BEFORE THE ACCIDENT COMPENSATION APPEAL AUTHORITY
AT WELLINGTON

[2014] NZACA 13

ACA 01/05 & 02/05

IN THE MATTER	of the Accident Compensation Act 1982
AND **IN THE MATTER**	of an appeal pursuant to s.107 of the Act
BETWEEN	**GRACE NEE HARLAND** Appellant
AND	**ACCIDENT COMPENSATION CORPORATION** Respondent

HEARING
15 April 2014 at Auckland

AUTHORITY
Robyn Bedford

APPEARANCES

P Nee Harland, as advocate for the appellant
P McBride, counsel for the respondent

DECISION

[1] This appeal concerns a request for backdated attendant care under s 80(3) of the Accident Compensation Act 1982, made by Mr Nee Harland on his daughter's behalf on 10 March 2003 in respect of injuries Grace suffered on 3 June 1988 as a result of a forceps delivery birthing accident which damaged her spinal cord. .

[2] The appeal has a convoluted history, which has culminated in ACC raising a procedural/jurisdictional objection to it proceeding, made through submissions filed for the hearing. ACC participated in the hearing, but on the understanding that this did not amount to a concession of jurisdiction and this issue must be dealt with before the substantive appeal is considered.

[3] The objection raised is that the appeal that was reinstated is ACA 2/05, not ACA 1/05. The Authority and the appellant mistakenly viewed the ACA 2/05 appeal as being about s 80(3) of the Act. This appeal is about jurisdiction and s 80(3) cannot properly arise in this appeal, which is the only appeal now before the Authority and the only matter listed for hearing. The Authority could not rectify this as a matter of procedure and the appeal had to be dismissed.

Procedural history

[4] ACC declined the s 80(3) application on 10 March 2003 and Mr Nee Harland applied for a review of the decision on 12 March 2003. The review decision upholding ACC's decision dated 20 February 2004 was wrongly issued under the Accident Insurance Act 1998 with the right of appeal lying to the District Court. Mr Nee Harland filed a notice of appeal in the District Court on 3 March 2004 and the appeal was allocated AI 120/04.

[5] On 18 February 2004, Mr Nee Harland made a second application for review of the decision dated 10 March 2003. This basically repeated the first application for review, except for a reference to filing further medical information. This application was dismissed when the Reviewer declined jurisdiction. Again the decision was issued under the 1998 Act and the right of appeal was given to the District Court. Mr Nee Harland filed a notice of appeal in the District Court and the appeal was allocated AI 225/04.

[6] The appeals were transferred to the Appeal Authority in January 2005, and were allocated ACA 1/05 and 2/05. By letter dated 26 January 2005 to Mr Nee Harland, which Mr McBride brought to my attention in his submissions, the Registrar, Brian Hayes, said that AI 120/4 is now ACA 1/05 and AI 220/04 is now ACA 2/05.

[7] On 14 March 2007, Mr Nee Harland withdrew both appeals because he had come to the conclusion after speaking to Mr McBride, that they would not succeed. He then pursued a separate application under s 80(2)(b) of the 1982 Act, which was the subject of a separate review and ultimately, an appeal before the Authority under ACA 1/08.

[8] That appeal was heard by Mr Cartwright and dismissed in his decision under *Nee Harland v ACC* [2010] NZACA 4. Mr Nee Harland made an application for leave to appeal the decision to the High Court, which came before me in 2012. I declined leave to appeal in *Nee Harland v ACC* [2012] NZACA 2.

[9] In the course of making my decision I looked at the history of the proceedings and I was concerned that the first review decision applied the attendant care provisions of the 1998 Act, without Mr Nee Harland being heard. Consequently the attendant care application had never been decided on its merits. It also appeared that Mr Nee Harland had withdrawn the appeals on a misunderstanding, as ACC had not at any stage carried out an assessment of Grace's need for constant personal attention under s 80(3) and there was no evidence either way as to whether she would meet the legal test under the section.

[10] I indicated that under the circumstances I would give consideration to an application to reactivate the first appeal and to bring it to a hearing, following the Authority's decision in *Adair v ACC* [2010] NZACA 5, that when an appeal is withdrawn because of a mistake or lack of intention rather than dismissed, and provided there is no abuse of process, it may be brought back for hearing. I said that I considered that a simple statement that the appeal was withdrawn under a mistake of fact and that the determination of the (s 80(3)) application on its merits and with the appellant having the right to be heard would suffice. I made directions for the filing of an application within 28 days if Grace elected to proceed and for ACC to file submissions in opposition within 28 days after receipt of the application.

[11] Mr Nee Harland filed the application on 12 March 2012 and stated that he had withdrawn appeals 1/05 and 2/05 under a mistake of fact and law. The court file shows that on 13 March 2012, the ACA Case Manager brought up the ACA 2/05 Registration record, which stated that the appeal was filed on 21 January 2005; the decision type was noted as attendant care and the bring up Comment reads:

> "*Was ACA 1/08. Rcvd application fm Mr Nee Harland - reinstate appeal – awaiting subs fm counsel for resp within 28 days.14 Mar12 FM* (Frances Marsh)"

[12] On 14 March 2014 Ms Marsh emailed Mr Nee Harland and Julian Castle of ACC Legal Services. The email said:

> "*ACA 2/05 G Nee-Harland (Was ACA1/08 – this file is now closed)*
> *The application is to reinstate the 2005 appeal.*
> *The Authority acknowledges receipt of this application.*
> *We shall await Counsel for the respondent to file and serve any opposition within 28 days, as directed by the Authority in G Nee Harland v ACC – decision NZCAA [2012] 2.*
> *A telephone conference will be allocated for the first available date thereafter*."

[13] Mr McBride filed submissions in opposition to the application for reinstatement on 13 April 2012. The entituling reads: WAS ACA 1/08 NOW ACA 2/05. The waistband of the submissions read: **MEMORANDUM OF COUNSEL FOR RESPONDENT – OPPOSITION TO REINSTATEMENT OF SECTION 80(3) APPEAL**.

[14] The decision to reinstate the appeal was issued under ACA 2/05, [2102] NZACAA 6 on 21 May 2012. All subsequent dealings between the Registry, the Authority and Mr Nee Harland and Mr McBride concerning Grace's application for 24 hour care under s 80(3) were under the aegis of ACA 2/05. Mr McBride has acted for ACC at every stage of the proceedings since the two appeals were filed in the District Court in 2004, and has actively challenged every decision made by the Authority since 2012, except for the decision to reinstate the first appeal under s 80(3).

