PURSUANT TO S 160(1)(b) ACCIDENT COMPENSATION ACT 2001 THERE IS A SUPPRESSION ORDER FORBIDDING PUBLICATION OF THE APPELLANT'S NAME AND ANY DETAILS THAT MIGHT IDENTIFY THE APPELLANT

IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 132 ACR 290/19

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

Hearing: 4 July 2022
Held at: Rotorua/Rotorua-Nui-A-Kahumatamomoe

Appearances: The Appellant is self-represented
S Churstain for the respondent

Judgment: 11 July 2022

RESERVED JUDGMENT OF JUDGE P R SPILLER
[Claim for personal injury - s 67 and Schedule 1, Accident Compensation Act 2001]

Introduction

[1] This is an appeal from the decision of a Reviewer dated 2 October 2019. The Reviewer dismissed an application for review of the Corporation's decision dated 1 May 2019 declining to fund further treatment from Dr Gil Newburn, Neuropsychiatrist.

Background

[2] On 6 June 1977, GG sustained a head injury when she fell off a horse and was knocked unconscious. On 30 September 1992, a claim for cover for this injury was lodged by GG, and she was subsequently granted cover for "Fracture; Head (except face)".

[3] Between January 1992 and December 1993, there are records of Dr Gil Newburn, Neurologist, having seen GG several times.

[4] On 3 April 1998, GG hit her head on an air conditioning exhaust housing unit placed at head height, and fell, resulting in a traumatic brain injury. GG was subsequently granted cover for a "Post-traumatic brain syndrome Head (except Face)".

[5] On 15 April 1998, Mr Murray Ashbridge, Ophthalmologist, reported that, despite GG's concerns, there was nothing significantly wrong with her eyes, and that any difficulties in focus might be due to possible bruising of the higher coordinating mechanisms.

[6] On 28 April 1998, GG's GP prescribed her analgesics and referred her to a chiropractor and a neurologist. Her symptoms included poor concentration, fatigue, poor balance, vision problems and weight gain.

[7] On 1 July 1998, Ms Joanne Smith, Neurological Occupational Therapist, provided an assessment report of a brain injury caused by the accident of 3 April 1998. Ms Smith noted GG's problems as fatigue, anxiety, planning difficulties, slow processing, and an inability to assist her husband with his work. Ms Smith recommended a Training for Independence Programme ("TI"), consideration for home help, and a vocational assessment to determine capacity to return to work following the TI.

[8] On 2 July 1998, Dr Gil Newburn provided a report listing symptoms suffered by GG. He noted that she had suffered a "severe brain injury" in the past and he had previously assessed her in relation to this. Dr Newburn began treatment with

methylphenidate. He recommended that GG be assessed regularly by an occupational therapist with brain injury experience, to "ensure she does not deteriorate across a range of neuropsychiatric symptoms and that she receives appropriate management to recover".

[9] Between 7 September 1998 and 23 December 1999, GG saw either Dr Newburn or Ms Smith a total of 12 times. Dr Newburn changed GG's medication five times in this period. The last report of Ms Smith stated that GG had achieved gains over the previous year and had set goals of returning to employment.

[10] On 22 February 2001, Dr John Smith, having examined GG, provided a neuropsychological report,. He noted that GG had suffered a head injury three years prior to the examination, and presented with difficulties in memory, concentration, organisation and social/emotional behaviours. Dr Smith reported that, as three years had passed since her last accident, further significant cognitive recovery was unlikely. Dr Smith recommended an occupational therapy review and a clinical psychology review.

[11] On 26 December 2001, GG noted her concerns about the lack of assistance she had been receiving and how she had been portrayed in case notes.

[12] In May and June 2001, GG saw Ms Ora Ryan, Psychologist. She reported that, in addition to GG's two head injuries, there was evidence that GG had suffered some degree of trauma associated with alleged sexual abuse. Ms Ryan assessed that "features of a Borderline Personality Disorder that appeared to be directly attributable to the alleged abuse and head injuries are evident in [GG]'s passive-aggressive inter-personal style of managing conflict". Ms Ryan noted that GG expressed her disappointment and perception of the mismanagement of her injury.

[13] In August 2001, after 10 sessions with GG, Ms Ryan provided a report. Ms Ryan considered that GG had areas that still needed attention, but she had the skills to continue to address these. Ms Ryan noted that GG had gained assertiveness and self-confidence and intended to revisit some secondary school studies to open up

future employment options. It was thought that GG had made significant gains during her counselling.

[14] On 10 August 2001, Dr Newburn reported that GG still had motor planning difficulties, and he suggested that she take up a gym programme.

[15] On 22 January 2002, Dr Francis Matete, of the Rotorua Mental Health Unit, provided a report following a self-referral by GG. Dr Matete stated that GG's anger stemmed from her feelings of depression and despair. He diagnosed Post Traumatic Stress Disorder ("PTSD"), and a past traumatic brain injury with memory impairment and poor concentration. Dr Matete recommended rehabilitation with the assistance of a social worker, a neuropsychological assessment, continuing under Dr Newburn's care, and taking her medication.

[16] On 15 February 2002, Dr David Keightley-Phillips provided a report. He recommended deep muscle relaxation to address stress and anxiety, eye movement desensitisation, rational emotive therapy, and personal counselling for problem-solving and conflict resolution.

[17] On 4 March 2002, Professor Des Gorman and Dr Kathleen Callaghan, of UniServices, completed a file review and provided a report. They found a lack of definitive diagnosis, as treatment outcome was based on an appropriate diagnosis of all factors responsible for ongoing symptoms. They recommended that a case conference be held, involving all health practitioners involved in GG's case, to provide a clear diagnosis and outline an ongoing management plan.

[18] On 12 April 2002, Dr Newburn reported that GG had expressed concerns regarding Ms Ryan's diagnosis of borderline personality disorder, and that there was no evidence that she was suffering from that. Dr Newburn believed that it would be inappropriate to consider any strategies in relation to this diagnosis.

