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 004 ACR 197/20

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

Hearing: 13 December 2021
Held at: Auckland/Tāmaki Makaurau

Appearances: B Hinchcliff for the appellant
F Becroft for the Accident Compensation Corporation

Judgment: 18 January 2022

RESERVED JUDGMENT OF JUDGE P R SPILLER
[Claim for mental injury caused by physical injury – s 26(1)(c) Accident Compensation Act 2001]

Introduction

[1] This is an appeal from the decision of a Reviewer dated 14 September 2020. The Reviewer dismissed an application for review of the Corporation's decision of 6 May 2020, declining the appellant's claim for mental injury caused by treatment.

Background

[2] The appellant was born in 1975.

[3] On 8 October 2003, the appellant had an emergency caesarean section. The procedure was performed by Dr Raj Kumar. During the operation, an epidural needle was inserted three times into the appellant's lower back. Dr James Moore and Dr Charles McFarlan, Anaesthetists, reported that there was temporary paraesthesia (burning or prickling sensation) of the right leg and foot from the epidural spinal needle. On 9 October 2003, Dr Kumar recorded:

> Routine Lower segment Caesarean section was carried out. Baby and placenta were easily delivered. Cord gases were done. Blood loss was about 400ml. IV antibiotic was given.

[4] On 22 July 2004, Mr Anil Sharma, Specialist Obstetrician and Gynaecologist, noted that the appellant reported having pain in the left side of her Caesarean section scar after any form of exertional exercise but had no other related symptoms. Mr Sharma reported that the Caesarean section scar was well healed, and there were no palpable masses or lump. Mr Sharma recommended re-strengthening exercises.

[5] On 29 June 2005, an ultrasound scan of the appellant's left lower abdominal wall found no solid or cystic mass in the abdominal wall in relation to the caesarean scar, the abdominal scan was within normal limits, and no cause was found for the reported pain.

[6] On 21 July 2005, Mr Sharma reported that more chronic pain was being experienced by the appellant on the left side of her caesarean section scar:

> I remain at a loss with regard to the cause of the pain and it does not really resemble the endometriosis type of pain that one can get after endometriosis enters the surgical scar. At the current time I do not feel that she would be in anyway helped by exploration of her wound or further surgery.

[7] On 12 December 2005, Dr Falah EI-Haddawi, Surgical Registrar, reported left iliac fossa pain of about two years' duration following a caesarean section. He found that the wound of the caesarean section looked very clean and healthy with no

evidence of hernia. He suggested that the diagnosis could be a neuroma or a completely incidental finding.

[8] On 20 January 2006, a treatment injury claim was made by the appellant, in relation to her caesarean operation. Dr Ellen Skelton, GP, noted:

> Patient had caesarean section … on 8/10/03. Prolonged period before epidural in place. During surgery apparently large blood loss, with an episode where surgeon spattered assistants with blood. Immediately after surgery started complaining of left sided lower abdominal pain. Was kept in hospital for 9 days. Since then has seen numerous GPs and specialists and is currently being investigated for chronic pain. Baby was born with hepiplegia unsure if intellectually challenged at this stage.

[9] On 11 April 2006, a treatment injury advice form was completed by Dr Pravin Nahar, Obstetrician & Gynaecologist. He concluded, in light of the medical information available, that there was no identifiable physical injury due to the treatment provided in the caesarean operation.

[10] On 11 April 2006, the appellant's treatment injury claim was declined by the Corporation, on the basis that it did not accept pain in itself, with no known cause, to be a physical injury. The appellant lodged a review application.

[11] On 16 October 2006, Dr Jane Creighton, Surgical Registrar, noted that the pain the appellant described was in the left iliac fossa, being radicular in nature, extending from the iliac spine to the area of her C-section scar. Dr Creighton also noted a fairly complex social situation, in that the appellant was sole carer for her disabled three-year-old son who had epilepsy, she had problems with her diet, and she was unable to work. Dr Creighton referred the appellant to Pain Management Services and did not think that there was anything that could be surgically remedied.

[12] On 10 July 2007, Dr McFarlan, the Anaesthetist who had attended the appellant at her operation, attended and reported on the appellant. He recorded that she described constant, "destroying" pain starting in her scar and branching from it. She also referred to an aching pain in the back of the left leg which the appellant thought, broadly speaking, was in the same area where she had had some discomfort during the attempted epidural. Dr McFarlan advised:

> I came on initially when one of my colleagues was unable to get the spinal in and [the appellant] was becoming very distressed with the paresthesia and I did a spinal with no obvious paresthesia and we went on to do the caesarean section. … The time of the birth, in many ways, this is where [the appellant]'s problems began.