ACC's argument

[15] Mr McBride made 12 pages of submissions to support ACC's objection to the appeal proceeding under ACA 2/05 which, he had discovered while writing his submissions, should have been under ACA 1/05. Mr McBride framed his legal argument on the contention that there is no jurisdiction for the Authority to recall or correct its previous decisions (whether under the powers of a Commission of Inquiry or otherwise) and that as it with the same provision concerning the power to determine its own procedure as contained in s 108(11), the Authority was in no different position than the Deportation Review Tribunal in *Browne v Minister of Immigration* [1990] NZAR 67, 69 – 70. This case did not, however, concern an appeal to which the wrong file number was allocated by a Registrar, but what Eichelbaum CJ described as a complete re-hearing of a case that had been properly decided and in which it was not a matter only of "*the procedure of the Tribunal*", but a significant aspect of jurisdiction.

[16] Mr McBride also relied upon *P v ACC* [1993] NZAR 416, in which *Browne* was applied, and in which he submitted that Doogue J held that there was no power to

change a decision (under the 1982 Act) after its issue. This case did not concern an appeal to which the wrong file number had been allocated by the Authority Registry, but a review decision which had been issued and favoured the applicant, and which the Review Officer purported to change by issuing a Supplementary Decision at ACC's request some four months later, which materially altered the decision in ACC's favour. Here, ACC, contrary to the arguments Mr McBride made, ACC argued that the Review Officer, like a Court, could first, change its mind before a decision was "*perfected*"; secondly, correct clerical errors or accidental slips, and thirdly, amend the formal record of his decision so that it expressed his true intention.

[17] Doogue J assumed that the three principles ACC cited could apply to a Review Officer. He decided that the first principle did not apply, because the Review Officer had done everything necessary to perfect his decision in terms of the Act; nor could the second principle apply because it was not suggested that there had been any clerical error or accidental slip and the formal record could not be amended because there was no such record such as a registry book or order of the Court into which the decision is translated. The only principle which could possibly apply was the removal of ambiguity, and there was no ambiguity whatsoever in the decision.

[18] Mr McBride also submitted that there was prejudice to ACC, because it was being called to answer an appeal not currently listed for hearing, and he refused my request to withdraw the objection because it was clear that the appeal that the Authority intended to be reinstated was the first appeal against the s 80(3) decline decision, there was no prejudice whatsoever to ACC because Mr McBride had fully argued ACC's opposition to the reinstatement, and it was simply a clerical error by a different Registrar who allocated the wrong number to the application for reinstatement and thus to the reinstatement decision.

[19] Mr McBride sought costs against Mr Nee Harland, the basis of which was not explained, but could only be on the basis that Mr Nee Harland conducted the appeal under the ACA number Ms Marsh told him and Mr Castle was the correct ACA number of the file, and thus wasted ACC's time in defending an appeal that remained withdrawn.

Decision

[20] ACC's application to dismiss the appeal under 2/05 is entirely without merit, as should have been obvious to Mr McBride when he read the cases he relied upon to contend that a clerical error or slip by the Authority Registry was incapable of correction and that the interests of procedural niceties outweigh and should displace, the interests of justice. The objection to jurisdiction is very close to bullying tactics aimed at a vulnerable appellant and does ACC little credit.

[21] Regarding costs, there is no power under s 110 for the Authority to award costs against an appellant except in terms of subs (3), which permits the Authority to make an award of costs on an application for an adjournment against either ACC or the appellant as the applicant, and when in the interests of justice, the Authority considers the adjournment should be allowed, but that inconvenience will be caused to a party or the Authority. However, If Ms Harland had been represented by an independent advocate, I would have increased any award of costs made in this appeal to reflect the inconvenience caused to the Authority by ACC's objection.

The s 80(3) appeal

[22] As so often happens in the appeals that come before me, the parties provided minimal factual information and I have taken the background facts from the bundle of documents assembled by the Authority to obtain a specialist assessment of Grace's needs for constant personal attention/24 hour care under s 80(3).

[23] The best description of Grace's accident and injuries is by Mr Taine, Orthopaedic Surgeon, in the report he prepared for ACC on 13 January 1992, when Grace was aged three years and seven months for the purpose of assessing her permanent impairment under s 78 for the payment of lump sum compensation:

> "***HISTORY OF EVENT***
>
> *In the course of final stages of delivery, to assist in overcoming some obstetric difficulty, forceps were applied to the infant's head, an attempt made to turn the child to assist the delivery, and as the child's condition was not good, the delivery was completed by caesarian section.*
> *After delivery the child's condition was poor, she was generally limp and required respiratory assistance.*
> *Owing to the lack of spontaneous movements of the arms and legs and the condition of apparent paralysis it was concluded that there had been some degree of damage to the spinal cord, probably in the cervical region, leaving her with a state of quadriplegia, although it was not possible to gage the completeness of this state.*
>
> ***SUBSEQUENT PROGRESS***
>
> *Following birth respiratory assistance was required for the first six weeks, the muscle tone was generally depressed, but this was still quite apparent at the age of six months and it was more obvious on the right than the left. Some increase or restoration of normal muscle tone appeared after a few months and a definite return of movement and therefore strength could be gauged by the age of 10 months and improvement continued to be made.*
> *General child care was maintained. Physiotherapy supervision was also continued, particularly to keep her joints mobile normally and to avoid any affects of muscle imbalance as the power returned.*
> *From approximately one year of age she spent a considerable amount of time under the care and supervision at the Wilson Home for Crippled Children in Auckland. It became more apparent that the weakness continued more profoundly on the right side than the left. She had been unable to crawl as the right arm is not strong enough to hold her up, but nevertheless she was able to stand and walk by the age of two. She has made slow but steady progress in the past year but it seems has not achieved many further physical milestones in the past year or so. There has been a deficiency in growth on the right side affecting both arm and leg. The asymmetry adding to the difficulty already present from the general muscle weakness."*

The specialist evidence

[24] By consent, Debbie Andrews, the Paediatric Physiotherapist instructed by ACC to prepare a Backdated attendant Care assessment in 2008 under the ACC Social Rehabilitation Assessment (SRA) user guides – Updated June 2007, was instructed

by the Authority to prepare an assessment of Grace's need for constant personal attention under s 80(3). There were unfortunate mistakes made with her instructions and the first assessment she prepared dated 13 February 2013 was deficient in some respects. Mr McBride also raised several objections to the content of the instructions, and Ms Andrews was asked to prepare a second assessment with additional questions by the Authority and Mr McBride. That assessment, dated 29 September 2013 formed the primary basis of the evidence given and considered at the hearing.

