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

[2023] NZACC 202 ACR 180/21

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

Hearing Heard at:	25 October 2023 Auckland/Tāmaki Makaurau
Appearances:	A Carlyle for the appellant F Becroft for the respondent
Judgment	12 December 2023

RESERVED JUDGMENT OF JUDGE D L HENARE
[Cover and entitlements s 20, 67 Accident Compensation Act 2001]

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[1] The appellant challenges two decisions by the Corporation, upheld at review, both dated 27 November 2020:

(i) The first decision declines cover for a head injury as a result of an accident on 1 March 1996; and

(ii) The second decision declines an entitlement to weekly compensation in respect to accidents on 1 March 1996 and 16 February 2008.

[2] The appellant says he has suffered from the effects of traumatic brain injuries (TBI) for which he is entitled to both cover and weekly compensation. He relies on a covered concussion injury he suffered on 1 March 1996, exacerbated by further injury in 2008. He says the Corporation's 27 November 2020 decision declining cover for a head injury is inconsistent with the earlier covered decision by the Corporation.

[3] The Corporation agrees the appellant has cover for a concussion injury (a traumatic brain injury). The claim as lodged was essentially a claim for entitlement to weekly compensation arising from the 1996 injury. In consequence, the main issue is whether the appellant continues to suffer the symptoms of his covered 1996 injury.

Agreed facts

[4] The appellant was granted cover for contusions to the face and nose suffered in an accident on 1 March 1996, when he was hit in the face on the rim of a grinder wheel while working. The claim form refers to the appellant as having been "KO'd".

[5] No significant entitlements were paid on the claim at the time. There are however reports in the period that followed from Mr Curtis, Orthopaedic Surgeon and Mr Baker, Neurologist who reference a back injury in August 1996, as well as back pain developing after the 1 March 1996 injury, and other issues in regard to concentration.

[6] The appellant emphasises a functional capacity evaluation from April 1997, of Judy Ryn, which identifies post-concussion syndrome and symptoms including reduced concentration, variable memory lapses and not always feeling "with it". Although the assessor suggested that further neurological/psychological testing might assist, no applications for entitlements were made, and there were no further investigations into the claim

[7] The next significant interaction on the claim was an application for an independence allowance in 2004. At that stage there was investigation into the nature of the claim and an acceptance that the appellant had suffered a head injury in the 1996 accident. Historical notes were obtained which included an MRI scan report of the head from 29 May 1998 which was reported as normal. The Corporation also received various reports that referred to a significant mental health background with a number

of mental health admissions since 1997, due to recurrent suicidal thoughts or suicide attempts. A psychiatric report from Dr Rankin, Psychiatrist from November 1997 diagnosed borderline personality disorder, parasuicides and self-harm behaviours.

[8] Dr Collier undertook an impairment assessment in 2005 and accepted that there was impairment in regard to the mental status, integrative functioning, as well as some emotional and behavioural effects, and issues with fatigue. An independence allowance was paid based on a 15% whole person impairment. No other claims for entitlements were made.

[9] In February 2008, the appellant was involved in a motor vehicle accident. He sought further assistance from the Corporation indicating that he had had more difficulties since that accident. He claimed an injury related hearing loss and virtual impairments.

[10] Through 2008 various visual and audiological tests were undertaken. The Corporation accepted cover for some injury related hearing loss. The appellant was also referred to Dr Timmings, Neurologist for review.

[11] Dr Timmings reported on 17 July 2008. He did not think that there was any evidence of a neurological disorder. He described the original injury as at worst a mild concussion and was concerned that many of the appellant's symptoms presented as factitious. He noted the significant psychiatric history since March 1996, and did not think that the appellant's presentation was as a consequence of either the 1996 or the 2008 accidents.

[12] On 11 September 2008, the Corporation issued a decision suspending the appellant's entitlement on the 1996 claim on the basis of Dr Timmings' advice. A review application was filed against that decision, but a review hearing was not set down within the required 3 months- which meant that there was a deemed review decision in the appellant's favour and the suspension decision was set to one side.

[13] In 2009, there was a further application for an independence allowance relating to both the 1996 and 2008 injuries.