[13] Dr McFarlan noted that the appellant had a small lump over the left lateral end of her caesarean scar, which he thought was part of the scar complex and not a neuroma. He advised that the appellant's left leg pain could be related to radicular problems from the spinal anaesthesia but noted that there was no neurological evidence to support that. He thought that the stiffness present around the hip would fit with piriformis syndrome, and he suspected that this was the actual cause of the problem. He also noted that "there is obviously also a very large element of distress and psychosocial problems in the appellant's life".

[14] On 29 May 2008, Professor Cindy Farquhar, Professor of Gynaecology, reported that "no obvious injury seems to have occurred at the time of the surgery". However, Professor Farquhar accepted that the appellant had been left with a pain syndrome that had changed her ability to function and was affecting her on a daily basis, and which was not present prior to the pregnancy and delivery. Professor Farquhar noted two possibilities for the pain: that this was secondary to adhesions formed following the caesarean section or that the pain was from a neuroma. Professor Farquhar added that, as to the more likely diagnosis of adhesions, this injury was an infrequent consequence of the procedure of caesarean section.

[15] On 13 June 2008, Dr Christopher Moughan, Medical Adviser of the Treatment Injury Unit, advised that formation of adhesions was regarded as an ordinary body response to surgery properly applied, occurring in 93% to 100% of patients. As to neuroma, this appeared as a possible but not probable diagnosis that was difficult to confirm reliably.

[16] On 24 February 2009, a note from Dr Illy Delasau, Surgical Registrar, advised that "there is a lot of social and history [sic] surrounding the pain". Dr Delasau noted that the appellant's CT colonography, the MRI of her spine, the ultrasound, and the MRI of her abdomen and barium enema were all unremarkable.

[17] On 6 November 2009, Dr Moughan advised:

> Although possible injuries as cause of pain have been raised, further exploration was required to arrive at the probable cause. Following further exploration in the form of EUA caesarean scar and diagnostic laparoscopy on 30/7/2009 by Mr Hammodal, a definitive cause for [the appellant]'s ongoing pain does not appear to have been found.

[18] On 15 April 2010, a review of the Corporation's decision of 11 April 2006 was dismissed by the Reviewer. The Reviewer found that the appellant had failed to provide sufficient evidence to meet the criteria for a treatment injury. A lengthy period then ensued without further medical records.

[19] On 5 December 2015, Mr Antony Field, Orthopaedic Spine Surgeon, reported that the appellant had been admitted under orthopaedics with a further exacerbation of her long-standing back pain. Mr Field noted that the appellant described a number of unusual symptoms which were hard to reconcile with the clinical picture. Mr Field reassured the appellant that there was no evidence of an acute orthopaedic surgical problem.

[20] During 2016, the appellant was treated at the Auckland Regional Pain Service for her chronic pain.

[21] On 18 April 2016, Dr Wei Chung Tong, Pain Specialist, reported that the appellant's main problem at that stage was back pain following the caesarean section. He advised that she was traumatised by the anaesthesia inserted by a trainee. He noted that the appellant believed that her back, colon, and ovaries had been damaged. Dr Tong also noted that the appellant was financially stressed, was on a solo parent disabled and disability allowance, was the single parent of a disabled child with autism, and had recently been diagnosed with depression.

[22] On 9 September 2016, a further note from Mr Brett Donaldson, Senior Physiotherapist, referred to persisting widespread pain.

[23] On 19 September 2016, Mr Field noted that he found it hard to ascribe the appellant's symptoms to a spinal lesion and considered it very likely that she had a

form of chronic pain disorder. Subsequent scans ruled out any structural abnormality.

[24] On 9 November 2016, Mr Field reported that he believed that the appellant was suffering from central neuro-sensitisation syndrome with a 13-year history of pain but with no evidence of any surgically treatable lesion.

[25] On 29 June 2018, a treatment injury claim was filed for the appellant's mental injury as a result of two unsuccessful epidural insertions on 8 October 2003. The claim form indicated that there had been foetal distress, leading to an emergency caesarean with two failed epidural attempts. The form noted that the appellant had suffered long-term back pain, headaches, hypersensitivity, and numbness in her left foot, leading to a mental injury, and that she first sought or received treatment for the injury immediately after birth. The form also noted that the appellant had had no underlying health problems prior to the event.

