partner; and

(ii) person A's spouse or partner has then passed the infection directly to the child or third party.

[17] The critical words in the present case are those set out in s 32(1)(c):

> (c) not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment …

The parties' positions

[18] There was little dispute about the concept of "not a necessary part … of the treatment", and the real controversy between the parties was as to the meaning of the words "not [an] ordinary consequence of the treatment".

[19] The essence of the submission being advanced by Accident Compensation Corporation (ACC) (the appellant in the cases of Ng and "L" and the respondent in the case of "HK") is encapsulated in the written submission that:

> An injury will be an ordinary consequence of treatment (and hence not a covered treatment injury) if the injury is a commonplace consequence of treatment in the circumstances of the claimant.

[20] The submission went on to say:

> … the amendment was not intended to significantly extend cover for medical mishap (to use the old language of the 1992, 1998 and original 2001 Acts); rather it simply, in ACC's submission, was a recognition that a hard-edged statistical cut off could be artificial and arbitrary in some cases.

[21] The claimants' submission was fundamentally different. On their behalf, it was submitted:

> … that s 32(1)(c) is a mixed objective/subjective test. The objective element of the test is the use of the word "ordinary". The subjective element of the test is the individual factors contained in s 32(1)(c)(i) and (ii). However, in order for an injury caused by treatment to be excluded from cover, it must be objectively expected to occur for that person. It is not sufficient that the injury be "foreseeable" or "commonplace".

[22] The claimants went on to submit that the legislature had intended to achieve "a paradigm shift from medical misadventure to treatment injury", that the tests in s 32 needed to be read sequentially, and that ACC's submission conflated the test for whether an injury is caused by treatment in s 32(1)(c) with the test for whether an injury is an ordinary consequence of treatment.

[23] It was further submitted:

> The claimants' position is not based wholly on statistics. Rather, the position is that the question of whether an injury is ordinary must have some objective basis. That is, an injury caused by treatment can only be excluded from cover under s 32(1)(c) if the injury was expected in the majority of analogous cases.

[24] The claimants also took issue with the submission for ACC that the claimants' outcomes without treatment had to be factored into the assessment of "ordinariness" of their injuries sustained through treatment. This was submitted to be:

> … an example of where an adjustment is not appropriate, as there is no evidence that their outcome without treatment contributed to the risk of the injuries they seek cover for.

The three appeals

[25] Leave to appeal was granted in each of the three appeals. Although there were three separate decisions, the same Judge (G M Harrison) dealt with each of the appeals, delivering decisions on 16 March 2018 (Mrs Ng), 5 June 2018 ("L"), and 5 July 2018 ("HK").

[26] In each of the cases, Judge Harrison granted leave in respect of different questions of law. The precise wording of the questions differed from case to case.

[27] The specific questions of law can be distilled into the following issues:

(a) What is the meaning of "not [an] ordinary consequence"?

(i) Does it mean a consequence that has a 50 per cent or greater chance of occurring (i.e. does it need to be more likely than not)?

(ii) If not, does it, for example, mean a consequence that is sufficiently commonplace that its occurrence in the individual claimant's circumstances is not beyond the normal range of medical or surgical failure?

(iii) Is an "increased risk" or "reasonable risk" the same thing as an "ordinary consequence" of treatment for the purposes of the Act?

(b) Is the test a qualitative or quantitative one, or a mixture of both?

(i) If the enquiry is a qualitative one (in whole or in part):

a. Should it be based on the actual presentation of the claimant?

b. Should the evidence of background risk of injury (in the absence of treatment) be taken into account?

c. Should the evidence of what actually occurred in the course of treatment be taken into account?

(ii) What weight should be accorded to statistics?

(c) Is there presumptive cover for injuries that occur during treatment unless excluded by statute?

Interpretative approach

[28] The provisions of the Act are to be interpreted from its text in light of its purpose.[8]

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[8] Interpretation Act 1999, s 5.

[29] The relevant text of the Act is not just the text of the immediate section. The legislation as a whole must be looked at. As Thomas J said in *Queenstown Lakes District Council v Palmer*:[9]

> The subsection must be interpreted as a whole having regard, not only to the language that is used, but also to the context of the subsection, to the scheme and purpose of the Act, with reference, if that is necessary, to the history and policy of the legislation and to the consequences of the interpretation which is under consideration.

[30] In *Commerce Commission v Fonterra*, the Court noted that the analysis mandated by s 5 must have regard to the initial and general legislative context and any relevant social or other objective of the enactment.[10]

[31] Section 3 of the Act starts by identifying the purpose of the Act as being:

> The purpose of this Act is to enhance the public good and reinforce the social contract represented by the first accident compensation scheme by providing for a fair and sustainable scheme for managing personal injury that has, as its overriding goals, minimising both the overall incidence of injury in the community, and the impact of injury on the community (including economic, social and personal costs), …

[32] In addition to the orthodox principles of interpretation, the Courts have identified some principles that are particular to the Act itself. One of those is the obligation to give the statute a generous interpretation.

[33] The existence of this obligation was recognised by the Court of Appeal in *Adlam v Accident Compensation Corporation*.[11] At [9], the Court of Appeal referred to the judgment of McGrath J in *Harrild v Director of Proceedings* where he had said:[12]

> The policy of successive accident compensation statutes in New Zealand, including the 2001 Act, has been to provide compensation for persons suffering personal injury without requiring that they show fault to establish their entitlement. The legislative bar to suits at common law is the consequence of the universal nature of coverage under the legislation. A

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9 *Queenstown Lakes District Council v Palmer* [1999] 1 NZLR 549 (CA) at 553. See also *Adlam v Accident Compensation Corporation* [2017] NZCA 457, [2018] 2 NZLR 102 at [9].

