IN THE DISTRICT COURT
AT WELLINGTON

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

[2021] NZACC 132 ACR 3/21

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

Hearing: 21 July 2021
Heard at: Christchurch/Otautahi

Appearances: Mr Pivac on his own behalf
Mr C Light for the respondent

Judgment: 17 August 2021

RESERVED JUDGMENT OF JUDGE C J McGUIRE
[Section 377 – Independence Allowance for Personal Injury Suffered before 1 July 1999]

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[1] The issue in this appeal is the correctness of the respondent's decision of 17 March 2020 which advised that:

[a] The level of impairment for a lump sum payment had been assessed at 2% that is less than the minimum of 10% required for payment.

[b] The level of impairment for an independence allowance had been assessed at 12%. Lump sum compensation that had been paid for injuries suffered prior to 1 July 1992 in the amount of 5% had to be deducted

from this amount. The balance of the impairment of 7% was less than the minimum of 10% required for an independence allowance payment.

Background

[2] Mr Pivac has cover for the following injuries which were assessed for an independence allowance or for lump sum compensation.

Independence Allowance

3/5/80- broken tooth injury.
16/12/82 – closed fracture maxilla.
10/4/89 – open wound of upper right arm.
30/10/89 – open wound to right knee.
28/9/94 – concussion – brain injury.
28/9/94 – post traumatic stress disorder.

A Lump Sum Compensation

18/7/08 – open wound of forehead.
13/4/16 – fractured left elbow.
22/9/16 – open wound of scalp.

[3] In 1991 the appellant received a lump sum payment of $850 under s 78 of the Accident Compensation Act 1982 for his right arm injury suffered in an accident on 10 April 1989. This equates to a 5% impairment (i.e. $850 out of a maximum payment of $17,000).

[4] On 28 February 1999, Dr Ross McCormick reported on an assessment of Mr Pivac's whole person impairment for the injury suffered before that date. Dr McCormick assessed the whole person impairment for these injuries at 50%. The major portion of the impairment was attributed to a head injury at 49%. A deduction of 5% was made for the previous lump sum payment.

[5] Dr McCormick carried out a further assessment on 22 June 2004 reporting on 27 June 2004. Dr McCormick's final report of 27 June 2004 was provided with amendments and dated 12 July 2004.

[6] Dr McCormick's assessment was that the whole body impairment for the covered injuries was 16%. Dr McCormick explained the reason why this assessment differed from his earlier assessment which was that when he assessed Mr Pivac he was not displaying psychiatric signs or symptoms. He said that ACC may wish to refer Mr Pivac for a chapter 14 psychiatric assessment to ascertain whether there was any additional impairment due to his fluctuating psychiatric state and whether this was the result of his head injury in 1994.

[7] ACC subsequently investigated whether Mr Pivac was entitled to cover for a mental injury in relation to the covered injury suffered on 28 September 1994. On 12 October 2007 ACC advised Mr Pivac that cover had been granted for a post traumatic stress disorder injury.

[8] ACC then referred Mr Pivac for another independence allowance assessment.

[9] On 7 December 2007, Dr Peter Thakurdas reported on the impairment assessment. The injuries assessed were, the right arm injury suffered on 10 April 1989; the right knee injury suffered on 30 October 1989; and the head and post traumatic stress disorder injuries suffered on 28 September 1994. The assessed degree of impairment for the right arm injury was 22%; the degree of impairment for the right knee injury was 8%; the degree of impairment for the head injury was 16%; and the degree of impairment for the post traumatic stress disorder was 12%. The combined degree of whole person impairment was 48%.

[10] On 20 May 2008, Dr Thakurdas reported again on an impairment assessment with the addition of two further physical injuries, namely a broken tooth suffered on 3 May 1980, and a fractured jaw and maxilla injury suffered on 16 December 1982. The degree of whole person impairment for all the injuries was assessed at 57%.

[11] On 18 July 2008 the appellant suffered an injury to his forehead. He sought lump sum compensation for this injury.

[12] Dr Fenwick assessed Mr Pivac and reported on 8 May 2010. The assessment addressed the 2008 injury as well as the injuries suffered before the 2001 Act came

into force, namely the independence allowance injuries listed above. Dr Fenwick's assessment was that the degree of whole person impairment for the covered injury (to his forehead) in 2008 was 0%. Dr Fenwick's assessment of the appellant's head injury of 28 September 1984 was 3% whole person impairment.

[13] Mr Pivac's appeal to the District Court against a review decision dismissing his review application was successful. In *Pivac v ACC*,[1] Judge Beattie held that Dr Fenwick had failed to explain the reasons for the significant difference between her assessment and the earlier assessments for an independence allowance. Judge Beattie accepted that Mr Pivac did not have any entitlement to a lump sum payment arising from the July 2008 injury because there was no evidence of impairment in respect of that injury.