[25] Dealing with the first assessment, it became clear during Ms Andrew's questioning by the Authority, that Ms Andrews had misunderstood the nature of her inquiry, and had assumed that as Grace's injury itself was constant i.e. her condition/diagnosis was unchanging although developmental changes did occur, so was her need for constant personal attention. Because the condition was permanent, she assumed the needs were also, and this led to Ms Andrews not considering Grace's injury related needs in sufficient detail. This is confirmed by her Review Comments for each of the two periods she considered, being from Grace's discharge from hospital at age 3 months and 9 days to 2 years and from age 2 years to 4 years.

[26] Ms Andrews also said at the commencement of her evidence that she did not then have the experience needed to understand what was required for a s 80(3) assessment and that this became much more clear through the questions asked by the Authority and Mr McBride for her second assessment and she had also undertaken other training during the intervening time. For her second assessment she had used much shorter time periods and looked at factors that went to the nature of the injury, rather than the fact that Grace's diagnosis was of a permanent nature.

[27] Mr Nee Harland based his submissions on the first assessment as Ms Andrews had supported Grace's need for constant personal attention for the full period at issue, however, I am satisfied that the first assessment is too unreliable and lacking in detail to be accepted as good evidence by the Authority. This leaves the second assessment, which repeats much of the factual information in the first assessment, but the conclusions reached are more in line with the legal definition of what is required.

[28] The questions Ms Andrews was asked are repeated below:

> *"**Questions from the Counsel for the Respondent (Mr P McBride)***
>
> *a) What the Appellant's (Grace's) objective injury needs (as opposed to age related or other needs) were at the relevant times, those being from the date of discharge from hospital in 1988 to 30 June 1992.*
>
> *b) Whether, by reason of these needs Grace needed to be constantly personally attended to ("required constant personal attention")*
>
> *For the purpose of answering question b), the meaning of "constant and personal attention" means:*
>
> - *A. Constant personal attention means attention required by the injury, over the full 24 hour period of every day, with only such interruptions as do not interrupt continuity;*
> - *B. The "constancy" requirement is directed exclusively to the level need for personal attention over each 24 hour period.*

- *C. The type or intensity of the required attention might vary over the course of a 24 hour period, but the need for attention must exist continuously throughout that period*
- *D. the assessment excludes from consideration periods that a mother may be expected to give personal attention to a young child for significant periods during the day" in any event and*
- *E. Any heightened level of maternal attention to the supervision of childhood activities required by reason of the injury must be of such a level as to itself amount to a requirement for constant personal attention*
- *F. "the injured person, because of the need for constant personal attention, was primarily in a high care situation, whether at home or in an institution, rather than being sufficiently able as to be out and about on a regular basis, such as going to school and*
- *G. the focus is on objective necessity for constant personal attention given the injury, not on the level of any attention that might or might not have been given.*

Questions from the Authority

- *Please give your opinion as to whether Grace's need for personal attention was constant as a result of her injuries. See comments dated 29.09.13 throughout this report*

- ***Are there any ACC criteria in respect of infant children, and if so, could you please list them?*** *Did you apply the criteria to your assessment of Grace?*

As outlined in the original RAC report the following excerpts are from the ACC Social Rehabilitation Assessment (SRA) user guides – Updated June 2007)

2. "When assessing attendant care for a child under 14 years *(assessors are to) use your professional judgement on their expected developmental milestones. Remember ACC meets the injury related need for attendant care, not the age related needs" (pg 56)*

3. Supervisory care for children under 14 years. *"Children's need for supervision should be considered in relation to the effects of the injury, and* ***have regard to*** *the normal supervisory need required by a child of the same age. The assessment report should reflect the consequences of the injury on achievement of developmental milestones versus that of normal child development. The assessor is expected to use their professional judgement regarding this. ACC is responsible for all injury related supervisory needs of the child. If the child cannot be left alone because of injury related factors such as the risk of seizures, fitting, stopping breathing, harm to self or to others, then this must be reflected in the provision of attendant care."(pg. 56)*

- *My professional judgment related to expected developmental milestones was applied to Grace's original report. This was a combination of my experience as a paediatric therapist and reference to standardised Developmental assessment tools.*

At that time the assessment tools I used were the Carolina Curriculum (0 to 2 years and 2 to 5 years), and the LAP (Learning Accomplishment profile).

- *Since that first assessment in 2008 this assessor has put considerable effort and resources into this particular assessment process in order to provide a more robust and validated assessment of retrospective support needs. I now primarily reference the age norm related data from the HELP (Hawaii Early Learning Profile), PEDI (Paediatric Evaluation of Disability Inventory) and available Plunket information for babies. Plunket is the chosen for reference as the main provider of "well child" services in New Zealand. We also now reference Wee FIM (Wee Functional Independence Measure) from the age of 3 years to 7 years and the FIM over 7 years. In the process of completing both reviews I have considered these assessments when making my recommendations.*
- *Regarding typical patterns of parental supervision for toddlers and preschoolers the research paper "Understanding Unintentional Injury risk in Young children 1: The Nature and scope of caregiver supervision of young children in the home" by Barbara A. Morrongiello, PHD, Michael Corbett, BA, Meghan McCourt, BA, and Natalie Johnston, BA, Psychology department, University of Guelph*

6) Are there any Non-physical, injury related needs that Grace would probably have experienced at the relevant ages, that would contribute to her need for constant personal attention? None identified as being consistent with the criteria.

7) The following factors would appear to be relevant for injured children as they are for adults:

- *Safety including self harm, avoiding harm to self and others and inability to summon assistance · Inability to act appropriately in an emergency.*
- *Ability to control body temperature*
- *Assistance required to cough*

8) please apply these criteria to your assessment of Grace's need for constant personal attention, or add any further comments See relevant comments throughout

9) Is it possible to put the factors that you have identified as contributing to Grace's need for constant personal attention into a hierarchy? See relevant comments throughout

10) It is not necessary for you to be certain beyond a reasonable doubt, but your conclusions should be more likely than not, to be the case

Assessors Response

In the process of completing this response I have completed the following activities:

- *Reviewed the "Backdated Attendant Care (BAC) report" dated 29.07.08 written by myself, Deborah Andrews, PRS Ltd, with particular attention to the period referencing Birth to 4 years of age (pages 4 to 10).*
- *Reviewed my first Response dated 13.02.13*
- *As for the previous response I found that the documents reviewed in the completion of my original BAC report were detailed and complete. The report I wrote based on those reports was thorough and clear. Therefore I did not feel the need to interview Grace or her parents in order to complete this review."*

[29] Ms Andrews quoted the history of Grace's injury as described by Mr Taine, but apart from this I have repeated the assessment in full, except for the references to the reports that Ms Andrews considered relevant for each period:

