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

IN THE DISTRICT COURT
AT WELLINGTON

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

[2021] NZACC 137 ACR 106/19

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

Hearing:	21 May 2021
Heard at:	Auckland/Tāmaki Makaurau
Appearances:	B Hinchcliffe for the Appellant D Tuiqereqere for the respondent
Judgment:	30 August 2021
Released (due to Covid):	14 September 2021

RESERVED JUDGMENT OF JUDGE NICOLA MATHERS
[Claim for Mental Injury s 26 Accident Compensation Act 2001]

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[1] This is an appeal from a Review decision of 30 April 2019 upholding the Accident Compensation Corporation ('ACC') decision of 16 November 2018 declining the appellant's claim for a mental injury as a treatment injury.

[2] The appellant seeks cover for a treatment injury under s 32 of the Accident Compensation Act 2001 ('the Act').

Background

[3] The appellant underwent a lumbar puncture on 3 August 2016. Between three and five attempts were made by a house surgeon before the lumbar puncture was successfully carried out. On 15 August 2016 the appellant lodged a claim for cover for a treatment injury for pain in the lumbar spine caused by the lumbar puncture. ACC investigated the claim, obtaining medical comment from Dr Anderson, a neurologist. The claim was declined on 9 November 2016. The appellant then lodged a review of that decision. At the review hearing, ACC's decision was quashed with the Reviewer directing that ACC obtain further evidence. Further evidence was obtained from Dr Anderson but that resulted in ACC again declining the claim on 16 June 2017.

[4] The appellant then lodged a review from that decision and obtained evidence from Dr Penney, an osteopath. The review was dismissed, and an appeal was filed. Judge A Sinclair dismissed the appeal on 29 January 2019. She considered whether the evidence demonstrated that the appellant had suffered a physical injury that was responsible for his ongoing pain in the lumbar spine. In doing so she considered the evidence from Dr Anderson, Dr Penney, and Dr Mossman, a neurologist. Judge Sinclair found that the insertion of the needle caused some soft tissue injury but that this injury was "*an ordinary consequence of the lumbar puncture procedure*".

[5] Then on 14 November 2017 the appellant's GP, Dr Norton sought cover for "back pain with repeated attempts to perform lumbar puncture with CONSEQUENTIAL DEPRESSIVE DISORDER, request that latter be documented as an additional diagnosis". The claim was not investigated as required under the Act and a deemed decision to accept cover for "depressive disorder" was made. the appellant was advised of this on 23 March 2018. In the same letter of advice, ACC said they were required to continue the investigation and once sufficient evidence was obtained to make a substantive decision the deemed decision would be revoked and replaced with a fresh decision.

[6] ACC obtained the appellant's clinical notes from the Auckland District Health Board and his treatment with Cornwall House from 28 April 2017 to 7 March 2018.

[7] ACC referred the appellant to Dr Asteriadis, a psychiatrist, for an assessment. Dr Asteriadis provided a full report and answered the various questions that were posed to him by ACC as follows:

> ***a.*** ***Are you able to identify a mental injury caused by treatment? The physical injury identified by ACC in the case of [the appellant] is the necessary insertion of the needle for the lumbar puncture procedure. Is the mental injury identified as clinically significant, behavioural, cognitive, or psychological dysfunction:***
>
> *Yes, I believe so, as above 17.*
>
> *I have noted the summary from paragraph 17:*
>
> *… On this basis, I would like to propose, that Provisionally speaking [the appellant] has an adjustment disorder with DEPRESSIVE SYMPTOMATOLOGY, ANXIETY SYMPTOMATOLOGY and PAIN SYMPTOMATOLOGY.*
>
> ***b.*** ***What is the cause of the mental injury?***
>
> *It appears that the pain subsequent to the second LP, led to a lowering of [the appellant's] mood and anxiety.*
>
> ***c.*** ***What is the date when [the appellant] first sought or received treatment for the symptoms of a mental injury?***
>
> *It appears [the appellant] sought treatment for the pain almost immediately, and then it appears that within a few months time, he was on an antidepressant, Citalopram. I am uncertain whether his GP started that, or whether Cornwall House CMHC, started that.*
>
> ***d.*** ***If there is mental injury which is clinically significant behavioural, cognitive or psychological dysfunction, and if the mental injury suffered was a result of the physical injury caused by treatment; in my own opinion, taking into account all the circumstances of the treatment including the underlying health condition as a clinical knowledge at the time of treatment, is the mental injury identified as an ordinary consequence?***
>
> *Yes, I believe so. [the appellant] suffered pain which obviously is subjective rather than objective, but nevertheless:- and thereafter depressive and anxiety symptomatology. In due course, he sought treatment from a CMHC for having suicidal thoughts, and Depression.*

