

**Lisa Gill**  
Appellant

**Accident Compensation  
Corporation**  
Respondent

**Before:** D J Plunkett

**Counsel for the Appellant:** C Hollingsworth

**Counsel for the Respondent:** P McBride

**Date of Hearing** 17 March 2015

**Date of Decision:**

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**DECISION**

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**INTRODUCTION**

[1] This is an appeal by Lisa Gill against the decision of a review officer on 27 September 2012.

[2] Ms Gill suffered a serious brain injury shortly after birth, arising from meningitis. A claim for accident compensation was made many years later. The Corporation accepted coverage, not for the illness, but for the consequences of its late diagnosis and treatment. A retrospective claim was then made against the Corporation for “attendant care”, being the care that Ms Gill’s parents had provided to Lisa as a result of her severe handicap.

[3] The essential issue for me is whether Lisa’s covered injury (brain damage) required a level of care continuous enough to meet the statutory threshold for attendant care payments and, if so, whether it arose from the covered injury (the late diagnosis and treatment) or from the course that the illness would have been expected to take anyway.

## BACKGROUND

[4] Ms Lisa Gill was born on 9 November 1987. By the second day after her birth, she had developed symptoms which could have indicated meningitis. Her condition worsened and meningitis was eventually diagnosed and treated. However, Lisa had by then developed cerebral palsy and had permanent brain damage. She is now 27 years of age and has always been, and remains, incapable of looking after herself. Lisa was brought up by her parents until a few years ago, when in her early 20s she was placed in a residential unit with support on a 24-hour basis.

[5] A claim for accident compensation cover was not made until 1 August 2008, almost 21 years later after the injury. By this time, the Accident Compensation Act 2001 (“the 2001 Act”) was in force.

[6] The Corporation initially refused cover, but that decision was reversed on review in a decision dated 26 November 2010. The reviewer found that Lisa’s brain injury was covered under the 2001 Act as a “treatment injury”. It was found that the extent and consequences of her injury would have been less if diagnosis and treatment had not been delayed. The reviewer found that the consequences of the brain injury had been significantly contributed to by the delay in treatment. The reviewer noted that Drs Broadbank and Richardson found that had Lisa received appropriate treatment, there would have been a lessening in the severity of her injury by 10% to 50%.

[7] While the reviewer found that Lisa had suffered a treatment injury under the 2001 Act, it is not the full extent of the brain injury that is covered. It is only that part of the brain damage attributable to the late diagnosis and treatment that is the treatment injury covered by the 2001 Act.

[8] I note here that the ambit of the injury or coverage is determined under the 2001 Act and is not a matter before me.

[9] Once coverage was accepted under the 2001 Act, there were rights to various benefits under that Act and the now repealed Accident Compensation Act 1982 (“the 1982 Act”) which was in force when Lisa suffered her covered injury. As will be seen later, it is the rights under the 1982 Act over which this Authority has jurisdiction.

[10] Claims were accordingly made to the Corporation for historical entitlements. One of them was for attendant care, being the care provided to Lisa by her

parents. Due to her brain damage, this care was greater than that which would ordinarily be provided to a baby or young child.

[11] At this juncture, I note that I am only concerned with the care that was given to Lisa in the period following her discharge from hospital on 10 December 1987 until the repeal of the 1982 Act on 30 June 1992.

[12] In terms of the statutory criteria for attendant care, there is a requirement for constant care or attention. To look at whether this threshold for care was needed during the relevant period, I will first review the affidavit sworn by Lisa's mother, Mrs Linda Gill, on 25 October 2013, as to the care actually provided. I will then look at the medical evidence from the health practitioners who treated Lisa. This is followed by the expert reports obtained from Ms Deborah Andrews (paediatric physiotherapist) on behalf of the Corporation and then those obtained in reply from Ms Megan Powell (injury management nurse) on behalf of Lisa. Neither Ms Andrews nor Ms Powell treated Lisa at the time or subsequently.

#### *Evidence of Mrs Linda Gill*

[13] In her affidavit, Mrs Gill notes that one of the hospital paediatricians (Dr Rowley) gave her his home phone number with instructions to call him at any time, which reinforced to her the absolute uncertainty of Lisa's life. There was worry about fluid retention on the brain and they had to watch carefully for signs of stress, such as swelling to the fontanelle. A neurodevelopmental therapist also made an early visit to the home. The family were willing to work very hard to lessen the impact of the damage to Lisa's brain. They were told by the therapist that Lisa would have to be taught as much as possible over the first two to three years. The therapist would come for one hour every week and plot the following week's work in a book. This occurred until Lisa was 16 months old.

[14] They then investigated the Doman programme available at an Australian centre. So, for the following 18 months (I assume this to mean from about the age of 16 months), Lisa's parents and four volunteers would work six days every week to assist Lisa with exercises. She learned to crawl correctly, to walk and to use her eyes. Nothing just happened as each new skill required an investment of a lot of time and energy.

[15] As Lisa became mobile, locks were added to every drawer, door and gate. She had an intense need to "mouth" everything. This danger required constant monitoring. The home had to be reorganised to eliminate hazards. As Lisa had

no spatial awareness or concept of heights, even simple activities became traumatic as there were dangers and potential accidents everywhere. Lisa had an aversion to certain personal cleaning and grooming activities, as well as to dressing and undressing. There was no easy way and she never totally learned to tolerate these simple procedures which she was unable to achieve for herself. Toilet training began at the age of three years and while she mastered control of urination, she has never controlled her bowel motions.

[16] In Lisa's second or third year, the family received 28 days of respite care, which increased slightly over the years.

[17] At the age of three years, Lisa began to suffer grand mal epileptic seizures, resulting in a number of hospital stays. There were dozens of appointments with a large array of medical and health practitioners. There were hundreds of forms to fill out, with the appointments taking time and being stressful and emotional. There was worry and anxiety with the threat that something major could happen. This was with the family in the first few years. They jumped at every noise and woke to check when she did sleep.