> *"Grace was lifeless at birth and required resuscitation and full respiratory support. On day 4 it was reported in the ward notes that the neurologist spoke with the family and said that if she did not show signs of neurological return resulting in some ability to make some independent respiratory effort by day 7, there was little hope for her survival. When reassessed on day 7, she had made just enough of a respiratory effort to convince the doctors to give her a bit longer on ventilation.*
>
> *She made a very gradual recovery over the next 3 months, gradually gaining the strength to make weak movements of her arms and legs. Her legs were always stronger than her arms and her Left side stronger than her Right. She was fed breast milk via a Nasogastric (NG) tube, gradually increasing her ability to sustain respiratory effort, and on day 44 she was extubated. During this time, she frequently suffered excess secretions in varying amounts, but was too weak to cough.*
>
> *On day 48 Jenny tried breast feeding but Grace's suck was very weak, uncoordinated and inefficient. Efforts to establish breast feeding were continued 2 xs per day, but Grace was not able to gain enough nutrition to make this viable. She was introduced to bottle feeding with a Pigeon spoon and was weaned off NG feeding by the time of discharge home on 12/09/1988.*
>
> *Review comments dated 29.09.13*
> *Grace had significant physical and medical needs related directly to her birth injury. These comments relate specifically to Grace's injury related needs not her age related needs.*
>
> *While in hospital she required full respiratory support (ventilator) to breathe for her because the damage to her spinal cord had paralysed the muscles that usually draw breath in and out. If she had not had this support she would have died. Fortunately as the swelling around Grace's spinal cord started to subside over the first week she did regain just enough activity in the respiratory muscles to convince the doctors to keep her alive longer and see what recovery she could achieve. Please note that the muscle action they observed was just a hint of activity, movement was extremely weak and ineffective, thus she continued to require ventilation for a further 37 days. Even once she was able to breathe on her own she was so fragile that she needed to remain in hospital until she was considered "strong enough" to be managed at home. The fact that she was*

considered ready to go home in no way implies that she was "recovered", or that she was ready to go home because she now had the same need for parental support as a typical baby of her age. It would have been purely a reflection of the fact that the doctors considered that Grace now had just as much chance of survival being cared for at home as she did in hospital, OR that keeping her in hospital did not give her any further advantage over being cared for at home. She still had significant injury related needs that were over and above the support typically provided for a baby by a parent.

From hospital discharge at age 3 months 9 days (14 weeks) to 6 months
Reports relevant to this period:
- *Item 3. Developmental profile at 4 months and 7 months*
- *Letters to Auckland University by Paediatrician and Visiting Therapist dated6/10/1988*
- *Plunket Nurses' notes from visits between the ages of 4 and 6 months*

From previous Review report 13.02.13
At the time Grace was discharged from hospital, she was described by the Paediatric Registrar as having:
- *Significant hypotonia in all 4 limbs with marked head lag*
- *Significant feeding difficulties resulting in failure to thrive*

Developmental progress information was taken from Plunket Nurse's notes, Orthopaedic Clinic notes, Neuro developmental therapists' reports and Jenny's recollection:

Mobility and Positioning:
- *Grace was described as a weak, floppy baby. Jenny described her as "vulnerable" on all levels. Jenny would use wedges and positioning pillows provided by Visiting Neuro developmental Therapist (VNT) to prop Grace up, however she would repeatedly slip down and require repositioning (of most concern was her airway).*

Respiratory Management:
- *Due to her failure to thrive and her inability to effectively clear secretions from chest by coughing, extra care was taken to ensure that Grace did not get sick. When she did get sick, she required her parents' assistance to clear the secretions.*

Review comments dated 29.09.13
In the following areas the need to intervene would have been intermittent but the support need was constant (ever present) throughout a 24 hour period. The fact that it was intermittent does not change the fact that it was a constant need. These needs existed outside of times when a mother would typically be attending intensively to her child, eg feeding, bathing, dressing. This need continued even when Grace was asleep.

<u>Maintaining a patent airway</u>: Grace has extremely poor head control, due to the spinal cord paralysis affecting her neck muscles. Newborn babies have the ability to hold their head in the correct alignment to maintain a patent airway. Due to her complete lack of head control Grace at 3 months would have still needed to be specifically positioned so that her airway was open. She would then have needed almost constant monitoring of her head position when she

was awake as any little wriggle with her arms or legs could have caused her head to move to the side and potentially obstruct her airway. When she was settled in sleep the risk was slightly less as she would not have been wriggling her arms and legs unless in a phase of Active sleep (when sleeping babies make arm and leg movements and even cry a little as though they are awake, but they are actually just active in their sleep). Typical babies can be left alone to resettle during active sleep. Grace would have needed to be checked to ensure her airway was open.

- *This need was constant (could happen at any time over 24 hours) however intervention (repositioning her head) would have been intermittent.*
- *Typical parental responsibility: When awake: Babies of 3 to 6 months typically follow a 3 to 4 hour sleep wake routine. While awake they require intensive support for feeding and winding for approx 45 mins. They will then have a little play time on the floor before settling back to sleep. While on the floor they become more active developing the ability to turn their head side to side and lift it off the floor when in prone (tummy time). They also develop trunk control by rolling and tummy time. After 3 months the baby is generally able to reposition their head and protect their airway if they have a spill, therefore the risk of aspiration or airway obstruction is negligible. When Sleeping: Plunket recommends that babies up to the age of 6 months are swaddled to sleep, and placed in their own cot or cradle in the same room as a parent as this reduces the risk of SIDS (Sudden Infant Death Syndrome). If correctly positioned in bed there is usually no need to be concerned about the baby maintaining a patent airway and there is only the requirement to reposition the baby if they become unsettled eg due to wind. Therefore the need to check the baby in response to every little sound or movement is not a typical parental support requirement, if fact it is actively discouraged as parental attention often wakes the baby from active sleep.*

***Clearing secretions**: While on the ventilator Grace needed assistance (suctioning) to clear away the secretions (mucous) produced as a normal part of respiratory function. It is usual to see an increase in secretions as a result of the irritation created by intubation and this increase in mucous production continues after weaning off ventilator support. Once she was extubated she was too weak to cough and therefore would have required further assistance in the form of postural drainage techniques and possible suctioning to clear the secretions. If she had not been assisted to clear secretions these would have created an obstruction and increased the work of breathing. She would have needed someone present both day and night to assist her to clear secretions whenever they built up to a level that required clearing (threatened to create an obstruction or increase the work of breathing).*