[14] Dr Collier undertook a further impairment assessment in December 2009. He arrived at a 10% whole person impairment, but then, on the basis of Dr Timmings' advice, apportioned out the full 10%, agreeing that the effects of the injuries were spent: despite his permanent finding in 2005 of a 15% whole person impairment.

[15] Mr Mines, Advocate began acting for the appellant around this time and the independence allowance decision was challenged (which was subsequently withdrawn).

[16] Later, Mr Mines arranged for Dr Newburn, Neuropsychiatrist to provide a report. Dr Newburn had been treating the appellant for some time and provided a report on 29 August 2012. He concluded the appellant presented with significant consequences of a traumatic brain injury including a range of typical cognitive issues and the development of bipolar affective disorder. Dr Newburn provided similar reports on 5 October 2013 and 20 February 2014, and later opinions in 2020 and 2023.

[17] In the meantime, the Corporation declined various requests in regard to funding for eye and ear related treatment because it did not accept that ongoing symptoms were injury related. Notwithstanding, the Corporation indicated to Mr Mines that it would continue to consider requests for entitlements from the appellant as they were made.

[18] In April 2017, the appellant sought lost wages in relation to the 1996 accident. He also asked that the Corporation fund a neuropsychological report.

[19] The Corporation subsequently arranged an internal comment from Psychology Advisor, Dr Macniven and an external multidisciplinary panel report. Dr Macniven reported on 10 November 2017. He acknowledged a mild head injury in 1996, followed by a long history of psychiatric difficulties and concluded that a link between current symptoms and the index accident was tenuous. The Panel, comprising Dr Kennedi, Psychiatrist, Mr Cleary, Orthopaedic Surgeon, Dr Hill, Neurologist and Dr Farnell, Pain Specialist, concluded that the appellant had recovered from a possible mild concussion in March 1996. Their conclusion was there was no relationship between the appellant's ongoing symptoms and that accident.

[20] On 21 February 2018, the Corporation issued a decision declining weekly compensation on the 1996 claim. The same day, it issued a decision formally approving cover for concussion (alongside the face and nose contusions and hearing loss that had already previously been formally accepted on the claim).

[21] At a conciliation meeting in July 2018, the parties agreed to obtain a neuropsychological assessment.

[22] A neuropsychological assessment was completed by Mr Dick, psychologist in 2019. He also did not link the appellant's symptom profile to an injury suffered in the accident.

[23] Dr Newburn provided a further report on 15 May 2020, in which he diagnosed mild neurocognitive disorder due to two traumatic brain injuries and bipolar affective disorder, the cause of which he was unsure.

[24] The Corporation then agreed to consider Dr Newburn's recent evidence and the effects of the 2008 claim and issue a new decision on cover and entitlements across both claims.

[25] Further evidence was provided by Dr Thakurdas, Internal Medical Advisor (on 11 August 2020 and 24 November 2020) and Dr Newburn on 29 October 2020.

[26] The Corporation then issued the two decisions on appeal.

[27] The decisions were upheld at review in 2021. The Reviewer, Mr Vogel agreed that the appellant had not suffered any additional head injury (over and above the long covered and acknowledged mild concussion) and that his incapacity was not, on balance, injury related.

New evidence

[28] For the appeal, additional evidence was filed:

(i) A neuro-optometric assessment dated 20 February 2018.

(ii) A neuro-optometric assessment dated 20 January 2023.

(iii) A report from Dr Newburn dated 1 March 2023.

(iv) A report from Dr Macniven dated 8 March 2023.

Relevant Law

[29] Section 20 of the Accident Compensation Act 2001 (the Act) is the general cover provision. Under s67 of the Act, there is no eligibility for entitlement unless there is a covered injury.

[30] It is settled law that entitlements will only be available under the Act, if there is sufficient evidence that the need for assistance is causally linked to a covered injury.[1]

[31] Causation is the issue. The leading authority on causation is the Court of Appeal's decision in *Ambros*[2]

[32] Robust inferences on causation can be drawn. However, there must be sufficient evidential basis to support such an inference.

[33] Furthermore, in *Cochrane* the High Court stated: [3]

> An appellant may not establish causation simply by showing that the injury triggered an underlying condition which the appellant was already vulnerable… or that the injury accelerated a condition that would have been suffered anyway… The question is simply whether the necessary causal nexus continues to exist between the injury and the condition.