[18] A lack of sleep was a severe issue as Lisa did not sleep normally until she was about 16 years old. She was hard to get to sleep, slept poorly and woke between 4.00 and 5.00 am practically every morning. When she grew out of a cot, they made a bed on the floor and built a fence around it. When she learned to escape, she would usually sleep with her mother, with her father sleeping in another room.

#### *Medical evidence*

[19] A report from Dr Stack, paediatric registrar, of 19 November 1987, identified Lisa's problems as group B strep. meningitis, group B strep. pneumonia, convulsions and hypotonia. Dr Stack recorded that on her second day of life, Lisa became lethargic with poor feeding and developed a fever. An infection screen identified meningitis. By this stage she had a bulging fontanelle. The course of her meningitis was complicated by the presence of convulsions which by day three were uncontrolled, despite medication. While being ventilated, there were problems with the collapse of one or other lung. She was then successfully extubated.

[20] At five days old, Lisa was very hypotonic with poor suck and gag reflex. She had very little spontaneous movement. She was receiving medication and

had no further convulsions. Her pneumonia resolved and she no longer required ventilation. She remained however very hypotonic and unresponsive.

[21] The next report is from Dr Brown, paediatric registrar (10 December 1987). The problems were identified as group B streptococcal meningitis, septicaemia, pneumonia, convulsions and communicating hydrocephalus. There was no further clinical evidence of convulsions, but an EEG on 1 December was abnormal. Lisa would be continued on medication and this would be reviewed in some months. A further follow up had been arranged in one week's time with a head ultrasound scan. She would then be seen in the unit two weeks later and again in one year. Mrs Gill had been given a head circumference chart and shown how to measure this.

[22] According to Dr Brown, Lisa had been referred to the National Acoustic Centre. The extramural visiting therapist had also been contacted and would visit Lisa at home for early intervention with physical and occupational therapy. Lisa was discharged with Phenobarbitone medication and this dose would be reviewed as she grew up. Dr Brown concluded that Lisa had suffered an extremely serious neonatal meningitis.

[23] A report from Dr Gounder, senior house surgeon at a paediatric clinic, dated 25 February 1988, stated that Lisa had been doing well for her age and the only worry was increased tone in her upper limbs. They planned to see Lisa again in the clinic in four months' time, with a head ultrasound before that. They had told Mrs Gill not to hesitate to contact them if Lisa had any problems before then. Her Phenobarb would be reduced. Lisa was active, feeding and growing well. She had not had any seizures and had been taking an interest in her surroundings.

[24] A neurodevelopmental therapist, Ms Penman, wrote a report on 4 April 1988. All of Lisa's milestones were within normal limits but there were some areas which had to be watched. She was basically a slightly hypotonic child who sometimes demonstrated a slight increase in tone down her right side. The two main areas that needed to be monitored were of expressive language, and symmetry and integration of movement, though Ms Penman felt that her progress was excellent.

[25] Ms Barton, speech language therapist, reported on 10 February 1989. She had been seeing Lisa since October 1988. Lisa was making slow progress with her pre-speech skills, but she would continue to visit her regularly at home to assist with pre-speech development.

[26] There is another report from Ms Penman dated about 22 February 1989. Lisa's language and other skills (social, motor, adaptive) showed an average age for these skills of between 6.5 and 9.3 months (Lisa's age then being 9 months). She was making satisfactory progress in all areas with the exception of her speech and language. Ms Penman commented that all of her skills had been won by very hard work from her mother.

[27] A further report from Ms Barton (8 May 1989) stated that Lisa continued to make slow progress with her communication and related cognitive skills. She would continue to see Lisa monthly at home.

[28] The next report is from Dr Dezoete, developmental psychologist (3 August 1989). He recorded that in June, Lisa's parents had taken her to the Australian Centre for Brain Injured Children and the family were now carrying out a Doman-type programme six days per week until 3.00 pm. He noted her excessive mouthing of objects. Her cognitive development was very delayed. There were gaps in development, particularly in language. Lisa's motor development was just below the average range for her chronological age. Mrs Gill and others worked daily with Lisa and her mother had noticed some gains for those efforts.

[29] There is a joint report (31 October 1989) from Ms McLean, advisor on handicapped children and Ms Barton, speech language therapist. They continued to visit Lisa at home. Her progress concerning various skills was noted. The report recorded that the neurodevelopmental therapist was no longer visiting.

[30] Dr Rowley, paediatrician, reported on 29 November 1989. He had seen Lisa at the age of two years as a follow up of her neonatal meningitis and subsequent hydrocephalus and neurodevelopmental delay. Her mother had reported that she was generally very well with good health and good weight gains. He noted that she saw Mr McKay regularly for a squint, which would be corrected when she was older. Her eyesight was satisfactory. Lisa was under Ms McLean of Special Education Services and also saw Ms Barton for speech therapy monthly.

[31] Dr Rowley noted that Mrs Gill had undertaken a programme based on the Doman method. The doctor found Lisa to be physically active and mobile. She was functioning cognitively at only about the one year level. Her understanding was improving but her speech remained nonexistent. On examination, Dr Rowley found Lisa to be a well looking child with good growth and the general examination was normal. It was clear that Lisa was going to need ongoing

neurodevelopmental input and it was appropriate to refer her to the Mangere hospital team.

[32] According to Dr Wake, paediatric registrar (17 January 1990), the diagnosis for Lisa was developmental delay and strabismus. Her past history of meningitis had been complicated by seizures requiring anticonvulsants and assisted ventilation and since that time her developmental delay had become progressively more obvious. She was a very healthy little girl who never required hospital admission and had no convulsions since the neonatal period. She was on no medication apart from some oils and cream for mildly dry skin. A speech therapist continued to visit. She was seeing Mr McKay regularly at intervals and her vision was good in both eyes though there was a variable divergent squint. Her audiology had been checked and was normal.