10 *Commerce Commission v Fonterra Co-operative Group* [2007] NZSC 36, [2007] 3 NZLR 767 at [22].

11 *Adlam v Accident Compensation Corporation*, above n 9.

12 *Harrild v Director of Proceedings* [2003] 3 NZLR 289 at [130]. Similar comments were made in the same case by Elias CJ at [19] and Keith J at [30].

> "generous, unniggardly interpretation" of what was personal injury by accident under earlier accident compensation legislation was seen by this Court as in keeping with that legislative policy: *Accident Compensation Corporation v Mitchell* [1992] 2 NZLR 436 at 438 per Richardson J. I regard that approach to interpretation as unaffected by the narrower approach to defining personal injury since the 1992 Act …

[34] In *J v Accident Compensation Corporation*, Kós P made some observations about the application of the "generous" construction.[13] Although he dissented from the majority overall, his comments in relation to this point were consistent with the majority decision. At [52], he said:

> The importance of this principle lies where more than one available interpretation exists. If the Act is unavoidably niggardly or ungenerous, that is that. But if a reasonable choice presents, the more generous path should be taken. (citation omitted)

[35] Kós P also said:[14]

> In *Accident Compensation Corporation v Ambros* we noted that the aim of the accident compensation regime is not to assign blame but, at the broadest level of generality, to promote distributive rather than corrective justice by spreading the economic consequences of negligent conduct over the whole community and to provide compensation for injury (regardless of fault).

[36] The majority in that case (Cooper and Asher JJ) explained that although the Act should be interpreted generously, this was not so as to displace the primacy of the Interpretation Act 1999.[15] By that they indicated that the Court was still directed to ascertain meaning from the text of an enactment in the light of its purpose. However, they expressly endorsed the "generous and unniggardly" interpretation that had been reiterated in *Harrild v Director of Proceedings*.

[37] The courts have also confirmed that, notwithstanding what had been, at times, restrictions to the scope of cover available under the Act, the obligation to undertake a "generous and unniggardly" interpretation remains.

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13 *J v Accident Compensation Corporation* [2017] NZCA 441, [2017] 3 NZLR 804.
14 At [53] (citation omitted).
15 At [14].

[38] In the case of *Murray v Accident Compensation Corporation*, Kós J upheld the principle of a generous interpretation of the Act notwithstanding "more crystalline legislative drafting" that followed later versions of the ACC legislation.[16]

[39] Such an approach has been confirmed recently by Collins J in *W v Accident Compensation Corporation* where he held that claimants should "not be declined cover where the language of the statute is clear and unambiguous".[17]

[40] Having now identified the broad purpose of the Act as set out in s 3, it is necessary to try and discern the purpose behind the 2005 amendments that produced s 32 in its present form.

Origins of 2005 amendment

[41] Concerns arose that the processes put in place to determine whether there was medical misadventure under the 2001 Act led to some deserving claimants being unfairly and arbitrarily denied cover for injuries sustained as a result of medical treatment.

[42] Consultation was sought as part of the process of review of the medical misadventure regime. The Consultation Document, titled *Review of ACC Medical Misadventure*, was released to the public in 2003, putting forward three options for consideration.[18]

- Option 1: Retain the current ACC medical misadventure system, with some minor amendments to the definition of medical error and mishaps.
- Option 2: Provide cover for injuries sustained in the treatment process if they could have been prevented.
- Option 3: Provide cover for unintended injuries in the treatment process, including all adverse medical events, whether or not preventable, provided they were unintended, or unexpected or an unlikely outcome of treatment.

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16 *Murray v Accident Compensation Corporation* [2013] NZHC 2967 at [36].

17 *W v Accident Compensation Corporation* [2018] NZHC 937, [2018] NZAR 829 at [33].

18 Office of the Minister for ACC *Review of ACC Medical Misadventure: Consultation Document* (2003) at 13.

[43] The Consultation Document commented that health care was a complex area where unintended injuries did occur, given that there was an inherent risk in all treatment, and it was unrealistic to expect that there would always be 100 per cent positive outcomes.[19]

[44] For this reason, it was important to have an informed understanding of the likely consequences:[20]

> The term "unintended" is used to distinguish between the intended and likely consequence of treatment and an "unexpected" injury that was not intended. For example, while having a gall bladder removed, the bile duct is damaged. The surgical cut made to remove the gall bladder is an expected injury as a result of the surgery, but the damage done to the bile duct is an unintended injury.

[45] The Cabinet Social Development Committee (the Cabinet Committee) summarised the consultation received in a document titled *Medical Misadventure Review – Conclusions and Recommendations*.[21]

[46] The Cabinet Committee noted that Option 3 had received the most support in the consultation process and the proposal was made to replace the medical misadventure cover provisions of medical error and medical mishap with cover for personal injury caused by treatment. The Cabinet Committee stated:[22]

> The proposal will not cover injuries that are a necessary part of treatment, such as a surgical incision during an operation, or which result from the claimant's underlying medical condition.
>
> Other options were considered – the status quo, as well as retaining, with modification, the existing medical error and medical mishap framework for cover, and cover for injuries that could have been avoided or prevented. However, they would not overcome enough of the problems to warrant change.

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19 At 6.
20 At 6.
21 Office of the Minister for ACC *Medical Misadventure Review – Conclusions and Recommendations* (2004).
22 At [8]-[9].