[19] On 30 April 2002, GG met with Professor Gorman. He recommended that, prior to the case conference, GG have blood tests, an MRI of her head, psychiatric assessment and subsequent diagnoses, and repeat neuro-psychometric assessment

with a fatigue and depression measurement. He also recommended obtaining hospital records from 1977. Professor Gorman stated that GG's most significant injury was her brain injury sustained in 1977, but that she had recovered well. He assessed that the 1998 injury was minor, and that the prescription of methylphenidate for a head injury was not well supported.

[20] On 23 May 2002, Dr Smith reassessed GG after reviewing reports and letters from other practitioners. He stated that GG's profile was similar to the previous assessment in February 2001, with discrepancies between her verbal and non-verbal abilities. Dr Smith noted that GG showed visual memory deficit and significant reduction with information processing and speed. He observed that depression and fatigue could affect such tests. Dr Smith considered that GG's performance was reflective of an underlying cortical injury.

[21] On 12 June 2002, Dr Newburn again wrote to the Corporation, stating that there were broad areas of agreement between his views and those of Professor Gorman. However, he stated that Professor Gorman's use of "minor" did not mean that the injury was trivial, and that GG had presented with at least one hypomanic episode. Dr Newburn also stated that there was no requirement for an MRI as "even in cases with severe recent injury, there may be no abnormality shown on an MRI scan", and that Dr Jan Reeves would not be an appropriate choice to assess GG. Dr Newburn recommended that an assessment be completed by Dr Greg Finucane.

[22] On 28 June 2002, the MRI concluded that "there is focal atrophy in the right temporal lobe with underlying gliosis and this is compatible with prior trauma".

[23] On 18 July 2002, Dr Jan Reeves, Psychiatrist, provided a report noting that GG denied any symptoms of hypomania and stated that her pressured speech and somewhat impulsive behaviour in 1999 were related to stress at home. Dr Reeve diagnosed GG with major depressive disorder (currently in remission), dysthymic disorder, cognitive impairment secondary to head injury, and Cluster B personality traits. Dr Reeve also recommended that a case conference be held to discuss a suitable rehabilitation plan. GG subsequently wrote numerous emails to challenge the accuracy and actuality of events during the assessment.

[24] On 3 September 2002, following a case conference, a report was completed. Authors of the report were comprised of Dr Reeves (Psychiatrist), Dr Briscoe (GP), Dr Smith (Neuropsychologist), Professor Gorman and Dr Callaghan (UniServices), and Ms Sue Oldham (ACC). They diagnosed: hypomanic episode likely secondary to methylphenidate, major depressive disorder (in remission), dysthymic disorder, cognitive impairment secondary to head injury, Cluster B personality traits, post-concussion syndrome, and hypertension. They noted radiological evidence (MRI) of significant brain injury.

[25] On 20 January 2003, Dr Smith provided a brief report summarising his previous two reports.

[26] On 3 June 2003, Dr Newburn provided a three-page criticism of the UniServices report (of March 2002) and recommendations. He stated that the three separate episodes of trauma suffered by GG had resulted in issues arising around her sense of disruption of personal integrity. He assessed that bipolar affective disorder was not an uncommon consequence of brain injury, and that GG was currently presenting in the depressive phase of the disorder. Dr Newburn did not believe that GG was fit to work. He noted that the specific reasons for the incapacity were the depressive phase of bipolar disorder, against a background of brain injury and sexual abuse, with significant anxiety about engaging in any process or activity over which she did not have complete control. Dr Newburn offered himself "to see GG at a frequency which is consistent with good practice", and recommended interventions by a psychologist who had experience and expertise in working with the brain injured. Dr Newburn again questioned the expertise of Dr Reeve in this situation.

[27] Between 20 June 2003 and 26 May 2004, GG visited Dr Newburn on multiple occasions. On 12 March 2004, Dr Newburn stated:

> I note in responding that [GG] has had an extremely difficult 6 weeks. There have been a number of issues that have occurred, all of which have threatened her sense of mastery, which as you know from previous reports is a major factor for her arising from her various injuries. These in themselves have further depressed her, and have resulted in an overdose.

[28] Dr Newburn recommended an initial assessment by an occupational therapist who understood and had expertise in the management of those with brain disorder and post-traumatic stress disorder, and by a clinical psychologist who had similar experience.

[29] On 25 May 2004, Dr Newburn made a request for the extension of treatment of GG, consisting of cognitive/behavioural management, the provision of education and support, and pharmacological intervention.

[30] On 10 June 2004, the Corporation declined to fund the extension of treatment sought by Dr Newburn. The decision stated that, aside from GG's depressive/dysthymic symptoms (which could be managed by a GP), there was no evidence that continued psychiatric input was likely to be of benefit.

[31] On 1 July 2004, Professor Gorman stated his concern that vocational progress had not been made. He stated that there was a need for cognitive behavioural therapy, monitored exercise, and occupational therapist support, and that medication had not been rationalised, which was concerning for the board that had previously discussed this issue.

[32] On 19 November 2004, Dr Greg Finucane, Psychiatrist, met with GG. On 29 November 2004, he provided a detailed report, discussing GG's history of injuries and persisting neurological, depressive and anxiety symptoms. Dr Finucane diagnosed post-traumatic stress disorder (in remission), major depressive disorder (partial medication induced remission), post-concussional disorder, personality changes (due to head trauma), and borderline traits. Dr Finucane recommended no further investigations, medication changes to be monitored by Dr Briscoe with the consideration of the suggestions in his report, and a psychiatrist, experienced with cognitive impairment, to be lead provider for GG. Dr Finucane concluded:

> It is implausible that her difficulties are the result of the TBIs alone and hence improving her ability to manage anxiety and depressive symptoms but also participate in interpersonal settings in a more rewarding way will be of benefit for her level of function and participation in due course.

[33] On 31 May 2005, Dr Finucane followed up his initial comment by stating that there would be no reason to believe that GG would be incapable of any occupational activity, but it would be most unlikely for her to expect to return to work for more than "half time".