[33] Dr Wake noted that Lisa remained in nappies although her mother was beginning to attempt toilet training. Her greatest deficiency seemed to be in the cognitive and language areas, with few words and frequent grunting. Medical examination showed mild hypotonia, particularly of both lower limbs. Her head circumference was relatively small, but there were no other abnormalities. Mrs Gill had a well established support system and invested an enormous amount of time in Lisa.

[34] Dr Vogel, paediatrician, noted on 17 September 1990 that Lisa's problems were neonatal group B meningitis and developmental delay. Lisa had been well in herself and her mother reported she was making good progress. She continued with the therapy based on the Melbourne programme. She was enrolled at a local kindergarten, probably to start at about the age of three and a half years. At the time, Lisa was about to commence two mornings a week at a preschool. It appeared to Dr Vogel that Lisa was making good progress.

[35] Lisa was admitted to Auckland Hospital on 22 September 1990 and discharged two days later on 24 September. The discharge report is from Dr Wong, paediatric registrar (11 October 1990). The diagnosis was status epilepticus. She had been admitted to the critical care unit on 22 September following a prolonged generalised seizure lasting for between 30 and 60 minutes. She was still convulsing on admission, with poor circulation and respiration. She was incubated and ventilated.

[36] Dr Wong noted that Lisa had suffered neonatal meningitis and convulsions in the neonatal period. Following three months of Phenobarbitone, there had been

no further seizures until this time. Her other problems had been developmental delay as a result of the meningitis. Her main problem with development was speech as she only had one or two words at the age of two and a half years. Lisa had been rapidly weaned and extubated and had been given an ongoing anticonvulsant prophylaxis in the form of Phenobarbitone. She had been discharged looking her normal self. There would be a follow up through the Mangere hospital and the Phenobarbitone might be stopped if she remained seizure free.

[37] Ms Lenberg, paediatric speech therapist, reported on 4 March 1991 that she was seeing Lisa on a fortnightly basis. Lisa was making pleasing gains in the communication area and was visually more alert. She was no longer involved with the Doman programme. Her parents would contact Mrs Penman to discuss ongoing physical therapy programmes.

[38] Dr Gapes, paediatric registrar, reported on 21 March 1991. The problems were identified as status epilepticus, recurrent seizures and developmental delay secondary to neonatal meningitis. Lisa had been admitted to hospital via ambulance with a prolonged seizure during which she appeared unresponsive. On arrival she did not require further medication to control the seizure. She was observed overnight and returned to her normal usual self in the early hours of the morning. Lisa had a slight fever but was normal to examination. It was decided to recommence Lisa on Epilim. There would be a further follow up with the outpatient clinic.

[39] Dr Newman, paediatric registrar, reported on 8 October 1991. He recorded that since the last visit, Lisa had been fairly well and had no seizures since March 1991. She continued on Epilim. She was receiving speech therapy every two weeks and education at a preschool, one morning a week and day care two mornings a week with an itinerant teacher from IHC. Her eyes were being treated with exercises. Her development appeared to be progressing steadily. She had several words, was feeding herself, able to peddle a trike, undress herself and was starting to put on her socks. Lisa was not toilet trained.

[40] According to Dr Newman, the only problem was that Lisa was waking between 2.00 am and 4.00 am in order to get into the parental bed, but Mrs Gill had managed by firm and persistent means to get her back to bed within about an hour and stay there. She appeared to be satisfactorily nourished. She had a rash on her buttocks for which Dr Newman suggested a barrier cream. She appeared



to be doing satisfactorily. No arrangements had been made to see the family again.

[41] The report from Dr van der Westhuyzen, paediatrician, of 10 April 1992 noted that Lisa had marked developmental delay. She did not toilet or dress herself but had just started to undress and could feed herself. She had poor comprehension. She could ride a bike well. Her speech was markedly retarded, with only one or two words. Her hearing appeared to be normal but her eyes moved in different directions. Lisa had suffered four grand mal convulsions. Phenobarbitone had been tried which had resulted in significant behavioural difficulties and Tegretol had also resulted in several problems. Her last convulsion had been one year previously. Lisa was generally well although she had had chicken pox.

[42] Dr van der Westhuyzen found her problems to be cerebral palsy, post-strep group B meningitis, uncoordinated eye movements, speech delay and seizures. As to the latter, she was on Epilim. The dosage could be decreased if her mother found it was causing significant behavioural problems. This would be assessed at a follow up. Lisa would be reviewed again in six weeks' time.

#### *Evidence of Ms Deborah Andrews*

[43] Ms Deborah Andrews, instructed by the Corporation, has 30 years' experience as a physiotherapist, including considerable paediatric experience. She commenced contracting with the Corporation full-time to provide paediatric community services in 1997. She has extensive acute and community paediatric experience, having worked with children in the community for over 18 years and having developed a specialty in paediatric disability and rehabilitation services.

[44] Ms Andrews' first report concerning the relevant period (dated 2 June 2011) is some 39 pages in length. It is described as a retrospective support needs assessment. It assessed Lisa through the various stages of development; birth to discharge at three weeks, aged three to six weeks, six weeks to three months, three to six months, six to 12 months, 12 to 18 months, 18 months to two years, two years to two years six months, two years six months to three years, three to four years, four to five years and later stages which are not relevant to this appeal.

[45] There is a detailed assessment in the report of the different activities in the development of a child at each stage and an estimation by Ms Andrews of the time

required to complete those tasks on a daily basis, over and above the usual time that would be invested by a parent for a baby developing normally.

[46] I note that the hours estimated for Lisa's care increase as she grew older. As a baby up to three months old, the hours are very low, less than one hour per week (excluding age-related care). From three to six months, they are little more than one hour per day. During the age span of three to four years, Lisa needed to be kept in the same room as an adult at all times to monitor her behaviour to keep her safe, with the additional care required being just under seven hours daily. The highest daily hours during the relevant period (up to 30 June 1992) are for the ages of four to five years, at just under 12 hours per day.