[8] Dr Asteriadis was asked by ACC to clarify his answer in relation to the ordinary consequence question and he responded as follows:

> ***Please explain in what elements in [the appellant's] particular circumstances made his mental injury an ordinary consequence?***
>
> *The injury seems to have occurred in late 2016, and there are notes from a Community Mental Health Centre, in 2018, mentioning [the appellant] being depressed. A further note from the CMHC, mentions the precipitating factor of a worsening depression, and increasing suicidal ideation was precipitated by chronic ICP back pain. In addition, the CMHC mentions as a long-term stressor, post-lumbar puncture for raised ICP, and acute social stressors. It is also true that [the appellant] had a long history of depression in his teens, secondary to being bullied.*
>
> *A further note from Cornwall House CMHC, mentions that the lumbar puncture left the Client with sciatic pain down his left leg, calf and foot. It seems [the appellant] took various medications for pain following the lumbar puncture, that appears to have left him with various problems. [The appellant] also saw the Auckland Regional Pain Service, which mentions issues with persistent lower back pain, which was related to a lumbar puncture procedure in 2016.*
>
> *On page 3 of my report, it mentions that [the appellant] felt that his second lumbar puncture was "bunbled", as were 5 attempts to get into his spine to measure the Intracranial Pressure. Thereafter, he was not able to continue working. It is stated he could only sit for 2 hours comfortably. Various medications were said to have been tried for the pain, including Codeine, Ibuprofen, Tramadol, Gabapentin, and Nortryptiline. Later, Citalopram, an antidepressant, was prescribed. [The appellant] was later sent to Cornwall House CMHC because of severe depression and suicidal ideas. He has had counselling with the Auckland Regional Pain Service.*
>
> *The Accident date in the notes is given as 3 August 2016. I believe the above elements, in [the appellant's] particular circumstances, made his mental injury an ordinary consequence. Ordinary is defined as "usual, normal, standard, typical, stock, common, customary, habitual, accustomed, expected", etc.*
>
> *One Commentator has mentioned that having ongoing pain, following this sort of procedure would be unusual. At the same time, I am told there were several different attempts at the index injury lumbar puncture, and [the appellant] felt the procedure was "bungled". While there may not have been anything of note on the MRI, that does not mean that there was not some injury to the spine or spinal nerves, which is not visible on present means of investigation.*

[9] The matter was then referred to ACC's Complex Claims Panel which recorded:

> *[The appellant] has depressive and anxiety symptomatology after the second lumbar puncture of 03/08/2016.*
>
> *<u>Psychiatric advice</u>*
>
> *Provisionally speaking [the appellant] has an adjustment disorder with depressive symptomatology, anxiety symptomatology, and pain*

symptomatology. It appears that the pain subsequently to the second lumbar puncture led to a lowering of [the appellant's] mood and anxiety. [The appellant's] mental injury is an ordinary consequence of the pain that followed the lumbar puncture.

Panel outcome

Panel agreed that there is a mental injury identified to be adjustment disorder. How3ever, it is noted that the pain has not been found to be symptom of any physical injury including the lumbar puncture wounds. Therefore, the adjustment disorder is not because of a physical injury caused by treatment.

[10] On 16 November 2018, ACC advised the appellant that the claim for a treatment injury had not been approved. ACC's decision is recorded in a treatment injury report. That report noted:

ACC sought advice from psychiatrist Dr Asteriadis who, following assessment, found that you have an adjustment disorder with depressive symptomatology, anxiety symptomatology, and pain symptomatology. He felt it appeared that the pain subsequent to the second lumbar puncture led to a lowering of your mood and anxiety. Dr Asteriadis advised that your mental injury is an ordinary (likely) consequence of the pain that followed the lumbar puncture.