[34] Issues of causation will generally be determined by the medical evidence.

Mr Carlyle's submissions

[35] Mr Carlyle submits that the appellant has suffered head injury in 1996, exacerbated by the accident in 2008, for which he is entitled to cover. This submission is based on evidence from experts showing deficits in vision and hearing as well as mental health issues, all of which are consistent with a TBI diagnosis.

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1 *Sparks v Accident Compensation Corporation* 45/2006 (DC)

2 *Accident Compensation Corporation v Ambros* [2008] 1 NZLR

3 *Accident Compensation Corporation v Cochrane* [2005] NZAR 193 (HC) at [25]

[36] Mr Carlyle relies particularly on the evidence of Dr Newburn, who provided specialist psychiatric care to the appellant from 2006. Mr Carlyle also referred to the evidence of Judy Ryn, Dr Collier, Brenton Clark and Paul Dickson whose reports are summarised below.

[37] Dr Newburn opined the appellant suffers from bipolar affective disorder (BAD) and he has a set of symptoms typical of this disorder. Dr Newburn stated that the appellant also has broad range of symptoms not diagnostic of BAD but typical of those arising from a TBI.

[38] While Dr Newburn opined the appellant suffers from BAD, he refutes other experts' opinion that Mr Murphy's symptoms are consistent with borderline personality disorder (BPD). In Dr Newburn's opinion dated 1 March 2023, he explains that TBI can lead to symptoms that are also seen in BPD. He noted the connectivity between the salience network, default mode and executive networks are commonly described in both brain injury and BPD literature. Dr Newburn suggests that the absence of prior evidence of BPD rules out a personality disorder diagnosis. He explains that for a diagnosis of personality disorder, there needs to be an enduring and usually lifelong temperamental and behaviour changes causing distress to the individual and to others in their environment. Reviewing the appellant's history, Dr Newburn points to positive vocational skills, activity, and social relationships prior to the 1996 injury. Douglas Hibbs, Psychiatrist, supports this opinion, by also refuting a BPD diagnosis.

[39] In summary, Dr Newburn considers the appellant's ongoing symptoms are the direct result of a TBI. He explained the appellant had a typical injuring event, with a typical and enduring set of symptoms. He commented that physical damage to the brain can be inferred from the abnormality in auditory evoke response. He opined there is no other cause for these symptoms, noting that based on the history available, the appellant did not suffer from a premorbid personality disorder.

[40] Mr Carlyle refers to the report of Judy Rynn, Occupational Therapist, who assessed the appellant in relation to a back injury on 9 August 1996. Mrs Rynn opined that the Appellants symptoms, including reduced concentration, variable memory lapses, and not always feeling 'with it' related to a possible post-concussion syndrome.

[41] Mr Carlyle also refers to Dr Collier's whole person impairment assessment dated 11 April 2005 which indicated a 15% whole person impairment as "permanent and stable". Following the accident in February 2008, Dr Collier assessed 10% whole person impairment. He acknowledged the improvement in the rating is due to improved attention based on taking amantadine and selegiline. Dr Collier opined the effects of the injury were spent.

[42] Mr Carlyle submits Dr Collier's conclusion failed to account for the daily medication taken (amantadine and selegiline) and the 10% emotional and behavioural and 0.3% hearing impairment. This is supported by Dr Newburn's assessment, which found that on several occasions when the appellant stopped his medication, his attentional function deteriorated markedly. A deterioration in hearing was supported by the assessment of Emily Hunter, Audiologist, on 7 July 2004.

[43] Mr Carlyle refers to the evidence of Mr Clark, Neuro-Optometrist who supports the view of Dr Newburn. The key ocular and visual related findings are :

(i) Mild astigmatism;

(ii) Reduced amplitude of accommodation for age;

(iii) Uncomfortable binocular vision, despite optimal refractive compensation of astigmatism and a reading addition for near;

(iv) Discomfort with convergence, despite normal convergence amplitude;

(v) Photophobia;

(vi) Marked increase in binocular comfort with addition of a tint (30% blue light);

(vii) An increase in binocular comfort with a small degree of base in prism;

(viii) Abnormal egocentric localisation (several centimetres left of centre)

(ix) Sequential and simultaneous visual memory slightly below average;

(x) Rapid automatic naming slightly below average; and

(xi) Perceptual motor efficiency slightly below average.