[47] There was a second report from Ms Andrews on 3 October 2011. In terms of the statutory criterion for attendant care ("constant personal attention"), Ms Andrews had the following to say about Lisa:

3 weeks to 20 months – Lisa needed constant personal care and attention at this age, related primarily to her age and not her injury. All newborns require constant personal care and attention.

20 months to three years four months – Mrs Gill followed the Doman programme which was extremely intensive during the day but did not require constant personal attention and care at night.

2 years – by this age Lisa was displaying difficulty settling at night and was falling behind in the development of her self-care skills, therefore requiring additional parental support.

3 years – by this age Lisa was displaying challenging behaviour that required much closer supervision than typically required for safety management.

4 years – Lisa required "in the same room supervision" for challenging behaviour at a time when other children are able to play safely, with an adult elsewhere in the house.

[48] In summary, according to the second report, Ms Andrews assessed Lisa as having throughout her childhood needs that were over and above those of a typical child, which was a reflection of just how challenging Lisa was to care for but at no time did she require constant personal care when she was asleep.

[49] Ms Andrews provided another report on 24 March 2014 concerning whether Lisa required constant personal care and attention from the age of three weeks to the age of four years and six months. This was in response to the first report of Ms Powell. Ms Andrews noted a number of points in concluding that Lisa did not require such personal care and attention due to her injury-related needs:

- (i) The primary result of her illness was extensive brain damage and her only ongoing long-term medical condition was seizures.
- (ii) Lisa did not require home care nursing services and did not have repeated hospitalisations other than when her seizures returned at about three years. She had been weaned off seizure medication at four months.
- (iii) Lisa was off all medication by the age of four months. This would not be consistent with a child with high health and complex medical needs. She was repeatedly described as thriving and growing well, other than in respect of development.
- (iv) Lisa had significant developmental issues from an early age and required a lot of support to develop motor, language and cognitive skills. This support is not required on a 24-hour basis, as it is not given while a child is asleep. She did, however, have very high support requirements while awake.
- (v) Lisa went on to develop significant further cognitive and behavioural concerns that resulted in her being extremely difficult to manage and requiring significantly greater levels of supervision throughout all of her waking hours. Although she was difficult to settle at night and woke early, once she was actually asleep her needs for behavioural support ceased.

[50] Ms Andrews final report is undated, but appears to have been produced on about 11 November 2014. It was a response to the second report of Ms Powell. In her view, the presence of brain damage was not of itself life threatening. The dispute here was as to the complexity of Lisa's medical presentation and how this impacted on the burden of caring for her.

[51] According to Ms Andrews, Lisa's hydrocephalus and seizures required management. A caregiver would have to recognise symptoms and follow instructions. This would be regarded as instruction rather than specialised

training. It required monitoring of Lisa and watching for signs of intracranial pressure (bulging of the fontanelle) and then acting appropriately. Looking and touching the fontanelle can be performed while completing age-related care. Seizure management requires comfort, reassurance and sometimes repositioning until the seizure passes and/or administering medication. This monitoring can be performed in conjunction with naturally occurring contacts with the child.

*Evidence of Ms Megan Powell*

[52] Ms Megan Powell, instructed by Lisa's solicitors, is a nurse who specialises in providing health and injury management. She has 23 years experience in nursing and support care roles, including home care. Her speciality interest is occupational health and safety.

[53] Ms Powell concluded in her first report of 20 January 2014 that Lisa did require constant personal care from the date of discharge from hospital at three weeks until (at least) the age of 4.5 years. This additional specialised training, monitoring and care was outside the norm and required someone to be within hearing distance at all times over a 24-hour period.

[54] In the view of Ms Powell, Lisa's multiple health conditions were life threatening. An assumption was made that specialised health observations, monitoring and needs resulted in constant personal care which were "applied" to her immediate carers. Lisa required additional time, more than usual, with special consideration and training for carer observation, monitoring and immediate life saving interventions in the home environment.

[55] For example, there was the possibility of further seizures, requiring the administration of medication and possible aspiration that could occur as a result of seizures or infections. There was the monitoring of chest infections/common cold complications and her lung function due to pneumonia, cardiac failure, "multiple collapsed lungs post-birth", hypotonia and hydrocephalus, with resuscitation and ventilation required. This was outside what would be considered normal constant care for an infant. Seizure medication (anticonvulsants) was continued until it was reduced on 25 February 1988 (at the age of 3 months) and finally ceased on 4 March 1998.

[56] In Ms Powell's view, Ms Andrews had not considered medical needs and other nursing care that were applicable due to Lisa's immediate underlying health conditions. These translated into constant personal care. According to Ms Powell,

Lisa would be regarded as high risk, high need and high dependence baby. The diagnosis of meningitis and subsequent hydrocephalus required specialised training.

[57] Ms Powell's first report noted that Lisa had not met all the expected reflexes for her age and she had impaired communication. During her third year of life, respite care was provided. The assessment for such care required high or very high needs. In Ms Powell's opinion, constant personal care was required and actually provided by her family and other carers. At no stage was Lisa a normal developing infant.

[58] It was apparent to Ms Powell that the specialists were unable to ascertain the full degree of her physical and cognitive impairment until she was about three years of age. Her normal expected tone and reflexes were incomplete, late or missing. There were visits from a developmental therapist on a fortnightly basis commencing immediately after discharge from hospital. During Lisa's first 28 days of life, she required additional support and there were training requirements for her parents in order to monitor her health.