[26] The appellant's claim was accompanied by a letter from her GP, Dr Sally McLaren, also dated 29 June 2018, which read:

> This lady has requested, on the advice of her lawyer, that we lodge another claim for treatment injury caused by her failed epidural in 2003. She says she has a mental injury caused by her chronic pain which she believes resulted in a failed epidural attempt on 8/10/03 before a caesarean.

[27] The Corporation began assessing the claim, collating the necessary medical records. The Corporation noted a related claim which was a declined treatment injury claim around the same procedure, for pain in the lumbar spine, arachnoiditis, an L3/4 central annular tear and an L4/5 central disc bulge. That claim was declined on the basis that there was no evidence of any physical injury caused by treatment over and above the necessary insertion of the epidural canular.

[28] The medical notes subsequently received included the original caesarean section operation note and subsequent reporting from Waitemata District Health Board, which confirmed a history of pain following the surgery, as well as various investigations to uncover the source of the pain, but to no avail; and that, by 2005, the working diagnosis was chronic pain syndrome.

[29] The Corporation attempted without success to contact the appellant, in order to facilitate an appointment with a psychiatrist, to establish a formal mental injury diagnosis. On 29 March 2019, a decline decision was issued, on the basis that, at that stage, there was insufficient information on file to establish the diagnosis of a mental injury.

[30] On 8 April 2019, the appellant applied for a review of the Corporation's decision. She subsequently agreed to undergo psychiatric assessment.

[31] On 5 March 2020, Dr Nosheen Sheikh, Consultant Psychiatrist, completed a psychiatric assessment. Dr Sheikh noted that prior to 8 October 2003 the appellant was an active person working fulltime; however, since the surgery, she had struggled to cope physically, socially, emotionally, mentally, and financially. Dr Sheikh listed physical problems (centring around pain) and various psychological issues. She also noted that the appellant's only child was born with cerebral palsy, epilepsy and left-sided hemiplegia, and required full-time care. Dr Sheikh noted that the birth experience itself was traumatic, starting with problems in the pregnancy, preeclampsia, a difficult labour, a failed epidural insertion, foetal distress, and an emergency caesarean section. This was followed by the shock of having a child with disabilities. Dr Sheikh advised: "In short; her life, circumstances and attitude all changed after 2003 and she has never felt the same since".

[32] Dr Sheikh diagnosed post-traumatic stress disorder (PTSD) and adjustment disorder with a differential diagnosis of major depressive disorder and chronic pain syndrome (physiological and psychological). In Dr Sheikh's view, the PTSD was as a result of a traumatic birthing experience, and the PTSD led to an adjustment disorder with intermittent major depressive episodes. Dr Sheikh noted:

> As there is no previous history of mental health issues, and [the appellant] suffered from mental illness after the incident of 2003, so it is most likely that trauma during delivery either because of birthing experience itself or due to epidural failures (through physiological and/or psychological pathway) caused pain and symptoms of PTSD as she felt like losing control, not being listened to, not being told the extent and consequence of procedure, not being reassured and not being supported through the whole procedure especially felt no empathy about what she went through during labour and how she felt after she received the news about her son having born with several disabilities and had to be resuscitated. So in short, the root cause of her depression/anxiety/adjustment

> disorder/PTSD symptoms is traumatic birthing experience and physical/emotional effect of epidural failure.
>
> ... a traumatic birthing experience, prolonged labour, foetal distress, failed epidural insertion, painful epidural experience, emergency caesarean section, feeling of loss of control/autonomy, neonatal distress, news of having a baby with abnormalities, having to care for a disabled baby, lack of empathy from hospital staff, premature discharge, loss of freedom and followed by other several losses could have possibly caused her mental/emotional difficulties and current mental condition/problems.

[33] On 30 March 2020, Dr Sheikh's report was reviewed by Dr Duncan Frazer, Clinical Neuropsychologist. He suggested seeking further clarification from Dr Sheikh on the cause of the appellant's mental injury.

[34] On 11 April 2020, Dr Sheikh provided a follow-up report on the appellant:

> The causation of her mental injury (PTSD and adjustment disorder and depressive episodes) is complex and multifactorial including her early experiences, pregnancy complications, peri and postpartum traumatic experiences, caring of disabled child, several losses and ongoing difficulties which she relates psychologically with the epidural failure but considering her circumstances, it is highly likely that there was mechanical effect of epidural procedure causing pain and the constant pain leading to development of mental injury. However, I don't believe that her current difficulties are directly linked to the surgical insertion for the caesarean section and/or the puncture wounds that were required for the insertion of the epidural catheter, and my opinion is based on the presence of other more significant factors which could be contributing to her mental injury, details of which can be found in my report.