[44] Mr Clark commented that the appellant's visual impairments are consistent with post-traumatic vision syndrome (PTVS) and one or more past TBI's. In his 2018 assessment, Mr Clark explained given it is 20 years since the date of injury, it is difficult to reach any conclusion with certainty. However, he notes the appellant maintains his vision problems began in 1996 following the injury.

[45] Mr Carlyle also refers to the evidence of Mr Dickson, Optometrist, with experience in neuro-optometric rehabilitation, who also linked the appellant's symptoms to a TBI. Specifically, he recognised the presence of convergence insufficiency, accommodative dysfunction and vestibular-ocular reflex difficulties, all of which are common vision problems associated with brain injuries.

[46] In summary, Mr Carlyle submits the expert evidence demonstrates that the appellant suffered a TBI in March 1996, likely aggravated in the 2008 motor vehicle accident, which is the direct cause of his ongoing symptoms and incapacities.

The Corporation's submissions

[47] Ms Becroft submits there is insufficient evidence that the appellant suffered head injuries for which he is entitled to cover, and which have incapacitated him. Ms Becroft submits the decision to decline weekly compensation, on the basis that the appellant's ongoing symptoms are not related to a minor head injury suffered in 1996, is correct.

[48] In Ms Becroft's submission, the injuries suffered by the appellant were mild and are not related to his ongoing symptoms which are not accident related. Ms Becroft submits the reports from Mr Dick, Neuropsychologist, and the Multidisciplinary Panel are comprehensive and persuasive. The historical evidence regarding the severity of the injury, including an early neurological report from Mr Baker and a 2008 neurological report from Dr Timmings, and more recent opinions of Dr Macniven are also compelling.

[49] Ms Becroft refers to the conclusions of the Multi-disciplinary Panel that the appellant suffered a mild concussion in 1996 with no significant loss of consciousness, evidence of intracranial haemorrhage or skull fracture, retrograde amnesia, or post traumatic amnesia. The Panel also noted that following the 1996 injury the appellant returned to full-time work and no GP visits were made until later that year when he

presented with lower back pain. The Panel agreed the likely diagnosis was BPD, unrelated to injury.

[50] Ms Becroft submits that the weight of the specialist evidence supports no causal link between the appellant's symptoms and the 1996 covered injury or that the evidence supports a new head injury caused by the 2008 accident.

Discussion

[51] The Court notes the appellant hit his face on the rim of a grader wheel in the accident in 1996. Cover was then approved for contusions to the face and nose. The Corporation originally approved cover for contusions to the face and nose, and subsequently approved cover for a concussion injury alongside the cover for contusions and the hearing loss claim accepted by the Corporation.

[52] Ms Becroft explained when Dr Kittaly filed a medical certificate on 2 July 2020 for a head injury, it was a claim for entitlement filed in relation to the 1996 claim. The Corporation's 2020 decision declined cover for any new head injury claimed, not to remove cover for the concussion injury granted. Simply, the appellant does not have cover for any head injury as a result of the February 2008 accident.

[53] However, the reviewer adopted a pragmatic approach looking at all the evidence relating to cover and entitlements. Ms Becroft explained it makes sense the focus of the claim is to entitlements to weekly compensation dating back to 1996, reviewing all the available evidence, including the 2008 accident but noting the appellant does not have cover for any head injury arising from the 2008 claim. The Court agrees a pragmatic approach is sensible. Mr Carlyle put the case for entitlements on the basis that the appellant's ongoing symptoms relate to both accidents.

[54] Accordingly, this appeal raises issues in respect to a head injury and entitlement to weekly compensation for incapacity dating back to claims in March 1996 and February 2008.

[55] The main issue is one of causation and the severity of the covered head injury. Are the appellant's symptoms causally related to injuries suffered in March 1996 or in the accident in February 2008?

[56] Mr Carlyle drew the Court's attention to the case of *Harrild* cited in *Ambros,* that it will be appropriate for matters to be decided in favour of a claimant even where the medical evidence is only prepared to acknowledge a possible causal connection. However, the Court cautioned:

> [73] The generous and unniggardly approach referred to in Harrild may, however, support the drawing of a robust inference un individual cases. It must, however, always been borne in mind that there must be sufficient evidence pointing to proof of causation, on the balance of probabilities, for a Court to draw even a robust inference on causation. Risk of causation does not suffice.