- *This need was constant (could happen at any time over 24 hours) however intervention (assisting her to clear secretions) would have been intermittent.*
- *Typical parental responsibility: by 3 months babies have the innate ability to clear their airway of unwanted material by coughing therefore there is no parental requirement to assist in the clearing of secretions.*

***Feeding**: Grace's suck was too weak to breast feed or bottle feed using a typical teat. Initially she was Nasogastrically tube fed and when she finally managed a safe swallow she was able to transition to a bottle with a Pigeon spoon which did not require sucking. Most newborn babies are immediately*

able to feed successfully from the breast or bottle and instinctively coordinate breathing and swallowing in order to protect their airway. By 3 months of age babies are efficient feeders being able to pace their feed. While in hospital Grace was not able to orally feed at all. Once she did manage to swallow safely she was able to move to the bottle with Pigeon spoon, however she continued to need an adult to pace the flow of milk into her mouth at a speed that she could safely manage to swallow and protect her airway. · This need was constant (would need this support at any time she fed throughout a 24 hour period) however intervention (careful positioning her head and pacing of her feed) would have been intermittent (was required only during feeding).

- *Typical parental responsibility: feeding of a typical baby 3 to 6 months of age requires intensive parental attention.*

***Vulnerability to illness**: Grace experienced failure to thrive as a result of her feeding difficulties. In her weakened state she would have been extremely vulnerable to illnesses and Jenny would have been unlikely to take her anywhere outside of the home between 3 and 6 months of age.*

In regards to safety including self harm, avoiding harm to self and others and inability to summon assistance:

- *Like all babies of 3 to 6 months of age Grace was not at risk of self harm or causing harm to others.*
- *Grace was more at risk of harm from others due to her very weakened state, poor head control and vulnerability when being moved.*
- *Grace was able to cry, although weakly, to summon parental assistance In regards to inability to act appropriately in an emergency:*
- *Grace was like all other babies of 3 to 6 months, she was not able to act appropriately in an emergency.*

In regards to Ability to control body temperature:
- *Grace was like all other babies of 3 to 6 months in that she was totally reliant on others to monitor her body temperature and dress her appropriately*
- *Grace was more vulnerable to illness than a healthy 3 to 6 month old infant, and the consequences of illness where greater due to her inability to cough and clear secretions.*

In regards to Assistance required to cough:
· See comments above

Hierarchy of importance of these needs:
1. *Maintaining a patent airway by careful positioning and monitoring 24 hours a day.*
2. *Special care taken to ensure safe swallow during feeding tasks.*
3. *Clearing secretions and assistance to cough 4. Managing risk of harm from others, inability to act in an emergency, monitoring of temperature are considered the same as a typical baby of this age.*

From 6 months to 12 months
Reports relevant to this period:
- *Confirmation from ACC accepting the claim dated 20/02/1989*

- *Letters to Auckland University by Paediatrician and Visiting Therapist dated 20/04/1989 and 02/05/1989*
- *Plunket Nurses' notes from visits between the ages of 6 and 12 months*
- *Item 4. Hand over report and Home programme by Jan Piggot, Senior Physiotherapist, Wilson Home 26.06.89 (aged 1 yr)*
- *Item 5. AHB Therapy notes dated 13.6.89 (aged 1yr)*
- *Item 7 AHB Pre panel assessment 30.05.89 by Dr DL Jamieson, Paediatrician, and Panel evaluation 13.06.89 by full Multidisciplinary Team.*

From previous Review report 13.02.13
Grace's social and language development were consistently reported to be within normal limits, indicating that she was cognitively intact. She did however have significant Gross motor developmental delay.

- *At 9 months Grace was able to sit independently when placed, without the use of hands to support her. However, she had significant trunk weakness, as evidenced by her documented thoracic kyphosis and reduced stamina, and she was only able to hold the position briefly before requiring support, indicating significant weakness.*
- *Grace was able to roll independently on the floor at 10 months (a 5 to 6 month milestone).*
- *Grace was beginning to creep very slowly at 11 months, but her left arm was significantly stronger than her right arm. Right arm weakness meant she was unable to crawl, however by 12 months she was able to prop in forearm support in prone, a skill typically achieved by 4 months.*
- *At 12 months Grace could be placed standing at a couch without splints (i.e. she could take her own weight when placed) to perform a static activity such as reading a book. She had no standing balance and had reduced trunk righting reactions on the right side, and therefore required her carer's hands very close. Grace still had an initial head lag on pull to sit and was not able to perform any transitional movements to change her position e.g. prone to sit or pull to stand. Her Gross Motor skills assessed by Physiotherapist (PT) were scattered between 3 and 10 months*
- *Grace had a present but weak pincer grip in both hands at 10 months, but was still too weak to hold a bottle or a cup at 11 months, as would usually be expected.*
- *Grace was not robust and when she was around other children, Jenny had to be particularly vigilant to ensure Grace's safety*
- *Due to Grace's small stature, poor mobility and balance skills, she was supervised much more closely than would be considered typical for her age.*

<u>Maintaining a patent airway</u>: During her second 6 months of life Grace progressively developed better head control meaning that she was able to turn and position her own head, then roll, sit and finally creep forwards. Therefore she became independent in maintaining her own airway and the need for support in this area ceased.

<u>Clearing secretions</u>: Grace continued to have difficulty clearing secretions throughout her first year.

- *This need was constant (could happen at any time over 24 hours) however intervention (assisting her to clear secretions) would have been intermittent.*
- *Typical parental responsibility: Babies of 6 to 12 months do not require assistance to clear their airway of unwanted material by coughing therefore there is no parental requirement to assist in the clearing of secretions.*

<u>Feeding</u>: Grace continued to need an adult to pace the flow of milk into her mouth at a speed that she could safely manage to swallow and protect her airway.

- *This need was constant (would need this support at any time she fed throughout a 24 hour period) however intervention (careful positioning her head and pacing of her feed) would have been intermittent (was required only during feeding).*
- *Typical parental responsibility: feeding of a typical baby 6 to 12 months of age requires intensive parental attention.*

<u>Vulnerability to illness</u>: Grace experienced failure to thrive as a result of her feeding difficulties. In her weakened state she would have been extremely vulnerable to illnesses and Jenny does however recall taking Grace for long walks in the pram when unsettled, on a daily basis. As regards F. "the injured person, because of the need for constant personal attention, was primarily in a high care situation, whether at home or in an institution, rather than being sufficiently able as to be out and about on a regular basis, such as going to school" Grace was most likely taken out into the community at this age.