[59] Ms Powell noted that Lisa was admitted to a clinic with a prolonged convulsion on 22 September 1990 (aged 2 years, 10 months). She was discharged after two days on anticonvulsants. It was observed that Mrs Gill had rechecked her daughter one hour after putting her to bed, noting that Lisa's head was turned to the right, drooling, limp and that she was taking occasional breaths. This showed that constant personal care and attention was given. It demonstrated the additional burden of caring for a child with epileptic tendencies, which would have required special monitoring, training, observations and precautions. These needs for Lisa had been previously documented and continued to remain as constant personal attention, requiring a high level of care, with someone within hearing distance at all times.

[60] In Ms Powell's opinion, Ms Andrews had not referenced the enormity of the implications of Lisa's requirements as a high risk infant. Nor had she taken into account the ongoing health monitoring or observation of her underlying medical disability. Lisa was discharged with "significant life-threatening and multiple health concerns" in addition to her developmental issues, but these were not fully considered by Ms Andrews.

[61] A second report from Ms Powell, on 30 June 2014, noted a report from Dr Richardson (15 March 2009) stating that Lisa sustained an extremely severe

infection which left her severely brain damaged, with a lifelong requirement for significant support. Lisa required more time than was usual, with carers observing and monitoring, including watching for immediate lifesaving interventions in the home environment. Speciality training and guidance from medical specialists to monitor health and safety in the home environment would have been undertaken by Lisa's carers.

[62] Ms Powell did not know of any other parent discharged home with a newborn given direct access to specialist care services over a 24-hour period, or requested to watch for persistent hydrocephalus care and epilepsy management. Lisa's constant personal care needs were over and above those of a typical normal developing child. A normal developing child would not be assigned a specialist therapist prior to the age of one month with a review being conducted on a fortnightly basis at home.

#### *Corporation's decision on attendant care*

[63] The Corporation wrote to Lisa's parents on 2 December 2011 concerning her entitlement to attendant care from 11 November 1987 (date of injury) until 30 June 1992 (the expiry of the 1982 Act). According to the Corporation, constant personal attention was more than simply living under the same roof providing assistance on a daily basis. It had to be shown that due to the injury, the client was not safe to be left alone for any period. The Corporation did not consider that Lisa's injury related needs were such as to require constant personal attention. Accordingly, such compensation was declined pursuant to section 80(3) of the 1982 Act.

[64] A separate decision was issued on the same day, 2 December 2011, accepting attendant care under the 2001 Act in the period from 1 April 2002 to 10 October 2010, including "sleep-over care".

#### *Review decision on attendant care*

[65] A review of the decision concerning the earlier period was sought. The reviewer's decision was issued on 27 September 2012.

[66] It is a relatively short decision made without reference to any of the factual or expert evidence relating to Lisa's condition and needs. That is because the focus of those representing Lisa at that time had been whether her entitlement to attendant care under the 1982 Act could be "grandparented" to periods later than 30 June 1992 under subsequent legislation. The reviewer found, correctly, that

Lisa was not entitled to the benefit of any transitional or grandparenting provision. However, the reviewer additionally found, virtually as an aside, that there was no evidence from which he could infer that Lisa required constant personal attention as a result of her “treatment injury”, thereby resulting in an entitlement under section 80(3) of the 1982 Act.

[67] It is from this decision that Lisa appeals to the Authority.

### **THE CASE ON APPEAL**

[68] The Authority received from Lisa’s counsel written submissions (15 November 2013, 2 July 2014), an affidavit from Mrs Gill (25 October 2013), a joint bundle of documents and a supplementary bundle of documents. Counsel for the Corporation provided written consolidated submissions (29 January 2015). Oral submissions were made by both counsel at the hearing. After the hearing, counsel for Lisa provided a further document and counsel for the Corporation an additional memorandum (18 March 2015).

### **THE LAW**

[69] An appeal lies to the Authority against certain decisions of a review officer (sections 101, 107 of the 1982 Act). Such an appeal lies in this case. An appeal is by way of a rehearing (section 109(1)). The Authority can confirm, modify or reverse a decision, or refer the matter back to the Corporation (section 109(7) & (8)).

[70] Notwithstanding the repeal of the 1982 Act, the Authority continues to have jurisdiction over certain claims arising from personal injury by accident occurring on or before 30 June 1992 (section 391 of the 2001 Act). It is the 1982 Act that is applicable to Lisa’s entitlements in the period up to 30 June 1992, given the date of the accident.

[71] The relevant entitlement provision of the 1982 Act at issue here is section 80(3):

**80 Compensation for pecuniary loss not related to earnings –**

...

- (3) Where a person suffers personal injury by accident in respect of which he has cover and the injury is of such a nature that he must have constant personal attention, the Corporation, having regard to any other compensation payable, may pay to that person, or if it thinks fit to the administrator of that person, such amounts as the Corporation from time to

time thinks fit in respect of the necessary care of the person in any place of abode or institution.

...

[72] The higher courts have set out the principles to be applied in assessing whether an injured person “must” have “constant personal attention” allowing the Corporation to pay for the “necessary” care of that person.

[73] The High Court had this to say in *Accident Rehabilitation and Compensation Insurance Corporation v Campbell* [1996] NZAR 278 at 285-286:

...

This case however, has to be resolved on the basis that up until April 1995, constant personal attention equated to 24-hour care and that the necessary care level would involve the continuous attendance of persons on the individual throughout. Clearly the level of attention required would vary. To some extent that is reflected in the level of hourly rate and variations within the rate where it is acknowledged that assiduous attention to the individual is not constantly required such as some cases (but only some) when he or she is asleep. The entitlement to vary the rates in accordance with that factor is undoubted in light of the clear statutory direction contained in the words “such amount as the Corporation from time to time thinks fit in respect of the necessary care”. The ability of the Corporation to temper expensive full time caregiving and to apply a cushioning principle is contained in this aspect of the discretion. What is in issue here, however, is whether under the same discretion or otherwise in accordance with s 80(3), the Corporation can dictate a lesser number of hours than the full entitlement which the words ‘constant personal attention’ involve and the evidence requires. Necessary care could, we imagine, involve other than the personal attendance by persons on the individual concerned and monitors and electronic devices might be provided which would supplement the necessary care. We would not wish to see that possibility excluded but it will depend on the facts of each case as to what necessary care can be provided in the case of a person requiring constant personal attention.