[57] The evidence is crucial to the Court's determination. There must be a robust evidential basis to establish causation. Here, the period spans some 25 years. The starting point is the contemporaneous evidence.

[58] The appellant's symptoms when he presented for treatment following the 1996 accident were described as "low grade, constant backache". There are consistent reports of back pain and muscle spasms between 1996 and 1997. The report from Mr Curtis from November 1996 also notes the presenting symptoms relate to back problems.

[59] There is a lack of evidence related to neurological symptoms in the initial period following the index injury. These symptoms are later relied on by Dr Newburn in establishing a link between the injuring event and the lingering effects of traumatic brain injury. The symptoms noted by Dr Newburn include slowed information processing, impaired divided attention, reduced frustration tolerance, photophobia, phonophobia and fatigue. Some evidence of these symptoms is first reported by Judy Rynn, who assessed the appellant in the year following the initial injury. Ms Rynn reported symptoms relating to possible post-concussion syndrome. These symptoms include reduced concentration, variable memory lapses, and not always feeling 'with-it'. It is relevant that Ms Rynn's conclusions were based primarily on the appellant's self-reporting. The Court observes the contradiction between Ms Rynn's report that the appellant "was knocked out for what is estimated to be 5 minutes" in contrast to the GP notes on initial presentation post-injury that the appellant was "left dazed but no L.O.C", that is loss of consciousness. This presentation supports the view noted by Dr Baker in 1997 that the concussion was mild. Mr Baker considered there was

difficulty in assessing the true nature of muscle twitching. He opined that anxiety and depression were symptoms in play.

[60] The contemporaneous evidence also shows pre-accident mental health issues in the appellant's medical history. The 1997, 1998 hospital and psychiatric reports consider pre-accident mental health issues as a young person, reporting by the appellant's father and psychological assessments in 1991. The history shows a clear shift following the accident in which the appellant presented for treatment for mental health issues resulting in a diagnosis of BPD. The 1998 and 1999 in-patient reports refer to issues in his formative years which is at odds with the subsequent reporting from Dr Newburn.

[61] In 1997 Dr Baker reported the appellant remembering seeing "everything white" and he noted a "momentary loss of consciousness", he took a week off work but then he noted leg pain and recurrent problems with his back. Dr Baker noted concussion. However, Dr Baker indicated that nothing had shown up on the CT and MRI scans which he viewed. The neurologist suggested there was no evidence of anything serious.

[62] In 2004, a GP note referred to a fall in 1996 and there were records for back problems and head problems and mental health issues, but it was difficult to tie the symptoms to the accident because "it was difficult to sort out which is which".

[63] What is to be made of the contemporary evidence? Mr Carlyle submits the appellant's back issues are consistent with a head injury. However, the Court finds the contemporaneous evidence does not correlate the symptoms of any back injury with head injury.

[64] Between 1999 and 2005 the evidence shows all medical presentations by the appellant are in the nature of mental health issues.

[65] The contemporaneous evidence does not suggest any head injury of significance. The Court observes the claim form as lodged refers to loss of consciousness but no actual claim for head injury was then filed. GP visits were infrequent and when the appellant did present more regularly, it was two years after the accident, and in relation

to lower back pain. Considering whether back spasms were related to a concussion injury, Mr Baker reported there was no evidence of anything serious. Mr Baker opined that several of the symptoms suggest anxiety and depression may be playing a substantial part.

[66] It is undoubted there were significant psychiatric issues present during the appellant's formative years that likely predisposed the appellant to mental health issues in adulthood.

[67] I turn to review the later evidence.

[68] It is not until Dr Collier's report in April 2005 that mention is made of a 0.3% hearing impairment, almost 10 years after the index injury. Mr Carlyle referred to Dr Collier's report that the concussion injury was permanent and stable in support of his submission of relevance of this report to the appellant's ongoing symptoms. The Court observes while Dr Collier's report focusses on the presenting symptoms to arrive at a 15%impairment, he does not address the issue of causation. The Court also observes that Dr Collier notes a detailed history of mental health issues.