Supervision requirements:

- *Typical parental responsibility: When babies of this age are awake it is suggested that parents ensure they are "in the same room" so they are able to provide "eyes on" supervision and intervene if safety is compromised eg if baby pulls to stand on something unstable. Parents typically baby proof the house as infants become mobile by creeping and crawling so that there is less risk of harm in the home environment. Parents need to take the baby with them as they move through the house going about household tasks.*
- *Babies typically sleep at least 2x in the day during which time the parent provides a reduced level of intensity regarding safety supervision (keeping a listening ear via an open door or a baby monitor)*
- *Babies of around 9 to 12 months require more intensive parental support as they start to crawl, pull to their feet and cruise. Once mobile babies are much faster and the need for vigilant supervision increases into the second year.*
- *Once babies are able to sit independently they are less vulnerable to other children however they still require parental support when around other boisterous preschoolers.*

  Due to her injury Grace took a long time to develop her gross motor skills and required a lot of support to do so. It is true that she required a longer period of intensive supervision than is typical as she mastered gross motor skills (right through the period covered by this report). She was also very unsettled and did not sleep during the day so the need to assist her was present throughout her waking hours. Jenny remembers taking her for long walks in the pram to settle her, so at this stage they clearly would have left the house.
- *The need was injury related, and was constant. It was different in that she developed very slowly however at this age there is the need for intensive supervision required for typically developing babies and therefore Grace's need was not greatly different in this regard.*

<u>Support at night with repositioning</u>: Grace was reported to develop independent rolling by 10 months, however she was also reported to still need support to turn in bed at night until she was 2 years old. This seems incongruous however it was possibly related to the surface she was rolling on (soft mattress is harder to

move on), level of alertness (easier when awake and active, not so easy when sleepy). Therefore at night she required turning, repositioning for comfort and pressure relief, and resettling two to three times per night between the hours of approx 8.30 pm and woke at 7.00 am (10.5 hrs). For the period that she was not able to reposition herself at night,

- *This need was injury related as Grace was too weak to perform the transitional movements to roll*
- *This need was constant and support was required for positioning intermittently throughout a 24 hour period.*

In regards to safety including self harm, avoiding harm to self and others and inability to summon assistance:

- *Like all babies of 6 to 12 months of age who are learning to move Grace was at risk of self harm when trying out new skills (pull to stand and walking). For Grace it was more related to needing to actually challenge her to develop necessary skills and needing to be "hands on" her while she practiced in order to keep her safe. This level of "hands on" support lasted well beyond the time a typical baby requires this type of support.*
- *Grace was more likely to be knocked over by other boisterous preschoolers, however all babies require some degree of supervision around preschoolers in order to manage their safety.*
- *Grace was able to cry to summon parental assistance In regards to inability to act appropriately in an emergency:*
- *Grace was like all other babies of 6 to 12 months, she was not able to act appropriately in an emergency.*

In regards to ability to control body temperature:

- *Grace was like all other babies of 6 to 12 months in that she was totally reliant on others to monitor her body temperature and dress her appropriately*
- *Grace was more vulnerable to illness than a healthy 6 to 12 month old infant, and the consequences of illness where greater due to her inability to cough and clear secretions (Grace developed pneumonia when she was 2 ½ yrs old) In regards to*

Assistance required to cough:

- *See comments above*

Hierarchy of importance of these needs:

1. *Special care taken to ensure safe swallow during feeding tasks.*
2. *Repositioning for comfort and pressure cares at night until 2 yrs*
3. *Clearing secretions and assistance to cough*
4. *Managing risk of harm from others*
5. *Inability to act in an emergency, monitoring of temperature are considered the same as a typical baby of this age.*

From 12 months to 2 years

Reports relevant to this period

- *Wilson Home reports dated 13/09/1989*
- *18 month developmental checklist*
- *Hospital notes dated Dec 1989 (aged 18 months) to Dec 2003*
- *Wilson Home Therapy reports dated 05/07/1990 (aged 2 yrs 1 month) From previous Review report 13.02.13*

Grace continued to develop Gross Motor skills slowly though her second year. She was able to walk independently by the age of 2; however she was very unstable and required closer supervision than a typical child of this age.

Wilson Home Therapy reports dated 05/07/1990 *(aged 2 yrs 1 month) Gross Motor Skills remained scattered between 10 and 12 months, representing a significant level of delay in mobility skills.*

Review comments dated 29.09.13
Clearing secretions: Grace continued to have difficulty clearing secretions throughout her second year

- *This need was constant (could happen at any time over 24 hours) however intervention (assisting her to clear secretions) would have been intermittent.*
- *Typical parental responsibility: Babies of 12 to 24 months do not require assistance to clear their airway of unwanted material by coughing therefore there is no parental requirement to assist in the clearing of secretions.*

Feeding: Grace needed a lot of parental support for feeding in her second year. However it is typical for parents to need to provide close supervision as children of this age are mastering finger feeding and drinking from a cup and to spoon feed them.

- *Typical parental responsibility: feeding of a typical baby 12 to 24 months of age requires intensive parental attention.*

Vulnerability to illness: Grace was taken for long walks in the pram when unsettled, Therefore she was taken out into the community. As regards F. "the injured person, because of the need for constant personal attention, was primarily in a high care situation, whether at home or in an institution, rather than being sufficiently able as to be out and about on a regular basis, such as going to school"

Supervision requirements:

- *Typical parental responsibility: Babies are now "toddlers" who quickly become "runners" by 18 months of this age. They do not have any inherent safety management skills therefore parents are required to provide a high level of vigilant supervision "in the same room" whenever baby is awake.*
- *Toddlers typically sleep 2x in the day during which time the parent provides a reduced level of intensity regarding safety supervision (keeping a listening ear via an open door or a baby monitor)*
- *Once Toddlers are able to walk independently they are less vulnerable to other children however they still require parental support when around other boisterous preschoolers who could push them over.*

Due to her injury Grace took a long time to develop her gross motor skills and required a lot of support to do so. It is true that she required a longer period of intensive supervision than is typical as she mastered gross motor skills (right through the period covered by this report).