ACC assessed the relevant clinical information

ACC acknowledges that you experienced pain following a lumbar puncture and that you have since developed a mental injury identified to be an adjustment disorder. However, it is noted that the pain has not been found to be symptom of any physical injury including the lumbar puncture wounds. Therefore, the adjustment disorder is not because of a physical injury caused by treatment.

In summary the clinical evidence does not support that a treatment injury occurred; accordingly your claim is declined for cover.

[11] As a result of the declinature, a review application was lodged. ACC then obtained a report from Dr Macleod, a psychiatrist, and he provided a report on 21 February 2019. In that report he said:

Lumbar Puncture is an accepted diagnosis and potentially therapeutic intervention for idiopathic intracranial hypertension. [The appellant] initially underwent this intervention on the 5th September, 2015, an intervention that was apparently uncomplicated though didn't result in significant symptomatic improvement. Lumbar puncture was then performed again on the 3rd August, 2016. This intervention apparently required several attempts to obtain CSF, not an uncommon occurrence. Not surprisingly this was uncomfortable and painful for [the appellant]. He experienced acute lower back pain secondary to the local trauma involved in the4 intervention – this is to be anticipated with this procedure, though it would be expected to be transient. Unfortunately [the appellant's] back pain has subsequently been persistent. A clinical review by Dr Anderson, Neurologist confirmed there was no persisting neurological

abnormality, an MRI affirmed this on. Dr Anderson commented that the pain was constant across the lumbar spine and radiated into the right leg, this report being 23rd September, 2016. Unquestionably, the lumbar puncture caused acute back pain. The critical question is why this acute pain, without detectable enduring organic/physiological damage, evolved into a chronic pain syndrome.

…

Dr James Wright, Psychiatrist documented on the 10th May, 2017 that: "[the appellant] presents with multiple social, psychological and medical problems, a life history of repeated failure to continue in a multiplicity of jobs and training schemes, despite early academic promise as a school boy. Raised in a strict religious with a younger brother with Asperger's Disorder, he dropped out of school because (he was) unhappy, and then left the Air Force because he did not like the notion of combat. He has never sustained employment for very long, he dropped out of both a music degree and primary school teaching. He has a leaky home rental with conflicts with rent and ACC tribunals. In short he presents with apparently self-defeating intractable life problems, low mood and occasional suicidality, with dependent traits and passive aggressive traits".

…

[The appellant's] history of psychological vulnerabilities prior to the onset of idiopathic intracranial hypertension (and the associated investigations) would likely be risk factors for him to evolve a chronic pain syndrome after an acute pain event. His persisting pain would likely be further perpetuated by his ongoing depression, his attributions of a medical misadventure, and his sedentary lifestyle.

I would suggest that the physical injury associated with the lumbar puncture precipitated a Chronic Pain Syndrome, but that this was not the cause of the Chronic Pain Syndrome. Had [the appellant] not possessed the psychological vulnerabilities documented it would reasonably have been expected that the acute pain associated with the procedure would have spontaneously settled (as indicated by the study of epidural analgesia). It is important to note that, not surprisingly, [the appellant] is adjusting to the disabling symptoms associated to idiopathic intracranial hypertension, specifically visual impairment and headache. These issues, as well as other concomitant psychosocial stresses, such as difficulties with rental property, would also likely be driving his ongoing psychological symptoms.

It is difficult to answer the questions you raise with confidence for chronic pain remains a disorder of ongoing aetiological uncertainties. However I would conclude that he hasn't suffered a mental injury relating to the lumbar puncture of the 3rd August, 2016. There are other plausible risk factors and possible explanations for the ongoing mental symptoms that [the appellant] has unfortunately experienced. For the patient lumbar puncture is an unpleasant and temporarily uncomfortable, if not painful, procedure, but not one commonly associated with ongoing mental trauma or psychological sequelae. Adjustment Disorder, anxiety symptomatology and pain symptomatology are not ordinary consequences of lumbar puncture.

In summary I would opine that [the appellant] did not experience a mental injury consequent to the accepted physical injury associated with lumbar puncture. The physical injury he suffered was an ordinary consequence of the

treatment, but not one associated with enduring psychological or psychiatric consequences.