Recent Medical Reports

[14] ACC arranged for a neurological review by Dr Paul Timmings, Neurologist. This occurred on 30 July 2018 and he reported to ACC the same day. In his report he stated that on examination, there was no evidence of focal neurological deficit. He said that memory testing was likely to be highly unreliable. He said:

> I therefore believe that it would be appropriate to place more reliance on the physical neurological examination, which shows no clear deficit. That should be corroborated by brain MRI imaging, which I suspect will also show no clear deficits.

[15] On 27 October 2018, Dr Timmings commented on the MRI scan that had been obtained. He said there was no evidence of any condition that could be due to a brain injury. He said that the brain was normal for Mr Pivac's age without any specific atrophy or other changes.

[16] On 3 May 2019 Mr Berry, a clinical psychologist and neuropsychologist, reported on the assessment of Mr Pivac carried out on 26 April 2019. The assessment was carried out at ACC's request. After a quite detailed review of Mr Pivac's reports and medical records, going as far back as Auckland Hospital Connolly Unit records from 1993, Mr Berry referred to the neuropsychological test

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1 *Pivac v Accident Compensation Corporation* [2011] NZACC 361.

results. He said that Mr Pivac's response to a test administered by him resulted in a profile consistent with that of people who present with a schizotypal personality disorder.

[17] He said:

> Overall, Mr Pivac's current presentation appears to be a complex mix of premorbid, index-accident and post-traumatic factors. Precise quantification of these factors is difficult to determine but on the balance of probabilities it is my opinion that traumatic brain injury is not the most significant contributor to Mr Pivac's current presentation.

[18] He recommended that Mr Pivac consider undergoing treatment with a clinical psychologist who is experienced in the treatment of people with personality disorders. He said:

> Mr Pivac could make progress towards greater independence and wellbeing if he is able to focus on the contributions of psychological factors to his current presentation rather than organic brain damage.

[19] Dr Kritzinger, psychiatrist, assessed Mr Pivac on 7 June 2019 and reported to ACC the same day.

[20] After a detailed review of the reports and medical records and his examination of Mr Pivac, Dr Kritzinger said that Mr Pivac was unreliable with regard to reporting his symptoms and his history. As to the claimed head injuries, the nature of his complaints and the severity was very difficult to reconcile with a mild traumatic brain injury. Dr Kritzinger said that his MRI scan of his brain did not reveal any evidence of a brain injury and this excluded a moderate or more severe contusional injury.

[21] Dr Kritzinger commented that there was consistent evidence of poor symptom and performance validity based on the neuropsychological assessments by Dr Fraser in 2009 and Mr Berry in 2019. These were severe and consistent with simulation.

[22] Dr Kritzinger said:

> In summary, there is consistent evidence in the history and also on his assessment today both qualitatively and quantitatively, that Mr Pivac is intentionally simulating physical and well as psychological as well as cognitive

> impairment. This makes it impossible to reliably explore whether there are any enduring injury relating consequences. It is noted that he has been involved in a large number of incidences that plausibly could have resulted in a mild TBI but that none of these would be severe enough to plausibly be linked with permanent disability or dementia. On objective measures such as an MRI brain and formal neurological examination there is no evidence of focal neurology or any significant contusional and/or axonal injury. The brain imaging is also completely incompatible with his cognitive performance. On at least two full neuropsychological assessments there has been consistent evidence of poor performance validity to a degree which simulation (malingering) should be considered.

[23] Dr Kritzinger also said that it was most unlikely that further investigations would illuminate matters.

[24] Dr Timmings commented again on 19 July 2019 following Dr Kritzinger's and Mr Berry's reports. Dr Timmings said that the reports were consistent with the opinion that he had formed when he evaluated Mr Pivac in July 2018. He said that the reports were consistent with the MRI imaging which showed no evidence of traumatic brain injury. There was no evidence to support the contention that Mr Pivac had sustained a persisting deficit as a consequence of any concussion or head injury that he had suffered.

[25] Dr Timmings concluded:

> No evidence has been identified or uncovered in all these investigations to suggest that Mr Pivac is suffering the consequences or long term effects of traumatic brain injury.

[26] In a further report dated 5 August 2019, Mr Berry commented on Dr Kritzinger's report. He said that Dr Kritzinger's report was consistent with his own report. As Dr Kritzinger had also concluded, Mr Berry's conclusion was that psychological factors rather than organic brain damage were central to Mr Pivac's presentation.

[27] Mr Pivac applied for a lump sum/independence allowance. ACC advised in a letter of 11 November 2019 that the injuries listed at the beginning of this background section would be assessed.

[28] Dr Russell Meads carried out an impairment assessment of Mr Pivac on 19 February 2020 and reported on 24 February 2020.

[29] After referring to the medical records and his examination of Mr Pivac, Dr Meads noted that the assessment was difficult and that there were several inconsistencies in the history given by Mr Pivac. He said that these inconsistencies had been noted in many reports by specialists, including neurologists, psychiatrists and psychologists. These had also been noted in previous impairment assessments. He noted that a diagnosis of pseudologia fantastica (pathological lying) had been made.