[69] Mr Carlyle submitted the 2008 accident was a significant accident which would have effect for ongoing symptoms. The clinical notes in evidence record a motor vehicle accident, following which there was a clinical examination of head, skull face and jaw together with a note "NAD" which is no abnormality detected. Further, the claim form sets out the read codes of the injuries noted also in the schedule of claimant injuries being: a lumbar sprain, neck sprain and contusion of the knee and lower leg. There is no claim lodged for concussion or a head injury. The Court finds while the accident was significant and there might have been concussion in relation to it, there was not a clinical diagnosis nor claim filed for concussion following examination.

[70] The next evidence relates to reporting in 2008 by Dr Timmings. He had the historical documents and addressed the 1996 accident which the Court observes is in the same terms as Dr Baker. Dr Timmings is also aware of the 2008 accident, and he noted symptoms of hearing and vision issues which can cause the appellant to feel emotional. However, the neurologist concludes that there is no evidence of neurological disorder and the appellant's mental issues are not in consequence of the

1996 or 2008 accidents. This opinion was subsequently noted later by Dr Collier who noted the 1996 injury would have been spent.

[71] It is clear there are two reports from neurologists which do not consider the symptoms to be accident related.

[72] The hearing impairment comes from Mr Clark who examined the appellant in 2012 and again in 2022. Both examinations found visual systems consistent with an acquired brain injury. These issues have been persistent overtime and the Corporation accepted cover for injury related hearing loss. There appears to be no evidence of an alternative explanation for the ongoing visual and hearing deficits suffered by the appellant. The evidence of Mr Clark is consistent with the specialists who have investigated the appellant's eyes and ears over the years to around 2010. However, careful review of Mr Clarke's opinions appears to be based on subjective assessments derived from the appellant's self-reporting. It comes long after the date of injury making it difficult to establish causation.

[73] There are then a number of reports from Dr Newburn which are in the main treatment reports, rather than deal with causation. Dr Newburn's key reports are dated 5 October 2013, 15 May 2020, 29 October 2020 and 1 March 2023.

[74] Dr Newburn's October 2013 report details 19 symptoms which he says came on after the 1996 accident, including: slowed information processing, impaired divided attention, reduced frustration tolerance, photophobia, phonophobia and fatigue– all symptoms that worsened following the 2008 accident. Ms Becroft submits that Dr Newburn's opinion relies on temporality and the assertion that even minor head injuries can cause enduring symptoms.

[75] Dr Newburn's 15 May 2020 report reiterates the appellant suffers from a mild neurocognitive disorder and personality change due to TBI and BAD with a questionable causative link to injury. Dr Newburn negated the pre-injury psychiatric history explaining this was normal in the context of issues the appellant was experiencing in life.

[76] The Court finds Dr Newburn downplays the history of mental health issues prior to injury, which other specialists have considered relevant. There is heavy reliance on self-reporting and no real engagement with the opinions expressed by the other physicians involved.

[77] Dr Newburn's letter dated 29 August 2012, discusses the appellant's bipolar diagnosis, opining no pre-accident mental health history. He stated:

> There is no evidence of predisposition to this, either in premorbid symptomatology, or family history or such like. He therefore seems to be one of the individuals who has developed this disorder as a consequence of brain injury.

[78] However, Dr Newburn contradicts himself in his report dated 5 October 2013, when he suggests a history of predisposition:

> While it is more likely than not that this has arisen from an inherited predisposition from his mother, one cannot absolutely rule out the development of bipolar disorder on the basis of brain injury.

[79] In the same report, Dr Newburn states:

> Within the context of stressors, overload and alcohol consumption there have been a number of overdoses in the period of time after his injuring event but not prior.

[80] Dr Newburn contradicted himself again in his report dated 15 May 2020 explaining:

> In adolescence, following the death of his mother, there were a clear set of adjustments, which fell within the range of normal bereavement processes. He did take an overdose of asthma related medication within this context.

[81] The Multidisciplinary Panel and Dr Newburn disagree over the appellant's mental health diagnosis. I take into account though the Panel conducted a review on the papers, the disciplines of representatives are pain physician, neurologist, psychiatrist and orthopaedic surgeon. They note they are satisfied that the records have been made available to them which contain sufficient clinical information to reach an informed opinion agreeing a history of mental health issues in records, possible mild concussion in 1996 and the appellant would have recovered from that; history of back pain with no symptoms consistent with concussion related history.