[12] The appellant then saw Dr Walls, an occupational medicine specialist and Dr Snell, an occupational medicine physician who prepared a report on 25 February 2019. They responded, as follows, to two specific questions Mr Hinchcliffe asked:

> ***2. What is your response to the comment from ACC that [the appellant's] pain condition was caused by the index event as described?***
>
> *Chronic post-dural puncture backache following lumbar puncture is described in the medical literature as occurring in approximately 0.3% of cases.*
>
> *The exact pathophysiology of the condition is not known however there are a number of structures postulated to be the pain generator following dural puncture and conceivably the traumatic nature of the Dr may have increased the risk [the appellant's] case.*
>
> ***3. Did the lumbar puncture cause [the appellant's] pain condition?***
>
> *I have no doubt that the lumbar puncture precipitated [the appellant's] low back pain.*
>
> *He has no previous history of low back pain and he experienced immediate pain following the procedure that has not resolved since this time and is confirmed with multiple entries in his patient notes.*

[13] The appellant also provided a written statement of 20 March 2019 where he said:

> *In September 2015, I had a lumbar puncture procedure with no adverse effects.*
>
> *I had no lumbar pain prior to 3 August 2016.*
>
> *I had pain during the lumbar puncture procedure on 3 August 2016. This pain continued unrelenting to a high level which has caused my mental injuries, especially depression. This pain still continues today.*

The review hearing

[14] The Reviewer, Mr McKenzie, considered all the medical reports and counsel's submissions and noted correctly that the appellant has a mental injury, although the specific diagnosis is unclear. He then went on to consider whether the mental injury is because of the lumbar puncture. After considering the medical evidence, Mr McKenzie found it did not show that the appellant's mental injury was caused by

the lumbar punctures. I set out Mr McKenzie's discussion in relation to the evidence and his conclusion.

> *I accept the evidence supports the onset of acute pain following the lumbar puncture, and this is reflected in Dr Anderson's contemporaneous notes. As noted by Dr Macleod, acute lower back pain is to be anticipated with this procedure, and this is not surprising given that it took several attempts to insert the needle. Dr Snell and Dr Walls were also in no doubt that the lumbar puncture "precipitated" [the appellant's] back pain. However, there appears to be limited evidence to support that [the appellant's] ongoing pain was caused by the lumbar puncture.*
>
> *In Dr Macleod's view the pain following the lumbar puncture would be expected to be transient. Other experts, including neurologists Dr Anderson and Dr Mossman, also commented that ongoing pain would be an unexpected and unusual complication of a lumbar puncture.*
>
> *It is also important to keep in mind that [the appellant's] ongoing pain may have caused his mental injury, but that is not sufficient to establish cover. Pain is a symptom, and for [the appellant] to be successful he must be able to show that the pain was caused by the lumbar puncture.*
>
> *Dr Asteriadis provides some support for [the appellant's] case, commenting that it appears that the pain subsequently to the lumbar puncture led to a lowering of [the appellant's] mood and anxiety. Despite this, I do not consider that Dr Asteriadis's reports (or the reports from the other experts, including Dr Snell and Dr Walls) provide sufficient evidence to conclude that the lumbar puncture caused [the appellant's] ongoing pain which in turn caused his mental injury.*
>
> *I agree with ACC's submission that the most helpful opinion in this case is from Dr Macleod. He has provided the most relevant and comprehensive opinion regarding chronic pain syndromes with respect to the specific facts of [the appellant's] case. After discussing the relevant history, Dr Macleod comments that there are other plausible risk factors and possible explanations for the ongoing mental symptoms that [the appellant] has experienced.*
>
> *Although Dr Macleod suggested that the physical injury associated with the lumbar puncture "precipitated" a chronic pain syndrome, my reading of his report is that he does not believe the lumbar puncture "caused" a chronic pain syndrome. Dr Macleod makes this clear when he qualifies his comment by saying "but that this was not the cause of the Chronic Pain Syndrome". His conclusion is also unequivocal:*
>
> > *I would opine that [the appellant] did not experience a mental injury consequent to the accepted physical injury associated with lumbar puncture. The physical injury he suffered was an ordinary consequence of the treatment, but not one associated with enduring psychological or psychiatric consequences.*
>
> *In conclusion, I find there is insufficient evd4 to show that the lumbar puncture caused [the appellant's] pain which was a material cause of the mental injury. This means that I agree with ACC's decision to decline cover for [the*

appellant's] mental injury as a treatment injury. The application for review is dismissed.