[30] Dr Meads first assessed the brain/nervous system because there were several injuries that possibly had an impact on his brain or nervous system. He said that the 1994 injury was possibly the most traumatic. However, he noted that Dr Timmings found no evidence of neurological deficit and the MRI of the brain in 2018 was reported as normal. Dr Meads assessed 0% whole person impairment in this respect.

[31] For the facial injuries, that is, injuries to the teeth, jaw and the soft tissues over the face Dr Meads assessed 7% whole person impairment. He attributed this impairment to the 1982 injury.

[32] For the right upper arm wound suffered in 1989, Dr Meads considered that there was no impairment for the covered injury.

[33] For the left upper arm injury suffered on 13 April 2016 Dr Meads assessed 2% whole person impairment.

[34] For the right knee injury suffered on 30 October 1989 Dr Meads assessed 3% whole person impairment.

[35] For various scars as a result of the injuries, Dr Meads assessed 2% whole person impairment.

[36] Dr Meads did not make a specific rating for pain.

[37] For the post traumatic stress disorder, the whole person impairment was assessed at 38%. Dr Meads noted that any impairments, because of non covered conditions or non covered symptoms or behaviours, had to be deducted. He noted that there had been a diagnosis of schizotypal personality disorder and cluster B personality traits. There had also been a comment concerning a factious disorder and/or malingering. There was also a diagnosis of pseudologia fantastica or pathological lying.

[38] Dr Meads said:

> The assessor makes note that all of these conditions/traits may impact on aspects of Dion's life and his mental wellbeing. It is noted that the functional abilities/activities of daily living, social activities, adaption and decompensation can be affected. They may contribute to impairment in activities of daily living with restriction of different activities. They may contribute to impairment in social activities with respect to avoidance of numerous social activities and decreased ability to interact meaningfully with other. They may contribute to impairment of concentration, persistence and pace with negative effects on concentration. They may contribute to impairment in adaptation/ decompensation by lowering the threshold for stress and altering the ability to deal with stress affecting both abilities at home and work.

[39] Dr Meads further noted that Dr Kritzinger said that Mr Pivac did not spontaneously volunteer any post traumatic stress disorder symptoms nor were these elicited on a semi-structured symptom exploration. He noted that Dr Kritzinger therefore questioned whether Mr Pivac had ever had PTSD and if he had PTSD this now appeared to be in full remission.

[40] Dr Meads then said:

> The assessor is of the opinion when taking into consideration the history and the documentation, the history given by Dion, the presentation and examination of Dion on the day of the assessment, that it would be safe to say, that in all probability, that all the impairment related to mental impairment is related to non covered conditions. For that reason we should consider apportionment/attribution of impairment.

[41] Dr Meads said that he was of the opinion that it was appropriate to apportion or attribute all of the mental impairment to non covered conditions. The resulting final whole person impairment for the covered mental injury of post traumatic stress disorder was therefore 0%.

[42] Dr Meads referred to Dr Thakurdas's assessments and to Dr Fenwick's assessment in which she estimated that there was no impairment related to brain injury.

[43] At the end of Dr Meads' report, he summarised the whole person impairment for each of the covered injuries. The total whole person impairment for injuries covered under the 2001 Act was 2%, that is, for the fractured left elbow injury. The whole person impairment for injuries eligible for an independence allowance was assessed at 12%.

[44] Dr Collier, psychiatrist, conducted a peer review of the assessment. He said that the assessment by Dr Meads correctly identified the lack of rateable impairment for the head injuries and for the claimed mental injuries. Dr Collier agreed that there were ratings made under chapter 14 (for mental injury) but these all required apportionment, which was well justified, and in his opinion, correct. Dr Collier said that the estimated whole person impairment that Dr Meads found was 38%. This was consistent with the history but did not reflect injuring events and was correctly apportioned down to 0%. Dr Collier further agreed with the assessment for the physical injuries.

[45] Mr Pivac applied for review of ACC's decision. In a decision dated 26 November 2020 the review application was dismissed.

[46] The Reviewer noted that there was no clear and cogent evidence that the assessment was flawed. She noted that there was no medical evidence to the contrary. The Reviewer referred to *Irons v ACC*,[2] and stated she could not take into account Mr Pivac's own opinion of his level of impairment. The Reviewer concluded that ACC's decision was correct and dismissed the application.

[47] In brief written submissions made via email on 3 March 2021, Mr Pivac makes these points:

[a] All of his injuries are permanent.

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[2] *Irons v Accident Compensation Corporation* [2012] NZACC 108.

[b] Dr Thakurdas' report of 48% total body impairment is true and correct.

[c] He asks that the Court reinstate his independence allowance from the date it ceased.

[d] He asks that Dr Thakurdas's report be entered into evidence as his true and correct legal medical report, on which to base his legal independence allowance.

