**BEFORE THE ACCIDENT COMPENSATION APPEAL AUTHORITY**
**AT WELLINGTON**

**[2014] NZACA 12**

**ACA 09/00**

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

**HEARING**
14 April 2014 at Auckland

**AUTHORITY**
Robyn Bedford

**APPEARANCES**
R Allen and M Appleby counsel for the appellant
P McBride counsel for the respondent

## DECISION

[1] On 10 October 1983, Ms Taukamo was the driver of a motorbike and was involved in an accident which left her a T5 paraplegic. Ms Taukamo has cover under the Accident Compensation Act 1982 for this injury and for a mental breakdown she suffered on 8 August 1989. The appeal concerns ACC's decision to decline Ms Taukamo's claim for a backdated payment of compensation under s 80(3) for 24 hour care for the period from her discharge from hospital in 1984 up to 8 August 1989. There is a preliminary issue, being that the notice of appeal was filed some four months outside the one month time limit for filing an appeal under s 108(1).

### *Procedural background*

[2] In the Appeal Authority's 1999 decision accepting cover for Ms Taukamo's mental breakdown in August 1989,[1] Mr Cartwright referred the question of Ms Taukamo's arrears of compensation under the 1982 Act back to ACC to address, particularly under s 80(3). By letter dated 12 April 1999, Ms Taukamo made a formal application for backdated attendant care under s 80(3).

[3] ACC conducted an investigation through two senior claims managers, but did not obtain a medical assessment. ACC decided that Ms Taukamo did not qualify for the equivalent of constant (24 hour care) but accepted that her level of personal support/attendant care and childcare required review. This was stated in the

[1] *Taukamo v ACC* Decision No. 15/99, Peter Cartwright, 26 March 1999

decision letter dated 16 July 1999, which confirmed ACC's earlier oral advice declining compensation under s 80(3). The right of review was given under the Accident Insurance Act 1998, instead of the 1982 Act, but this was rectified and the review was held under Part 9 of the 1982 Act.

[4] Bill Wilson QC, the appointed Review Officer, did not make a decision under s 108(9)(2)(a); he instead made a report and recommendation under s 102(9)(2)(b) and recommended that ACC should decline Ms Taukamo's application for payment of backdated attendant care under s 80(3), on the grounds that although Ms Taukamo clearly needed some personal care, she did not require *constant personal attention* in terms of the section. Mr Wilson did not give any right of appeal against his report and recommendation, which is consistent with the wording of s 102(10), which provides that on receipt of the report, ACC must consider the application and give a decision thereon.

[5] ACC made the decision on 17 December 1999 and notice of the decision was given as required under s 102(11). The notice confirmed that ACC accepted Mr Wilson's recommendations, which were presented to the Board by Mr Wilson at a meeting on 16 December 1999. The notice did not contain the right of appeal against ACC's decision as required under s 102(12), which provides: *Every notice under subsection 11 of this section shall contain information as to the applicant's right of appeal under this Act.*

[6] A notice of appeal was filed in the District Court on 11 May 2000, by Mr Praat, who was then acting for Ms Taukamo, and states that the appeal is brought against the decision of ACC dated 16 December 1999 declining a review of ACC's decision to grant her claim for 24 hour attendant care pursuant to s 80(3). Mr Praat also filed an application for leave to appeal out of time ("the application"). The grounds for the application can be paraphrased as being that on 19 January 2000, Ms Taukamo's solicitors expressly reserved leave to appeal and sought to negotiate an alternative remedy which would provide her with substantially increased benefits in respect of earlier cover. When that remedy was unsuccessful, the notice of appeal was filed.

[7] By 2004 the application and appeal were properly before the Appeal Authority. Mr Cartwright saw the appeal as being against Mr Wilson's conclusion that "*It could not be said that it was necessary that personal attention be constantly available to her in her home*." As Mr Cartwright was concerned that there was almost a total lack of medical evidence to justify Mr Wilson's conclusion, Dr McNaughton, Rehabilitation Physician, was instructed by consent by the Authority to assess Ms Taukamo's need for constant personal attention under s 80(3), from the date of her accident in 1983 up to the date of instruction.

[8] Dr McNaughton's assessment dated 13 February 2006 did not support Ms Taukamo's need for constant personal attention at any stage, except for a "*possible exception*" period between mid 1989 and late 1991 relating to her covered mental breakdown. ACC paid Ms Taukamo compensation for 24 hour care for the period it estimated was contemplated by Dr McNaughton. Thereafter, negotiations and review applications continued and other decisions and payments were made but Ms Taukamo's appeal effectively remained at a standstill, despite efforts by the Authority up to 2010 to bring it to a conclusion. I picked up the appeal in February 2012.

***The application for leave to appeal***

[9] Mr McBride set out a detailed chronology charting the progress of the appeal from 2006 and made extensive submissions in which he relied upon excessive delay both before and after the application was made, inadequate reasons for the delay, prejudice to ACC because of the retrospective assessments and the lack of merit in Ms Taukamo's claim given the expert evidence. This also affected the overall interests of justice, which did not favour an extension of time.

[10] Mr Allen, speaking to Mr Appleby's submissions, relied on Mr Praat's claimed reservation of the right to appeal as contained in his letter of 11 May 2000, and attributed responsibility for the subsequent delays to Ms Taukamo's mental breakdown, her claim to be physically "*near death*", the time ACC took to investigate her claims, attempts to settle through negotiation and the prejudice she suffered through ACC's various failures, and submitted that the delays after the notice of appeal were filed were sanctioned by the Authority.[2] Mr Allen also submitted that there was no prejudice to ACC, and ACC had accepted through its ongoing investigations and the formal apologies and payments that the standard of care that Ms Taukamo had received was inadequate.

[11] All counsel made comprehensive submissions on the relevant law, but there was only a general discussion of the decision under appeal and of the appeal documents, in terms of the date of Ms Wilson's review decision and the reason given by Mr Praat for the late filing, and whether this was well founded. The primary decision letter dated 16 July 1999 and ACC's decision confirming acceptance of Mr Wilson's recommendations dated 17 December 1999 were produced to the Authority for the first time in the bundle of documents and authorities Mr McBride handed up for the hearing.

[12] I have not discussed the submissions in detail, as my analysis of the decision documents at paragraphs [3] to [6] shows a crucial factor which settles the issue of whether or not the late appeal should be allowed to proceed, being that no appeal rights were given either by Mr Wilson on review, or more importantly in light of s 102(12), by ACC in the decision letter of 17 December 1999. The absence of appeal rights is fatal to ACC's objection to the late filing of the notice of appeal, as the giving of appeal rights is mandatory under the statute.

[13] Where a statute provides a mandatory time for filing an appeal and a mandatory requirement for the decision maker to give notice of the right to appeal and the time allowed, the failure to do so must have the consequence that if time has started to run on the making of the decision, the statutory time limit does not come into play provided an appeal is filed within a reasonable time. I am satisfied that under the circumstances, the statutory time for filing an appeal had not elapsed when Mr Praat filed the notice of appeal.[3]

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[2] Mr Cartwright's notes on the court file and his various directions and memoranda do not support this. For example, in the memorandum dated 27 September 2004, Mr Cartwright said that time was of the essence in the resolution of the appeal as there were matters before the District Court that depended upon a decision under s 80(3).

[3] See *Cruickshank v ACC* 20/10/05, Judge Beattie, DC Auckland 310/05, where a review application was filed two years out of time, but was allowed because ACC had not complied with its statutory obligation to give any advice of a right of review. In this case, either time had not started to run, or at least had not yet elapsed, and taking a pragmatic view, Judge Beattie considered that the application for review had been lodged within time and required the review provisions of the Act to be set in train. Judge Beattie affirmed *Cruickshank* in *Esapour v ACC* Decision No. 155/2009, when he accepted

[14] I also consider that the irregularities in the appeal documentation are sufficiently minor in their legal impact that it is appropriate for the appeal to proceed as though properly filed against the decision of 17 December 1999 by ACC[4] and I think it is appropriate to take a pragmatic view of the documentation pursuant to the discretion afforded to the Authority to determine its own procedure under s 108(11) and s 108(10), which provides: *Proceedings before the Authority shall not be held bad for want of form.* By virtue of subs. (12), ACC's decision dated 17 December 1999 is the decision against which the right of appeal lies to the Appeal Authority and that appeal will proceed.

***The substantive appeal***

***Compensation received on account of childcare, home help and attendant care to December 2006***

[15] The compensation payments Ms Taukamo has received are relevant to my consideration as s 80(3) provides that ACC must have regard to any other compensation payable when making payment of compensation for constant personal attention, but as with every other aspect of this appeal, the facts are inordinately and unnecessarily confused and contradictory and no counsel involved has attempted to reconcile the dates, the periods or the classification of the payments made following Ms Scragg's report to ACC dated 21 February 2006 and Dr McNaughton's assessment.

[16] The decision letter from ACC to Mr Allen dated 24 November 2006 set out ACC's decisions in respect of Ms Taukamo's claim for payment of arrears of attendant care following Dr McNaugton's assessment and noted that Ms Taukamo claimed for attendant care, home help, childcare, cannabis[5], vehicle costs, housing modifications, electric bed and wheelchair. ACC made the following payments it described as being for "*constant personal attention/attendant care*":

- 1 February 1984 – 30 June 1988: $94,085.00 paid on 23/8/00 and topped up on 17/9/02 following a reference to mediation, the decision of 17/9/02 was confirmed.
- 1 July 1988 – 5 April 2000: $392,867.00 less the $20,000.00 advance paid on 13 March 2006.
- 6 April 2000 onwards: attendant care and home help determined via needs based assessments.