[15] After the review hearing and before the hearing of the appeal, further medical reports have been provided. The first is from Dr Isichei, a consultant psychiatrist. He prepared a report on 12 June 2019 and answered three questions put to him by Mr Hinchcliffe. I set out the questions and the answers below.

> ***4. Did the lumbar punctures cause the lumbar pain condition and then the pain condition causing [the appellant's] depression?***
>
> *The relationship between his lumbar puncture and the onset of his back pain means that the lumbar puncture precipitated his back pain. This was followed by lowering of his mood, increased anxiety and suicidal ideation. He required treatment with an antidepressant (Citalopram) and he was followed up by a community mental health team (Cornwall House). Lowering of his mood and increased anxiety following the onset of his lower back pain means that it is likely that the pain caused his depressive episode.*
>
> ***5. Can depression occur within two weeks following a pain condition? If not, how long?***
>
> *Depression is commonly associated in patients experiencing pain. Chronic pain conditions are frequently comorbid with depression and anxiety. Depression can be precipitated and exacerbated by pain. It can occur within weeks or months of the onset of a painful condition. There are a number of studies which have reported the association between depression and pain (as noted below). Patients with chronic pain have an increased incidence of depression when compared to patients without chronic pain. The long term conditions most strongly associated longitudinally with the development of depression include back pain and migraine headaches (Persistent pain and wellbeing – A World Health Organisation study in primary care, JAMA, 1998, 280:1142, and Long term medical conditions and Major Depression, J.Affect, Disord, 2001, 6335-41). Several epidemiological studies have shown that pain is strongly associated with anxiety and depressive disorder. The characteristics that most strongly predict depression are the diffuseness of pain and the extent to which pain interferes with activities (British Journal of Psychiatry June 1996, Vol 168, pp 101-108). The onset of depression can vary from weeks to month between individuals. The severity of pain, the impact it has on daily activities and the duration of the pain are all relevant regarding the onset of depression on patients with pain.*
>
> ***6. Is Dr Macleod's opinion correct that [the appellant's] condition was more likely due to his pre-existing conditions?***
>
> *Dr Macleod noted that [the appellant's] history of psychological vulnerabilities prior to the onset of idiopathic intracranial hypertension would be risk factors for him to evolve a chronic pain syndrome after an acute pain event. He also noted that his persisting pain would be further*

> *perpetuated by his ongoing depression, his attributions of a medical misadventure and his sedentary lifestyle.*
>
> *Although [the appellant] may have had "psychological vulnerabilities" prior to the onset of intracranial hypertension and his lumbar puncture, this does not indicate that his subsequently problems with depression was caused by these "psychological vulnerabilities". There was a significant deterioration in his mood following the onset of his back pain which suggests that this was the precipitating factor for the deterioration in his mood. People with a history of depression can go into remission with treatment and may relapse if there is another precipitating factor. It does not necessarily mean that the pre-existing condition caused the relapse. It is unlikely that the depressive and pain condition would have occurred without the lumbar puncture treatment.*

[16] Then on 18 June 2019 the appellant made a written statement in response to comments made by Dr Wright in his report of 10 May 2017. He said the reason why he had lost jobs in the recent past was because of the pain from the lumbar puncture procedure. He was not sure where Dr Wright obtained the information about him being abandoned throughout his life, because he had been in a long term relationship since 2013, he is married to that person, is still close to his parents, and has a good group of friends that he has had since university. In relation to tenancy issues and the leaky home, that all occurred after the lumbar puncture. He had no suicidal tendencies prior to his lumbar puncture, he still has lumbar pain and did not have any prior to the lumbar puncture.