[35] On 6 May 2020, the Corporation issued a revised decision, again declining cover for a treatment injury, on the basis that there was no evidence that the appellant had suffered a mental injury as a result of a physical injury suffered in treatment. A review was lodged against that decision.

[36] On 25 August 2020, review proceedings were held. On 14 September 2020, the Reviewer dismissed the review, on the basis that there was insufficient evidence to establish that the appellant had suffered a mental injury as a result of a physical injury suffered in treatment.

[37] On 21 September 2020, a Notice of Appeal was lodged.

Relevant law

[38] Section 20(1) of the Accident Compensation Act 2001 ("the Act') provides that a person has cover for a personal injury if, *inter alia*, the personal injury is of the kind of injury described in section 26(1)(c) and the personal injury is described in section 20(2).

[39] Section 26(1)(c) provides that personal injury means mental injury suffered by a person because of physical injuries suffered by the person. Section 27 defines "mental injury" as "a clinically significant behavioural, cognitive, or psychological dysfunction".

[40] Section 20(2)(b) of the Accident Compensation Act 2001 ("the Act') provides that a person is entitled to cover for personal injury that is a treatment injury suffered by the person.

[41] Section 32(1) of the Act provides that treatment injury means personal injury that is—

> (a) suffered by a person—
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> > (i) seeking treatment from 1 or more registered health professionals; or
> >
> > (ii) receiving treatment from, or at the direction of, 1 or more registered health professionals; or
> >
> > (iii) referred to in subsection (7); and
>
> (b) caused by treatment; and
>
> (c) not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment, including—
>
> > (i) the person's underlying health condition at the time of the treatment; and
> >
> > (ii) the clinical knowledge at the time of the treatment.

[42] In *Accident Compensation Corporation v Monk*, Miller J stated on behalf of the Court of Appeal:[1]

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[1] *Accident Compensation Corporation v Monk* [2012] NZCA 615, [2013] NZAR 1.

> [18] … the legislation does not define "physical injury". However, the term has been defined judicially as bodily harm or damage having some appreciable and not wholly transitory impact on the person. So the ordinary meaning of the statutory language is that any such physical injury suffices for the purposes of s 26(1)(c). …
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> [30] A mental injury may be covered under s 26(1)(c) of the 2001 Act only if it results from a physical injury, and the mental injury must further result from an accident or qualify as a treatment injury. Like Mallon J, we are not persuaded that the ordinary meaning of the statutory language or the object of the legislation further requires that the physical injury be defined as a physical injury that is itself covered.
>
> [31] … Where a person suffers mental injury because of physical injury, and the physical injury is a necessary part or ordinary consequence of treatment received by that person, the mental injury is a personal injury for which there is cover under s 20 of the Accident Compensation Act 2001.

[43] In *Accident Compensation Corporation v Ambros*, the Court of Appeal envisaged the Court taking, if necessary, a robust and generous view of the evidence as to causation:[2]

> [67] The different methodology used under the legal method means that a court's assessment of causation can differ from the expert opinion and courts can infer causation in circumstances where the experts cannot. This has allowed the Court to draw robust inferences of causation in some cases of uncertainty (see para [32] above). However, a court may only draw a valid inference based on facts supported by the evidence and not on the basis of supposition or conjecture. …
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> [70] Finally on this topic, we note that the generous and unniggardly approach advocated in *Harrild v Director of Proceedings* [2003] 3 NZLR 289 (CA) at para [19] per Elias CJ, at para [39] per Keith J and at para [130] per McGrath J was used by the High Court in this case to modify the causation test. This, in our opinion, is not an appropriate application of the principle, given the plain words of the 1998 Act and the rejection of the increased risk test in *Atkinson*. The generous and unniggardly approach referred to in *Harrild* may, however, support the drawing of "robust" inferences in individual cases. It must, however, always be borne in mind that there must be sufficient material pointing to proof of causation on the balance of probabilities for a court to draw even a robust inference on causation. Risk of causation does not suffice.

[44] In *Hornby v Accident Compensation Corporation*, the Court of Appeal accepted that three possible situations might arise under section 26(1)(c):[3]

> [34] … First, mental injury arising out of an accident and resultant physical injuries. Secondly, a pre-existing mental condition may be aggravated somehow, solely because of the physical injuries. Thirdly, the physical injuries

[2] *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.
[3] *Hornby v Accident Compensation Corporation* [2009] NZCA 576.