[17] On 30 July 2009, ACC wrote to Mr Allen as follows:

> "*It has come to ACC's attention that there is an error in ACC's letter of 24 November 2006 regarding attendant care.*

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ACC's submission that any failure to provide review rights does not invalidate the decision, but rather has the effect of delaying the commencement of the time within which an application for review must be lodged.

[4] Mr McBride framed the issue in his submissions as being whether Ms Taukamo can establish that ACC was wrong to accept Mr Wilson's report and recommendation, which confirms that ACC understood the appeal to have been brought against the ACC decision letter of 17 December 1999.

[5] The second decision letter dated 24 November 2006 referred to Ms Taukamo's request that ACC reimburse her $82,000.00 for cannabis purchased for pain relief. The request was declined because there is no provision in ACC legislation that allows for payment for illegal drugs.

*For the period 1 July 1988 to 5 April 2000,ACC advised that it had determined that Ms Taukamo required "constant personal attention". This is incorrect.*

*With reference to the calculation, please note that based on Dr McNaughton's report ACC concluded that Ms Taukamo* ***potentially*** *required 24 hour care for the period 1 July 1989 to 31 December 1991 only. ACC has given Ms Taukamo the benefit of the doubt in that regard. Based on the circumstances claimed to have been prevailing in that period, ACC has accepted that and has paid Ms Taukamo compensation under s 80(3) for the period 1 July 1989 to 31 December 1991, but, in reliance upon Dr McNaughton's report, not otherwise. The amount payable, $392,867.00 has not changed*.

Accordingly, under section 65 of the Injury Prevention, Rehabilitation, and Compensation Act 2001, ACC revises its decision of 24 November 2006 regarding attendant care compensation for the period July 1988 to 5 April 2000.

*If Ms Taukamo is not satisfied with this decision she can apply for a review*."

[18] The ACC calculation sheet for the $392,867.00 attached to Ms Taukamo's brief of evidence states in explanatory notes that the payment was for combined cares of 103 hours and 30 minutes per week for the period from 1 July 1988 to 30 June 1989, based on a review decision of 18 August 2005. Deduction for hours in other care was made only on that disclosed in the McNaughton report, during the period 1 July 1989 to 31 December 1991.

[19] Mr McBride said that the money paid to Mr Allen on 14 December 2006 included $444,586.00 that ACC paid on account of backdated childcare from 1984 until the youngest child turned 18 (which would have been in 2001). The decision letter relating to this was not produced, but Ms Taukamo's counsel did not object to Mr McBride's claim in the submissions filed in reply, so I have assumed this payment is accepted as having been made.

[20] In terms of Ms Taukamo's historical compensation, she received the maximum $27,000.000 lump sum compensation for her spinal cord injury in March 1984[6] and she received $11,700.00 lump sum compensation for the mental breakdown injury following the 1999 appeal decision.[7] In addition, the 1999 appeal decision records ACC's comments in the decision letter dated 14 May 1993, in which it declined Ms Taukamo's claim for cover for the mental breakdowns she suffered on 14 May 1990 and 10 September 1991, that by this time she had received $29,000.00 by way of wages compensation and in excess of $95,000.00 by way of home help and attendant care. The letter records that ACC also paid for the supply and modification of a motor vehicle, wheel chairs and appliances, home alterations, removal expenses and re-education expenses. The expenditure as at May 1993, including the $27,000.00 lump sum compensation, totalled $210,000.00.

[6] See ACC assessment Volume 1 of the medical files, doc 12 and letter Bathgate/ACC 8/3/84, doc 17.
[7] See Anne Scragg's Report 21/2/06, page 4.

***The time period at issue***

[21] The period that is encompassed by this appeal is from the actual date of Ms Taukamo's discharge from hospital, through to the latest date established by the evidence as the date that the housing modifications were completed to a satisfactory extent, but excluding any period for which compensation for 24 hour care has already been paid. I have chosen this as the cut off date, as while both experts agree that Ms Taukamo did not need 24 hour personal care due only to the nature of her injuries, they both qualified their opinions by their comments relating to the possible impact on Ms Taukamo's need for 24 hour care when she was living in an unmodified house where she did not have adequate bathroom and toilet access.

[22] Ms Taukamo's evidence was based on a discharge date of 31 January 1984 and Mr McBride took the discharge date in his chronology as 9 April 1984, following Dr Seemann's identification of this date in his assessment. Neither party addressed the possible date the housing modifications were completed.

***The specialist medical evidence***

[23] There are two specialist assessments, being Dr McNaughton's assessment dated 13 February 2006 and an assessment dated 18 September 2013, by Dr Richard Seemann who is also a Specialist Physician and holds the same qualification in Rehabilitation Medicine as Dr McNaughton, which was obtained by me as the Authority. Dr Seemann, was instructed by consent when Dr McNaughton declined to revisit his assessment and make further comment that I requested on certain issues raised by his assessment, but Mr McBride reserved his position in respect of the terms of the instructions given to Dr Seemann concerning the legal test under s 80(3).

[24] The same evidence files given to Dr McNaughton were given to Dr Seemann along with a copy of Dr McNaughton's report and Dr Seemann was instructed to consider Ms Taukamo's need for constant personal attention from 31 January 1984, the date stated as Ms Taukamo's discharge from hospital to an unmodified house in June 1989 and from January 1992 to 30 June 1992, so to exclude the period under s 80(3) where ACC accepted (as far as the Authority was aware) that Ms Taukamo required constant personal attention under s 80(3).

***Dr McNaughton's assessment***

[25] Dr McNaughton did not interview Ms Taukamo because she would not consent to this, and he assessed her medical issues and expected level of functioning by reference to the World Health organisation "*International Classification of Functioning, Disability and Health"*, which he said provides a framework that describes "*the connections that exist between impairments (e.g. weak legs), activity limitations (e.g. unable to walk or dress oneself) and participation restriction (e.g. unable to fulfil roles as a worker or parent). Importantly, it also acknowledges the interactions with the environment, supports and personal factors*."

[26] Dr McNaughton described the issues arising from the framework as it applied in Ms Taukamo's case as follows:

> *"4.2 so, for someone following spinal cored injury, it is not just the impairments that arise from that injury that bear on their ability to undertake activities*

*and participate in the community. I will try and describe these issues as I see them for Ms Taukamo with this framework in mind.*

*4.3 After a mid-thoracic spinal cord injury such as occurred for Ms Taukamo in 1983, if 'complete' (which essentially means no motor or sensory function below the level of the lesion), and if there were no other injuries, the person would have no function in their legs or bladder but have normal arm function. Loss of some trunk control can affect the ability to safely reach objects while sitting in a chair. In Ms Taukamo's case, the injury was 'incomplete' so that there was some motor function and some sensation below the lesion level although not sufficient to walk unaided.*

*4.4 For the purposes of discussing the usual abilities of a person with this problem, I think it is reasonable to consider the spinal cord injury as 'complete', accepting that this is somewhat overstating the actual situation in Ms Taukamo's case.*

*4.5 For a 'complete' mid-thoracic spinal cord injury without other important injuries or illnesses, a rehabilitation team would expect for that person to be able to be independent in basic activities of daily living (transferring – bed to chair, chair to toilet, chair to shower, chair to car, dressing, showering, eating, grooming, managing bladder – generally with self-catheterisation, most often managing bowels) as well as independent in some extended activities of daily living such as cooking, driving a car, shopping. Importantly, this would be based on the assumption that environmental factors were satisfactorily dealt with (ie the house was set up for someone in a wheelchair with good access into the house, through the house and into the shower and toilet areas, the wheelchair was suitable, working surfaces were satisfactory for someone in a wheelchair and aids were provided to facilitate various functions including handrails where necessary. Obviously if the toilet is inaccessible to someone in a wheelchair, that person might require someone available 24 hours a day to get them out of their chair and through a narrow doorway into the toilet or bathroom if there was an unexpected urinary or faecal accident.*

*4.6 In Ms Taukamo's case, there is clear evidence of a mental health disorder in addition to the spinal cord injury which in its own turn contributes impairments (e.g. reduced awareness, poor decision making) that lead to increases in activity limitations for some of the time. In my opinion the various psychiatric assessments suggest that this disorder is best described as a combination of underlying personality disorder compounded by substance abuse and manifesting as episodes of a schizophreniform state, probably not meeting standard criteria for the diagnosis of schizophrenia.*

*4.7 In Ms Taukoma's case, pain and spasms are clearly additional impairments which contribute to her activity limitation. Pain and spasm can be consequences of spinal cord injury. These can be very difficult to manage and the medications used are not often particularly effective. Some people find cannabis more effective for spasms than 'conventional' medications and when I saw Ms Taukamo around 10 years ago, I was convinced that this was the case for her. However, pain is by its nature subjective and it is very hard to quantify the impact of pain on activity*

*except by self-report. The psychiatric assessment by Dr McLeod (referred to in the discharge summary dated 26 July 1988) makes the link between the difficulty adjusting to a new disability and difficulty managing pain. In my opinion, some weight needs to placed on the letters from Dr David Pilditch a the Dunedin Hospital Pain Clinic (dated 18 November 1987 and 25th November 1987) describing marked reductions in pain reporting and medication usage over a one week admission to hospital. He found a marked discrepancy in the subsequent reporting of pain and his clinical observations during that inpatient stay. Given that reporting of pain plays such a big part in subsequent discussions of the need for attendant care, these reports cast some questions over the veracity of that reporting and/or the degree to which pain may have been affecting daily activities. The report from Jean Heath, District Nurse Supervisor (23 September 1988) says that 'Based on our visual observation ... pain would appear to play a very small part in her stated inability 'to cope' and that analgesic medication had been stopped 'with no apparent untoward effects'.*