[17] Dr Isichei's report was referred to Dr Macleod and he also considered the report from Doctors Walls and Snell. On 16 September 2019 he said:

> *I acknowledged this claim presents complex deliberations about a condition which has limited medical understanding (chronic pain), in association with a condition that the actual cause of is essentially unknown (Major Depressive Disorder, though we do have an understanding of the risk factors and the theoretically neurochemistry underlying this condition).*

[18] He also notes that Dr Walls said, "*[The appellant] has never previously been diagnosed with a mental health disorder*" and he presumed that Dr Walls did not have access to the information because that opinion clearly is contradicted by the reports from Cornwall House and Dr Asteriadis. He goes on to say:

> *There is no doubt, supported both clinically and in the literature, that chronic pain is highly correlated with major depression, and that it is likely to precipitate past affective vulnerabilities if they are evident. However, in my*

experience of three decades of attending a Pain Management Service, a view that is increasing supported by the literature, is that in those without a prior history of depression the dysthymic mood associated with chronic pain is not particularly antidepressant responsive. This would seem to be a feature of [the appellant's] more recent mental health, s noted in his 2018 notes from Cornwall House. It is also noted that [the appellant's] pain occurred immediately following the second lumbar puncture, as would be expected. Seemingly the onset of the subsequently depression was rapid. Certainly in those with a bipolar affective disorder history mood switches can be very rapid and dramatic, but for the majority of patients who suffer unipolar depressions, depressions tend to be of a relatively slow evolutionary process, often occurring over weeks to months. But frankly there is very limited literature about this to my knowledge.

Both Dr Walls and Dr Isichei acknowledge that the lumbar puncture precipitated back pain, which was followed by a lowering of the mood. Dr Isichei stated that "depression can be precipitated and exacerbated by pain", a view certainly supported in the literature, but raises the question as to whether or not precipitating factors are causative factors. The academic difficulty is that the cause of affective disorders is unknown, though many risk factors are recognised, but whether these cause or precipitate the disorder is questionable.

[19] He then responds to the specific questions that were put to him by ACC:

7. Do you remain of the same opinion regarding the cause of the pain condition as expressed in February? Please explain.

My opinion hasn't changed since February. There is obviously no doubt that the acute pain was caused by the lumbar puncture, but as to why the acute pain morphed into a chronic pain remains speculative. [The appellant's] past psychological history and then present psychosocial stressors would suggest that these would likely have been relevant influences.

8. What was the cause of [the appellant's] depression post the lumbar puncture. Did the pain and low mood aggravate a pre-existing depressive condition or did it cause the depressive episode?

Chronic pain predisposes to Dysthymia and Major Depression. In my opinion [the appellant's] past psychiatric history is relevant.

9. If you disagree with Dr Isichei could you identify areas of disagreement and explain why you disagree?

I would argue that there are differences between precipitating and causative factors.

10. What relevance, if any, does the idiopathic intracranial hypertension condition have regarding [the appellant's] depression?

Chronic headache, or indeed any chronic pain or condition would be a risk factor for precipitating and aggravating major depression.

> *In conclusion, I think it is very difficult to be diagnostically confident in view of the complexities and associations of [the appellant's] physical and mental states.*

[20] Dr Macleod was then asked to provide further comment in relation to the appellant's written statement. He did so on 29 October 2019, saying:

> *With respect the difference between precipitating and causative influences, I note that Dr Ben Isichei, in his report of the 12.6.2019, also concluded that the onset of back pain was the precipitating factor for the deterioration of his mood. The Oxford Dictionary of Current English defines 'precipitation' as being "the hastening occurrence of an event, or making an event occur prematurely", whereas 'causation' is the "thing that produces an effect". As I previously mentioned I don't consider that modern medicine understands the cause of depression, or rather the multiple causes of depression. However we are familiar with many of the risk factors and precipitants for major depression and [the appellant's] history of dysthymia/depression and psychological vulnerability would, in my opinion be a more probable explanation for his evolution of chronic/persisting ain after an unpleasant soft tissue injury resulting in acute pain. In addition to this pain there are other acknowledged psychosocial stressors that are probably aggravating factors as well.*
>
> *In response to question 2. My view remains that [the appellant's] acute pain precipitated a depressive response in a person with affective risk factors, rather than being the cause of the subsequently depressive episode.*
>
> *In conclusion I maintain my opinion that on the balance of probabilities, pre-existing psychological and psychiatric vulnerabilities account for the emergence of more significant affective symptoms associated with, and aggravating, chronic pain. These were diagnosed by Dr Asteriadis as an adjustment disorder with depressive symptomatology, but the reports of Cornwall House, would suggest that his dysphoria most likely developed into a Major Depression.*
>
> *However, I do concede that in most psychiatric conditions, differentiating causative from precipitating influences is contentious.*

