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 27 ACR 104/22

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

Hearings:	14 December 2022 and 31 January 2023
Heard at:	Auckland/Tamaki Mākaurau
Appearances:	The Appellant via phone on each occasion Ms F Becroft for the Respondent, in person on 12 December 2022; via phone on 31 January 2023
Judgment:	20 February 2023

RESERVED JUDGMENT OF JUDGE C J MCGUIRE
(Cover Issues;-Causation; Gradual Process; Personal Injury; s 20(2); s 25; s 26; s 30)

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[1] At issue on this appeal is a decision by the Corporation dated 5 June 2019 declining a claim for tuberculosis.

Background

[2] The appellant lodged a claim form with the respondent on 27 September 2018. The description of the injury was as follows:

> Positive QuanteFERON Gold 22 September 2018. Exposure at work resulting in enforced time off work and was given prophylactic treatment.

[3] The injury date on the claim form was 22 September 2014. The claim form noted that the appellant was at that time, employed as a doctor by a DHB.

[4] The Corporation allocated the claim to WellNZ because the DHB was an accredited employer.

[5] On 11 October 2018, WellNZ sent a letter of introduction to the appellant and asked if it could discuss the claim further with her.

[6] On 15 October 2018, the claim was reviewed by an employee of WellNZ, Vanessa Oliver, who made a cover decision recommendation. She noted in the recommendation that there was no evidence of a specific accident or series of events, or a clear link between an accident and an injury. The recommendation concluded that the claim did not meet the criteria of ss 25, 26 or 28 of the Accident Compensation Act 2001.

[7] On 15 October 2018, WellNZ issued a decision declining the claim on the basis:

> It has been established that your injury sustained on 22/09/2014 did not occur at work …

[8] On 31 October 2018, the appellant wrote to ACC saying:

> My injury was sustained at work, as I was exposed to TB whilst working as a doctor in the DHB. The date 22/09/2014 is the date of investigation results. The exact date of exposure to a patient was not asked by my healthcare provider and no contact tracing took place …
>
> I was working at the DHB in 2014 when I fell ill and needed prophylactic treatment and time off work …

[9] On 1 November 2018, the appellant wrote to WellNZ indicating she had been exposed to many patients whilst working at the DHB and that she was working in the cardiothoracic department at the time and that she was falling ill with URTI's (upper respiratory tract infections) very often.

> … DHB were not concerned about contact tracing or to find out which patient may have given it to me as they were fast to point the blame to somewhere else, ie. my own family members or other places, despite me never having any positive TB test prior to that time and no one in my family being ill with TB prior to my period of illness in 2014.

[10] In November 2018, WellNZ responded to the appellant and indicated it would reconsider the claim as a work-related gradual process disease or infection. It subsequently sought further information from the appellant in regard to the condition and symptoms, and when she believed the exposure had occurred.

[11] The appellant responded with this history:

> Started in 2014 between June-August when I started having a cough and febrile episodes. A family member visited me who was well prior and became unwell. So I got concerned and did a check and realised I had been exposed to TB. My chest x-ray was clear. Sputum samples were clear. My QuantiFERON Gold which had never been positive came back positive. I was treated at the DHB by a respiratory physician for prophylactic treatment secondary to TB exposure. My QuantiFERON Gold is now negative, which is an uncommon switch from positive to negative and I am unsure of the relevance of this.

[12] In response to further questions from ACC, the appellant advised:

> A family member visited me when I was unwell in Auckland in 2014. She came to Auckland fit and well, with no medical issues or any diagnosis prior, and left Auckland sick. She was subsequently diagnosed with TB for the first time. I cannot give you any further information, as the privacy of the other individual has to be respected.

[13] The appellant also said:

> As a doctor in a hospital working in the anaesthesia department, we are exposed to many different types of workplace factors and environments. We are also exposed to patients airways at all times. We are exposed to patients from different backgrounds and origins, and yes it is very possible to be exposed to a respiratory illness whilst working in theatre and also in the cardiothoracic ward.

[14] Notes were subsequently sought from the DHB and the appellant's general practitioner.

[15] There is a note of a consultation on 23 September 2014. The note reads:

> A late addition: occurred on 22/09/14. Asked by Ann Culpin, OH&S Vocational Rehab Advisor to speak with [the appellant], who has had a persistent cough and is a recent TB close contact. Spoke with [the appellant] who stated her mother had been staying with her, and on return to Malaysia her mother had a CT which showed TB nodules. [The appellant] stated she felt well in herself, but had a persistent cough. Had stayed off work today. Discussed with Dr Allum. Advised for [the appellant] to see her GP and that she would require a QuantiFERON test and a CXR to clear her from having active tuberculosis. Received phone call from [the appellant] in the afternoon of 22/09/14 stating had been to her GP, had her QTF test and was going to have a CXR. Wanted to know when she could be cleared to come back to work. Discussed again with Dr Allum and advised [the appellant] it would be her GP who would clear her, as this was the person who had ordered the tests.