*4.8 Other 'secondary impairments' can occur over time that can lead to increases in activity limitation, most notably musculoskeletal problems in the upper limb related to a wheelchair existence. There was nothing in the file notes suggesting that this applied to Ms Taukamo. As people with spinal cord injury age, the effects of ageing, particularly on the musculoskeletal system (stiffness, reduced range of movement) can change the health care needs of someone where the primary condition has not changed with time. There is some evidence from Dr Anthony's letter to ACCC (dated 11 June 2001, in Capital & Coast DHB file) of 'loss of power in her upper trunk' which he attributes to 'some neuronal fallout to do with the ageing process'. This power loss could lead to more difficulties with transfers (also referred to in that letter).*

*4.9 'Personal factors' can include the support of a spouse, personality factors and the need to manage the needs of dependents, in this case Ms Taukamo's children. Sometimes it is necessary to provide more support for personal needs (such as showering or dressing) so that these can be accomplished in a shorter time and using less energy than would have been the case if they were done without support so that the person can use the 'extra' time and energy on other activities such as parenting or work."*

[27] After reviewing the assessments of Ms Taukamo's function over time, and assessments of her support needs over time, Dr McNaughton concluded as follows:

*"**7. Opinion***

*7.1. In making a recommendation regarding the need for attendant care during the period from the time of injury 1983 to the present it is necessary to use several strands of information:*

- *Knowledge of a reasonable or usual level of care required given the known deficits .*
- *Consideration of other factors that might impact on this reasonable or usual level of care (as per the ICF framework)*
- *Actual assessments of personal care and home help that were done*
- *An assessment of these assessments as to whether they*

*sufficiently considered all relevant factors in reaching their conclusions about level of care .*

7.2. ***Reasonable or usual level of care for someone with complete (or nearly complete) mid·thoracic spinal cord injury,*** *For someone with dependants, in a suitably modified home and able to manage bladder and bowel cares independently, full independence using a wheelchair for mobility would be the expectation of most people. Extra help would be reasonable for some people to shorten the duration and/or energy expenditure for some tasks eg showering, dressing, meal preparation, housework to allow them to meet other goals such as being involved in work or study or allowing time for parenting. Extra help with management of (especially young) children dressing, meal preparation, getting ready for school might also be reasonable in some situations. A home environment suitably modified for a wheelchair existence should be considered standard for someone in this situation, It is clear that at various times, appropriate modifications to homes in which Ms Taukamo lived were delayed, Nevertheless, mostly the modifications would make for reduced difficulty in daily tasks rather than turning them from unmanageable to manageable. So, although some increase in direct assistance or supervision might be required in a home awaiting modification (eg requiring help with transferring on and off a toilet or into a bathroom), it is extremely unlikely that this would translate to the need for care 24 hours per day. In this absence of significant other disabilities, it is hard 10 conceive a situation where 24 hour care would be required for someone in this situation. Even with poorer transferring ability than Ms Taukamo had, once in bed, a requirement that someone be available to help overnight would not usually be reasonable."*

7.3. ***Other factors.*** *Aside from the home environment and children as mentioned in 7.2 above, the main-other factors to consider are mental health disorder, obesity, pain and spasms and effects of ageing.*

7.3.1***Mental health disorder*** *It is clear from the recent Appeal Authority judgement that the 'mental, breakdown' in 1989 has been accepted as a separate claim against ACC. Although I am unable to agree with this conclusion from the material provided to me, the existence of this separate claim requires that the effect of that mental breakdown be considered in regard to the question of need for attendant* care. This mental health disorder as having a major impact during 1989 (admission August 1989) and 1990 (admission May 1990). She was reported to be 'free of psychotic symptoms 6-8 months' in the letter of 16 July 1991 by Kate Wood, Psychiatrist. There was further trouble in September 1991 requiring admission to a Psychiatric ward. In my opinion, the reports during the period from mid 1989 to late*1991 suggest that, at times, Ms Taukamo was having substantial trouble managing her basic activities of daily living and immediately prior to the various admissions was requiring more help than she was· receiving. It should be noted that people with men\al*

*health disorders who are decompensating will not uncommonly refuse help that is being offered. In my opinion, it is possible to make a case for the need for provision of substantial amounts of care for some weeks and possibly months during this time. Nevertheless, reading the nursing notes during the admissions to psychiatric wards, my impression is that Ms Taukamo was not requiring any regular care at night and so I would conclude that, even during this period when she was living at home, with adequate amounts of care during the day, there was probably not the need for 24 hour care. This doesn't alter the fact that she did not receive ' adequate amounts of care' at times during this period. . .*

7.3.2. ***Obesity.*** *This can, at least in part, be attributed (to a life in a wheelchair. With increasing weight, transfers become more difficult and tasks such as self-catheterisation become more problematic. It is likely that increased weight prior to the gastric bypass operation in 1992 contributed to an increase in difficulty with self-care. However, I could find no clear evidence that this made more than a modest difference and certainly insufficient to make 24 hour care required.*

7.3.3 ***Pain and spasms.*** *These are well-established consequences of spinal cord injury. They were clearly a big problem for Ms Taukamo according to her own reports. As mentioned under 4.7, there needs to be some caution applied to these self-reports. Even. The Surwood report of 1998, which posits a very significant effect, the pain and spasms on care, doesn't conclude that care overnight would be required as a consequence of these symptoms*

7.3.4 ***Effects*** *of ageing. By 2001 (admission to Burwood) there is the suggestion of increased trunk weakness, attributed to ageing. Difficulty with transfers contributed to an assessment of 47'hours per week of personal care and home help plus 8 hours per day sleepover. The pattern of admissions in 2009 (pressure areas) and 2092 (after falls from her wheelchair) add to the picture of someone much less able to cope with basic activities of daily living safely.*

7.3.5 ***Summary of other factors.*** *The extra effect of these other factors would make the 'ideal' situation as described in the first sentence of 7.. 2 ie full independence, unlikely to be reasonable. The most significant factor regards a mental health disorder which the Appeal Authority has attributed to poor quality support following the1983 injury, Although a case could be made for the need for 24 hour care at times when there was significant decompensation of this disorder (1989-1991), my opinion is that reasonable levels of care during the day (albeit more than Ms Taukamo actually receive) would have been sufficient without requiring 24 hour care during this period, However, from around 2000, the impression I get from the pattern of admissions and the Burwood report of 2001 is, at*

*least, of someone Where 24 hour care would be desirable if not strictly necessary.*

*7.4 Actual assessments of care needs. These have been presented above. The compelling finding is that at no stage 'does any of the reports suggest the need for anything near to 24 hour care uni.il tile Burwood report (if 2001 which suggests overnight care as part of a package of 103 hours per week, The reports come' from many different sources and it is hard for me to accept systematic under-reporting of care needs. The 1998 Burwood report (which was not based on their current observation of care needs) makes substantial allowances for child care and supervision and makes substantial allowance for the effect of pain and spasms. Their total (104 hours per week or around 15 hours per day), although substantial, still falls short of 24 hour care. .*

*7.5* ***Assessment of these assessments of care needs.*** *Assessments can be wrong for many reasons including too narrow a focus, personality issue with a client, a desire to keep the funder of the assessment happy. However, my experience of community and hospital health!) care professionals involved in such assessments is that the needs of the client still matter the most. If 24 hour care really was necessary, I Would have expected someone, somewhere to have said so in one of these assessments, I can only conclude that, in the opinion of many health care professionals involved with Ms Taukamo over the years up to 2001 , none of them felt that 24 hour care was necessary or even desirable. The only caveat to this is that, for a' period of time, a live-in housekeeper was present, effectively available 24 hours a day and available overnight. While this does not mean that 24 hour care was necessary during this time, any assessments that occurred would have allowed for the presence of someone available 24 hours per day without actually spelling this out. A similar argument could be advanced with the presence of children who, as they got older, may have been able to help at times during the day and night without paid help being required. The comments of Dr Haas (report 1995) and the Kenepuru Hospital admission in 1995 suggest that the presence of children was necessary (rather than just desirable) in order for Ms Taukamo's basic needs to, be met. The contrary argument is that, where there was no live-in help and the children were either too young, or had left home. there is no report that suggests that overni9ht care was necessary.*

***8. Overall summary***

*From the foregoing, I conclude that a case for the provision of attendant care ie 24 hour care, from the time of injury in 1983 to at least 2000 can not be made. A possible exception to this may have been short periods (weeks, possibly months) between med 1989 and late 1991 when the effects of a mental health disorder in addition to the deficits from the spinal cord injury made self care very difficult. However, in my opinion, even for these periods reasonable amounts of daytime care should have been sufficient and overnight care was not necessary as attendant care must be to meet the provision in the Act. From 2000, 24 hour care would have, at*

*least, been desirable and possibly necessary although there is no assessment available to me which has actually stipulated that 24 hour care was necessary ..."*

***Dr Seemann's assessment***

[28] Dr Seemann interviewed Ms Taukamo and where possible, he spoke to the people identified as her caregivers apart from her children, who were considered too young to have reliable memories. Dr Seemann said with respect to the time period he was asked to consider, that Ms Taukamo was not discharged from hospital care related to her accident until 9 April 1984 as recorded in the letter from Mr B McMillan dated 11 April 1984.