[47] The Cabinet Committee later determined that claimants ought not to be excluded from cover under the new regime if they had an increased risk of injury that they sustained from treatment received.[23]

[48] They noted that the phrase "greater risk" aligned with the use of the one per cent rarity definition for medical mishap, which was being moved away from, and thus recommended not having this as a requirement for treatment injury. They said:[24]

> Cover does not relate to whether a claimant knows about a risk or not. For example, if the claimant knows that s/he will have a greater risk of injury on the rugby field and s/he suffers the injury, the claim is still considered for cover under "personal injury caused by accident". It should be noted that claims that were excluded under the greater risk provisions may continue to be declined under Treatment Injury because the injury might be considered to be a necessary part of treatment. For example, consider the personal injury of nerve damage following the removal of a tumour that was enveloped by nerves. In this case the surgeon had to cut nerves to remove the tumour; the injury was inevitable and therefore was a necessary part of the treatment.
>
> …
>
> Some other injuries that are "more than likely to occur" should also be considered for cover but only where they are not a necessary part of treatment. For example, bedsores are fairly common injuries but are not considered to be a necessary part of treatment.

[49] One of the particular aspects of the medical misadventure regime which drove the change, was the idea that medical error criteria requiring that a registered health practitioner be found to be at fault was at odds with the ACC scheme's "no fault" basis, and also hindered the medical misadventure claim process.[25]

[50] The speeches of various members of Parliament in the Parliamentary Debates, indicated that they thought that the amendments achieved two things:

(a) the removal of the requirement to find fault that was an essential feature of the medical misadventure regime; and

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23 Office of the Minister for ACC *Medical Misadventure Review: Further Issues Associated with Change from Medical Misadventure to Treatment Injury* (2004) at [19]-[21].

24 At [20]-[21].

25 Injury Prevention, Rehabilitation, and Compensation Amendment (No 3) Bill 2004 (165-1) (explanatory note) at 2.

(b) the elimination of the need for a claimant to obtain medical specialist reports.[26]

[51] However, what the proponents of the amendment thought they were achieving, and what they actually achieved, are two different things.

[52] It is now clear that, at least in relation to cases where the allegation is one of failure to treat, or treat in a timely manner, the obligation to establish fault (in the form of departure from a recognised and accepted standard) was abolished in name only with the Court of Appeal interpreting the 2005 amendment as continuing to require some form of fault. In *Adlam v Accident Compensation Corporation*, the Court said:[27]

> … the decision as to whether there has been a treatment injury will often turn on whether some other course of treatment should have been taken other than the treatment in fact provided or withheld.

[53] The Court also acknowledged:[28]

> It will be apparent from our reasoning that we have discerned a legislative policy that, while not requiring a finding of negligence, still operates on the basis that a treatment injury will only have occurred where there has been some departure from a standard and that departure has caused a personal injury.

[54] Given that departure from a standard is still necessary, at least in the case of a failure to treat claim, it is inevitable that the need for claimants in such cases to obtain expert reports, with all their attendant cost and delay, continues to exist. To that extent, there is a disconnect between the purpose of the Act (in particular the mischief at which the amendment was directed) and its outcome. However, I acknowledge that in cases other than those involving things like failure to treat claims which inevitably involve close scrutiny of a health professional's actions, the new concept of treatment injury will not always require the establishment of departure from a standard.

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[26] See Parliamentary Debates: (5 August 2004) 619 NZPD 14695-14708; (3 May 2005) 625 NZPD 20162-20178; (4 May 2005) 625 NZPD 20263-20275 and 20291; (5 May 2005) 625 NZPD 20333-20347.

[27] *Adlam v Accident Compensation Corporation*, above n 9, at [71]. See also Stephen Todd "Treatment Injury in New Zealand" (2011) 86 Chicago-Kent Law Review 1169 at 1200.

[28] At [65].

[55] One of the criticisms of the medical misadventure regime was that the criteria applied were, “arbitrary, often bearing little relation to the circumstances of the patient, resulting in claimants unfairly missing out on cover”.[29]

[56] To address this perceived arbitrariness, the Injury Prevention, Rehabilitation, and Compensation Amendment Bill (2005) proposed to:

(a) remove the requirement to show that an adverse consequence was “rare” (meaning it would only occur in less than one per cent of cases) in order to establish medical mishaps; and

(b) remove the requirement to show that an adverse consequence was severe in order to establish medical mishaps.

[57] The 2005 Amendment Bill, as initially drafted, provided:

> **Treatment injury** will not cover injuries that are an anticipated part or consequence of the treatment, such as surgical incision during an operation, or which result from the claimant’s underlying health condition.

[58] At the Select Committee stage, the majority of the Health Committee changed this provision to:[30]

> **Treatment injury** means personal injury that is–
>
> …
>
> (c) not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment.

[59] Clearly, the 2005 amendment was intended to, and did achieve, the abolition of the statistical or quantitative “hard-edged” restriction of rarity and also the qualitative restriction of “severity”.

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[29] Injury Prevention, Rehabilitation, and Compensation Amendment (No 3) Bill 2004 (165-1), (explanatory note) at 2.

[30] Injury Prevention, Rehabilitation, and Compensation Amendment (No 3) Bill 2004 (165-2).

[60] The interpretative problem with the use of the words "ordinary consequence of treatment" as the new criterion for eligibility for cover for a treatment injury, is that they have no recognised meaning either in law or in medicine.

[61] In the absence of any authoritative medical or legal definition of "ordinary consequences", both parties submitted that the "plain meaning" of the words could be ascertained from the dictionary definition. Although they both refer to the Shorter Oxford English Dictionary, ACC emphasised antonyms to "ordinary" such as "extraordinary and unusual", whereas the claimants emphasised synonyms such as "with no distinctive features, normal or unusual" or "usual, normal, standard, typical, stock, common, customary, habitual, accustomed, expected, wonted, everyday, regular, routine, day-to-day, daily, established, settled, set, fixed, traditional, quotidian, prevailing".