[e] He says he would like the reports written by Dr Kritzinger and the other reports removed from his ACC record as they were negligent.

[48] In oral submissions in Court Mr Pivac again submitted that Dr Thakurdas's 2008 report was the true assessment and he asked that the reports of Dr Meads, Dr Kritzinger, Dr Berry and Dr Timmings be removed from his ACC records.

[49] He said that the reports were negligent and recorded bad and misleading things about him.

[50] Mr Pivac also submits that Drs Meads, Kritzinger, Berry and Timmings have not given any conclusions as to why their assessments are low. He says the four doctors are negligent.

The Respondent's Submissions

[51] Mr Light refers to the transitional provisions in s 377 of the Act which apply to independence allowances for personal injuries suffered before 1 July 1999. In respect of injuries suffered before 1 July 1999 the assessment is made under Part 4 of Schedule 1 of the 1998 Act. However, any assessment or reassessment must be done on the basis of the whole-person impairment for the combined effect of all injuries suffered before 1 July 1999 for which the person has cover, as provided for in s 377(3)(a). He also refers to s 377(3)(b) which provides that any lump sum compensation received under the 1972 or under s 119 of the 1972 Act or s 78 of the 1982 Act must be deducted from the percentage of combined whole-person impairment.

[52] In respect of injuries suffered from 1 July 1999 to 31 March 2002 s 378 also requires an assessment of an independence allowance to be conducted under Part 4 of Schedule 1 of the 1998 Act. This section further modifies provisions of the 1998 Act.

[53] Mr Light refers to cls 58 to 63 in Part 4 of Schedule 1 of the 1998 Act which regulate the assessment and payment of independence allowances. Clause 58(1) provides that ACC is liable to pay a claimant an independence allowance if:

- The claimant has suffered a personal injury for which he or she has cover; and
- An assessment carried out under cl 60 establishes that the personal injury has resulted in a degree of whole person impairment of 10% or more.

[54] Clause 60 regulates the assessment of entitlement to an independence allowance, as follows:

- ACC must appoint assessors to do independence allowance assessments. (clause 60(1).
- The assessor assesses the claimant's percentage of whole person impairment arising from each claim that is referred to the assessor for assessment (clause 60(2)).
- An assessor must do the assessment after the claimant's condition has stabilised (clause 60(3)).
- The assessor must use the American Medical Association Guides to the Evaluation of Permanent Impairment (fourth edition) ("AMA Guides") (clause 60(4)(a)).
- The assessor must exclude any impairment that does not result from the covered personal injury (clause 60(4)(b)).

Assessment for Lump Sum Compensation

[55] Mr Light refers to Part 3 of Schedule 1 to the Act which applies to claims for lump sum compensation for permanent impairment. He makes these points:

[a] ACC can only assess a claimant's entitlement to lump sum compensation if it receives a certificate from a medical practitioner indicating that the claimant's condition resulting from the personal injury has stabilised and it is likely that there is permanent impairment resulting from the personal injury, or if after two years since the personal injury the claimant's condition resulting from the personal injury has not stabilised but it is likely that there is permanent impairment resulting from the personal injury (Schedule 1, clause 57(1)).

[b] An assessor who has the appropriate skills, qualifications and training for the particular assessment, assesses the claimant's percentage of whole person impairment (clause 58(2); clause 59(2)).

[c] The assessor must assess the claimant in accordance with the Injury Prevention, Rehabilitation, and Compensation (Lump Sum and Independence Allowance) Regulations 2002 (regulations 4(1) and (2)). The regulations specify that the assessor must use the American Medical Association Guides to the Evaluation of Permanent Impairment (fourth edition) ("AMA Guides") and the ACC User Handbook to AMA ("the ACC user handbook") as the assessment tool (regulations 4(1) and (2)). The ACC user handbook prevails if there is conflict between it and the AMA Guides (regulation 4(3)).

[d] The assessor must exclude from the assessment any permanent impairment that does not result from the personal injury for which the claimant has cover or arises from personal injuries suffered before the commencement of the Act (clause 59(3)(b)). The assessor must include in the assessment any permanent impairment for which the claimant has received lump sum compensation under the Act (clause 59(3)(c)).

[e] A claimant who has suffered more than one personal injury must be assessed by establishing the combined effect of those injuries (clause 59(5)).

[f] No claimant is to be assessed as having more than 100% whole person impairment (clause 59(6)).

[g] A claimant is only entitled to lump sum compensation if their degree of whole person impairment is 10% or more (clause 56(3)).

[56] Mr Light refers to the case of *U v ACC*[3] in which Judge Powell recognised that the mental effects of the appellant's back pain which were covered, together with the non covered conditions that impacted on the mental injury should also be apportioned, so long as the impairment had been credited in the first place.

[57] Mr Light also referred to the decision in *MT v ACC*[4] where Judge Ongley said:

> … Apportionment is a skilled exercise, assisted by specialist skill and experience, and by particular experience in assessment of impairment and apportionment within the structure of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" (the AMA Guides).