[29] The first part of the assessment briefly records Ms Taukamo's medical history, the concerns she expressed about her care and the results of Dr Seemann's physical examination. I have repeated the assessment from this point:

*"**Interviews with Caregiver's***
*I was provided with a list of carers for Linda from 1984-92. I attempted to contact everyone on the list apart from Linda's daughter Pania:*

***Richard Williams** -no reply to message left on mobile Annette Cabral -I spoke with Annette who was a friend of Linda's prior to her accident and observed what was happening at the house after Linda's return from Burwood Hospital. She says that Linda couldn't provide the care necessary to the five children in the house. She was particularly concerned for the youngest; who she thinks was about 3 years old. Linda could not control the children. Her children ended up providing her with cares such as taking her to the toilet and bathroom, washing her after she was incontinent of faeces, and putting in her intermittent urinary Catheter·. On one occasion the kids were doing the vacuuming and vacuumed up hot ashes, setting the cleaner on fire. Annette says that was a close call to a disaster·. She can recall Linda coming round to her place one night at about midnight with the kids as she had locked herself out to the house.*
***Pania Tulia** Linda's daughter. The Court has directed that I should not contact Linda's children. I think this is appropriate given their age at the time.*
***Licia Mihaka** - I was able to speak to Licia. She was a friend of one of Linda's daughters, Rena. Licia was aged between 6 and 10 years at the time. She can recall Rena dragging Linda on a sheet into the shower as the house was unmodified for her wheelchair. When the girls were naughty they would run up the stairs as Linda could not chase them. Licia was never a carer for Linda.*
***Jeff Pringle** - the number provided was stated to be incorrect by the person answering the phone.*
***Rudi Verhoef** - I spoke with Rudi - he was a next door neighbour from about 1986-9 and gave assistance when Linda had problems. He called in most days. He did not provide any overnight assistance. Linda had Mongrel Mob members staying in the house who were intimidating. He can recall one time when Linda slashed her waterbed and was found lying in her faeces after a couple of days. Rudi helped to clean her up. Rudi says that he thought the ACC case manager, Dallas Parke, was not helpful to Linda at that time.*
***Dr Robin Stephen** - Linda's GP in Port Chalmers. I spoke with Dr Stephen's stepson, Daryl. Dr Stephen has a dementing illness and would not be able to answer questions about Linda.*

***Dr L McLennan*** *- was not Linda's GP in the time periods quoted above so I have not contacted him.*
***Mr. Alan Bean*** *- was the Burwood Spinal Unit specialist caring for Linda. He has been retired for 10 years now. Alan stated that he recalled Linda well. He said that he did not think that she required 24 hour care at that time as she was paraplegic and independent in her wheelchair and with transferring.*

***Concluding Remarks***
*I do not believe that it is possible to reconstruct what Linda's life was like at the time periods in question in any detail from eyewitnesses. The most appropriate means to do so in my opinion is with contemporaneous written records and/or with photographic evidence that may be available.*

*It is clear that Linda's situation was complex. If well functioning, a person with this level of spinal cord injury should not require 24 hour care. In fact many young paraplegics are independent of attendant caregivers in the community, although usually need assistance with housekeeping if living alone. In Linda's case however there were multiple factors increasing her care needs:*

1. *A chaotic domestic situation*
2. *Loss of natural supports - in particular her husband soon after her discharge from Burwood Spinal Unit - and a very poor relationship to her adoptive parents*
3. *Poorly developed coping and probably also life skills*
4. *Unmodified houses*
5. *Marijuana and alcohol usage*
6. *A neuropathic pain disorder and frequent leg muscle spasms (with significant marijuana, and later opiate and benzodiazepine usage as a means of management). These drugs all affect cognition and motivation.*
7. *Reported occasional nocturnal bowel incontinence*
8. *The gradual onset of mental illness*

*These issues are all intertwined and related to Linda's lifestyle choices to a great extent in my view. Being an adopted child is also known to predispose to mental health and behavioural issues. I count this as a factor in her chaotic presentation.*

*The records provided however do indicate many attempts to problem solve Linda's problems and to provide balanced assessments of her needs taking into account her unique situation.*

*The one area that I see as clearly lacking in the reports is due attention to her childcare needs. The focus was largely on Linda, but at that time I understand that childcare was not recognized as part of ACC's responsibilities under the legislation. Linda was not able to provide care for her children due to her preoccupation with her own care. Her use of marijuana and her pain issues no doubt also impacted on her ability to do this.*

*I do not personally think that Linda needed attendant cam for herself 24 hours a day. Even if incontinent at night, she would be able to clean herself up, provided of course that she was in a modified house in which she could access the bathroom.*

*However a holistic view is needed; indeed in the Maori world, the whanau and not the individual is the key point of focus. In Linda's case, for the benefit of the family group, and in particular the wellbeing of her children, another able bodied adult in the house fulltime would have given appropriate support.*

*Finally, I have two further comments in regards to the specific time periods in question:*

1. *Linda was in hospital care after her accident up until 9'· April 1984, therefore should be assessed for attendant care needs from that date onwards, not January 1984 as stated.*
2. *Linda was suffering from morbid obesity in early 1992, as judged by her undergoing gastric bypass on 5"' May 1992. Obesity and the post-operative complication of failure of the abdominal wound to heal could be factors in increased attendant care needs at that time, but I cannot ascertain that from the records provided, which are relatively sparse compared to other time periods.*

*The medical issues in this report are complex; I am happy to provide further clarification required."*

***Dr Seemann's oral evidence***

[30] Dr Seemann sat through the evidence given by Ms Taukamo and Ms Cabral and was then cross-examined by counsel. In response to questions from Mr Allan, Dr Seemann again confirmed the date of Ms Taukamo's discharge from hospital as being 9 April 1984, and agreed that Dr Stephens' description of Ms Taukamo's circumstances as "*appalling*" was a description not normally used by a doctor about a patient with paraplegia.

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[31] In response to Mr McBride's questions, Dr Seemann agreed that he was familiar with Dr McNaughton's professional standing and said that he respected his clinical judgment. When questioned about the impact of the particular questions asked on the differences between his own assessment and Dr McNaughton's assessment, Dr Seemann said that he did not know what questions were asked of Dr McNaughton, but said that it was possible to make a general prediction of what a person needs on the basis of their injury as Dr McNaughton had done. He also agreed that Ms Taukamo's deterioration since 1992 and her need for attendant care since then was not an indication of her requirements in 1984.

[32] When questioned about the fact that Dr McNaughton had not examined Ms Taukamo, Dr Seemann said that this was of relatively minor importance because of the nature of Ms Taukamo's injuries. Dr Seemann agreed that it was difficult to prepare retrospective assessments because of issues with memory over time, and said that this was why he had asked for the photos and other information in his own assessment. He also agreed that now that he was aware from Ms Taukamo's evidence that Dr McNaughton had seen Ms Taukamo in inpatient settings in 1984 and 1995, that Dr McNaughton could have had an advantage over him and that if Ms Taukamo's children were taken out of the equation, she would have needed substantially less care. Dr Seemann accepted Mr McBride's correction of his understanding that childcare was not recognized by ACC as part of its responsibility at the time, and said when asked about the effect of cultural circumstances on the level of care needed, that there could be an impact because of differing cultural circumstances given the nature of the injury needs.

***Evidence for Ms Taukamo***

[33] According to Ms Taukamo, she was discharged from the Burwood Spinal Unit on 31 January 1984 to her unmodified home at Aramoana with her six children to care for, who were aged between 1 and 13 at the date of her accident. She returned to hospital briefly in April 1984 and was then formally discharged on 9 April 1984. The Aramoana home was not suitable so, she moved to an unmodified state house in Mosgiel. She received no attendant care or childcare and from then on and her life moved from crisis to crisis on an hourly basis because she realised that it was impossible to look after her herself or her six children and her husband. By November 1984, her two year old son had a broken leg and the other children were unable to toilet him and care for him. She said that ACC files disclose that ACC knew she was "*struggling to adapt to a bad situation but if he (Mr Park) was to cut my home help further this would put the Corporation into an embarrassing situation*". Nothing changed but later home help was dispensed with on many occasions.

[34] By this time they were living at 13 Magnetic Street, Port Chalmers, which was another unmodified house. There was no wheelchair access, no suitable bathroom and showering facility for her. It was a double storey house. The hallways and door openings were too narrow, the light switches and door handles were too high to reach, the only heating was an open fire and the kitchen bench was too high for her to reach. Due to lack of money and limited mobility to pay her bills, the power was cut off and a coin operated electricity meter was installed about 6 ft up one wall. The lack of modifications made every task she had to perform arduous and next to impossible.

[35] Her husband left her in 1985 because he was required to do so much around the house and dealing with her needs, which included dealing with her period and faecal and urinary incontinence, and the promised help from District Nurses never eventuated. She constantly called ACC for help, but her case manager, Dallas Park, did not respond positively.

[36] Ms Taukamo was unable to add anything more specific during cross-examination concerning the timing and nature of her house modifications, or the timing of the personal care needs that she asserted fell to be performed by her children because of ACC's failure to provide the care and help she desperately needed. She agreed that she could not remember the events and circumstances she was recounting with "*crystal clarity*" because of her head injury and her breakdown. She did however, strongly maintain that she discharged herself home on 31 January 1984, and that because she had no assistance whatsoever from ACC, she had to readmit herself to hospital a few weeks later because she was in such horrific circumstances.

[37] Ms Taukamo said she was housebound except for a period in 1988, when a friend, Rudy Verhoff, came and rescued her and took her shopping for food and paying bills. When questioned about Ms Cabral's evidence in her statement that she helped transport her for food and that the children had to carry her into her car in dreadful and difficult circumstances, Ms Taukamo said that she had a car for three years and she agreed that she and the children travelled independently. Ms Taukamo also agreed that her main concerns were for her ability to the care for her children, rather than her own personal care.