The discretion could extend also to the cost of the 24-hour care both as to hourly rate and such things as one caregiver being available to care for more than one such person. ...

[74] *Campbell* has not been interpreted to mean that one on one personal care over 24 hours is necessary, though the care must be “constant” so some level of care or monitoring is required over 24 hours, as is clear from the decision of the High Court and Court of Appeal in the case of *Matthews* (citations below).

[75] In the High Court (*Matthews v Accident Compensation Corporation* HC Wellington, CIV-2004-485-2143, 31 March 2006), MacKenzie J said:

[18] I do not consider that [*Campbell*] is properly to be regarded as authority for the proposition that the term “constant personal attention” necessarily means that personal attention on a 24 hour per day basis is required and that nothing less can meet the test. ...



[19] The term “constant personal attention” does require a high level of care. Mr Millard draws attention to the following definition of the word “constant”, in the *Oxford English Dictionary*:

Of actions, conditions, processes, etc.: Continuing without intermission or cessation, or only with such intermissions as do not interrupt continuity

He submits that the level of attention involved can fluctuate, but that the word “constant” requires some level of attention over the full 24-hour period and that attention is provided only with such interruptions as do not interrupt continuity. As to the level of attention required by the use of the word “personal”, Mr Millard submits that that means individual, one on one attention.

[20] The question whether constant personal attention is required is one to be resolved on the facts of each particular case. As *Campbell*, recognises, the level of care required may vary throughout the day, and the discretion available to ACC as to the rate to be paid may accommodate that variation. That involves a factual inquiry, based on the circumstances of the particular case. It is undesirable to place a gloss on the words of the statute. Whether a case which involves individual, one on one attention for part of each 24-hour period, and a lesser level of attention for other parts of the day, meets the test is to be determined more by a close examination of the facts than by a close dissection of the plain words of the section.

[21] Applying those principles to the facts here, the evidence is that throughout much of the relevant period, if not all of it, Brent has been able to carry on a substantially normal life, attending school, playing sport, socialising, and the like. He was able to do so, subject to a level of attention and care from his mother in particular which was greater than the level of attention which would be required for a child who had not suffered such injuries. A mother may be expected to give personal attention to a young child for significant periods during the day. That is insufficient to qualify, since the “constant personal attention” required must be necessitated by the injury. The question is whether the heightened level of maternal attention in the supervision of childhood activities which was required in this case was of such a level as to amount to constant personal attention.

[76] The requirement for some level of personal care over 24 hours, albeit with a fluctuating level of care, was made clear by the Court of Appeal in *Estate of Simpson and Matthews v Accident Compensation Corporation* [2007] NZCA 247:

[23] We are satisfied that this phrase means that an injured person requires some level of personal care over a 24 hour period. The level of care can fluctuate over the 24 hour period: *AIRC v Campbell* [1996] NZAR 2789 at 285 (HC). The phrase does not mean that nothing less than 24 hour per day attention will meet the test. However, as noted by MacKenzie J, “the word ‘constant’ requires some level of attention of the full 24-hour period and that attention is provided only with such interruptions as to not interrupt continuity”: at [19]. The focus is on the level of care required by the injured person and not on who provides it. The fact that a person goes to a respite place or school does not break continuity if the injured person needs constant attention during that period. The applicability of s80(3) is a factual inquiry of whether the heightened attention required is of such a level as to amount to constant personal attention.

[77] The “place of abode” at which the constant personal attention is provided can be the person’s house.

## ASSESSMENT

### *Jurisdiction and procedure*

[78] There is potentially a jurisdictional issue. The notice of appeal to the Authority concerns only the grandparenting issue (entitlements under the 1982 Act continuing beyond the repeal of that Act). That had been the focus of the reviewer in the decision being appealed to the Authority. Mr McBride, for the Corporation, points this out without contending that the Authority has no jurisdiction over the substantive issue as to whether there is any entitlement under section 80(3) of the 1982 Act. For the record, I find that I do have jurisdiction since the reviewer did find that there was no entitlement under section 80(3), despite that finding being incidental to the decision.

[79] The procedure adopted by the previous Authority, after the notice of appeal had been filed, was somewhat unusual. She heard the substantive appeal on 28 November 2013, at that hearing declining to grant an adjournment sought by counsel for Lisa in order to obtain further expert evidence. The then Authority also made observations on the merits of the appeal.

[80] Following the hearing, the Authority immediately had second thoughts concerning the refusal to grant an adjournment. Accordingly, without seeking submissions from the parties, the Authority issued a decision on 9 December 2013 recalling the oral decision declining the adjournment and formally granting an adjournment. This was said to be done in the interests of justice to enable Lisa to adduce further evidence.

[81] That evidence was duly filed, being Ms Powell's reports, to which Ms Andrews on behalf of the Corporation responded. Again, neither counsel takes issue now with the unusual process. I record, as the present Authority determining the appeal, that I have had no regard to the observations of my predecessor concerning the merits of this appeal recorded in the transcript of the earlier hearing.

### *Whether care of Lisa meets the statutory criteria for attendant care payments*

[82] The assessment for me is not whether Lisa in fact received from her parents a level of care meeting the statutory threshold (being "constant"), but whether constant care was "necessary" (or "must have") in terms of section 80(3). Furthermore, it must arise from the injury and not be age-related or arise from the inevitable course of the meningitis. It will be recalled that the covered injury is not

the meningitis itself (being a disease, not a treatment injury) nor the full brain damage it caused, but the enhanced brain damage caused by its delayed diagnosis and treatment.