- *The need for more vigilant supervision around other mobile children was injury related.*
- *The fact that it was required for longer than is typical was injury related · However supervision for a typically mobile child is very intensive at this age therefore this requirement could be excluded based on the fact that a mother is expected to give a young child attention for significant periods of the day.*

<u>Support at night with repositioning</u>: At night she required turning, repositioning for comfort and pressure relief, and resettling two to three times per night between the hours of approx 8.30 pm and woke at 7.00 am (10.5 hrs). For the period that she was not able to reposition herself at night,

- *This need was injury related as Grace was too weak to perform the transitional movements to roll*
- *This need was constant in that it would have applied at any time she was asleep over a 24 hour period.*
- *Typical toddlers do not require support to reposition themselves at night.*

In regards to safety including self harm, avoiding harm to self and others and inability to summon assistance:

- *Unlike typical toddlers 12 to 24 months of age who are independent walkers Grace was at risk of self harm when trying out new skills (pull to stand and walking). For Grace it was more related to needing to actually challenge her to develop necessary skills and needing to be "hands on" her while she practiced in order to keep her safe. This level of hands on support lasted well beyond the time a typical baby requires this type of support.*
- *Grace was more likely to be knocked over by other boisterous preschoolers than her typically developing peers.*
- *Grace was able to call out to summon parental assistance*

In regards to inability to act appropriately in an emergency:

- *Grace was like all other infants of 12 to 24 months, she was not able to act appropriately in an emergency.*

In regards to ability to control body temperature:

- *Grace was like all other babies of 12 to 24 months in that she was totally reliant on others to monitor her body temperature and dress her appropriately*
- *Grace was more vulnerable to illness than a healthy infant of 12 to 24 months, and the consequences of illness where greater due to her inability to cough and clear secretions (Grace developed pneumonia when she was 2 ½ yrs old) In regards to*

Assistance required to cough:

- *See comments above*

Hierarchy of importance of these needs:

1. *Special care taken to ensure safe swallow during feeding tasks.*
2. *Managing risk of harm from others*
3. *Repositioning for comfort and pressure cares until 2 yrs*
4. *Clearing secretions and assistance to cough*
5. *Inability to act in an emergency, monitoring of temperature are considered the same as a typical baby of this age.*

Age 2 yrs to 4 years

Reports relevant to this period:

- *Item 22 Physical Therapy Re-Assessment dated 02.03.93 (aged 4 yrs 9 months)*
- *Wilson Home therapy report dated 05/07/1990*
- *Paediatric therapy report dated 18/03/1991 (aged 2 yrs 9 months)*
- *CDU reports, orthopaedic reports and education reports variously dated*
- *Assessment of disability report, Dr G.T. Taine, Orthopaedic Surgeon, dated 23/01/1992*

From previous Review report 13.02.13

- *From the age of 2 years Grace was able to roll over and reposition herself in bed.*
- *Paediatric Therapy Report dated 18/03/1991 (aged 2 yrs 8 months) stated: "Able to get up from the floor independently and climb onto a chair. Gradually gaining stamina with walking"*
- *Assessment of Disability Report, Dr G.T. Taine, Orthopaedic Surgeon dated 23/01/1992 (aged 3.5 yrs). The primary issue of concern was mobility arising from general muscle weakness and generalised hypotonicity, although there was no spasticity. Grace was able to stand and walk unaided, although unsteadily.*
- *Grace had asymmetrical growth, with her Right side being smaller than the Left. The Right leg was shorter than the Left by 2 cm, adding to instability in walking. The Right arm and hand were obviously smaller. Her spine, however, was straight.*
- *Grace was issued with an Ankle Foot Orthosis (AFO) for everted right foot and ankle that required 6 monthly reviews.*
- *Grace had partial loss of overall muscle power in all 4 limbs. Weakness of her trunk was evident, in that she was unable to sit and maintain a symmetrical upright posture for long without slumping.*
- *Although not unwell, Grace was small and not robust.*
- *Failure to thrive was documented.*
- *Grace had normal bladder and bowel function and wore a night nappy.*
- *Developmental report at 2 yrs 8 months states that "Grace indicates she want to go to the toilet and is out of nappies during the day". She still required assistance however to get onto the toilet at play centre, but was independent by the time she started school*
- *At 2yrs 8 months Grace was able to dress and undress age appropriately, with the exception of buttons.*
- *Grace was hospitalised for pneumonia in July 1992. She continued to have a weak cough, requiring postural drainage when she got a "cold". Children of this age usually clear secretions spontaneously unless they have respiratory pathology.*
- *Age 2 yrs 8 months "uses a spoon successfully in her right hand. Drinks from a cup held with one hand and chews well."*

Exercise management (including therapy home programmes):

- *Jenny was conducting a home programme daily. Grace required a lot of encouragement to use her Right hand as well as progress her mobility skills*
- *Grace attended CDU twice weekly and hydrotherapy sessions weekly.*
- *Lack of stamina and fatigue were a significant problem. Grace needed a lot of rest although not necessarily sleep. Jenny had to actively balance her need for rest with constructive exercise in the form of therapy.*

Safety Management (Education Participation):

- *Jenny attended Play Centre with Grace daily from 9.00am to 12.00 noon. Grace was unable to attend a regular kindy, where one to one supervision is not an option, as she needed one to one direct supervision for safety and stimulation. There is no doubt that the above indicates that Grace's care continued to be an all consuming and a full time job at this stage. All of her needs over and above a typically developing child were injury related needs. Consideration should be given to the fact that, from the age of 2 until they*

start school, a typical child largely fits in with the parents' lives, going wherever the parents needs to in their own daily activities. It is very clear that this was not the case for Jenny.

Her days revolved around meeting Grace's rehabilitation needs. In the case of day care or preschool, it would be expected that a child could be left in the care of the educational facility of choice from the age of 2 to 2 ½ onwards, without child requiring any additional support for participation or safety. Again, this was clearly not the case for Grace.

All reports state that Grace was doing very well (relative to the severity of the injury). In reality all gains were as a result of extremely hard work and dedication from Jenny. Grace's recovery was not the spontaneous and naturally occurring event that normal development is expected to be. Helping Grace to achieve independent mobility and self cares continued to be all consuming.

Review comments 29.09.13

Supervision: By the time a typical toddler is 2 years of age they are extremely robust. The walk, run, climb efficiently, they have effective balance reactions including the ability to recover balance if knocked, and have effective protective saving reactions (put hands out to save the face) if they happen to fall over. Based on the fact that Grace was very unstable on her feet she had a significantly greater need for parental support in order to be around other children at a place like play centre.

- *Her weakness and balance issues were constant throughout a 24 hour period*
- *Her need for support was intermittent but did not change the fact that it was constant.*
- *The heightened level of maternal attention to the supervision of childhood activity was as a result of her injury and was considered to be of such a level as to itself amount to the requirement for constant personal attention*
- *However based on the requirement that the injured person, because of the need for constant personal care and attention was primarily in a high care situation, whether at home or in an institution, rather than being sufficiently able as to be out and about on a regular basis (such as going to school) excludes this from consideration. Grace at this time was attending hydrotherapy sessions, and therapy sessions at the CDT on a weekly basis as well as attending play centre.*

Summary

Based on the criteria described it is this assessor's opinion that by reason of the described injury related needs Grace required constant personal attention during the period from discharge home from hospital until the age of 6 months."