[38] Ms Taukamo vividly described lying in her waterbed, incontinent and unable to care for herself, and finally being forced to slash her waterbed she was in such distress. I have not repeated this evidence in any detail as the 1999 appeal decision and her counsel's submissions, place this as not occurring until 1989, in the period in 1989 leading up to Ms Taukamo's first mental breakdown and for which she has already received compensation for 24 hour care.

[39] Annette Cabral also gave evidence in a statement and orally as to Ms Taukamo's living conditions and the very arduous and personal care tasks the children were called on to perform, which were described in some detail, as was the chaos in which the family lived, again appearing to relate to 1989, rather than the period at issue. Ms Cabral said that she cared for Ms Taukamo and would assist her in doing her exercises and turned her over in bed and she dressed her bedsores. She would also take the children to school and kindergarten and pick them up and try to keep the house tidy. Ms Cabral said that Ms Taukamo could not go anywhere without assistance, but she reported an incident where Ms Taukamo drove to her house late at night with her children because they were locked out of her house, which was also in Ms Taukamo's evidence.

[40] Ms Cabral described specific episodes where the children had to either care for Ms Taukamo or themselves in graphic detail, including them performing procedures such as catheterisation, sterilisation of equipment, cleaning faeces and dragging their mother to the bathroom in the unmodified house in order to wash and clean her, then dry and dress her and then on the count of three, roll their 22 stone mother back on to the bed.

[41] The difficulty with Ms Cabral's evidence is that she clearly was not present on any of these occasions and cannot have been speaking from her own observations, her evidence was framed as vaguely as Ms Taukamo's in terms of the timing of any of the events she talked about and she suggested that the six children were with Ms Taukamo throughout, which was the major reason in her view that Ms Taukamo needed at least two people with her for 24 hours a day – one for her own cares and one for the six children.

[42] Neither Ms Taukamo nor Ms Cabral acknowledged that any care was provided by ACC, and the overall impression from their evidence was that ACC refused to modify Ms Taukamo's house for wheelchair living and that she was left to the care of her young children and her friends.

***The contemporaneous evidence***

[43] I have relied on the Burwood Report to a limited extent, but I have taken most of the information from the two volumes of medical and ACC evidence assembled by Mr Sara for Dr McNaughton's assessment, which I have paraphrased below.

[44] At the time of her accident, Ms Taukamo was separated from her de facto husband, and living at 46 Aramoana Road, Port Chalmers. She was caring for all six children, who were then cared for by a friend with financial assistance from ACC while she was in hospital. Her partner, Mr Atkins, was very supportive while she was in hospital and they reconciled during this time.

[45] Ms Taukamo was returned "*home*" from Christchurch Hospital to Dunedin Hospital from 31 January 1984 to 12 February 1984, so that she could sort out housing and childcare issues from closer at hand.

[46] Caroline Reid, Occupational Therapist, Community Services, said in her letter dated 13 February 1984 to Lillian Margetts, Occupational Therapist and Acting Section Head, Burwood Hospital, that Ms Taukamo and her ACC rehabilitation officer Dallas Park and the Housing Corporation visited Ms Taukamo's house on 2 February 1984 and she and Ms Taukamo visited the house again, and the outcome was that alternative accommodation was necessary and either a Housing Corporation house would need to be rented, or an appropriate house for sale would have to be found. It was not appropriate for Ms Taukamo to return home if alternative housing did not eventuate before discharge even with temporary wooden ramping of the house, as she would be spending the working day alone.

[47] As the Aramoana house was not suitable for her return home, ACC paid Ms Taukamo lump sum compensation in the full amount of $27,000.00 in March 1984, to assist her to buy a more suitable home that could be modified (the Mosgiel house).

[48] Ms Taukamo referred in her evidence to a letter written in 1984 by her then lawyer, Susan Bathgate, to ACC, "*noting my difficulties and referring to my spending most of my time bedridden and prone, in pain and with the lack of promised housing modifications promised straining my relationship with my husband*". The only letter from Ms Bathgate to ACC on the file is dated 8 March 1984, and was written for the express purpose of seeking the maximum lump sum compensation award. Ms Bathgate in fact said:

> "*Since her admission to Burwood Spinal Unit following the accident I am instructed that she has been in considerable pain and was confined to her bed in a prone position until the last few weeks. My instructions are that the pain suffered by Ms Taukamo since the accident has been at times intense and difficult for her to deal with. She has been unable to care for herself in the most basic of her requirements until relatively recently*."

[49] The letter dated 5 April 1984 by Michele Collins, the Burwood Hospital Charge Nurse, Spinal Injuries Unit ("the Unit"), to the Charge Nurse at the Dunedin Hospital, records that Ms Taukamo was readmitted from Dunedin Hospital on 13 February 1984 following a break from the Unit so she could sort out legal and social problems for two weeks. Ms Taukamo was fairly close to discharge from the Unit and Ms Collins described her condition as follows:

> "*Linda is now independent with her sliding board transfers and with an extension pies to the shower chair she can cope with a bed ladder to pull herself onto and off the shower chair. She can cope with a bed ladder to pull herself up in bed and now manages to shower and dress herself. Her wheelchair management is acceptable and she is very much looking forward to her return to Dunedin so she and her de facto husband Ricky can start looking for housing for themselves and the children and to once again become a family.*
>
> *Bowel Regime: Linda has no set pattern for her bowel movement. She has developed sensation concerning her bowels and knows when she will have a bowel movement. She can go up to five days without needing to have a bowel motion. Once she has been, she is able to check her own bowel to ensure it is empty. This regime has proved successful for the last 2 months.*

> *Bladder Regime: Linda is now doing her own 6 hourly intermittent catheters and she appears to be coping with these well. She is mobilised on fluids. On discharge Linda will continue with self intermittents. Using the clean technique. She will need to obtain catheters from the District Nurses.*
> *…*
> *Linda is for discharge to Dunedin Hospital on Thursday 5 April, until her and Ricky can sort out housing accommodation*."

[50] The Outpatient Summary addressed to Mr McMillan, Orthopaedic Surgeon at the Dunedin Hospital, dated 5 April 1984 by Mr Bean, the Assistant Director of the Unit who cared for Ms Taukamo during this time, stated that Ms Taukamo was discharged from the Unit to the Hostel on 30 March 1984, as she seemed independent of nursing cares and was doing independent transfers with a sliding board and managing her own self intermittent catheterisation. Mr Bean said "*It is important for this to be successful she must make for herself a life without alcohol and try and keep her weight down".* Mr Bean said that the Unit would like to review Ms Taukamo in 3 – 6 months time, depending on when she could be discharged from Dunedin Hospital into the community.

[51] The reporting letter by Dr McMillan, Orthopaedic Surgeon, Dr B Williams, Ms Taukamo's then doctor dated 11 April 1984 states that on 9 April 1984, Ms Taukamo was given weekend leave (from Dunedin Hospital) to return to the Aramoana home. ACC had agreed to pay for her to stay in a motel when she returned because the Aramoana house was not suitable, but she did not return from leave as she had decided to stay there until more suitable accommodation was available in Mosgiel.

[52] It appears from the letter from Ms Taukamo's lawyer to ACC dated 1 August 1984, that the family moved to 92 Argyle Street, Mosgiel during Easter 1984. At some stage after Ms Taukamo returned home, the two eldest children went to live with relatives to help relieve the pressure on her. I have been unable to identify the date the oldest child left home.

[53] The letter from Caroline Inglis of Community Services to Mr Park dated 20 June 1984 is about the kitchen alterations and a new stove. The Burwood Report describes the house from Ms Taukamo's recollections as having temporary ramps, but otherwise unmodified for shower and toilet access and the kitchen was completely unusable for a "*wheelchair client*" and Ms Taukamo was mostly confined to the living room because of narrow doorways.

[54] The next letter on the medical file is from Ms Margette to Ms Inglis dated 21 June 1984, and states:

> "*Many thanks for your letter dated 18 June 1984. Linda called to see me at the Unit on Monday, 11 June on her return from a 3 week holiday. She expressed concern to me with regard to her washing line from the house. I consider it essential, as a mother of five, that she has access and is able to reach the washing line.*
>
> *The kitchen alterations are essential to her independence from the wheelchair*."

[55] The letter goes on to discuss the kitchen design and bathroom recommendations, a hall heater and a washing machine and the documentation to be forwarded to ACC. A memorandum dated 26 July 1984 from Mr Park to the Regional Manager, Dunedin, shows that the kitchen design itself was the major problem delaying the installation of the new stove and this was ongoing. Mr Park also said that Ms Taukamo was able to manage at home, however she still required considerable assistance and that she had her three younger children at home and appeared to be coping quite well, considering her living conditions. Home help would be required at least until all the alterations were complete and then may be able to be reduced.

[56] Dr Anthony's undated clinical notes appear to be for some time after July 1984, and describe an admission for reassessment, which is in keeping with his April 1984 letter to Mr McMillan. The notes record that Ms Taukamo was living in a state house and her husband had to lift her in and out of the bath. Dr Anthony described Ms Taukamo's condition as follows:

> "*Bowels are managed on a daily basis, with a glycerine suppository and manual evacuation (which Ms Taukamo had achieved while in hospital). She does a manual check daily. She has had no physio at all. She does no standing, she has no hobbies, no activities. On the whole she presents very well.*
>
> *Medically, she really has no problems…*
> *…*
> *On the whole Linda presents very well at this assessment. I have discussed with her the problem of her bladder and the options she has, either bladder training or staying on permanent self-catheterisation. I think in her situation, permanent self impermanent catheters would be the best thing, she has lost a lost a lot of weight. I wonder whether we should do anything about her pain, if it is not distressing her too much*."