[62] The claimants submitted:

> These plain language definitions indicate that the term "*ordinary*" is reserved for occurrences that are entirely unexceptional or expected under normal circumstances. For example, if a person had a fifteen-twenty per cent chance of surviving cancer, and they subsequently did, they would not naturally describe their subsequent survival as ordinary or expected, although it might be not uncommon. (citation omitted)

[63] For ACC, it was submitted:

> But moving away from a rigid 1 per cent rarity criterion and a high severity threshold does not logically or purposively require the court to accept that the only way to avoid ongoing arbitrariness is to allow cover in all cases where there is an adverse consequence that is below a 99 per cent (or 50 per cent) likelihood threshold.

[64] In support of the submission that Parliament had not intended a significant broadening of cover, reference was made to a report published by ACC in 2004 titled *Medical Misadventure Review – Conclusions and Recommendations* which estimated that the increase in cost likely to occur as a result of the amended regime would be $8.69 million per annum including GST.[31]

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[31] Office of the Minister for ACC, above n 21, at [69].

[65] It was said that because, at the time, medical misadventure claims amounted to some $47 million in costs for ACC,[32] this was a relatively modest predicted increase and therefore indicated that Parliament had not intended to greatly increase the scope of cover. However, the problem with suggesting that this document provides evidence of Parliament's intention is that it is not a document produced by Parliament. It was a calculation originally undertaken by the Department of Labour and then incorporated in a report published by ACC which was discussed by the Health Select Committee.

[66] At [8.11] of his submissions, Mr Butler submitted:

> It is noteworthy that these (limited) forecasted fiscal effects were noted by the Court of Appeal in *Adlam* when considering the proper interpretation of other aspects of the treatment injury regime.

[67] However, there is no reference by the Court of Appeal in *Adlam* to this matter either in the paragraph referred to in counsel's submissions or anywhere else.

[68] The relevant commentary on the Bill records that members of the Health Select Committee were divided as to whether the cost projections were even accurate. The commentary says:[33]

> Some of us are concerned that these costings are a conservative estimate only of what the real costs may be. Others of us think the estimation of costs is fair.

[69] Overall, I am not satisfied that any interpretative assistance can be gained from reference to the Labour Department's anticipated cost projections.

[70] It is clear that, in enacting s 32(1)(c), Parliament intended to expand the cover for treatment injury. The task for the Court is to work out whether the use of the words "not (an) ordinary consequence" represent "a paradigm shift" as argued for by the claimants or no significant extension of cover as argued by ACC.

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32 At [66].

33 Injury Prevention, Rehabilitation, and Compensation Amendment Bill (No 3) 2004 (165-2) at 3.

[71] Given the range of meanings that can potentially be ascribed to the words "ordinary consequences", this case falls within the category where there is a "reasonable choice" of interpretation and, as stated by Kós P in *J v Accident Compensation Corporation*, "the more generous path should be taken".[34] Such an approach would also be consistent with the decision of Collins J in *W v Accident Compensation Corporation* to the effect that claimants should not be declined cover unless the language of the statute is clear and unambiguous.[35]

[72] Although counsel submitted that this case was in the nature of a test case, as no other High Court judgment had focused on the meaning of s 32(1)(c), other cases can provide some useful guidance, notwithstanding that they were focusing on other provisions in the Act.

[73] One of those cases is the Court of Appeal's decision in *Adlam v Accident Compensation Corporation*.[36] That case focused on s 33(1)(d) and the issue of a failure to provide treatment or to provide treatment in a timely manner. However, the Court did make some general observations about treatment injuries. It said, "A treatment injury must involve some act or omission that has a causative effect in producing the personal injury".[37]

[74] In the present case, there was no dispute that this criterion was satisfied in each of the three cases.

[75] The Court also said:[38]

> … an assessment of what was an ordinary consequence of treatment must involve reference to the expected outcome of treatment given in accordance with proper medical practice.

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34 *J v Accident Compensation Corporation*, above n 13, at [52].
35 *W v Accident Compensation Corporation*, above n 17.
36 Above n 9.
37 At [40].
38 At [57].

[76] The Court rejected a submission that Parliament had intended that all, or almost all, of those who suffered an injury while undergoing medical treatment, were to have cover. It said:[39]

> Taken as a whole the provisions indicate a legislative intent to limit cover for persons who suffer injury while undergoing treatment, rather than providing cover for all those who suffer.

[77] The Court then followed this statement by making observations which are obviously directed at s 33(1)(d), but which may have a more general application. They said:[40]

> The injury said to be a treatment injury must be the consequence of a departure from appropriate treatment choices and treatment actions. The drafting could have simply provided for cover for all injury suffered while a person undergoes treatment. But that course was not taken. Rather, boundaries were set out that have the effect of limiting the availability of cover for injury during treatment. A failure in the sense of omitting to take a step required by an objective standard is necessary.

[78] In *Accident Compensation Corporation v McEnteer*, Dobson J said, of the new concept of treatment injury, "The scope of cover was to be for the unanticipated adverse outcomes arising from treatment."[41]

[79] He also held that the term "unanticipated" was not "to be measured by reference to some prospective norm" but what was required was a "retrospective specific analysis having regard to the condition of the claimant actually encountered by the treatment provider".[42]

[80] He also concluded that the approach to the interpretation of s 32(1)(c) required an:[43]

> … analysis of what constituted necessary parts and ordinary consequences of the treatment … to be evaluated after the treatment occurred, and is to reflect the actual condition of the claimant as revealed in the course of the treatment as it played out.

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39 At [62].

40 At [62].

41 *Accident Compensation Corporation v McEnteer* HC Wellington CIV-2008-485-1800, 1 December 2008 at [17].

42 At [18]

43 At [19].

[81] Dobson J also confirmed that the terms "necessary part" and "ordinary consequence" appearing in s 32(1)(c) were to be read disjunctively rather than cumulatively, and that cover was excluded if either provision applied.[44] I endorse that approach.