Case for the appellant

[21] Mr Hinchcliffe, after going through the various evidence at length submits that the Reviewer was wrong in declining cover for a mental injury claim. Here the appellant has suffered an adjustment disorder and depression mental injuries as a result of the lumbar puncture physical injury. Section 32(1)(a) of the Act requires that the appellant was under treatment at the time of the injury, which was the case, and a personal (mental) injury was caused by treatment, as required under s 32(1)(b) which Mr Hinchcliffe says is the case, and the result was not a necessary part or an

ordinary consequence of the treatment as required under s 32(1)(c), which again Mr Hinchcliffe says is the case.

[22] He submits that in accordance with the decisions of *Accident Compensation Corporation v Monk*[1] and *Waipouri v Accident Compensation Corporation*[2] a mental injury related to treatment, does not need to establish a physical injury. The fact that the appellant had a lumbar puncture and developed a mental condition following this is enough.

[23] He refers me to the Court of Appeal decision of *Hornby v Accident Compensation Corporation*[3] where the Court canvassed three possible situations where cover might arise under s 26(1)(c), namely:

> (ii) mental injury arising out of an accident and resultant physical injuries;
>
> (iii) a pre-existing mental condition may be aggravated somehow, solely because of the physical injuries; and
>
> (iv) physical injuries may have been a contributing cause, although not the only contributing factor to, the resurgence of a prior mental affliction.

[24] Mr Hinchcliffe submits that the appellant fits into the first category because there is no evidence that he suffered from an adjustment disorder or depression condition before the lumbar puncture and therefore he should attract cover.

[25] Mr Hinchcliffe reminds me that s 32(1)(c)(i) defines treatment injury as personal injury that is suffered by a person seeking treatment from one or more registered health professionals and caused by treatment; and not a necessary part, or ordinary consequence of the treatment, taking into account all the circumstances of the treatment including the person's underlying health condition at the time of the treatment. Mr Hinchcliffe argues that at the time of the treatment, being the lumbar puncture, the appellant was not suffering from any pre-existing condition of

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1 *Accident Compensation Corporation v Monk* [2012] NZCA 615, [2013] NZAR 1.
2 *Waipouri v Accident Compensation Corporation* [2017] NZACC 36.
3 *Hornby v Accident Compensation Corporation* [2009] NZCA 576, (2010) 9 NZELC 93,476.

depression. In any event if he did have a mental injury earlier it is quite different to the depression he has suffered as a result of the lumbar puncture.

[26] Mr Hinchcliffe submits that when one considers all of the medical reports, the fact that the appellant himself disputes any pre-existing mental conditions at the time of the injury and that Dr Macleod could not find evidence of pre-existing depression or adjustment disorder, the weight of evidence does establish a mental injury caused by the lumbar puncture treatment and the appeal should therefore be allowed.

Case for the respondent

[27] For ACC, Mr Tuiqereqere submits, in summary, that the evidence available does not establish the requisite causal nexus between the physical injury (a soft tissue injury) suffered as a result of the lumbar puncture and the appellant's mental injury. He goes on to submit that even if causation was established, the cover is excluded because the mental injury is an ordinary consequence of the treatment having regard to the appellant's underlying health condition.

[28] He submits that the evidence in the case demonstrates that the exclusion applies in the appellant's case. He refers in particular to opinion of Dr Asteriadis when he said that given the appellant's health history prior to the lumbar puncture, the mental injury was an ordinary consequence. Mr Tuiqereqere also relies heavily on Dr Macleod's various reports and in particular that of 21 February 2019 where he said that an adjustment disorder, anxiety symptomology and pain symptomology are not ordinary consequences of a lumbar puncture, it was a general statement only and not applying to the appellant's particular circumstances. However, when the appellant's underlying health condition was factored in, Mr Tuiqereqere submits that it is clear that Dr Macleod considered the mental injury to be well within the range of outcomes for the appellant and not something that would occasion surprise.