[34] On 13 June 2005, Phoenix Rehabilitation provided a TI report, advising that GG had withdrawn from the programme, and recorded that she stated that she had made enough progress to cope with tasks in and around her home.

[35] On 28 March 2007, Dr Newburn applied to Pharmac for methylphenidate for Attention Deficit Hyperactivity Disorder ("ADHD"). Dr Newburn had not previously discussed or diagnosed ADHD.

[36] On 13 February 2009, Dr Newburn reported that his management of GG had resulted in her remaining independent in the community, and that other interventions were inappropriate and had caused deterioration.

[37] On 18 August 2009, Dr Newburn diagnosed GG with bi-polar disorder and sought the continuation of care under his supervision.

[38] On 13 September 2009, Dr Briscoe advised that GG was not doing well and that there were currently various domestic stressors in her life. At the time, she had diabetes, and medication seemed to be a factor.

[39] On 24 March 2010, Dr Darren Malone, Psychiatrist, assessed GG for diagnoses and treatment options. He diagnosed PTSD, mood disorder due to general medical condition (TBI), personality change due to general medical condition, and post-concussion syndrome. He believed that the most pertinent risk seemed to be one of ongoing disability. He recommended monitoring blood pressure in relation to high doses of medication, referral to a neuropsychologist, and clinical psychological therapy to address GG's psycho-social problems.

[40] On 25 March 2010, Dr Malone commented further that he considered that the head injury of 1977 was more significant than the subsequent one in 1998. He

believed that, had there have been no head injury in 1977, she would have recovered far better and with less impairment from the 1998 injury.

[41] On 28 September 2010, Dr Newburn confirmed the development of affective disorder, with some features of bi-polar disorder, which, he believed, occurred as a consequence of traumatic brain injury. He stated that GG was suffering from increased depression requiring more medication (being the use of venlafaxine and the continuation of methylphenidate).

[42] On 22 February 2013, Dr Michael Kahan, Occupational Physician, provided a report of GG's ability to participate in return-to-work rehabilitation. He noted her problems as being two previous head injuries, depression, insulin dependent diabetes and hypertension. Dr Kahan assessed that GG should be involved in a work trial with a gradual increase in hours, and that she would benefit from a Work Preparation Programme. GG wrote a letter in relation to Dr Kahan's report. In response, Dr Kahan stated that his opinion remained unaltered.

[43] On 7 July 2013, Dr Newburn noted that GG still had a "significant range of issues".

[44] On 13 April 2016, Dr Newburn made a request for funding for melatonin.

[45] On 20 June 2016, after having sought medical advice, the Corporation declined to fund the cost of melatonin, on the basis that it was not primarily required to treat the injuries that the Corporation had agreed to cover. GG applied for a review of this decision.

[46] On 21 June 2016, Dr Newburn provided further comment regarding the request for melatonin funding.

[47] On 16 December 2016, an external medical multi-disciplinary panel met to review GG's case. The Panel comprised an Occupational Medicine Specialist/Pain Physician, a Neurologist, a Specialist Physician and Psychiatrist, an Orthopaedic Surgeon, and a Facilitator. On 21 December 2016, the Panel provided a report

detailing GG's background, previous medical examination and comments on a number of questions:

> ***1. What are the diagnoses of [GG]'s current symptoms current symptoms and disability? Please explain your reasoning for this.***
>
> … Multiple clinicians have identified personality characteristics consistent with borderline personality disorder as being a significant issue in [GG's] presentation. The Panel recognises this pattern and suggests that her maladaptive coping structure is at the core of both many of her symptoms, as well as the persistently confrontational nature of engagement. The Panel is not in a position to provide a definitive diagnosis of a characterological disorder as this should be done by a clinician seeing her over time and across a range of functioning…
>
> … there are a number of other mental health diagnoses including: PTSD, depression, anxiety and possible binge eating disorder which are either defined or alluded to in the record. The Panel does not contest these, but points out that a diagnosis of any cluster B personality disorder would provide a context for them which may provide a better clinical explanation for her symptoms.
>
> **Traumatic Brain Injury**
>
> The 1977 injury was a moderate to severe traumatic brain injury from which [GG] clearly made a full recovery… the 1998 event, at most, would represent a mild traumatic brain injury… the Panel considers that her current distress is not related to injury to the brain as an organ. The Panel does recognise that there has been a temporal relationship of profound disabling symptoms, but that this is most likely related to her underlying maladaptive coping mechanisms and her post-brain injury health care experiences which she may have experienced as challenging and invalidating.
>
> Post concessional disorder is appropriate because it recognizes that she had significant symptoms after the event, but it does not in any way confirm that they were caused by the event of 1998 as it relates to anatomic/structural impact on her brain.
>
> …
>
> ***4. Have you any other comments about this case?***
>
> The Panel is concerned about the issue of dual agency in Dr Newburn's care. The Panel is not impugning his motives nor suggesting malfeasance, but it is concerned that [GG] needs careful and respectful boundaries in her care and a clinical approach that validates her distress but does not validate invalid clinical attributions of the distress. Dr Newburn's communications in this case demonstrate advocacy and compassion for [GG] but he may not have the complete set of reports and data which would allow him the information to see patterns as evidenced by the panel and other clinicians.
>
> A particular concern is that Dr Newburn has, at various times, acted as her assessing clinician providing diagnoses that have not been made by other clinicians. He also has simultaneously acted as her treating physician and as an authority for ACC. The Panel is concerned that this may be evidence of some

> splitting behaviour by [GG] between Dr Newburn and other clinicians and this should be carefully monitored by Dr Newburn and others. This is the basis for the Panel's recommendation of a thorough review by Dr Finucane to act as an independent assessor and advisor to [GG], ACC and other clinicians. The Panel would expect this to entail a significant number of hours by Dr Finucane as this will require a thorough case review of public and private notes as well as collateral information, clinical re-evaluation and case discussion. …

[48] On 3 May 2017, a Reviewer upheld the Corporation's decision of 20 June 2016.