[58] Mr Light also refers to *W v ACC*[5] in which Judge Hole said:

> (b) It is not for the Court to form an opinion as to whether or not the AMA Guides have been correctly applied: this is the province of duly qualified medical practitioners. The Court must rely on the evidence of the medical practitioners in this regard.
>
> (c) In order to succeed in an appeal of this nature, it is for the appellant to establish on the balance of probabilities that the assessment was in some way flawed or incorrect. This requires credible expert evidence directed at the specific aspects of the assessment which are said to be incorrect.

[59] Mr Light submits that as there is no contrary medical evidence that shows material flaws in the evidence before the Court and in particular in respect of Dr Meads' assessment, the appeal must be dismissed.

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3 *U v Accident Compensation Corporation* [2018] NZACC 28.
4 *MT v Accident Compensation Corporation* [2009] NZACC 213 AT [22].
5 *W v Accident Compensation Corporation* [2004] NZACC 284 at [7].

The Appellant's Reply

[60] Mr Pivac's support person in Court, Ms Lunjevich, spoke of the daily struggles that Mr Pivac has. She says that he has been quite unwell and that no one comes to his aid. She says that he is too unwell to work.

[61] Mr Pivac added that nothing has changed since Dr Thakurdas did his assessment, that his condition is deteriorating. He said: "It is not getting any better."

Decision

[62] Since 1980 Mr Pivac has suffered a number of injuries for which cover was granted. In 1991 the appellant received a lump sum payment of $850 under s 78 of the Accident Compensation Act 1982 for his right arm injury suffered in an accident on 10 April 1989. This equated to a 5% impairment which yielded a lump sum payment of $850 out of a maximum payment at the time of $17,000.

[63] In 2007 Dr Thakurdas carried out an impairment assessment. This resulted in a combined degree of whole person impairment of 48%.

[64] In 2018 the appellant was referred by ACC to Dr Timmings, neurologist, for a neurological review.

[65] Dr Timmings' report noted that for the purposes of his review, ACC had provided 237 pages of associated information.

[66] Under the heading 'conclusions and opinion' in his report, Dr Timmings said:

> I find no evidence of focal neurological deficit on routine neurological examination. … if ACC are wishes to definitively evaluate for the possibility of intracranial injury or gliotic change, perhaps relating to a head injury in the distant past, the only way to obtain further information would be to undertake brain MRI imaging. As stated above, I have not identified evidence of focal deficit, although it is possible that personality difficulties and memory and concentration difficulties are as a consequence of head trauma in the distant past. This therefore would be a valid further investigation i.e. brain MRI scanning.

[67] Dr Timmings went on to say that as the appellant had previously been given a diagnosis of pseudologia fantastica (pathological lying) Dr Timmings said:

> On that basis it would be difficult for me to place any significant emphasis on any of the information he presents today. I therefore believe that it would be appropriate to place more reliance on the physical neurological examination which shows no clear deficit. That should be corroborated with brain MRI imaging, which I suspect will show no clear deficits.

[68] Further, Dr Timmings went said:

> I would recommend that ACC proceed with brain MR imaging which will give a clearer picture of whether or not significant traumatic brain injury has occurred at some time in the past. And that ACC proceed with a formal neuropsychiatric assessment, in the hope that a definitive diagnosis in that area may be emerge, noting that many authorities do not believe "pathological lying" to be representative of psychiatric disorder. However expert opinion, with up to date information, from a suitably qualified neuropsychiatrist would be helpful here.

[69] On 18 May 2019 Mr Pivac was referred to clinical psychologist and neuropsychologist, Steve Berry for a neuropsychological assessment.

[70] In his report of 3 May 2019, under the heading 'referral detail', Mr Berry said:

> One particular aspect of consent discussed was that, to gain the most accurate assessment possible, Mr Pivac's best effort was necessary and that to gauge his level of effort the assessment instruments contained hidden factors.

[71] Under the heading 'clinical interview findings and general psychological test results' Mr Berry noted:

> He appeared to understand questions but was not always able to provide a logical and ordered narrative of recent and remote events because he had a tendency to be vague, tangential and circuitous … at times he was contradictory and made statements that were not verifiable but seemed highly unlikely, contradictory to file information self-aggrandising and grandiose in nature … there was no sign or self-report that he was experiencing any symptoms of thought, anxiety or mood disorder, despite stating that he was "depressed" every day.

[72] Mr Berry noted that:

> Mr Pivac's responses to the MCMI-IV culminated in a profile that matched that of people who suffer a severe personality disorder. A severe personality disorder is a chronic disturbance in behaviour tendencies of which the individual is often unaware and which cause profound personal and social

disruption, often becoming more severe with adversity. This type of severe personality type which Mr Pivac's MCMI-IV profile is associated is called "schizotypal". People with schizotypal personalities disorder are often described as odd or eccentric and usually have few, if any, close relationships.