Ms Andrew's oral evidence

[30] While Ms Andrews agreed that all children need supervision and that many of the actions involved in caring for Grace would have to be performed by parents of the "*hypothetically normal child*" of Grace's age at the relevant periods, she repeatedly stressed the fact the Grace's needs were different because of the extreme and dangerous consequences for her of any care failure. She said that she deducted what a normal child would need in terms of care and supervision, and what was left convinced her that Grace did require the heightened level of attention that she would describe as being constant.

[31] The main factor that distinguished Grace's needs was primarily to do with her not being able to reliably breathe until she was about 6 months old, because she could not turn her head to open her airways. This meant that she had to be turned during the night and the consequences of not turning her could have been catastrophic. Ms Andrews also said that the time Grace's mother spent on her physiotherapy was almost exclusively for head control in the early stages, and after this, without the ongoing therapy from her mother, though Grace would eventually have achieved muscle control because she is such a determined person, her development and independence would have been severely delayed.

[32] Regarding the supervision Grace needed, Ms Andrews agreed that all children need some supervision, but in Grace's case, the consequences of not checking on her were far greater, because she continued to need clearing of mucus, and positioning so as not to get pressure sores, and her immobility presented problems again that were not present for a normally active child. Ms Andrews defined "*supervision*" as being eyes on contact. Regarding how she evaluated the information she was presented with by Grace's family, she said that you don't start with the parents' estimate of care needs, but go back through the day task by task, and then let the hours add themselves up.

[33] Ms Andrews gave an example of Grace's injury related supervision needs, being that at age 12 months, Grace was only able to prop her forearm, which was typically achieved at 3 months. When babies develop they start to stand and the typical child does not require "*eyes on*" supervision during this activity. Grace did, because of her motor skills and she required hands on and direct care to develop all her motor skills. She also needed to be protected with extra vigilance in all situations because the consequences of injury or illness were so much greater for her, than for the typical child. She agreed that Grace did not in fact get sick while she was aged under 4 years, but said that if she had it would be life threatening and this is why she needed such a high degree of supervision and greater input than for a normal child.

[34] Ms Andrews was questioned about Grace's night care needs and said that while a typical baby could wriggle its way out of an uncomfortable position, Grace could not. So while ordinary parents would be occasionally woken through the night, while the physical actions involved may be similar, in Grace's case the reasons and the care needs would be quite different. There were additional injury related needs that had to be attended to, and again, graver consequences if they were not met. Although she could not recall the exact reasons for having placed night cares second in her hierarchy (Ms Andrews did not bring her file to court to refer to) she agreed that when she prepared the assessment, she felt that this was extremely important in Grace's case and again stressed the consequences of failure being vastly greater. Ms Andrews said that the failure to thrive was a great contributor to Grace's night care needs because she was hungry and slept badly and there was a difference between Grace and a typical child, because feeding is tiring for a weak baby and they are more dependant on a night feed and this added weight to the importance of the night cares.

[35] At the end of her evidence, Ms Andrews said that the critical factor was also Grace's reduced airways and that rather than the 6 months that she had identified in her assessment as being the longest that Grace would have needed constant personal attention, the period was more likely to be somewhere between 12 to 18 months, as the factors she had identified may well have continued to be important to

this age. She could not be more specific, but said that her assessment of 6 months was too short.

The arguments advanced

[36] As noted, Mr Nee Harland based his case on Ms Andrews' first assessment and submitted that this supported the claim for the full period at issue.

[37] Mr McBride rejected both assessments, despite having fully participated in framing the questions and the legal test for Ms Andrews' second assessment. I will not go through his submissions in detail, as they were in the main directed to discrediting the first assessment and setting out the law to support the questions he put to Ms Andrews. Mr McBride submitted that the second assessment, though based on instructions deriving from ACC that do reflect s 80(3) and arriving at a markedly different result, was still not accepted for reasons to be addressed in cross-examination.

[38] Mr McBride's submissions made after hearing Ms Andrews' responses to his cross-examination and my own questions, were that in light of the established authorities,[1] Grace's claim could not survive because the constancy required was lacking. Her cares fluctuated over the course of the 24 hours, they were intermittent and had peaks and troughs, and the mere availability of care, or the parents' perception of the care required, was not sufficient. In addition, Ms Andrews agreed that Grace's parents took her out of their home for purposes other than therapeutic reasons, whereas the setting for constant personal attention was in a place of abode or institution.

Decision

[39] As ACC did not seek a second opinion, the only evidence of Grace's need for constant personal attention because of the nature of her injuries is that of Ms Andrews. Her first assessment must be disregarded for the reasons already expressed, I am satisfied on the basis of her second assessment and her oral evidence that Grace needed constant personal attention as this is defined by the accepted authorities, until she was aged somewhere between 6 months and 18 months old. On balance, I think that 12 months is a reasonable compromise between the two.

[40] The appeal is successful to this extent and ACC's decision dated 10 March 2003 is reversed.

[41] ACC is to pay Grace compensation under s 80(3) for the period from her discharge from hospital to age 12 months.

[42] Pursuant to s 109(8) ACC is directed to calculate the hourly rates for Grace's care by applying the rates paid for a specialist occupational therapist for the time that

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[1] *ARCIC v Campbell* [1996] NZAR 278; *Guthrie* (11/03); *Meimaris* (12/03); *ACC v Estate of Simpson and Matthews* [2006] NZAR 289; *Matthews v ACC Wellington*, CIV-2004-485-2143 and CIV-2004-485-2806, 31 March 2006; *Simpson and Matthews* [2—7] NZAR 496; *Matthews v ACC* [2001] NZACA 9; *Tangi v ACC* [2012] NZACA 4; *Landeshauptstadt Kiel v Jaegar* [2004] ICR 1258; *Laming v ACC* [2012] NZACC 134; *ACC v Howell* [2013] NZACC 38; *Condliffe v ACC* [2003] NZAR 481. Refer also to my discussion of the legal test under s 80(3) in *Chittock v ACC* [2014] NZACA 4.

Grace's mother spent giving her the necessary physical therapy during this time, in addition to the ordinary rates paid for day time and night time cares.

[43] ACC should use Mrs Andrew's 2008 assessment to calculate the therapy hours.

Costs

[44] No costs are awarded against ACC, as Grace has been represented by her father without charge. Mr Nee Harland is to submit a schedule of disbursements to Mr McBride and if these cannot be agreed, then submissions should be filed within 28 days and a decision will be made on the papers.

DATED at WELLINGTON this 30th day of April 2014

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R Bedford