[49] On 2 August 2017, the Corporation arranged for GG to have a neuropsychological assessment. The Corporation advised that this assessment would provide the Corporation with more information about how GG's injury was affecting her, and what types of rehabilitation might be of benefit to her.

[50] On 1 November 2017, Dr James Hegarty, Consultant Clinical Psychologist, having undertaken a neuropsychological/cognitive assessment of GG, provided a detailed report. Dr Hegarty assessed that:

> Based on the nature of [GG]'s injury, along with no reports of a prolonged period of pre, or post traumatic amnesia, she would be expected to have suffered a relatively mild injury, and to make a good recovery. From the file material available to me, it appears that this is the overall medical consensus regarding the severity of [GG]'s injury of 1998.
>
> … Overall, she showed intact abilities in relation to her predicted pre-injury abilities; this includes intact abilities of attention and working memory, processing speed, verbal reasoning, visual reasoning, motor sensory function in the upper limbs, and verbal memory…
>
> There were, however, several anomalies among her results; most notable among these was the accuracy of her copy of a complex figure which was significantly below her expected abilities…
>
> Overall, given her history, the medical reports I have had available to me, and [GG]'s performances on a range of neuropsychological measures, there is no current evidence to suggest a general impairment of cognition as a result of her 1998 injury… it is possible that any problems that might exist with visual processing and visual memory could stem from an earlier injury, rather than the injury of 1998.
>
> I note that Dr Newburn has in the past diagnosed [GG] as suffering from a bi-polar disorder. While I do not believe that there is evidence to support the development of a bi-polar disorder due to a mild to moderate brain injury, some of [GG]'s comments to me did suggest the possibility of a rapid cycling mood…

> … I believe [GG] has developed a firm belief that she is significantly cognitively disabled, and fears being pressured to perform, or engage in situations where she will not cope, or feel safe.

[51] On 18 December 2017, the Corporation's psychological advisor, Leona Manna, recommended that GG be referred back to Dr Finucane.

[52] On 26 March 2018, Dr Finucane assessed GG. On 28 April 2018, Dr Finucane reported:

> … all told, there is relatively little change in the presentation since 2007, and indeed since 2002 when the UniServices report was compiled…
>
> … going from the previous record, the history obtained at interview and the PAI results, there are mild residual depressive features so the diagnosis of Major Depressive Disorder in partial remission can stand. There is insufficient evidence for Post Traumatic Stress Disorder to be a relevant diagnosis, and whilst there may be some residual post concussion syndrome symptoms, it is equally possible given the PAI results that the correct diagnosis is a Somatic Symptom Disorder (or a combination of the two). The presentation of her personality functioning with sustained hostility is not in my clinical opinion in keeping with personality change due to brain injury as such (at least alone), hence if there is component of this there is also a component of maladaptive traits which are not brain injury related.
>
> The profile is not suggestive of malingering. The best diagnostic statement might include most of the above diagnoses, namely: Major Depressive Disorder, Mild Neurocognitive Disorder; Somatic Symptom Disorder; Personality change due to TBI; Personality Disorder NOS (with collateral history required to clarify the nature of this). …
>
> … causality is difficult to untangle here, given the index injury was mild and she was functional prior to that. Her emotional response to the injury, the resulting symptoms, to the treatment and non-accident related life stressors may have been just as important as the repeat brain injury itself producing this result. There is at least some contribution from brain injury (given the scan and the residual impairment of visual memory) but some contribution from non-accident factors in addition. Hence the best can be said is that her condition is multifactorial in nature and now resistant to change…
>
> … it does not appear possible to conclude that [GG] would engage adequately with therapists or clinicians who do not share her view that the sole cause of her symptoms is the index traumatic brain injury. However, engaging with clinicians who are of that opinion cannot be recommended on the above formulation since no progress would then be made on remediable aspects in any case, due to the time that has elapsed since the injury. The principles of fatigue management are well known to her and do not need to be re-inculcated.
>
> Therefore, no recommendation for any specific therapy will be provided.
>
> However, it should be noted that she does not have a diagnoses of Attention Deficit Hyperactivity Disorder and the current dose of methylphenidate is high

> in relation to its use after TBI; the dose has also increased considerably over the years and it may be contributing to fatigue and irritability, and perhaps even suspiciousness. It is my opinion that the methylphenidate should be reduced and discontinued if possible, since she is not more functional than she was before commencing it.

[53] On 22 May 2018, Dr Chris Dowling, Psychology Advisor, provided a report based on the available information. He stated:

> As such, both of these reports [Dr Finucane and Dr Hegarty] suggest it is unlikely that [GG]'s ongoing symptoms are directly and substantially caused by her 1998 injury… However, it is not clear if Dr Finucane considered the 1998 mild brain injury as contributing, or the previous moderate to severe brain injury in 1977… in regards to the additional possible diagnosis, my reading of Dr Finucane's report is that these are unclear, and as such determining causation is not possible.
>
> … In my opinion, determining the most appropriate treatment is difficult, as the current diagnoses and their causation are still unclear. As such, it is unclear whether ACC would be obligated to provide an intervention. I reviewed the sensitive claim (for which [GG] has cover for PTSD, however I note that Dr Finucane felt a PTSD diagnosis was not relevant. Based on my review of the information I agree with Dr Finucane that any intervention would likely be ineffective due to [GG]'s beliefs regarding the cause of her symptoms as being solely head injury related. It would be expected that a therapist would challenge this belief, with the available documents indicating that GG finds it difficult when this occurs. Given the wide range of [GG]'s difficulties, I also agree that Dialectical Behaviour Therapy would likely be a helpful treatment.