In addition to this problematic personality profile, the MCMI-IV results produced by Mr Pivac are consistent with results of people who are suffering high levels of acute depression, generalised anxiety and preoccupation with ill health with somatic complaints often being used to gain attention.

[73] Under the heading 'effort test results and validity', Mr Berry said:

8.4 Observation of Mr Pivac's behaviour and information obtained from psychometric measures of effort suggest that Mr Pivac was intentionally under performing on tests and consequently the results achieved, which were almost all in the extremely low range, are invalid and uninterpretable.

[74] Mr Berry considered a neuropsychological assessment conducted with Mr Pivac in December 2009 by registered psychologist, Dr Duncan Fraser. Mr Berry noted that Dr Fraser:

Noted that Mr Pivac had sustained at least two head injuries and possibly more concussions over the years, leading in an accumulative way, to disturbances in cognitive, physical and emotional functioning. However, it was noted that other psychological, personality and motivational factors were almost certainly compounding the cognitive deficits. … Dr Fraser noted that he found Mr Pivac to be an unreliable historian.

[75] Under the heading 'summary and conclusions', Mr Berry said:

9.5 To establish Mr Pivac's current cognitive functioning and general psychological state this psychological/neuropsychological assessment was performed. Two stand alone effort tests, and an indicator imbedded in a standard neuropsychological test plus observation of Mr Pivac's behaviour during testing, revealed that Mr Pivac's cognitive test results were probably affected by an inclination to perform poorly. As a consequence, extremely low (impaired) range results he produced are not valid and cannot be interpreted.

…

9.7 It is not clear with regard to any of the incidents in which Mr Pivac experienced head injury that he subsequently experienced a brain injury. Judging by his GCS (Glasgow Coma Scale) scores at the time of the accidents and by the durations of unconsciousness in conjunction with normal results from CT scans and an MRI performed in 2018, the most definitive statement that can be made is that, as a result of blows to his head, Mr Pivac *may* have experienced mild traumatic brain injury. Computed tomography is not sensitive enough to detect some of the subtle damage that can effect the functioning of brain cells. Even though

an MRI is considerably more revealing than a CT scan, a normal MRI scan also does not mean that there has been no cellular compromise. Resolution of the MRI is not high enough to detect subtle changes to the brain.

9.8 If Mr Pivac did indeed experience a brain injury as a result of the index accident, then based on a range of indicators including self-report of events, his acute GCS scores and medical observations and descriptions of the nature of the injuries he suffered, it would be classified as a mild traumatic brain injury. Taken singularly, the other head injury incidents experienced by Mr Pivac would be classified similarly.

9.9 If the mild traumatic brain injury hypothesis is accepted it should be noted that Mr Pivac's pattern of symptoms has been unusually complex and his recovery from the index accident has been slower than that experienced by the majority of people who suffer a mild traumatic brain injury. Most people with mild traumatic brain injury can largely recover within hours and the majority can generally anticipate full recovery within 3 to 6 months. Cumulative mild traumatic brain injuries can slow and restrict recovery but again, Mr Pivac's pattern and course of symptoms is not consistent with the theory of multiple brain injuries being the most significant factor in his presentation.

9.10 The present assessment reveals that Mr Pivac's personality profile is consistent with that of people who present with a schizotypal personality disorder.

…

9.12 Overall, Mr Pivac's current presentation appears to be a complex mix of premorbid, index accident and post traumatic factors. Precise quantification of these factors is difficult to determine but on the balance of probabilities it is my opinion that traumatic brain injury is not the most significant contributor to Mr Pivac's current presentation. Indeed, there is a case to be made that traumatic injury is not a significant contributor to Mr Pivac's current presentation at all.

Recommendations

9.13 Mr Pivac should consider undergoing treatment with a clinical psychologist who is experienced in the treatment of people with personality disorders. It may also be productive reviewing with his GP whether any medication might be of assistance, taking into account the above formulation. Mr Pivac could make progress towards greater independence and wellbeing if he was able to focus on the contributions of psychological factors to his presentation rather than organic brain damage.

[76] Psychiatrist, Dr Kritzinger, assessed Mr Pivac on 7 June 2019, and reported to ACC the same day. Under the heading 'impression' Dr Kritzinger said:

Previous assessors have alluded to what appears to be consistency in the unreliability of the history presented by Mr Pivac to various assessors and this

includes significant internal as well as external consistencies. This raises the reliability issue with regards to self-reported symptoms as well as the history. On cross section, Mr Pivac's presentation was entirely consistent with this and was remarkable for presenting a very large number of complaints and mostly at ceiling levels but not being able to substantiate these with regard to the evolution, pattern, intensity or impairment. It was noted that much of the history presented today was completely contradictory, for example he denied any previous psychiatric contacts. Similarly he denied initially any substance use or alcohol misuse, although this is clearly contradicted in his records. There were some elements in his account for example being a writer of some published books that could not be corroborated but appeared implausible. …

Based on a number of neuropsychological assessments there is consistent evidence of poor symptom and performance validity. It was noted that the degree of impaired performance documented by Dr Fraser in 2009 and Mr Berry in 2019 is severe and consistent with simulation.