[83] I will start by recording that it is irrelevant that the Corporation accepted on 2 December 2011 that Lisa required attendant care from 1 April 2002 onwards under the 2001 Act. The statutory criteria under the later Act was different and Lisa had by then reached the age of 14 and required a high level of care (24-hour support) due to developmental and behavioural issues. I am concerned with the criteria under the 1982 Act and with Lisa's needs from discharge from hospital (about one month old) until about 4 years, 8 months old (by 30 June 1992).

[84] Turning then to the relevant age period, Ms Powell, on behalf of Lisa, says that she did require constant personal attention, but Ms Andrews, the Corporation's expert, says she did not.

[85] There are essentially two primary areas where these experts differ:

1. health related care
2. night time care.

[86] I will deal with each in turn.

#### *Health related care*

[87] Ms Powell places great reliance on the care required as a result of what she describes as Lisa's life-threatening health condition, which in her view required specialised training for the carers and constant personal care, even at night. She identifies this as an aspect of care overlooked by Ms Andrews.

[88] Ms Andrews, in response to Ms Powell's reports, noted that Lisa's only ongoing long-term medical condition was seizures, that she was off all medication by the age of four months (which Ms Andrews says would not be consistent with a child having high health and complex medical needs) and that she did not require home care nursing services. Ms Andrews regarded the advice to the parents required as more aptly described as instruction rather than specialised training. According to Ms Andrews, the monitoring of Lisa for intracranial pressure could be done in conjunction with naturally occurring contacts with the child. Furthermore, seizure management required comfort and reassurance, and only sometimes repositioning and administration of medication.

[89] While Ms Andrews is not correct about the medication (Lisa resumed medication following her two hospitalisations), I find that the medical evidence overwhelmingly supports Ms Andrews and does not justify Ms Powell's description of Lisa's life threatening situation.

[90] Ms Andrews is correct in identifying seizures as the only serious medical condition. Lisa had convulsions in her first four days of life in hospital and was placed on medication. They had stopped well before her discharge. She ceased that medication on 4 March 1988 (at the age of almost 4 months). The only evidence before me of seizures after that is in September 1990 (aged 2 years, 10 months) during which she spent two days in hospital and again in March 1991 (aged 3 years, 4 months) also requiring another hospital admission of one to two days. She was recommenced on medication on both occasions for periods unknown to me.

[91] No doubt, Lisa's parents were anxious about potential seizures and watchful, but I do not accept that such few episodes led to any constant monitoring, during the day or at night, beyond the usual regular monitoring of babies and young children, after the age of 4 months. I can accept that in the immediate aftermath of the hospital discharges in December 1987, September 1990 and March 1991 there would have been heightened vigilance, but not continuously over the first 4.5 years (approximately) of Lisa's life.

[92] A review of the fairly extensive and regular medical evidence of those treating Lisa during the relevant period shows that she was in fact largely medically well. For example, I refer to Dr Rowley's report of 29 November 1989 ("generally very well with good health"), Dr Wake's of 17 January 1990 ("a very healthy little girl"), Dr Newman of 8 October 1991 ("doing satisfactorily") and Dr van der Westhuyzen of 10 April 1992 ("generally been well"). It was the developmental delays (primarily cognition and speech) and behaviour which became the focus of attention as she grew older, rather than health related concerns, let alone life-threatening conditions.

#### *Night time care*

[93] The two experts also differ on the need for constant personal attention at night. To some extent, this overlaps the first divergence in their evidence described above, since the need for monitoring or care during the day or night was primarily health-related according to Ms Powell (notably the risk of seizures).

[94] Ms Andrews is of the opinion that Lisa did not require constant personal attention at night. She did not require support while asleep. Ms Andrews acknowledged that Lisa was difficult to settle at night and woke early, but when asleep her need for behavioural support ceased.

[95] Ms Powell, on the other hand, emphasising Lisa's "high risk, high need, high dependence" conditions as a baby, her tendency towards epilepsy and her "significant life-threatening and multiple health concerns", considered that she needed someone within hearing distance at all times, including at night.

[96] In her affidavit, Mrs Gill records that Lisa did not sleep normally until 16 years of age. She was hard to put to sleep, slept poorly and woke most mornings between 4.00 am and 5.00 am. Lisa often slept with her (Mrs Gill) and her father slept in Lisa's bedroom. Mrs Gill also states that they "jumped at every noise" and woke to check on her when she did sleep.

[97] Dr Newman (8 October 1991) remarked that the only problem was Lisa's early waking (between 2.00 am and 4.00 am) in order to get into the parental bed, but Mrs Gill managed by firm and persistent means to get her back to bed within an hour and she generally stayed there. Ms Andrews (2 June 2011) noted, in relation to Lisa at 12 to 18 months old, that she started to wake between 4.00 am and 6.00 am every morning, until she was 16 years old. This necessitated an adult to be with her.

[98] I have already rejected Ms Powell's description of Lisa's life-threatening condition. I find the medical evidence and that of Mrs Gill on the problem of sleeping to be broadly consistent. Lisa was hard to get to sleep and woke early (with some inconsistency as to the waking time), then either slept with her mother with Mr Gill consigned to Lisa's bed, or Mrs Gill successfully returned Lisa to her own bed, or one of the parents remained up with her. This description of her sleeping pattern is consistent with the opinion of Ms Andrews that Lisa did not require constant care throughout the night.

[99] I appreciate that there can be varying levels of care associated with constant personal attention. There need not be one on one monitoring of Lisa when asleep by a person constantly observing her, in order to fall within the concept of constant personal attention.

[100] However, there must be a level of monitoring or care, due to the injury, that is consistent with constant personal attention. I find that there was no such level of care at night.