[82] The Court of Appeal in *McEnteer v Accident Compensation Corporation* upheld the reasoning of Dobson J.[45] They rejected the appellant's assertion that the focus was on an assessment made prospectively (before the treatment had commenced) rather than an assessment which included the events as they actually unfolded. On this topic, they said:[46]

> In the present case, before the operation began and the precise nature and location of the aneurysm was known, the surgeon could not predict with assurance the exact treatment required or the most likely outcome. Rather, he was faced with performing surgery with a range of possible risks attached to it depending upon what he found in the course of performing it.

[83] They went on to say:

> [20] We consider that s 32(1)(c) requires an analysis that is rooted in the facts of the particular case – what was the injury suffered? Was it suffered in the course of the treatment undertaken? Was that injury a necessary part or ordinary consequence of that treatment? The third question in particular requires expert opinion, but not expert opinion in the abstract; rather, it requires expert opinion reflecting what actually occurred.

[84] In the case of *Muirhead v Accident Compensation Corporation*, Judge Powell (as he then was) considered the meaning of "ordinary consequence".[47] Counsel for ACC had submitted that the word "ordinary" did not relate to probability but equated to "not peculiar" or "not strange" and had submitted that because the outcome that had occurred was reasonably foreseen, it could not be described as either peculiar or strange and therefore was not "ordinary".

[85] At [19], Judge Powell referred to a decision of Judge Joyce QC in *Shepherd v Accident Compensation Corporation* where he said:[48]

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44 At [21].
45 *McEnteer v Accident Compensation Corporation* [2010] NZCA 126, [2010] NZAR 301.
46 At [18].
47 *Muirhead v Accident Compensation Corporation* [2016] NZACC 272.
48 *Shepherd v Accident Compensation Corporation* [2013] NZACC 109 at [46].

> In the end, I find there to be real substance in Mr Sara's argument that the Parliament quite deliberately moved away from requirement of proof of rarity in favour of a distinctly more liberal (if thereby rendered unpredictable in its effects) formulation.

[86] He then rejected ACC's submission that "ordinary" meant "not peculiar or strange". He said:

> [21] In this regard I likewise find it difficult to accept [counsel for ACC's] submission that the ordinary consequence of treatment relates to the nature of the consequence rather than its likelihood. In submitting that "ordinary consequence" means a consequence that is something reasonably foreseen "not peculiar" or "not strange" is not supported by any case authority and instead reads too much into s 32(1)(c) in a manner inconsistent with not only the case law set out above, but also the wider consideration that this Court is required to take "a generous and unniggardly approach" to accident compensation legislation. As a result I conclude that to adopt [counsel's] interpretation would be to significantly and substantially make establishing cover for a treatment injury more difficult when a particular injury is foreseeable but not necessarily particularly likely. (footnote omitted)

[87] Judge Powell also stated:[49]

> … a person given a 10% chance of survival for five years post treatment would not consider such survival to be an ordinary consequence, nor would any reasonable observer conclude that a 10% or even 20% chance of an injury resulting from treatment would be an ordinary consequence or indeed the expected outcome of that treatment.

[88] The point at which a particular injury becomes an ordinary consequence would depend on a range of matters and be a matter of fact in each case.

[89] In the present case, while Mr Butler conceded that there was some role for statistics to play in determining whether consequence is "ordinary", he submitted:

> The inquiry should be a qualitative one which takes into account all the pre-, during, and post-treatment circumstances of the particular claimant. This must also include the background risk of injury to the claimant.

[90] Mr Butler deprecated the use of statistics as the principal method for establishing whether or not something was an ordinary consequence. He submitted (correctly) that "in order to be useful, the statistics must represent the circumstances of the particular person".

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[49] At [25].

[91] Mr Butler set out a number of “qualitative factors” which he said that the courts had recognised as being “relevant to an assessment of ordinariness”. These were:

(a) the specific nature of the operation being performed;

(b) the pre-treatment advice provided to the patient;

(c) the results and nature of any treatment provided in a pre-operative stage;

(d) the knowledge of the treating health professionals at the time of the treatment;

(e) the state of clinical knowledge relating to the particular medical condition; and

(f) the contribution of non-treatment factors to the adverse consequence that materialised, such as:

(i) whether the patient has a history of smoking;

(ii) specifically how a patient presents; and

(iii) the patient’s medical history.

[92] To the extent that these factors focus on the specific characteristics of the patient and of the treatment provided to the patient they are relevant. However, some of the factors (such as the knowledge of the treating health professionals at the time of the treatment) could potentially result in arbitrariness or injustice. I therefore do not accept that the subjective state of knowledge of the treating health professional (as opposed to the objective knowledge of a competent health professional) is relevant.

[93] If applied without measurement against the standard of what a reasonably competent health professional should have known, there is a risk that two claimants with similar problems, similar personal characteristics and similar outcomes could end

up with different decisions on coverage depending on whether or not the treating health professional had extensive knowledge of the risks and likely consequences of the proposed treatment or little knowledge. That would not be fair.

[94] Mr Butler also submitted that, in assessing the ordinary consequence of treatment, the Court was also entitled to have regard to what the consequences of the underlying health condition, if left untreated, would be. However, such an argument loses sight of the fact that what s 32(1)(c) is addressing is the ordinary consequence of the treatment, not the ordinary consequence (or outcome) of the medical condition. If a particular medical condition, left untreated, would likely result in death, but death was an extremely unlikely and unpredictable outcome of the medical treatment, then it is not possible to say that, notwithstanding the extreme rarity of the treatment having caused that outcome, there was no cover because it would eventually have happened anyway if there had been no treatment at all.

[95] There is no doubt that the failure of a treatment to achieve the desired cure does not, of itself, amount to "treatment injury".[50] That is something different from where the treatment, wholly unexpectedly, produces a similar adverse outcome to that which would ultimately have occurred as a result of the underlying medical condition. Indeed, the words "of itself" in s 32(3) indicate that a failure to achieve the desired result, coupled with other factors, may potentially amount to a treatment injury.