> may have been a contributing cause, although not the only contributing factor to, the resurgence of a prior mental affliction.

[45] In *W v Accident Compensation Corporation,* Collins J, in discussing the proper ambit and meaning of "because of" in section 26(l)(c) of the Act, stated:[4]

> [57] The issue as to whether a mental injury is suffered because of a physical injury is predominantly a question of fact, the answer to which will hinge upon how the evidence, including expert evidence, is interpreted and what inferences the decision-maker can reasonably draw. …
>
> [62] As noted by the Court of Appeal in *Ambros*, the "but for" test is a useful first step in determining whether or not a claimant has cover under the scheme. In the context of a claim under s 26(1)(c) of the Act, the "but for" test asks whether the claimant would have suffered his or her mental injuries without (or "but for") also having suffered his or her physical injuries. If the answer to that question is yes, then there is no factual connection between the claimant's physical and mental injuries and therefore no scope for cover under s 26(1)(c) of the Act. The majority of cases in which cover is denied under s 26(1)(c) fail to satisfy this test. The "but for" test is a useful screen for declining claims that clearly do not qualify for cover under s 26(1)(c) of the Act. …
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> [65] The present case illustrates how, in complex cases, there may be multiple contributing causes to a claimant's mental injury. In such cases it may be helpful to assess the extent to which a claimant's mental injury has been suffered because of their physical injuries. The physical injuries do not have to be the sole cause of the mental injury. It is sufficient that the physical injury materially contributes to causing the mental injury. This means that to satisfy s 26(1)(c) of the Act, the physical injury must be a cause of the mental injury in some genuine or meaningful way, rather than just in a trivial or minor way.

[46] In *Waipouri v Accident Compensation Corporation,* the claimant's underwent treatment during which a lumbar nerve was struck by the lumbar puncture needle. Mathers DCJ allowed the appeal and stated:[5]

> [35] In the end I am struck by the number of "possibles" and "probables" in the various reports. It seems to me that the Corporation and the Reviewer have taken a very technical view as to whether the nerve damage was causative of the ongoing suffering of Ms Waipouri.
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> [36] In cases such as this I may give preference to the treating specialist. I may also draw inferences, even robust ones, but only on facts supported by the evidence. I may also take account of "... lay, medical and statistical evidence." The Court of Appeal has cautioned against a niggardly approach and Miller J in *Cochrane v ACC* has cautioned against too much focus upon the required onus.

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[4] *W v Accident Compensation Corporation* [2018] NZHC 937, [2018] 3 NZLR 859.
[5] *Waipouri v Accident Compensation Corporation* [2017] NZACC 36.

[47] In *PN v Accident Compensation Corporation*, the claimant said she had suffered an acute reaction to stress following a gynaecological surgery and claimed mental injury in relation to treatment.[6] Judge Mathers allowed the appeal and stated:

> [51] From a common sense perspective, and viewing matters as per the Court of Appeal in *Ambros*, I am able to make a robust inference as to the cause of a condition where there is sufficient evidence to do so, but cannot do so on supposition or conjecture. I am also cautioned not to be niggardly and should not be overwhelmed by the onus of proof. I consider that there is sufficient evidence to do so.
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> [52] It seems to me therefore that the appellant had surgery, was placed in the lithotomy position and suffered an incision. The position in which a patient is put can cause resultant pain, either short term or persistent. The appellant has suffered persistent and continuing pain. Continuing pain can cause depression or mental disorder. A nerve injury may exist. Then there is the strong temporal link which is not conclusive in itself.
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> [53] So standing back, and taking a robust view of the facts, including all the various reports and their various assumptions and diagnoses, I am satisfied on the balance of probabilities that the appellant has a mental injury, being a Functional Neurological Disorder resulting from surgery, and being in the lithotomy position in which the appellant was placed, and involving bodily harm, being the surgery itself and/or leading to nerve damage. This constitutes a treatment injury.
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> [54] I therefore find that the Reviewer was wrong to decline the claim. I find that the appellant's mental injury was suffered as a result of physical injury and is covered as a treatment injury.

Discussion

[48] The issue in this case is whether the Corporation was correct to decline the appellant cover for mental injuries under a treatment injury claim.