[101] The parents slept in their own bed and Lisa in her cot or fenced in bed. On most nights she interrupted their normal sleep, climbed into their bed and forced her mother to return to her own bed early in the morning. It would seem her father on other occasions slept in her bed, so she could sleep with her mother. Sometime between 4.00 am and 6.00 am, Lisa would get up and stay up, requiring one of the parents to do likewise.

[102] While I accept there would have been a heightened level of monitoring and checking on her while she was on medication until the age of 4 months and in the immediate aftermath of the two hospitalisations for convulsions, I do not find that there was the requisite level of care or monitoring generally at night such that constant personal attention was given, even less than it was required. I do not accept that sleep, which most or all nights was interrupted and led to intervention in the way described, amounted to constant personal attention during the night.

#### *Other issues*

[103] It is submitted by Ms Hollingsworth that one of the factors considered persuasive by Ms Powell of the need for constant personal attention (in the form of constant monitoring of Lisa's condition) was that the family was given Dr Rowley's contact details and permission to contact him on a 24-hour basis (see Mrs Gill's affidavit para 7, Ms Powell's report 20 January 2014 at p3, submissions 2 July para 60).

[104] I do not agree that Dr Rowley's kind gesture is evidence that Lisa's condition was at all life threatening or medically serious. As Ms Andrews says (11 November 2014), Dr Rowley is a very caring and compassionate paediatrician who understood how devastating the diagnosis of extensive brain damage would have been for the family.

#### *Conclusion on constant personal attention*

[105] I remind myself that constant personal attention does not require 24-hour, one-on-one attention, since the level of care (more accurately attention, rather than necessarily active care) may vary over the 24-hour period. However, there must be a level of care or monitoring over 24 hours, such that care can be said to be constant or uninterrupted.

[106] Ms Powell is of the opinion that Lisa required constant personal attention on a 24-hour basis, day and night. I have already rejected the need for such attention at night and find that it was not, in fact, constantly provided at night.

[107] As for the day, Ms Andrews accepts that for a certain number of hours daily there was a need for constant personal attention due to the brain injury. It built up from a minimal period at infancy to just under 12 hours per day from the age of 4 years. At that quantity of hours per day, it amounts to constant personal attention during the waking hours. However, according to Ms Andrew's first report, it was not until the age of 4 that Lisa's need for such a high level of care (attributable to brain damage, that is, over and above that due to the usual age-related needs) was anywhere near 12 hours. For example, from the age of 3 to 4 years, the need was for just under 7 hours per day. The younger years required even less.

[108] Accordingly, the need for personal care attributable to the brain injury cannot be regarded as constant until the age of 4. At best therefore, constant personal attention during Lisa's waking hours was only required from 4 years old. During the relevant period from initial hospital discharge (December 1987) until 30 June 1992, that would have been for a duration of only about seven months.

[109] However, even accepting as I do the concurring opinion of both Ms Andrews and Ms Powell that Lisa required constant personal attention during her waking hours from the age of 4, that attention has not been shown to have been caused by the covered injury. Ms Andrews' calculation of the hours required to care for Lisa encompasses all the additional hours due to the full extent of her brain damage (over and above age related care). It is not confined to those hours caused by the greater severity of the damage due to the late diagnosis and treatment of the meningitis.

[110] There is no evidence before me of the additional hours required to care for Lisa, over and above not only her age-related care but also the hours that would have been required due to the normal course of meningitis for a neonatal baby.

[111] Dr Broadbent, neonatologist, was asked what difference there would have been to the brain damage if there had been an earlier correct response. In a report on 16 April 2010, he said it was difficult to say, as hour by hour the meningitis was becoming more established and progressively affecting her brain. In a second report on the same day, he opines that earlier treatment by antibiotics would have led to a 20% to 50% less severe outcome. Dr Richardson,

paediatrician, says in his report on 27 June 2010 that an earlier diagnosis may have made a 10% to 20% difference. He considered this guesswork rather than science.

[112] I do not think that these figures of 10% to 50%, even if scientifically based, have a direct relationship with the care hours needed. In other words, it is not established that a 10-50% reduction in severity necessarily translates to a concomitant 10-50% reduction in the hours of care needed.

[113] On the evidence before me, it is therefore not possible to say what difference the increase in the severity of the brain damage (itself a very wide range from 10% to 50%) had on the hours of care that would otherwise have been required.

[114] Ms Hollingsworth concedes in her oral submissions, correctly in my view, that it is not possible to differentiate the brain damage caused by the delayed diagnosis and treatment with that caused by the underlying illness. This inability to attribute care hours to the additional brain damage (caused by the covered injury) is another critical obstacle to Lisa's claim for attendant care.

[115] Given the limited cover (which is not contested), I do not accept Ms Hollingsworth's further submission that the Corporation must consider and weigh the totality of the brain injury. It is contended that to do otherwise (given that the medical evidence does not distinguish the brain damage caused by the injury) would be a niggardly approach and therefore contrary to the objectives of the Act. My task is to correctly apply the statutory criteria and not to be generous to a claimant because that would be fair. It is not a principal purpose of the legislation to be generous to claimants; *Robinson v Accident Compensation Corporation* [2007] NZAR 193 (CA) at [49], *Rangiwhetu v Accident Compensation Corporation* HC Wellington, CIV -2006-485-1402, 19 April 2007 at [65].

[116] In summary, I find:

1. Lisa did not require constant personal attention at night.
2. Lisa did not require constant personal attention during daylight or waking hours, except from the age of 4. Sleep interrupted the constant personal attention given during the day from the age of 4 (as per 1. above).



3. The number of hours of care attributable to the covered injury has not been established for any period of the day at any age.
4. Constant personal attention for which there is an entitlement under section 80(3) of the 1982 Act has not been established for any age prior to 30 June 1992.

## **OUTCOME**

1. The appeal is dismissed and the review decision is therefore confirmed.
2. Leave is reserved concerning costs. A party may seek costs within 21 days. If so, the other party may respond within 14 days.

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D J Plunkett