[96] Mr Butler submitted:

> To provide cover in situations where a patient has had surgery in order to prevent an outcome, and that outcome occurs anyway, would treat what is a result of a disease as being an injury.

[97] That submission is incorrect. If the treatment has itself unexpectedly produced the adverse outcome, it is the treatment and not the underlying condition that is the proximate cause of the outcome. In assessing whether an outcome is a reasonable consequence of the treatment, the probability that a similar outcome might have occurred anyway is irrelevant.

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50 See s 32(3).

[98] Mr Butler submits that whether or not surgery is undertaken on an emergency basis is relevant to the concept of ordinariness. He submits:

> … if the surgeon is operating with the understanding that if they do nothing the patient dies, they may not have the luxury, for example, of doing tidy incisions or resections that do not damage nerves.

[99] In such a case, when looking at matters such as statistical probability, what will need to be assessed is the reasonable consequences of surgery undertaken in haste in emergency circumstances as opposed to the statistical probability of the same surgery undertaken in a routine and unhurried situation.

[100] An assessment of whether surgery was undertaken in haste on an emergency basis, as opposed to surgery undertaken in a routine and unhurried manner, will be relevant if there is a materially different likely outcome. If there is, then this will be one of the factors that go toward considering whether the injury sustained could be said to be an "ordinary consequence" of treatment.

Analysis

[101] Applying the various principles of interpretation and observations from case law set out above, I have reached the following conclusions:

(a) There is no discernible statutory intention to make only a limited change to the extent of cover available for a treatment injury. Neither is this evidence of any intention to make a "paradigm shift" so that all or nearly all treatment injuries were now covered.

(b) The departure from a "hard-edged" statistical criteria was intentional; it was intended to extend the situations in which cover would be available and also to avoid the necessity to obtain specialist reports to establish cover.

(c) Although the aspiration for the legislation was the avoidance of the need to establish "fault" on the part of a health practitioner as a pre-condition to cover, in substance, at least in relation to claims of failure

to treat, as a result of the Court of Appeal's decision in *Adlam v Accident Compensation Corporation* that obligation remains, with there being a need on the part of a claimant to establish a departure from an accepted standard by the health practitioner(s) concerned. However, when the issue is not about a failure to provide treatment or to provide treatment in a timely manner, a departure from a standard is not a requirement. The focus is on whether the treatment injury was the ordinary consequence of such treatment.

(d) An assessment of what is an ordinary consequence involves measuring the outcome achieved against the expected outcome of treatment given in accordance with proper medical practice.

(e) The assessment of what is an ordinary consequence is not one made in the abstract prior to the treatment but one made with the benefit of the full knowledge of all the relevant circumstances. This will include an analysis of information discovered during the course of the treatment. It will be heavily fact based.

(f) Analysing whether the consequence of the treatment is "ordinary" does not simply involve a "qualitative" analysis. Of necessity, it has what has been described as an "experiential" component. That means that some form of statistical analysis is necessary.

(g) Statistics need to be used with care and it is not possible to eliminate all arbitrariness. This is because the statistical outcome may vary according to the breadth of the pool of prior events analysed. Such a pool could range from the statistics for a particular surgeon or medical team, particular hospital, a city or region, nationally or internationally.

(h) Using too narrow a statistical base may produce injustice leading to different outcomes depending on where in New Zealand the treatment took place; while using too broad a statistical base, particularly one which includes international data, may produce an unfair outcome

because the data based on international studies may be the consequence of factors unique to the countries concerned.

(i) The fact that, if no treatment at all had been administered, a patient may have sustained the same outcome as eventuated is not a disqualifying factor and the focus of the enquiry must be on whether or not the outcome was an ordinary outcome of the treatment itself.

(j) Where language used in the legislation does not have a clear and unambiguous meaning, the case law has established that a "generous and unniggardly" interpretation favourable to claimants is preferable.

(k) An interpretation which focuses on the synonyms to "ordinary" rather than the antonyms is more consistent with the requirement for a "generous and unniggardly" interpretation.

(l) The fact that some risk is foreseeable does not make that risk an ordinary consequence of the treatment.

(m) The term "ordinary" does not have a precise meaning in terms of statistical probability. However, the synonyms of normal, usual, standard, typical or expected are consistent with the interpretation "more probable than not".

(n) A treatment injury that would only occur in 15 or 20 per cent of similar cases could not reasonably be described as being an ordinary consequence.

(o) A generous and unniggardly interpretation of what is meant by "ordinary" is a consequence that is more probable than not.

[102] Therefore, other than in cases involving a failure to provide medical treatment or to provide treatment in a timely manner, whether or not a treatment injury is an ordinary consequence of treatment, will involve an assessment of whether or not, in the particular facts of the case, analysed after the event and once all relevant

information is known, the injury could be said to be more probable than not. If it is more probable than not that such a treatment injury would occur, then there is no cover. If on the balance of probabilities such a treatment injury is unlikely, then cover exists.

Answers to questions

[103] The answers to the specific questions set out at [27] are as follows:

(a) *What is the meaning of "not [an] ordinary consequence"?*

(i) *Does "ordinary consequence" mean a consequence that has a 50 per cent or greater chance of occurring (i.e. does it need to be more likely than not)?*

Answer: yes.

(ii) *No need to answer.*

(iii) *Is an "increased risk" or "reasonable risk" the same thing as an "ordinary consequence" of treatment for the purposes of the Act?*

Answer: no. An ordinary consequence is one that is more probable than not, rather than a consequence that there is simply a "reasonable risk" of occurring.

(b) *Is the test a qualitative or quantitative one, or a mixture of both?*

Answer: a mixture of both.