[57] The Burwood Report notes that in December 1984, the family moved to Magnetic Street Mosgiel, as Ms Taukamo felt this house required less modification and was not as damp. The downstairs living was more open plan and Ms Taukamo could get around, but until such time as a wet area shower, a wheel under the vanity unit and accessible toilet were in place, she was not expected to be able to manage her own self cares.

[58] The Unit inpatient summary dated 9 May 1985 records that Ms Taukamo was readmitted initially for reassessment on 16 February 1985. She was admitted as an inpatient from 17 February 1985 to 20 February 1985, and transferred back from the Christchurch Womens Hospital on 22 March 1985 to 8 May 1985.

[59] Mr Park's file note dated 22 May 1985 records that "*her de facto husband, Ricky Atkins, has now left the family home for good and this, of course, is going to cause considerable problems once Linda is returned to the Spinal Unit in approximately two weeks time*." Ms Taukamo had the two older children home with her for the school holidays and they would be returning to their father. Ms Taukamo had friends who could assist with the children, but arrangements would have to be made for full time childcare in her absence. Mr Park also said that Ms Taukamo requested progress to date with the housing alterations.

[60] Ms Taukamo rang ACC asking about home help on 4 June 1985, and the file note of the conversation records that Ms Taukamo said that she had an argument with her husband, so they split up and she had to call her girlfriend to come round to look after her and the kids. The girlfriend worked for Sunday and Monday at the usual home help hours and Ms Taukamo wanted an increase in the rate of pay for those particular days.

[61] Mr Park's file note dated 14 June 1985 records that he telephoned Ms Taukamo and she said that she was managing reasonably well since her husband's departure, however she was having problems in the evening. If she did require any assistance, she had to wake one of the children and this was not a satisfactory arrangement. The alternative was to have someone living in full time or some device where she could wake just one of the children and Ms Taukamo requested an intercom system. Mr Park noted that Ms Taukamo was surviving under considerable pressure, mainly due to house alterations not being completed, and obvious tremendous emotional strain. He recommended the intercom system be investigated. With regards to the house alterations, Mr Park mentioned that the plans had been drawn, but the kitchen alterations differed from the original design and a meeting was to be arranged once the plans were received. Ms Taukamo intended returning to the Unit in two months time irrespective of whether or not the alterations had started. Mr Park said that Ms Taukamo had a person in mind who would be prepared to live in permanently and she asked ACC to contribute towards accommodation expenses while this person was learning about her care at the Unit.

[62] Mr Park's rehabilitation report dated from 20 June 1985 to 4 September 1985 records on 26 June 1985, that a friend of Ms Taukamo's was travelling from the North Island to the Unit to learn how to look after her and that hopefully this would dispense with present home help arrangements. He had requested that his transport expenses and accommodation was paid while at the Unit. This was agreed and was subject to a successful period following discharge.

[63] The related memorandum dated 26 June 1985 records that Ms Taukamo was to leave Dunedin for the Unit on 29 June 1985 and Ms Margetts confirmed in a letter dated 27 June 1985, that she had done so. The hospital discharge notes confirm that Ms Taukamo was discharged home on 30 July 1985.

[64] The entry in the rehabilitation report dated 21 August 1985 records that the modification plans had been received from the Housing Corporation and a further meeting was to take place at the house to go through problems with the kitchen design and the en suite. The matter was being treated as urgent.

[65] Mr Park's file note dated 15 October 1985 records that he spoke to Ms Taukamo about home help. The situation was unclear concerning the actual amount of home help required, and he had been concerned that the amount she had been receiving for some time, which he said may seem excessive, although considering the circumstances may be well justified. He had engaged the services of an assessor from Dunedin Hospital to assess the amount of home help Ms Taukamo required and this would be reassessed once the alterations were complete. The alterations were discussed, and the only query Ms Taukamo had related to a sliding door in the bathroom area so she could supervise the children. She had three young children living at home and he thought the youngest were 4 and 5. The intercom had been installed and Ms Taukamo was far happier with the supervision of the children when they were in another room, and if she required anything herself in the evening.

Mr Park concluded with the comment that Ms Taukamo was in very good spirits and once the alterations had been done, he was sure she would be able to cope very well at home with minimal assistance.

[66] Mr Park's next memorandum dated 8 November 1985 reported that the assessment of Ms Taukamo's home help requirements could not be carried out accurately due to the house alterations not being carried out. He said that Ms Taukamo was aware that the home help would be reviewed when the alterations were complete and that they would reduce considerably.

[67] In Mr Park's memorandum dated 4 December 1985 concerning House Alterations, he said that at that time, Ms Taukamo had a live-in housekeeper and three children living at home aged 4, 5 and 8 years. With regard to the house alterations, due to the open plan and generous size of the kitchen the alterations would not be extensive. A smaller bedroom backed onto the main bedroom. The existing bathroom/toilet facilities were in another part of the house away from the small bedroom and would be very extensive to modify to Ms Taukamo's requirements and additional facilities would be essential because of the size of her family. The smaller bedroom could be divided and turned into an en suite. Other alterations were to be carried out to the carport drive and ramp, the existing balcony was to be extended and minor alterations had to be carried out to the laundry.

[68] The next relevant record is Mr Park's memorandum dated 20 May 1986. The house alterations had not been completed due to a dispute between ACC and the housing Corporation over contributions to the funding and tenders had not yet been called for. Ms Taukamo had been advised and though understanding, was becoming increasingly frustrated with the delay. She was very adaptable and managing under pressure and though he was not happy with the home help situation, he felt the ACC did not have any choice with regards to the number of hours being reimbursed. This was to be reviewed once the alterations were carried out but he recommended they be left in place in the meantime.

[69] On 10 July 1986, Mr Park recommended that ACC should fund the purchase of a waterbed to assist Ms Taukamo as a built in heating system and pressure relief.

[70] There are some hospital admissions records dated between 26 May 1987 and 26 July 1988, relating primarily to Ms Taukamo's treatment for chronic pain problems, which also involved various hospital admissions, and difficulties with prescription drug dependence and cannabis use for pain control.

[71] The Burwood Report states that in December 1987, it was recorded in the ACC notes that the housing modifications were completed at Magnetic Street. The only document that records Ms Taukamo's abilities and needs around this time is a Burwood Nursing Assessment form dated 7 April 1988. This records that Ms Taukamo gave the following information:

> *"Marital status: Married*
> *What type of Bed and mattress do you have? H20 bed.*
> *Do you turn at night? Yes.*
> *Type of Transfers: Independent.*
> *Do you drive? Ticked yes.*
> *Urinary system management and appliances: Intermittent catheters.*
> *How often do bowels move? Every 2 days*

*Bed/toilet: Toilet circled.*
*How long does procedure take: 10mins.*
*Who does your manuals? Self.*
*Any bowel problems? Constipation when not eating properly.*
*Do you shower? Bath circled.*
*Dressing – what can you manage yourself? Self.*
*What activities of daily living can you not do? Blank.*
*Do you have District Nurse, carer, flatmate, live alone, other? District Nurse circled + When needed.*
*Do you have other home help? Daily."*

[72] On 27 July 1988, a meeting was convened to discuss areas of concern raised by Ms Taukamo and try to find a solution. In attendance were Mr Park and two other ACC personnel, and representatives of Social Welfare, Maori Affairs, the Housing Corporation, the District Nurse, a Social Worker from Otago Hospital, an Occupational Therapist, a Public Health Nurse, Ms Taukamo's then solicitor Ms Weatherall, and Ms Taukamo's GP. Ms Taukamo and "*her party*" arrived 1 hour after the meeting had started. I have dealt with the matters discussed by drawing upon Ms Weatherall's reporting letter back to ACC, but I note that ACC offered to meet the costs of an accountant to get Ms Taukamo's finances in order and that Ms Taukamo was then receiving $250.00 per week for Attendant care/home help. This was to be reviewed but no reduction was seen in the near future.