[54] On 23 June 2018, Dr Finucane responded:

> In your report you mentioned "there is at least some contribution from brain injury (given the scan and the residual impairment of visual memory)". Do you see this as being related to the 1998 injury, or the 1977 injury?
>
> This appears related to the 1977 injury, not the 1998 injury…
>
> … my opinion is that there is a Somatic Symptom Disorder present whether or not there are residual symptoms from the mild TBI, given that the overall magnitude of her symptoms is not explicable on the basis of the mild TBI alone. Whilst [GG] has undergone a wide range of neuropsychological testing undertaken, she has not to my knowledge undertaken very sensitive testing of serial attention with the Paced Auditory Serial Addiction Test or the Computerised Test of Information Processing. If one or the other of these were to be administered and proved indicative of enduring features of brain injury then a Mild Neurocognitive Disorder (in relation to the following symptoms) could be considered present, but otherwise her severe fatigue and other incapacitating symptoms cannot in my opinion be attributed to the 1998 injury.

[55] On 4 July 2018, GG emailed the Corporation, stating:

> I need ACC to fund an appointment for 1 hour for me to discuss the bogus findings of Hegarty and Finucane, and particularly Finucane's statement that I should be taken off methylphenidate, with Dr Gil Newburn.

[56] On 5 July 2018, Mr Oliver Digby, ACC Case Manager, emailed GG stating:

> Hi [GG],
>
> You haven't outlined why a one hour appointment with Gil Newburn is necessary and appropriate to treat a covered injury. While you are entitled to disagree with Dr Finucane and Dr Hegarty's findings this doesn't necessarily mean that their findings are incorrect. Both specialists compiled their findings using the same comprehensive information that is held on your file along with the information that they compiled through the course of their face to face interviews.
>
> ACC have not declined your treatment request to see Gil Newburn, what will be required for your request to be considered appropriately is a full treatment rationale, treatment plan and copies of all previous consultation notes. You can approach Gil Newburn directly to request copies of this information or provide consent for ACC to request this directly from him. ACC can then make an informed decision as to whether this request for funding for treatment with Gil Newburn is appropriate.

[57] On 12 July 2018, Dr Jamie A B Macniven, Psychology Advisor, reviewed all available information and reports. He recommended asking Dr Finucane further questions having assessed that:

> Dr Finucane has postulated that [GG] has developed Somatic Symptom Disorder, but there is limited discussion within his reports regarding the aetiology of this condition. I note that [GG] sustained a likely severe traumatic brain injury aged 12, with apparently enduring cognitive sequelae (Dr James Hegarty, 01/11/17). It may be that this significant injury, at a time of significant social and cognitive development, may represent a significant causative factor for the development of the Somatic Symptom Disorder, in the context of other triggering stressors, potentially including the 1998 accident. As Dr Hegarty discussed as part of his assessment in 2017, it is possible that the 1977 accident affected [GG]'s emotional development, with reference to her developing 'uncharacteristic aggression' following this injury, which appears to have remained a theme in her interactions with various health professionals

[58] On 16 July 2018, Mr Digby emailed GG in response to a request for information, stating:

> Dr Finucane has already confirmed that your statements of corrections do not alter his opinion, as such there is no requirement for ACC to instruct

> Dr Finucane to provide detailed answers to the numerous questions that you created in the form of the multiple statements of correction.

[59] On the same day, GG responded, saying that she did not have to explain to Mr Digby why she needed to see Dr Newburn. Later, Mr Digby replied:

> Before treatment funding is approved ACC need to consider whether that treatment is necessary and appropriate treatment for your covered injuries. Your current request sits outside such a request as you have indicated that you want ACC to pay for a one hour appointment so that you can voice your opposition to the findings of the most recent assessments on your claim.

[60] On 23 August 2018, Dr Finucane responded to the questions posed by Dr Macniven:

> Please comment on the likely aetiology of [GG]'s somatic symptom disorder. Do you consider that this may represent a mental consequence of the 1977 severe traumatic brain injury?
>
> The aetiology of the Somatic Symptom Disorder was shaped by the rehabilitation input received after the 1998 injury, with all of her symptoms being attributed to brain injury rather than other causes of symptoms especially injury related and non-injury related stress. The premorbid personality characteristics were also important in predisposing to such a disorder.
>
> The Somatic Symptom Disorder is not a mental consequence of the 1977 severe TBI.
>
> Do you consider that the 1998 injury, in the context of prior TBI that may have created a significant vulnerability, may also represent a significant causative factor for the somatic symptom disorder?
>
> The 1998 injury was a precipitating factor for the Somatic Symptom Disorder, and provided a symptom focus around which the disorder could develop, but this disorder is essentially a stress related condition with no direct causal link to brain injury. The 1977 injury likely left GG with some personality features which increased the risk of developing the Somatic Symptom Disorder, again without being a direct cause of such a disorder.
>
> Hence both injuries could be seen as risk factors for but not substantive causes of the Somatic Symptom Disorder.

[61] On 4 September 2018, Dr Macniven again commented on GG's case:

> Dr Finucane has noted that the 1998 injury was a precipitating factor for the somatic symptom disorder, and provided a symptom focus around which this disorder could develop. However, he has clarified that this condition is essentially a stress-related condition with no causal link to brain injury. Dr Finucane is of the view that both of the injuries sustained in 1977 and 1998 were risk factors for the somatic symptom disorder but not significant causative factors.

> Dr Finucane has provided a clear rationale for his conclusion that [GG]'s somatic symptom disorder is not causally linked to her covered injuries. This condition appears to be the cause of her main current symptoms.
>
> Dr Finucane has previously noted that [GG]'s presentation has changed relatively little since 2002, suggesting that the various attempts at therapy over the past 16 years have not been successful (23/06/18). He has stated that, "it does not appear possible to conclude that [GG] would engage adequately with therapists or clinicians who do not share her view that the sole cause of her symptoms is the index traumatic brain injury' but that, 'engaging with clinicians who are of that opinion cannot be recommended on the above formulation since no progress would then be made on remediable aspects in any case, due to the time that has elapsed since the injury' (23/06/18). On this basis, further sessions with Dr Gil Newburn cannot be supported. I also note the previous external medical multidisciplinary panel comments regarding the issue of dual agency in Dr Newburn's care (21/12/16).