[82] Dr Newburn suggests the absence of prior evidence of BPD rules out a personality disorder diagnosis. Dr Newburn also explained that TBI can lead to symptoms that are also seen in BPD. While Dr Newburn may be correct in drawing attention to similarities between BPD and TBI symptoms, there are contradictions in his evidence. Further, the Court finds upon careful review of his reports that Dr Newburn oscillates when he does consider causation. In some reports Dr Newburn suggest the disorders relate to TBI but in others he says they sit as separate psychiatric diagnosis and are not related to TBI. The impression the Court also gains from Dr Newburn's reports is the very heavy reliance of the appellant's self-reporting, which is understandable in context of Dr Newburn's skills and qualifications. However, the Court notes that caution is required when an appellant is reciting his symptomology and history, at that point of 17 years after the accident. This position is underlined by the Court's review of the appellant's evidence in the transcript of evidence, that recollection of matters was difficult, including the Court notes in respect to pre-accident matters.

[83] Mr Dick's assessments in December 2018 and April 2019 are instructive. He considered mental health history, various reports from Dr Newburn, as well as administering a range of tests. The results of validity testing indicated the possibility of mild exaggeration of complaints and problems. He too noted a documented history of health issues prior to and following the index injury.

[84] Dr MacNiven's November 2017 report opines the appellant sustained a mild head injury in the 1996 accident, however, there is no evidence to indicate a moderate or severe TBI. Dr MacNiven refers to a long history of psychiatric difficulties that predate the index accident including reports of sensitive issues from the age of 14. He confirms the likely origin of the appellant's mental health difficulties date back to his childhood. The Court sets out the final conclusion of Dr Macniven with which the Court agrees:

> The review documentation represents consistent evidence across multiple clinical assessments by psychiatrists, neurologists, neuropsychologists and ophthalmologists, that [the appellant's] symptoms are unrelated to the concussion he likely sustained in 1996. The only assessors who deviate from this view are Gil Newburn and Brenton Clarke. Dr Newburn's and Mr Clarke's opinions appear to be based on subjective assessments largely derived from [the appellant's] self-report. An objective consideration of the clinical evidence, including neurological, neuroradiological, and neuropsychological date, in the

> context of a balanced understanding of the relevant clinical and scientific knowledge of brain injury, supports the view that the concussion of 1996 is very unlikely to be causally linked to [the appellant's] symptoms. A much more plausible explanation for his symptoms is his long history of significant mental health difficulties originating in his childhood.

[85] Finally, the evidence of Dr Weerakoon notes no ophthalmic abnormality and in any event the symptoms are not within his discipline and an opinion of a neurologist is preferred. In fact, there is evidence from two neurologists who agree there were no symptoms they could causatively link to a head injury.

[86] What is to be made of the weight of the evidence?

[87] On balance, I am satisfied the weight of the evidence leads to the reasonable conclusions that:

(i) The injury was mild, at best, and did not result in any immediate symptoms of significance.

(ii) The appellant has a significant premorbid psychiatric history which features strongly in the years following the accident.

(iii) The majority of specialists including neurologists, psychiatrists, psychologists, and ophthalmologists do not support a causal connection between the Appellant's ongoing symptoms and a head injury.

(iv) The only specialist to draw a line between ongoing symptoms and a mild head injury is Dr Newburn, who relies heavily on self-reporting and whose reports lack proper consideration of the history and are contradictory when discussing key facts.

[88] I conclude the evidence clearly and in compelling terms, discounts any causal link between the appellant's ongoing symptoms and the covered head injury suffered in 1996 or that the evidence supports a new head injury caused by the 2008 accident.

[89] I conclude the decisions of the Corporation are correct.

Decision

[90] Accordingly, the appeal is dismissed. There is no issue as to costs.

Suppression

[1] I consider it is necessary and appropriate to protect the privacy of the appellant. This order, made under s 160(1) of the Accident Compensation Act 2001, forbids publication of the name, address, occupation, or particulars likely to lead to the identification of the appellant. As a result, this proceeding shall henceforth be known as *JD v Accident Compensation Corporation*.

Judge D L Henare
District Court Judge

Solicitors: For the respondent: Medico Law Limited, Auckland