(i) *If the enquiry is a qualitative one (in whole or in part):*

a. *Should it be based on the actual presentation of the claimant?*

Answer: yes.

b. Should the evidence of background risk of injury (in the absence of treatment) be taken into account?

Answer: no.

c. Should the evidence of what actually occurred in the course of treatment be taken into account?

Answer: yes.

(ii) What weight should be accorded to statistics?

Answer: an assessment of what an ordinary consequence is has an experiential component and some form of statistical analysis is likely to assist such an enquiry. However, care needs to be taken to ensure that any statistics analysed relate to sufficiently similar situations so as to avoid arbitrary or unfair outcomes.

(c) Is there presumptive cover for injuries that occur during treatment unless excluded by statute?

Answer: no.

Application of findings to individual cases

Mrs Ng

[104] ACC declined cover for a treatment injury on the basis that the injury was an ordinary consequence of the treatment.

[105] On 7 January 2013, Mrs Ng became acutely unwell. A CT scan showed that she had three brain artery aneurysms.

[106] She had a stroke causing right-side hemiparesis following surgery to clip a left choroidal artery aneurysm in January 2013. Notwithstanding a prolonged period of

rehabilitation, a significant degree of impairment persisted. The surgeon, Mr Parker, lodged a treatment injury claim on 7 April 2015.

[107] The opinion of Mr Johnson, a neurosurgeon retained by ACC, was that although the risk of an anterior choroidal artery infarct was significant, it was not a necessary part of treatment. He expressed the further opinion that, despite the best efforts of the treating team, an untoward and unfortunate complication occurred.

[108] The ACC Complex Claims Panel considered that a risk of 16 to 22 per cent would be considered to be an ordinary consequence of treatment and declined cover. Judge Mathers, in her decision, refers to the evidence of Mr Parker where he said:[51]

> During surgery one employs certain techniques in order to minimise the risk of this outcome – but those techniques won't always work. And there's no good way to predict in advance which patients will be affected in this way. In essence, it's down to bad luck.

[109] Applying the criteria set out above, the outcome of a stroke as a result of treatment for brain artery aneurysms is not something that could be said to be an ordinary consequence of treatment in the sense of being more probable than not. In [9] of her decision, Judge Mathers has set out an extract from the report of the ACC Complex Claims Panel which indicates that, in arriving at their background risk assessment of 16 per cent to 22 per cent, they considered the "specific situation and presentation" of Mrs Ng.

[110] On the basis of the evidence referred to by Judge Mathers, she appropriately came to the decision that the treatment injury which occurred could not be described as an "ordinary consequence" nor a necessary part of the treatment.

[111] Accordingly, ACC's appeal in this case is dismissed.

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[51] *Ng v Accident Compensation Corporation* [2017] NZACC 48 at [24].

"L"

[112] On 1 March 2010, "L" underwent surgery to remove a spinal arteriovenous malformation. Post-operatively, the condition worsened, resulting in right leg weakness, numbness and urinary incontinence.

[113] In his decision, Judge Powell set out an extract from the evidence of the treating consultant neurosurgeon, Mr Aspoas:[52]

> This injury is not necessarily a part of or ordinary consequence of the treatment. It is a recognised risk of this type of surgery although it is rare.

[114] Mr Aspoas had not initially attempted to ascribe a degree of probability to the treatment injury. He did so in a subsequently requested report, the relevant passage of which was set out at [12] of the District Court decision and read:

> I do not believe that a [sic] neurological damage is an expected result of the surgery however it is a recognised complication and as previously highlighted I believe if we look at the most recent publications, the risk for this type of surgery that is of having a new Neurological deficit or bladder problems is just under 38%.

[115] ACC's specialist, Mr MacDonald, disagreed with Mr Aspoas's view, but it is not clear from the District Court judgment whether he ever expressed a probability percentage. The judgment discloses that a further report was obtained from another neurosurgeon, Mr Bok. The relevant part of that report is set out in the District Court decision at [13] and says:

> On the balance of probabilities, taking into account [L's] underlying health conditions and the clinical knowledge at the time of treatment, I consider the injury to her spinal cord, which was most likely due to ischaemic damage, to be an unusual and uncommon consequence of treatment.

Mr Bok referred to various statistics from various studies which he said supported his conclusion.

[116] The District Court decision notes that in response to the report from Mr Bok and further report from Mr Aspoas, ACC commissioned a report from Mr Johnson.

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52 *L v Accident Compensation Corporation* [2017] NZACC 147 at [8].

[117] At [18] of the District Court decision, the relevant passage in Mr Johnson's evidence is set out:

> It is not possible to put an absolute figure on the risk of right leg weakness and bladder dysfunction, but I think that a minimum risk of 10% would be a reasonable risk to have considered. Certainly, the risk of surgical intervention was less than the risk of non-treatment and the balance of probability was that [L] would not deteriorate following surgery.

[118] The District Court decision, at [20], records that Mr Johnson reviewed and analysed the reviews undertaken by Mr Bok, Mr Aspoas and Mr MacDonald and explained why he regarded the risk of the treatment injury which occurred as somewhere between his figure of more than 10 per cent and up to Mr Aspoas's figure of 38 per cent.

[119] This case illustrates some of the difficulties with statistics in that experts reviewing the same set of facts can come up with a wide range of statistical outcomes. However, none of the experts suggested that the outcome which occurred was more probable than not. The analyses by the various experts were all undertaken after the event and with full information of the circumstances of the complainant and of what had actually occurred during surgery.