The presence of significant response bias as well as impairment of impairment and symptom and performance validity measures therefore makes it impossible to reliably explore the nature and degree of any difficulties that could be associated with sequential mild brain injuries.

…

In summary, there is consistent evidence in the history and also on his assessment today both qualitatively and quantitively, that Mr Pivac is intentionally simulating physical as well as psychological as well as cognitive impairment. This makes it impossible to reliably explore whether there are any enduring injury related consequences.

…

Given the factors above it is therefore not possible to be entirely clear whether Mr Pivac may have had transient difficulties attributable to brain injury. However, consistently the pattern is probably better explained on him using symptoms to meet physical, material and social needs or avoid social responsibilities. The differential diagnosis would rest between a factitious disorder and/or malingering. There appears to be clear evidence of cluster B personality traits that emerged in early life, most likely antisocial.

I think it most unlikely that further investigations will illuminate matters. There does not appear to be any specific focus or specific interventions informed by a TBI rehabilitation model.

[77] A further report was obtained from Dr Timmings, dated 19 July 2019, after he had considered the reports of Dr Kritzinger and Mr Berry.

[78] Under the heading 'conclusion', Dr Timmings said:

Both these reports are consistent with the opinion that I formed when I evaluated Mr Pivac in July 2018.

…

> The neuropsychiatric and neuropsychological cognitive testing results are simultaneously congruent and incongruent with the MRI. They support the conclusions drawn by Dr Kritzinger and Mr Berry that these are congruent with my opinion and conclusion; that there is no evidence to support the contention that Mr Pivac has sustained a persisting deficit as a consequence of any concussion or head injury that he has suffered.
>
> The only conclusion that can be drawn is the conclusion drawn by Rudi Kritzinger, i.e. that Mr Pivac is fabricating his symptoms and disability, presumably as a mechanism to allow him to meet the physical, material and social needs and/or to avoid social responsibilities.

[79] On 5 August 2019 at the request of ACC, Mr Berry reviewed Dr Kritzinger's report.

[80] Mr Berry said:

> Dr Kritzinger's report is consistent with the report this writer prepared in May 2019. Specifically the two reports highlight that it is not clear with regard to any of the incidents in which Mr Pivac experienced head injury that he subsequently experienced brain injury. The two reports further converge on the conclusion that if Mr Pivac did indeed experience a brain injury as a result of the index accident, then, based on a range of indicators it would be classified as a mild traumatic brain injury. As with Dr Kritzinger's report this writer concluded that psychological factors rather than organic brain damage is central to Mr Pivac's presentation. Finally, both reports conclude similarly that Mr Pivac using a traumatic brain injury model is not recommended.

[81] On 11 November 2019, ACC wrote to Mr Pivac advising that following his application for a lump sum payment and independence allowance it would arrange for him to be assessed for these. Over an 80 minute appointment on 19 February 2020, Dr Russell Meads carried out that assessment. Dr Meads' report and worksheets comprise of 40 pages.

[82] He referred to the medical records and his examination of Mr Pivac. He noted that the assessment was difficult given that there were inconsistencies in the history given by Mr Pivac. He said that these inconsistencies had been noted in many reports by specialists who included neurologists, psychiatrists and psychologists. These inconsistencies had been noted in previous impairment assessments. At page 20 of his report he noted a diagnosis of pseudologia fantastica.

[83] He acknowledged that the 1994 injury was possibly the most traumatic and referred to Dr Kritzinger's report relating to system validity issues and exercising caution with regards to the interpretation of psychological and subjective somatic symptoms. He referred to the AMA guide. He referred to the relationship between chapter 14 and chapter 4 saying:

> The chapter 14 mental impairment measuring tool categories of daily living, social functioning, concentration/persistence/pace, and adaptation/ decompensation overlap with the chapter 4 physical measuring tools of mental status/integrative functioning, emotional/behavioural, and sleep/arousal disorders.
>
> To rate the mental injury and the physical injury independently and then combine those two in their entirety would create a major duplication of impairment.
>
> The assessor is of the opinion Dion has impairment related to mental status and integrative functioning, emotional and behavioural, preoccupation and fatigue. The assessor is of the opinion that impairment can be assessed using the tools of chapter 4 which allows us to look at organic loss related to the brain injury, and using the tools of chapter 14 which allow us to look at functional losses related to possible mental injury and to brain damage.
>
> The assessor is of the opinion that the majority, if not all, of impairment is related to mental injury.

[84] For his facial injuries, that is injuries to the teeth, jaw and the soft tissues over the face, Dr Meads assessed a total of 7% whole person impairment. This was attributed to the 1982 injury. For the right upper arm wound suffered in 1989 Dr Meads considered that there was no impairment for the covered injury.