[62] Dr Macniven assessed that:

(1) The clinical criteria for mental injury caused by physical injury did not appear to be met;

(2) Treatment of GG's somatic symptom disorder should be managed via the public health system, as this condition was not covered by the Corporation;

(3) Further treatment with Dr Newburn was not clinically indicated, for the reasons discussed above; and

(4) Further rehabilitation under the current claim was not necessary or appropriate, as discussed by Dr Finucane and the external multidisciplinary panel.

[63] On 10 September 2018, Mr Digby emailed GG stating:

> ACC will now need to assess what the exact cause of your ongoing incapacity is and whether that can be linked to either your sensitive claim or your 1977 or 1998 head injuries. This will need to be completed by a contracted psychiatrist and I will be in contact with you in due course regarding potential providers who could complete this assessment.
>
> Given that ACC still need to undertake the investigation outlined above, as well as the recent comments that have been raised over the nature of your rehabilitation input do you still seek ACC funding for treatment with Gil Newburn?

[64] On 3 April 2019, Dr John Vickers, Psychiatrist, provided a report following completion of a psychiatric assessment of GG, as requested by the Corporation:

> I note Dr Finucane's diagnoses of major depressive disorder, mild neurocognitive disorder, somatic symptom disorder and personality change due to TBI but these diagnoses are not related to the sexual abuse. …
>
> [GG] has a history of the childhood sexual abuse which continues to trouble her to the present day with residual PTSD symptoms …
>
> I consider [GG] to have enough core symptoms of PTSD to make the diagnosis as noted in section 20 above.
>
> She had sexual abuse counselling with Katrina Allison many years ago and said that she got on with life thereafter. She did not express an interest in pursuing this form of treatment again and I do not believe there to be an indication for sexual abuse counselling at present.

[65] On 29 April 2019, Ms Jane Lennan, Clinical Psychologist, provided comment regarding GG's diagnosis relating to her sensitive claim and whether any treatment was required in respect of that injury:

> I believe [GG] reaches clinical criteria for the diagnosis of PTSD to be considered a MISCA mental injury and a consequence of sexual abuse…
>
> She does not have a personality disorder relevant to this claim. Regarding your query re whether ongoing treatment should be funded with Dr Newburn. I believe this has already been answered by Dr Macniven's previous PA comment re whether treatment with Dr Newburn is clinically indicated. I support his conclusion that this is not indicated.

[66] On 1 May 2019, the Corporation issued a decision stating that it considered that the treatment being offered by Dr Newburn was not necessary or appropriate treatment for GG's covered injuries. GG applied for a review of this decision.

[67] On 7 August 2019, review proceedings were held. On 2 October 2019, the Reviewer dismissed the review, on the basis that the decision to decline further treatment from Dr Newburn in relation to GG's covered injury was correct.

[68] On 12 November 2019, a Notice of Appeal was lodged.

[69] On 8 July 2021, Dr Newburn again commented on GG's case:

> There is no evidence whatsoever for iatrogenesis or somatic symptom disorder. There is clear evidence for ongoing features, albeit attenuated, of post-traumatic

> stress disorder, a mild neurocognitive disorder consequent on traumatic brain injury, and a personality change due to a general medical condition, traumatic brain injury.
>
> These also subsume a range of other issues, including her secondary attentional deficit disorder, the impulse control disorder, the difficulty in emotional containment, and other responses, including hypomanic symptoms, in response to sleep deprivation, in itself a direct consequence of traumatic brain injury.

[70] On 22 July 2001, GG asked the Corporation to confirm if the Corporation had complained to the New Zealand Medical Council about Dr Newburn, that the Council had been unable to find a panel of experts to assess Dr Newburn's practice/practises in New Zealand, that a panel of experts was sent from Australia to assess his practice/practises, and the panel were unable to fault Dr Newburn's practice/practises.

[71] On 2 September 2021, the Corporation confirmed the above. The Council added that the New Zealand Medical Council had advised Dr Newburn that he met the required standard of competence for a doctor registered and working within a vocational scope of psychiatry and that no further action was required. The Council further stated that the performance assessment was a broad-based assessment that assessed a wide range of a doctor's practice of medicine, not specific concerns raised by notifiers.

[72] On 20 September 2021, Dr Macniven, commented on whether he considered Dr Newburn's report of August July 2021 adequately addressed the issues regarding the appropriateness of ongoing treatment. Dr Macniven stated:

> Dr Newburn's recent report does not appear to provide any further clinical rationale as to why ACC should have funded further treatment by Dr Newburn for [GG's] 1998 concussion in 2018.

Relevant law

[73] Section 67 of the Accident Compensation Act 2001 ("the Act") sets out the circumstances in which a person is eligible to receive entitlements:

> A claimant who has suffered a personal injury is entitled to 1 or more entitlements if he or she -
>
> (a) Has cover for the personal injury; and

(b) Is eligible under this Act for the entitlement or entitlements in respect of the personal injury.

[74] Clause 1 of Schedule 1 of the Act provides:

Corporation's liability to pay or contribute to cost of treatment

(1) The Corporation is liable to pay or contribute to the cost of the claimant's treatment for personal injury for which the claimant has cover if clause 2 applies,—

(a) to the extent required or permitted under an agreement or contract with any person for the provision of treatment; or

(b) if no such agreement or contract applies, to the extent required or permitted by regulations made under this Act; or

(c) if paragraphs (a) and (b) do not apply, the cost of the treatment.

(2) In subclause (1)(c), cost means the cost—

(a) that is appropriate in the circumstances; and

(b) as agreed by the Corporation and the treatment provider.

[75] Clause 2(1) of Schedule 1 of the Act provides that the Corporation is liable to pay the costs of a claimant's treatment if the treatment is, *inter alia*, for the purpose of restoring the claimant's health to the maximum extent practicable; necessary and appropriate treatment of the applicant's injury related condition; and of the quality required for that purpose.