Discussion and decision

[29] I have considered carefully the various submissions presented to me and in particular the decision of the Reviewer. I have deliberately set out above much of the various medical reports which were considered by ACC and the Reviewer.

[30] As to the law, the starting point for me is the decision of Mallon J in *Monk*[4] where the learned Judge in answering the question put to her held:

> *I accordingly answer "yes" to the question on which leave was granted. A mental injury suffered because of physical injuries can be covered as a treatment injury even if the physical injuries were a necessary or ordinary consequence of the treatment. The appeal is accordingly allowed. For the purposes of the appeal it was accepted that the lumbar puncture (involving a large needle going into the spine) amounted to "physical injuries". That issue, together with whether the issues referred to in [20] above and any other issues, that were not determined because of the view that was taken about the meaning of s 26(1)(c) an s 20(2)(b), are referred back to the Reviewer (or the District Court if both parties consider that is more appropriate) for consideration.*

[31] The *Monk*[5] decision was approved by the Court of Appeal where they commented:

> *… we are not persuaded that the ordinary meaning of the statutory language or the object of the legislation further requires that the physical injury be defined as a physical injury that is itself covered.*

[32] I have also been referred to the Court of Appeal decision of *Hornby*[6] where the Court considered three possible situations where cover might arise under s 26(1)(c). Mr Hinchcliffe, for the appellant, urges me to agree that the appellant comes within the first situation being "mental injury arising out of an accident and resultant physical injuries."

[33] The Reviewer concluded that "there is insufficient evidence to show that the lumbar puncture caused the appellant's pain which was a material cause of the mental injury".

[34] As will be seen from the list of the various medical reports I have set out above, there are a number of specialists who consider that the lumbar puncture caused significant pain to the appellant, which in turn resulted in the accepted mental condition. However, the Reviewer and ACC relied heavily upon a psychiatrist Dr Macleod. Both ACC and the Reviewer somehow drew a line between the word "precipitated" and the word "caused". Dr Macleod has said that the lumbar puncture precipitated a Chronic Pain Syndrome, but the Reviewer considered that in its proper

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4 *Monk v Accident Compensation Corporation* [2012] NZAR 1 (HC) at [21].
5 *Monk* above n 1.

context Dr Macleod did not think that it caused the condition. It is accepted by all concerned that the appellant does have a depressive disorder which in itself is a mental injury. I must say that in many of the cases that I have considered and where the medical evidence is not conclusive it causes difficulties for a judge to determine which of the medical opinions are to be favoured.

[35] I am considering matters as a judge, therefore I am approaching matters as per the question posed to Mallon J. In saying this, I prefer the evidence of the specialists favouring the appellant, rather than the evidence of Dr Macleod, because looking at matters from a common sense point of view, the following scenario is evident. The appellant had an earlier lumbar puncture procedure. Other than being painful at the time, he suffered no repercussions. On the second occasion the doctor carrying out the lumbar puncture had difficulty in correctly inserting the needle and a number of attempts were necessary. It caused immediate pain. The pain has continued. The appellant, it is accepted by ACC, now has a mental condition. Following these known facts and preferring the medical evidence I have referred to, I have no difficulty in accepting that a physical injury did occur when the lumbar puncture was carried out. I also have no doubt that a mental injury was suffered because of the physical injury and can consequently be covered as a treatment injury, even if the physical injury was a necessary or ordinary consequence of the treatment, which seems to be the case here. Put another way, I am satisfied on the balance of probabilities, that the mental injury, which is accepted, was a result of the physical injury, and can be covered as a treatment injury even though the physical injury was a necessary or ordinary consequence of the treatment.

[36] The appeal is therefore allowed.

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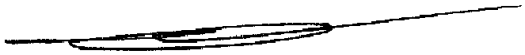
6 *Hornby*, above n3.

[37] The appellant is entitled to costs. I am confident the parties can agree costs, taking into account the principles set out in *Carey*[7] and, recently applied in *Nikora*. [8]



Judge Nicola Mathers
District Court Judge

[7] *Accident compensation Corporation v Carey* [2021] NZHC 748.
[8] *Nikora v Accident Compensation Corporation* [2021] NZACC 78.