[120] Judge Powell found:[53]

> As summarised above it is clear that Mr Johnson has undertaken far and away the most comprehensive analysis with regard to spinal AVMs generally, the underlying rationale for the March 2010 surgery, and the risk inherent in that treatment. As a result I prefer Mr Johnson's conclusions to the extent they conflict with the opinions proved [sic] by the other specialists. … In particular I am satisfied on the basis of Mr Johnson's analysis that Mr MacDonald was incorrect in asserting that the injuries suffered by the appellant in the sense it could be expected, and that Mr Aspoas' estimate of 38% likelihood of the injury resulting was also way too high and unsupported by the statistics as carefully reviewed by Mr Johnson.

On the evidence before him, Judge Powell was entitled to prefer the evidence of Mr Johnson.

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53 At [33].

[121] The decision reached by Judge Powell that the treatment injury sustained in this case was not an ordinary consequence of the treatment is consistent with the analysis I have set out above. Accordingly, the appeal is dismissed.

"HK"

[122] On 2 February 2003, HK was admitted to hospital with an ulcer over her right groin. An ultrasound scan revealed a lump medial to the common femoral vein, three centimetres below the surface of the skin.

[123] On 4 February 2003, surgery was unsuccessful with an attempt to aspirate the mass. On 7 February 2003, a CT scan indicated a possible pseudoaneurysm of the right femoral vein.

[124] In September 2015, HK's general practitioner submitted an ACC Treatment Injury Claim diagnosing "loss of sensation and quadriceps weakness" following femoral artery bypass surgery in 2003. ACC declined the claim for a treatment injury on the basis that HK's femoral nerve damage was an ordinary consequence of her treatment.

[125] ACC sought an opinion from a specialist, Mr Naik. One of the questions it asked him to answer was:[54]

> If treatment factors can be contributed to a femoral nerve injury, was [HK] at a reasonable risk of this injury occurring rendering it an ordinary consequence of treatment given the circumstances of her particular case?

[126] It is understandable that Ms Bransgrove, counsel for HK, was critical of this question as it implies that if there is a reasonable risk of a treatment injury occurring then that consequence will be "an ordinary consequence".

[127] Mr Naik provided ACC with an opinion which concluded that the femoral nerve injury occurred as a consequence of both treatment and non-treatment factors. The non-treatment factors included the fact that HK was an IV drug user, had a large pseudoaneurysm and had overlaying ulceration. The treatment factors he identified

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[54] *HK v Accident Compensation Corporation* [2018] NZACC 85 at [23].

included multiple surgeries in the groin and the pelvis with resultant scarring which would increase the risk of nerve injury.

[128] Before the District Court, Ms Bransgrove relied on a passage in *Health Law in New Zealand* to the effect that:[55]

> A well-recognised complication is not the same as an ordinary consequence. Just because a risk is known or well recognised in the medical literature is not enough to make it an ordinary consequence.

She also relied on the decision of Judge Powell in *Muirhead v Accident Compensation Corporation.*[56]

[129] Amongst other things, Ms Bransgrove submitted to the District Court that the Act created presumptive cover for injuries caused by treatment. She also submitted that, in order for a claimant to be disentitled, the outcome needed to be anticipated in something approaching 100 per cent but not less than 50 per cent of the cases.

[130] Mr Butler, who appeared for ACC in the District Court, submitted that there was no presumptive cover. He also advanced submissions similar to those made in this Court.

[131] No doubt, because of the way in which ACC framed its question of Mr Naik, he did not approach his task by analysing whether the treatment injury was more probable than not or, beyond identifying that there were both treatment and non-treatment causes for the treatment injury, attempt to ascribe relative percentage causation figures.

[132] The decision notes that the case involved emergency surgery rather than normal planned surgery.[57] It is not clear whether this factor would have affected the probability of the type of treatment injury sustained occurring.

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55 Ron Paterson and Peter Skegg (eds) *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) at [31.5.6].
56 *Muirhead v Accident Compensation Corporation*, above n 47.
57 *HK v Accident Compensation Corporation*, above n 54, at [73].

[133] The District Court judgment records that the only medical evidence report provided to the Court was that of Mr Naik and that HK did not provide any contradictory reports.[58]

[134] The District Court recorded Mr Naik's view that HK's "particular health status, at the time of the treatment in 2003 greatly increased the possibility of a treatment injury, being part of the ordinary circumstances which relate to her specific situation".[59]

[135] However, there was no attempt to analyse or apportion probability. This was because the Court accepted ACC's submission that "part of the purpose of the amendment in 2005 was to avoid statistical thresholds".[60]

[136] While part of the purpose of the 2005 amendment was to remove the "hard-edged" statistical threshold of rarity being one per cent, it was certainly no part of the intention for the amendment to avoid any statistical analysis and, to the extent that the decision implies otherwise, it is wrong.

[137] Judge Walker concluded:[61]

> I accept too, that the onus in respect to these proceedings remains with the appellant, and the wording of the section does not extend to the appellant having presumptive cover for injuries caused in the course of any treatment.

[138] These comments are correct.

[139] The difficulty for the appellant in this case was that there was no evidence before Judge Walker upon which he could have concluded that the treatment injury sustained in this case could be said to be something other than an ordinary consequence (in the sense of being more probable than not) of the treatment involved.

[140] In the absence of such evidence, and bearing in mind the obligation on HK, it cannot be said that the decision reached by the Judge was wrong, albeit some of the

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58 At [76].
59 At [81].
60 At [82].
61 At [83].

analysis of the Act contained within the decision is not in accordance with the observations in this decision.

[141] It also appears that the case was really argued in the District Court on the basis that there was presumptive cover. I have held that such a proposition is incorrect.

[142] Accordingly, this appeal is dismissed.

Costs

[143] The parties have regarded this case as a test case. My preliminary view is that there is some substance in that submission and that, accordingly, costs should lie where they fall.

[144] However, if the successful parties wish to apply for costs, they are to file memoranda within 14 days, with the respondents having 14 days to reply.

Churchman J