[76] Clause (2) of Schedule 1 of the Act provides:

When Corporation is liable to pay cost of treatment

(1) The Corporation is liable to pay the cost of the claimant's treatment if the treatment is for the purpose of restoring the claimant's health to the maximum extent practicable, and the treatment—

(a) is necessary and appropriate, and of the quality required, for that purpose; and

(b) has been, or will be, performed only on the number of occasions necessary for that purpose; and

(c) has been, or will be, given at a time or place appropriate for that purpose; and

(d) is of a type normally provided by a treatment provider; and

(e) is provided by a treatment provider of a type who is qualified to provide that treatment and who normally provides that treatment; and

(f) has been provided after the Corporation has agreed to the treatment, unless clause 4(2) applies.

(2) In deciding whether subclause (1)(a) to (e) applies to the claimant's treatment, the Corporation must take into account—

(a) the nature and severity of the injury; and

(b) the generally accepted means of treatment for such an injury in New Zealand; and

(c) the other options available in New Zealand for the treatment of such an injury; and

(d) the cost in New Zealand of the generally accepted means of treatment and of the other options, compared with the benefit that the claimant is likely to receive from the treatment.

[77] In *Gazzard*,[1] Judge Beattie stated:

> [28] It is a basic principle of the Act that a claimant only has a right to a statutory entitlement when that claimant can establish that entitlement arises as a consequence of the personal injury by accident for which cover was granted. ... The incapacity must be caused by or as a consequence of the personal injury by accident. In other words there must be a direct causal nexus between the injury which was suffered in the accident and the physical condition which is causing the incapacity at the time when that enquiry is being made.

[78] In *Gurney*,[2] Judge Beattie stated:

> [18] The key issue is whether the proposed surgery could be said to be necessary and appropriate, and in that regard Clause 2(2)(c) requires consideration of other options available for the treatment of the particular injury concerned. Finally, there is the cost/benefit consideration as contained in Clause 2(2)(b).
>
> …
>
> [21] In the final analysis, I find that whilst it is accepted as being the appellant's personal desire to have the surgical option and which he desired for his own personal reasons, on an objective assessment of necessity and appropriateness, cost and benefit, I find that the surgical option cannot be shown to be one that should be the respondent's statutory liability to pay.

[79] In *Raddock*,[3] Judge Henare stated:

> [67] Under the Accident Compensation scheme, the function of the Corporation is to determine cover and to provide entitlements to the extent claimants have

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1 *Gazzard v Accident Compensation Corporation* [2001] NZACC 313.

2 *Gurney v Accident Compensation Corporation* [2009] NZACC 179. See also *Wilson v Accident Compensation Corporation* [2016] NZACC 239, at [46] ("the mere fact Ms Wilson wished to proceed with the surgery cannot be determinative where the Corporation is being asked to fund that surgery").

3 *Raddock v Accident Compensation Corporation* [2019] NZACC 69.

> cover and in accordance with the Act. The costs to which the Corporation becomes liable are not at large. The extent to which the Corporation becomes liable is closely prescribed by clause 2(1). …
>
> [68] Clearly, the fact that Mr Raddock wishes to use Sativex, no matter it has provided pain relief for him, is not determinative. The Corporation is liable to pay for treatment only if the treatment is necessary and appropriate, having regard to the factors in clause 2.

Discussion

[80] As noted above, in June 1977, GG sustained a head injury when she fell off a horse, and in 1992 she was granted cover for "Fracture; Head (except face)". She was seen by Dr Gil Newburn, Neurologist, on several occasions. In April 1998, GG hit her head on an air conditioning unit and fell, resulting in a traumatic brain injury, and was granted cover for a "Post-traumatic brain syndrome Head (except Face)". From July 1998, Dr Newburn continued to see GG and provided reports on her condition. In July 2018, GG asked the Corporation for funding for an appointment with Dr Newburn. In May 2019, the Corporation issued a decision stating that it considered that the treatment being offered by Dr Newburn was not necessary or appropriate treatment for GG's covered injuries. The issue in this case is whether the Corporation's decision of May 2019, declining to fund further treatment from Dr Newburn, was correct.

[81] For GG to be entitled to treatment from Dr Newburn, she must establish, on the balance of probabilities, that her treatment is required in relation to a covered personal injury.[4] GG must therefore establish that her treatment arises as a consequence of (is directly caused by) her covered personal injury by accident.[5] GG must also establish, on the balance of probabilities, that her treatment is necessary and appropriate and of the quality required for that purpose.[6] Whilst it is accepted as being GG's personal wish to have the treatment in question, there needs to be an objective assessment of necessity and appropriateness, cost and benefit.[7]

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4 Clauses 1 of Schedule 1 of the Act.
5 See n1 *Gazzard.*
6 Clause 2(1) of Schedule 1 of the Act.
7 See n2 *Gurney*.

[82] GG submits as follows:

- The external medical multi-disciplinary panel, in its report dated 16 December 2016, was unable to substantiate its criticisms and concerns about Dr Newburn's treatment. The panel, who did not meet GG, ignored key evidence, and its report was based on incomplete, inaccurate information. The criticisms of the panel against Dr Newburn were petty, and in keeping with the Corporation's irrational dislike of/prejudice against Dr Newburn.

- The evidence provided in support of the Corporation's decision, notably, that of Dr Finucane and the Corporation's psychological advisors, failed to substantiate a replacement diagnosis of somatization symptom disorder, and were unable to draw a valid inference based on facts supported by evidence and not on the basis of supposition and conjecture. The reports of Dr Hegarty and Dr Macniven were flawed and discounted/minimised relevant information.

- Information obtained under the Official Information Act (noted above) supports Dr Newburn's standing as a specialist in the field of neuropsychiatry. Dr Newburn's correct advice is that an individual with secondary bipolar disorder should have specialist oversight for the remainder of their life, and that failure to provide such oversight reflects an acceptance of a lower standard of care than that which is expected to be practiced in any modern environment. GG needs Dr Newburn's services because he understands her condition, and she needs ongoing access to methylphenidate.

- GG's history, and the great gains made in neuropsychological tests, are in favour of quashing the Corporation's decision to cease funding of treatment with Dr Newburn.

[83] This Court acknowledges GG's submissions above. The Court also acknowledges Dr Newburn's reports, which include the following:

- In July 1998, Dr Newburn noted that GG had suffered a "severe brain injury" in the past and that he had begun treatment with methylphenidate.