[73] According to Ms Weatherall's reporting letter to ACC dated 1 August 1988, in which she provided a précis of the matters discussed at the meeting and the resolutions made, the housing modifications were still to be completed at that time, but it was ascertained that no further modifications could be made until certain steps were taken related to Ms Taukamo's financial situation, including her debt to Social Welfare that was being deducted from her benefit and the seven mortgages over the house, and it was contemplated that Ms Taukamo might have to declare bankruptcy. Ms Taukamo was also in debt to Social Welfare. Ms Weatherall said at pages 1 and 2 of her letter:

"1. *<u>Housing modifications</u>: The object of altering the house is to minimise the help being given to Ms Tulia. Some alterations are necessary and outstanding. The carport and ramp need to be levelled. The work that has been done on the bathroom has been done poorly and unless the finishing is completed there will be structural damage caused by water leakage.*
*….*
*4. Health/drug/pain/alcohol problems were identified. Ms Tulia acknowledges an alcohol problem. She has just been in Burwood Hospital where she had been receiving treatment. No report was available from Burwood Hospital.*

*5. Home help/child care appears to be a problem area. Ms Tulia receives and disburses the funds for her home help and her child care. It is impossible to identify the persons who are receiving the home help wages, and several people appear to be involved in the child care. The health nurse reported that while the children were very much loved and wanted and indeed charming and able children, there were areas of concern. The children do not appear to be kept clean which means they are having problems of rejection by their peer group at school. There is bedwetting. Generally the children's lifestyle is chaotic with the associated problems of chaos, lack of sleep, irregular meals and inadequate hygiene. It had been suggested that Ms Tulia and the children*

*could do with a break and that Health Camp facilities should be used. Unfortunately, this suggestion has been interpreted by one of Ms Tulia's confidantes as a move to take the children away from her. This of course is not the case. It was decided that further explanations concerning the benefits of Health Camp would be given to Ms Tulia.*

*6. <u>Lifestyle</u>: Ms Tulia's lifestyle is causing several problems. Not only is it impossible to identify who is looking after the children, it is also impossible to identify who is actually living in Ms Tulia's house. The citizens of Port Chalmers have until very recently been supportive of Ms Tulia, but her lifestyle is now causing the community to reject her. Her home is being seen as a focal point and gathering place for undesirable, if not criminal activities which has resulted in the decrease of the broader community support network that Ms Tulia has enjoyed, and an increasing reliance by Ms Tulia on a group of people who appear to be adding to her financial problems as well as all of the other problems that she has. She appears to be supporting more people than she is receiving support from. With her health and physical disabilities and family and financial responsibilities Ms Tulia seems to have reached the limit of her strength in supporting these groups of people.*

*7. Linda's own attitude appears to provide a problem.*
*(i) She has discovered being a Maori woman and is taking an increasing interest in her Maori heritage which is being regarded with alarm by some of her Pakeha friends.*
*(ii) Linda's attitude to her disability and her increasing use of drugs and/or alcohol for the purpose of what she calls "pain relief".*[8]
*(iii) The mobility that Ms Tulia demands in her lifestyle*
*are all causing problems for her and the agencies upon which she relies."*

[74] The Otago Hospital Board Community Services *Nursing and Attendant Care Assessment Report for Accident Compensation Corporation* dated 30 September 1988 states under *Client's Perception of Assistance Required* that Ms Taukamo requested assistance from 7am to 7pm for meal preparation, assistance with shower/bath and dress, housework and assistance with transfers when she was in pain. It was also noted that carers were required to visit at short notice should Ms Taukamo require assistance to clean herself following an accident during the night, or to support her if she was in pain. Nursing requirements could not be assessed because Ms Taukamo was not available at the appointed time and so no nursing assistance was being provided. Two hours per day were assessed as covering all other requirements. At this time Ms Taukamo had three children living at home aged 6, 9 and 10 years, and the only remaining modification to be done was listed as incomplete ramp access to the carport.

[75] The last ACC record of relevance is the file note by Mr Park dated 12 July 1989, in which he said that the mortgage documents had been completed and the rest of the alterations could proceed, but the issue for Ms Taukamo was that she insisted on using a bath, not a shower. Mr Park also said Mr Verhoff had been very involved of late with Ms Taukamo and that contact could be made through him, as Ms Taukamo did not have a telephone. At that time Ms Taukamo had her uncle living with her who

[8] Ms Taukamo wrote in a document she prepared on 4 April 1990, that she had become involved with the mongrel mob and that this turned into "*community kaos*" and that for four years "*<u>Everyday</u> I would drink a bottle of Port, swallow up to 20 pills and smoke ¼ oz Marijuana, then I was 'free*".

kept the outside of the house reasonably tidy and her daughter, who was very capable in the house, and the children obviously well looked after and happy.

[76] Mr Park also recorded that Ms Taukamo had set fire to her wheelchair and was dragging herself around at ground level and had to rely on other people to lift her places. He said he did not intend to help her as this was obviously what she wanted. This is the first indication on the file that ACC was failing to support Ms Taukamo and it was only a week before her admission to Dunedin Hospital, through Dr Stephens, for her first mental breakdown.

[77] David Mullen, the Psychiatric Registrar who examined Ms Taukamo, recorded his diagnosis in his clinical notes dated 8 August 1989, being:

> " *1. Drug Induced Psychosis.*
> *2. Abnormal Illness Behaviour.*
> *3. Psychogenic Psychosis.*
> *4. Other organic psychosis as she is unwilling to comply with physical examination this cannot be ruled out at this stage. "*

***The case for Ms Taukamo***

*[78]* Mr Allen quoted the legal test for assessing whether an injured person needs constant care and attention under s 80(3), as I paraphrased it in *Tangi v ACC*[9]*,* which was repeated in the instructions to Dr Seemann. Unfortunately, I realised for the first time when preparing the recent decision under s 80(3) in *Chittock v ACC*,[10] that there is an error in the *Tangi* decision that appears to allow for the fluctuation of need, rather than the level of care required, if the first sentence is read in isolation. The first sentence in the passage Mr Allen quoted reads: "*The need must be constant, if intermittent, over a 24 hour period".* As submitted by Mr McBride, this is clearly contradictory, and I should have picked up on it far sooner. The sentence should read "*The need must be constant, not intermittent, over a 24 hour period*." The rest of the passage reads:

> "*The level of care may vary but the need must require continuous attendance on the person throughout, during waking and sleeping hours and there must be more than the simple need for an increased level of personal care or attention. A carer does not need to be constantly beside the injured person but must be available when care or supervision is needed*."

[79] Mr Appleby contended that by adopting the ordinary and natural meaning required under the Acts Interpretation Act 1924, if evidence does exist that Ms Taukamo needed 24 hours a day care in the "*sense of having someone available to respond to her calls when she got stuck*" as stated by Dr Stephen in his letter addressed to the Authority in 2004 (the date is unclear), which was attached to Ms Taukamo's witness statement, that care should be provided. This letter formed the foundation of Ms Taukamo's claim, as both Mr Appleby and Mr Allen submitted that it was the only contemporary evidence of Ms Taukamo's needs by a specialist doctor who was treating her at the time, although I note that Dr Seemann spoke with Mr Bean for his assessment, and recorded that Mr Bean said that he did not think that Ms Taukamo needed 24 hour care at any time when he was treating her. The

[9] [2012] NZACA 4 at p 38
[10] [2014] NZACA 4 at pp 17- 19

facts concerning Ms Taukamo's needs and circumstances counsel relied upon to support the claim and Dr Stephen's involvement were, as was the case with Ms Taukamo's and Ms Cabral's evidence, primarily relevant to the period leading up to her first mental breakdown in 1989 and no submissions were made as to the correct date of Ms Taukamo's discharge from hospital.

[80] Regarding Dr McNaughton's assessment, counsel submitted that this was not as reliable as Dr Stephen's letter because it was not contemporaneous, and with historical reports, time always tends to minimise issues as they are necessarily removed from memory. Dr McNaughton's report was fundamentally flawed because he had applied the wrong test for constant personal attention and he had relied solely upon records, rather than an examination. Ms Taukamo's and Ms Cabral's recollections were more reliable, as was Dr Seemann's report as he examined Ms Taukamo and he took into account the lack of housing modifications to support Ms Taukamo's need for 24 hour care. Counsel relied on the fact of ACC's payments and the apologies given to Ms Taukamo and the acknowledgement that ACC had not provided her with the care that it should have, and also referred me to an extract from the Authority's 1994 decision in *Shortland v Accident Compensation Corporation*[11], and by implication, the 40 odd pages relating to Maori cultural values concerning death and illness.

[81] *Shortland* concerned a claim for increased compensation under s 79 by a Maori claimant who was a kaumatua and Mr Blackwood had increased the award of compensation to take into account that mana was lost because being a kaumatua, Mr Shortland had to rise when any person enters the meeting house. Because of his knee injury, Mr Shortland was able to stand only two or three times and was then obliged to remain seated irrespective of the number of visitors to the marae and thus lost mana. Mr Cartwright granted Mr Shortland's application for leave to appeal to the High Court to increase the award to the maximum allowed, because he accepted that a question of general or public importance was concerned, but the appeal was settled and the question remains potentially open for argument. I note, however, that the discretion available to ACC under s 79 and the purpose of the section are far wider than under s 80(3) and the evaluation of compensation is entirely subjective.

***The Case for the Corporation***

[82] Mr McBride provided 7 pages of detailed legal submissions, which he also spoke to, to support his contention that the legal test given to Dr McNaughton was correct, and that given to Dr Seemann was wrong. Rather than repeating Mr McBride's submissions, I have repeated the instructions given to Dr McNaughton below:

> ***"MEMORANDUM TO THE PARTIES***
>
> ***Attendant Care***
>
> *[11] Attendant Care is a shorthand description of the entitlement provided by s.80(3) of the Accident Compensation Act 1982 which provides as follows:*
>
> > *"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*

[11] 269/94. Appeal Authority, 12 September 1994, PJ Cartwright.