[49] Personal injury includes mental injury if it is suffered by a person because of physical injury suffered by the person.[7] Mental injury means a clinically significant behavioural, cognitive, or psychological dysfunction.[8] Physical injury is bodily harm or damage having some appreciable and not wholly transitory impact on the person.[9] Physical injury includes injury that is a necessary part or ordinary consequence of medical treatment received by a person.[10] It is not necessary that the

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[6] *PN v Accident Compensation Corporation* [2020] NZACC 102.
[7] Section 26(1)(c).
[8] Section 27.
[9] *Accident Compensation Corporation v Monk*, above n 1, at [18].
[10] At [31].

physical injury giving rise to the mental injury be itself covered.[11] The physical injury does not have to be the sole cause of the mental injury: it is sufficient that the physical injury materially contributes to causing the mental injury. The physical injury must be a cause of the mental injury in some genuine or meaningful way, rather than just in a trivial or minor way.[12] The Court can, if supported by the evidence, draw robust inferences of causation in some cases of uncertainty, and a generous and "unniggardly" approach may support the drawing of such robust inferences.[13]

[50] The Corporation submits that the appellant's claim fails because there is no identified physical injury suffered in treatment that has gone on to cause the mental injury. The Corporation accepts that the epidural procedure itself necessarily resulted in an injury at the epidural insertion point but submits that the mental injuries claimed did not arise from that particular physical injury.

[51] The Court makes the following findings.

[52] First, the appellant suffered physical injury, in the sense of appreciable bodily harm, as a consequence of medical treatment in the course of her emergency caesarean section on 8 October 2003. The Court notes, in particular, that during the operation an epidural needle was inserted three times into the appellant's lower back. Dr Moore and Dr McFarlan, Anaesthetists, reported that there was temporary paraesthesia of the right leg and foot from the epidural spinal needle. Dr McFarlan recalled that he came to the operation when one of his colleagues was unable to insert the spinal and the appellant was becoming very distressed with the paraesthesia.

[53] Second, the appellant has continued to suffer a mental injury, being a clinically significant psychological dysfunction. Dr Sheikh, Consultant Psychiatrist, has diagnosed that the appellant has post-traumatic stress disorder (PTSD), adjustment

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[11] At [30].
[12] *W v Accident Compensation Corporation*, above n 4, at [65].
[13] *Accident Compensation Corporation v Ambros*, above n 2, at [67] and [70]; *Waipouri v Accident Compensation Corporation*, above n 5, at [36]; and *PN v Accident Compensation Corporation*, above n 6, at [51].

disorder with a differential diagnosis of major depressive disorder, and chronic pain syndrome (physiological and psychological).

[54] Third, the appellant's physical injury was a genuine, meaningful cause of her mental injury. This finding is made in light of the following evidence:

(a) Dr McFarlan, the appellant's treating Anaesthetist, commented that the time of the birth was, in many ways, where the appellant's problems began.

(b) Professor Cindy Farquhar, Professor of Gynaecology, reported that, following the appellant's caesarean surgery, she was left with a pain syndrome that changed her ability to function and affected her on a daily basis, and which was not present prior to the pregnancy and delivery.

(c) Dr Wei Chung Tong, Pain Specialist, noted that the appellant's caesarean operation was a stressful and traumatic experience and that she was traumatised by the anaesthesia where she had a difficult epidural insertion by a trainee.

(d) Dr Sheikh, Consultant Psychiatrist, advised, in her initial report, that the appellant's PTSD arose as a result of a traumatic birthing experience, including the failed epidural insertion and painful epidural experience, and that the PTSD led to an adjustment disorder with intermittent major depressive episodes. Dr Sheikh noted that the appellant had, prior to the caesarean operation, no history of mental health issues and that she suffered from mental illness after the incident of 2003. Dr Sheikh found it most likely that trauma during delivery, either because of the birthing experience itself or due to epidural failures, caused pain and symptoms of PTSD.

(e) Dr Sheikh, in her follow-up report, listed the appellant's peripartum traumatic experiences as being one of the causes of her mental injury. Dr Sheikh affirmed that it was highly likely that the mechanical effect of

the epidural procedure caused pain and that the constant pain led to the development of the appellant's mental injury.

Conclusion

[55] The Court concludes that the appellant has cover for personal injury in that she suffered mental injury because of physical injuries.

[56] For the above reason, the appeal is allowed, and the review decision of 14 September 2020 is set aside.

[57] The appellant is entitled to costs. If these cannot be agreed within one month, I shall determine the issue following the filing of memoranda.

P R Spiller
District Court Judge

Solicitors: ACC Legal Limited, Auckland, for the appellant.
Medico Law Ltd for the respondent.