- In June 2003, Dr Newburn noted that the specific reasons for the incapacity were the depressive phase of bipolar disorder, against a background of brain injury and sexual abuse, with significant anxiety about engaging in any process or activity over which she did not have complete control.

- In March 2007, Dr Newburn applied to Pharmac for methylphenidate for Attention Deficit Hyperactivity Disorder ("ADHD").

- In September 2010, Dr Newburn diagnosed the development of affective disorder, with some features of bi-polar disorder, which, he believed, occurred as a consequence of traumatic brain injury. He stated that GG was suffering from increased depression requiring more medication (being the use of venlafaxine and the continuation of methylphenidate).

- In April 2016, Dr Newburn made a request for funding for melatonin for GG.

- As recently as July 2021, Dr Newburn advised that there was clear evidence for GG's ongoing features, albeit attenuated, of post-traumatic stress disorder, a mild neurocognitive disorder consequent on traumatic brain injury, and a personality change due to a general medical condition, traumatic brain injury. These also subsumed a range of other issues, including her secondary attentional deficit disorder, the impulse control disorder, the difficulty in emotional containment, and other responses, including hypomanic symptoms, in response to sleep deprivation, in itself a direct consequence of traumatic brain injury.

[84] However, as opposed to Dr Newburn's reports, this Court notes, in particular, the following medical evidence. This evidence formed the basis on which the Corporation's psychology advisors (Dr Dowling, Dr Macniven and Ms Lennan) presented their advice leading to the Corporation's decision of May 2019.

[85] First, there is the December 2016 report of the external medical multi-disciplinary panel comprising an Occupational Medicine Specialist, a Neurologist, a Specialist Physician and Psychiatrist, and an Orthopaedic Surgeon. The panel advised that GG's current distress was not related to injury to the brain as an organ. The Panel assessed that GG's profound disabling symptoms were most likely related to her underlying maladaptive coping mechanisms and her post-brain injury health care experiences which she may have experienced as challenging and invalidating; and that her significant symptoms did not in any way confirm that they were caused by the event of 1998, as it related to anatomic/structural impact on her brain. The Panel also expressed reservations about Dr Newburn's role in relation to GG, noting that he had acted as her assessing clinician and treating physician, providing diagnoses that had not been made by other clinicians. This Court recognises the expertise of the members of the Panel, and notes that its findings were based on GG's medical history, symptoms and examination findings as documented in the extensive records and reports reviewed. While the Panel did not have the opportunity to interview or examine GG, its views are entitled to some weight.

[86] Second, there is the November 2017 report of Dr Hegarty, Clinical Psychologist, following his examination of GG over two days for a period of eight-and-a-half hours. Dr Hegarty assessed that, given GG's history, medical reports, and performances on a range of neuropsychological measures, there was no current evidence to suggest a general impairment of cognition as a result of her 1998 injury. Dr Hegarty did not accept that there was evidence to support Dr Newburn's diagnosis of the development of a bi-polar disorder due to a mild to moderate brain injury. This Court notes Dr Hegarty's credentials, and his thorough assessment of GG in person and relevant information and finds that Dr Hegarty's opinion is entitled to be given weight.

[87] Third, there are the April, June and August 2018 reports of Dr Finucane, Psychiatrist, who had seen GG as early as November 2004. This Court finds that Dr Finucane's views are entitled to be given weight, in view of his qualifications and in-depth knowledge of GG's condition, and that they were not based on supposition and conjecture:

- Dr Finucane's April 2018 report followed a ninety-minute evaluation of GG and also an assessment of her previous history and examination and subsequent information. Dr Finucane assessed that causality of GG's condition was difficult to untangle, given that the index injury was mild and she was functional prior to the injury, and that the best that could be said was that her condition was multifactorial in nature. Dr Finucane further assessed that GG's engagement with clinicians who shared her view that the sole cause of her symptoms was the index traumatic brain injury, could not be recommended, since no progress would then be made on remediable aspects, due to the time that had elapsed since the injury.

- Dr Finucane's June 2018 report followed the receipt of further information and comment submitted by GG following the April 2018 report. Dr Finucane advised that there was a Somatic Symptom Disorder present, whether or not there were residual symptoms from the mild traumatic brain injury (TBI), given that the overall magnitude of GG's symptoms was not explicable on the basis of the mild TBI alone.

- Dr Finucane's August 2018 report followed a request for answers to questions put by the Corporation. Dr Finucane advised that the 1977 and 1998 injuries could be seen as risk factors for, but not substantive causes of, the Somatic Symptom Disorder. In particular, Dr Finucane noted that the 1998 injury was a precipitating factor for the Somatic Symptom Disorder, and provided a symptom focus around which the disorder could develop, but advised that this disorder was essentially a stress-related condition with no direct causal link to brain injury.

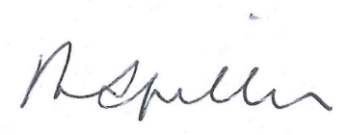
[88] Fourth, there is the April 2019 report by Dr John Vickers, Psychiatrist, following a 75-minute consultation with GG and the extensive medical documentation provided to date. Dr Vickers concluded that GG had a history of childhood sexual abuse with residual PTSD symptoms, but she did not express an interest in pursuing sexual abuse counselling again, and Dr Vickers did not believe there to be an indication for sexual abuse counselling at present.

Conclusion

[89] In light of the above considerations, the Court finds that GG has not established, on the balance of probabilities, that her treatment from Dr Newburn was required in relation to a covered personal injury, or that her treatment was necessary and appropriate and of the quality required for that purpose.

[90] This Court therefore finds that the Corporation's decision dated 1 May 2019, declining to fund further treatment from Dr Newburn, was correct. The decision of the Reviewer dated 2 October 2019 is upheld. This appeal is dismissed.

[91] I make no order as to costs.



P R Spiller
District Court Judge

Solicitors for the Respondent: Ford Sumner.