*personal attention, the Corporation, having regard to any other compensation payable, must 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."*

*[12] A holistic view of Ms Taukamo's life needs to be taken including personal, domestic, social and vocational needs. The question is whether did Ms Taukamo need to have someone with her 24 hours a day. Possible indications of need, rather than tests in and of themselves, or a checklist in any sense of that word, could be revealed by such factors as:*

- *Ability to carry out selfcares.*
- *Independent mobility*
- *Safety including self harm, avoiding harm to self and others and inability to summon assistance. This factor will include the ability to lock and unlock doors, turn on and off heaters and stoves, amount of overnight intervention required such as number of night turns, amount of night sweating and incontinent.*
- *Ability to act appropriately in an emergency.*
- *Ability to make appropriate decisions generally.*
- *Degree of function, body loss -hands -ability to feed, brush teeth and hold a cup. Leg and trunk control-ability to reposition, shift transfer.*
- *Blindness.*
- *Ability to carry out daily activities.*
- *Ability to prepare food.*
- *Ability to control body temperature.*
- *Assistance required to cough.*
- *Ability to dress.*

*The factors indicating the need for constant personal attention are never closed. Not all the factors have to be present in the one individual at the time to entitle them to 24 hour attendant care. It is a matter of fact and degree in each case."*

*[13] The Authority has in several recent cases set out the requirements of the statutory s.80(3) test as follows:*

*"[53] Section 80(3) applies only where a claimant's injury "is or such a nature that he must have constant personal attention". It is important to focus on the requirement that personal attention is mandatory and not really [sic merely] desirable as is made clear by the words of the section "must" and* ***"necessary".***

*[54] "Constant personal attention" means seven days a week, 24 hours a day. That is emphasised in such decisions as ARCIC v Campbell & Ors [1996J NZAR 278 where the Court said:*

*Once it has been established that a person needs constant personal attention, we fail to see how that can fall short of 24 hour care without in some way compromising the safety of the individual concerned".*

*[55] "Constant personal attention" is consistent with dictionary definitions of constant -"unremitting". The requirement is that attention must be*

*continuous and directed to the care of the particular claimant. Home help or assistance with looking after children falls outside the scope of s.80(3).*

*[56] It is important to recognise the impact of the concluding words of the section "In any place of abode or institution" which confirm that the intent of the legislation is that attendant care is payable only in respect of those who are confined to their home or institution: Matthews (1981) 2 NZAR 474.*

*[57] In the Appeal Authority decision in Condliffe the issue was the question of whether the Authority misdirected itself as to the nature of the requisite evidence to establish that the appellant was in need of "constant personal attention" under s.80(3) of the 1982 Act for the period from December 1991 to November 1992.*

*[58] Mr Rennie noted the decision of His Honour Judge Middleton in Condliffe v ACC 12/7/01 as Accident Compensation Appeal Authority 1012001 when the Court confirmed that "constant personal attention" had to be determined on the medical evidence. Following Condliffe v ACC unreported, Doogue J, HC Wellington AP 274102, 14 May 2003, it is now common ground that the judgment of the High Court in Condliffe clarifies that all relevant and probative evidence can be considered by the respondent and the Authority in determining entitlement to backdated attendant care. The relevant evidence is not limited to that of medical practitioners. All probative evidence is relevant. How the evidence is considered is a question of weight. It is to be noted, however, that contemporaneous medical evidence is likely to be the most helpful in situations of care needs.*

*[59] As with all issues of compensation, the onus lies on the claimant to establish that at the particular time they qualified for the particular compensation.*

*[60] The foregoing, then, are the criteria against which the evidence needs to be assessed.*

*Corkill (2105)""*

[83] The instructions given to Dr Seemann, along with the wording of s 80(3), were expressed as follows:

"*The investigation of the level of an injured person's need for personal attention (or attendant care) is a factual one and each case must be considered on its own particular facts, but the legal definition of "constant personal attention" requires the necessity for 24 hour care, which is to be assessed on an "holistic" basis rather than solely on the ability to meet self care needs.*

*The injured person's need for some level of personal attention must be constant, if intermittent, over a 24hour period.*[12] *The injured person may have recovered some level of independent self care and mobility, and the level of*

[12] See the comments at paragraph [78] above.

*care required may fluctuate or vary, but it must involve the need for continuous attention on the person throughout, during waking and sleeping hours. A carer need not be constantly beside the person, but must be at least within hearing distance on a 24hour basis and be available when care or supervision is needed. The need for supervision may be based on the safety of the injured person, or the safety of others in their household, Ms Taukamo's case is complicated by personal factors, such as her being the sole caregiver for four young children without the help of her two older children for a considerable part of the relevant periods, and also by her 1989 mental breakdown.*

*In this context, Ms Taukamo's emotional and mental states are also among the factors to be considered, as her need for constant personal attention may have been influenced by her mental state in addition to her physical injuries, as is the case with, for example, persons with brain injuries as well as physical injuries.*

*Ms Taukamo's home environment is relevant, particularly until she obtained modified accommodation, as is the help she was given by the children living with her and the extent to which they had to assist her with her personal care and take over the childcare and domestic tasks that she would normally be expected to perform, given their ages at the relevant times.*

*The focus of the investigation must be on Ms Taukamo's historical needs for attendant care in the two periods at issue between her discharge from hospital in January 1984 and 30 June 1992. The focus must be on the level of care required, not the level of care that was actually provided or assessed as needed at any given time*… "

[84] In my view, the instructions are similar, but the instructions given to Dr Seemann do not set out the very broad range of factors that may be considered and is more internally consistent – see Factors: Safety including self harm, avoiding harm to others and inability to summon assistance; Ability to carry out daily activities and Ability to prepare food, and the statement quoted at paragraph [13] [55], that home help or assistance with looking after children falls outside the scope of s.80(3). Dr Seemann's instructions are also more clearly directed to the need for a consideration of the facts as they apply to the injured person's particular circumstances, as enunciated by McKenzie J in *Matthews* at paragraphs [19] to [22]. This was another area where Mr McBride made detailed submissions, and he submitted that the injured person's circumstances were immaterial. According to Mr McBride, the focus had to be on the nature of the person's injury, and if they happened to live, for example, at the top of a building without stairs and could not access amenities or be safe because they were immobilised by injuries such as Ms Taukamo's, then their need for constant personal attention was not as a result of their personal injury, but of the environment in which they lived when the injury occurred.

[85] Mr McBride was on firmer ground in his submissions concerning the facts that counted against Ms Taukamo's need for constant personal attention. He based this on the medical file and the contemporaneous evidence being the best guide, and he highlighted various examples that demonstrated Ms Taukamo's ability to act independently and meet her own care needs. Mr McBride also, correctly in my view, submitted that Dr Stephen's letter added nothing to the evidence, as he was not an expert, his wording was vague, he did not identify the time at issue and he did not

identify any factual or legal basis for concluding the Ms Taukamo needed 24 hour care, or what he understood by the term.

[86] Mr McBride also echoed my own reservations with respect to the Burwood Report, in that the report wrongly addressed attendant care and home help as if the two were interchangeable, and he rightly submitted that substantially different tests apply and that notions of fairness cannot displace the stringent statutory requirements under s 80(3). Mr McBride referred me to *Condliffe v ACC*[13], and submitted that the question is a legal (and/or a medico legal one), and not a medico-social one, as presented by counsel for Ms Taukamo, and the contemporaneous medical records which were the best evidence given the time that had elapsed, did not disclose that Ms Taukamo required 24 hour care.

***Decision***

[87] The first issue I have to decide is the time period covered by the appeal. I am satisfied that Dr Seemann's suggested date is correct. Therefore, the earliest commencement date for any payment under s 80(3) is 9 April 1984, as the contemporaneous clinical records confirm that the discharge on 31 January 1984 was to Dunedin Hospital, not Ms Taukamo's home. The date when the housing alterations were completed, or at least brought to a stage where Ms Taukamo could access the toilet and bathroom cannot be identified with absolute accuracy, but it appears to be some time during December 1987. The remaining alterations were relatively minor and involved bathroom repairs and the access ramp and though inconvenient, should not have impacted on Ms Taukamo's need for constant personal attention after that date.

[88] As to the second issue, being whether Ms Taukamo required constant personal attention because of the nature of her injuries for any part of the period from 9 April 1984 up to December 1987, while I do not accept Mr McBride's submission that the environment within which the injured person must function after suffering their injury is irrelevant, I agree with his submissions in relation to the evidence of Ms Taukamo's actual level of need. I also think this is consistent with both expert assessments, not just Dr McNaughton's assessment as all counsel have assumed in their submissions, and I do not interpret Dr Seemann's assessment as supporting Ms Taukamo's claim, except like Dr McNaughton, for a possible "*exception period*" in this case related to the timing of her housing modifications, rather than to her mental breakdown.

[89] Both experts took Ms Taukamo's domestic circumstances into account. Both said that they felt that Ms Taukamo did not require constant personal attention for her personal needs and both raised the possibility that despite this, the state of the house modifications was relevant to her possible need for 24 hour care because their environment affects an injured person's ability to function, particularly in toileting and personal care aspects. Neither thought that Ms Taukamo should have 24 hour care because of her childcare demands. Both thought that Ms Taukamo's mental breakdown was also caused by factors other than her injuries and any lack of necessary care and assistance, though Dr Seemann did not go quite so far as Dr McNaughton and query the correctness of the 1999 appeal decision which gave cover for the mental breakdown, and this probably reflects the different emphasis put on considering Ms Taukamo's mental state rather than just her physical injuries as relevant to her need for constant personal attention.

[13] [2003] NZAS 481

[90] Finally, there is the matter of the compensation payments made to Ms Taukamo for the period at issue between 2002 and 2006. Although this is somewhat of a movable feast in so far as ACC's reasons for making the various payments are concerned, Ms Taukamo has received significant and in my view, extremely generous compensation for the time under consideration in respect of actual and notional attendant care under s 80(3), childcare and home help, as well as aids and appliances, housing modifications and other payments.

[91] I am satisfied that on the evidence before me, Ms Taukamo's need for constant personal attention for the period at issue has not been made out. However, even if I were minded to accept Ms Taukamo's evidence rather than the contemporaneous records, or the expert reports, I would not be minded to award her any additional sum at all under s 80 (3), as she appears to have already received what she would be entitled to if she had made out her case, if not substantially more.

[92] The appeal is dismissed.

**DATED** at WELLINGTON this 30th day of April 2014

……
R Bedford