[85] Dr Meads assessed a 2% whole person impairment for the left upper arm injury suffered on 13 April 2016. For the right knee injury suffered on 30 October 1989 Dr Meads assessed 3% whole person impairment. For disfigurement and skin impairment Dr Meads assessed 2% whole person impairment.

[86] At pages 29 and 30 of the report, Dr Meads assessed the issue of pain. He noted that pain had been assessed when assessing impairment in the ENT system and upper and lower extremities. He again referred to the AMA guide chapters 2 and 15 and the ACC user handbook. Taking these matters into consideration he concluded that there was not a specific rating for the appellant's pain.

[87] For post traumatic stress disorder Dr Meads assessed a whole person impairment of 38%. In doing so he referred to the ACC 2014 operational guidelines. He noted the following direction from the guidelines:

> Apportioning for conditions, which focuses on the covered mental injury, is our confirmed approach to mental injury apportionment in impairment assessments. Under this approach:
>
> - There is no apportionment of the covered mental injury even if it may be accepted that the cause of the mental injury itself may have been "multifactorial". This means that the attributable impairment is not "apportioned" and all the effects of a covered mental injury causing impairment are included in the overall impairment rating for that diagnosis.
>
> - Any impairments due to non covered conditions, non covered symptoms or behaviours (even when these do not meet a diagnostic threshold) are deducted.

[88] The report then says:

> The assessor is of the opinion when taking into consideration the history and the documentation, the history given by Dion, the presentation and examination of Dion on the day of the assessment, that it would be safe to say that in all probability, that all the impairment related to mental impairment is related to non covered conditions. The 38% whole person impairment being thus related resulted in 0% whole person impairment for the purposes of the assessment.

[89] Dr Meads added:

> The assessor makes note that in comparison with Dr Thakurdas's report with time objective findings have become more apparent when considering the facial and upper and lower extremity injuries. There is now no rateable loss related to nerve injury in the right upper extremity. It is noted that any impairment related to brain/injury concussion is now thought to be spent. It is noted that mental injury is related to factors other than the covered injury – PTSD.

[90] On 17 March 2020 Dr John Collier, specialist psychiatrist and psychotherapist, peer reviewed Dr Meads' report. Dr Collier said:

> Your report complies with both the AMA guides and ACC user handbook.
>
> Peer reviewer agrees with her head injury rating of 0%. Peer reviewer agrees that there are ratings made under chapter 14 but these all require apportionment, which is well justified and is, in my opinion, correct.
>
> The estimated whole person impairment you found in 38% is consistent with the history but does not reflect injuring events and is correctly apportioned down to 0%.

> Peer reviewer also notes that there are physical injury impairments and agrees with your rating for 2008 wound to forehead at 0%, 2016 scalp wound at 0%, 2016 left elbow fracture at 2%, 1994 concussion and PTSD at 0%, 1980 broken tooth at 0%, 1982 closed fracture of maxilla correct at 7%, 1989 right arm wound correct at 2% and 1989 right knee wound correct at 3%. These three injuries (1982, 1989) are correctly combined at 7 + 2 + 3 to 12%.
>
> Peer reviewer recommends the report be accepted.

Conclusion

[91] I conclude in this case that the assessments carried out by ACC have been carefully and professionally carried out and I accept them. In exercising fairness towards the appellant, ACC took the final step of a peer review. The peer reviewer, Dr Collier, confirmed the accuracy of Dr Meads' reports. Dr Collier recommended that the report be accepted. Having considered all the evidence in this case I find no fault at all with what the respondent has done. It has approached the reassessment process in a thorough and professional way. I accept the conclusions reached.

[92] Having heard directly from Mr Pivac and his support person, Ms Lunjevich, I acknowledge that he faces significant daily challenges. As clinical psychologist Mr Berry recommends, Mr Pivac should consider undergoing treatment with a clinical psychologist who is experienced in treatment of people with personality disorders. He notes that Mr Pivac could make progress towards greater independence and wellbeing if he was able to focus on the contributions of psychological factors to his current presentation rather than organic brain damage.

[93] As I endeavoured to point out to Mr Pivac during the hearing, for there to be cover and entitlements under the ACC legislation, the claim must fall within the parameters prescribed by the legislation, including, in this case, the AMA guides and the ACC user handbook to the guides. The result of the assessments is that the appellant has 0% whole person impairment for covered mental condition deriving from his covered injuries.

[94] For Mr Pivac to move on it will be very important for him to seek ongoing treatment with a clinical psychologist for his personality disorders and possibly medication support through his GP. Mr Berry recommends this at paragraph 9.13 of

his report of 3 May 2019. However, as this is outside the parameters of his ACC claims he will need to access this through the public health system.

[95] For the above reasons, I must dismiss his appeal.

[96] There is no issue as to costs.

Judge C J McGuire
District Court Judge

Solicitors: Young Hunter, solicitors, Christchurch for the respondent