[16] There is a further clinical note of a consultation on 25 September 2014. It read:

> Received an email from [the appellant] 24/9/14 stating her GP had said that [the appellant] is unfit for work until Friday (until he is assured [the appellant] is clear from TB …

[17] There is a further consultation note of 1 October 2014 which reads:

> Phone call with [the appellant]: her QuantiFERON test has come back positive, [the appellant] states her GP has spoken with the ARPHS physician and she has been told she should not be working until she has further investigations …

[18] There is a clinical letter following a consultation on 15 October 2014 with Dr Becky Lane, Respiratory Registrar. The letter reads:

> **Problems**
>
> A recent exposure to confirmed pulmonary tuberculosis case – new positive QuantiFERON Gold dated 22/9/2014, ? prior negative 2009.
>
> Mantoux test performed on 23/9/2014, 12 min in duration (? Previous result similar 2011).
>
> Chest x-ray normal at baseline (Horizon Radiology).
>
> 2. Prolonged cough from July to August 2014, now resolved.
>
> 3. Weight loss, now resolved.
>
> No regular medicines, no known allergies.
>
> [The appellant] is a 31 year old anaesthetic registrar at the … Hospital who presented to clinic today after recently being exposed to her mother, who has subsequently returned to Malaysia and is being treated for pulmonary tuberculosis.
>
> [The appellant] herself initially became unwell prior to her mother arriving in July this year, with a short illness associated with lethargy and fevers and productive cough. After that illness, she went on to have a chronic cough that continued while her mother was staying for three weeks in August, but has subsequently resolved.
>
> While her mother was visiting Auckland, she developed a cough with fevers and, because of insurance issues, returned to Malaysia after a three week stay. She was subsequently found to have seroconverted with a QuantiFERON Gold (prior negative March 2013) and was found to have evidence of nodules on her CT scan and possible abnormalities in her right apex of her chest x-ray. At this stage, it is unclear what the blood susceptibilities of her mother's tuberculosis infection are.
>
> [The appellant's] cough stopped towards the end of her mother's stay, towards the end it was dry and non-productive. She denies any history of haemoptysis. She has lost about three kilograms over the course of this year in the context of this illness, but has subsequently put this back on. She denies any prior health problems, does not take any regulation medicines.

She works as an anaesthetics registrar at … she has a good appetite, no history of fevers or chills and no night sweats. She has experienced some diarrhoea in the last two to three days and some vague abdominal pain, but she feels that this is most likely secondary to her returning to her Malaysia last week because her Grandmother passed away and she was required to attend the funeral.

She has been on and off work since her QuanteFERON Gold has returned positive and today is awaiting her third sputum prior to returning to work.

Apart from visiting Malaysia, New Zealand and Australia, she has visited Indonesia in 2013. She has a current partner, but he remains QuanteFERON Gold negative.

…

She has no known exposure to any animals or pets and no known asbestos exposure. She is a lifelong non-smoker and drinks minimal socially. She has no known allergies.

Aside from her mother, she has no known other TB contacts and has not worked on a TB ward.

…

I discussed [the appellant's] case with Dr M Nisbet at the time of her review. Our current thoughts are that once this third sputum has returned smear negative, we are happy for her to return to work. I have discussed with her cough (illegible) but she should take herself off work should she clinically deteriorate, develop fevers or become febrile. I have explained her sputum cultures will take six weeks to return if culture negative.

At this stage, she certainly would be a candidate for consideration of (illegible) preventive therapy because she likely has latent TB (reassuringly her baseline CXR done at Horizon Radiology and now reviewed by ourselves) is normal.

I have arranged for her to have baseline blood test done today and her third induced sputum, and I will communicate with the lab about having TB PCR performed on this.

Should there be any concern, please do not hesitate to contact us, otherwise we will review [the appellant] in six weeks. I have given her a work certificate to cover her until her third sputum returns.

[19] Also produced is a copy of a consultation dated 2 October 2018 with Dr Entwistle at Central Wellington Medical Limited under the heading "Subjective" is this:

Was on an anaesthetic training scheme in (location) at the time. Had to have time off due to exposure to TB.

[20] Under the heading "Objective" is this:

Appears anxious.

Vague answers to questions.

Long discussion.

Probably not an ACC issue, but could ask them.

> Advised to talk to the College/her own GP for help – goes back tomorrow to Australia.

[21] On 13 February 2019, the claim was transferred to ACC for ongoing management.

[22] In the meantime, WellNZ had arranged an assessment with Dr Antoniadis, Specialist Occupational Physician. Dr Antoniadis reported on 21 March 2019. He clarified in his report that the appellant was employed full time as an anaesthetics registrar when she tested positive for TB on 22 September 2014. The appellant had previously been negative to QuanteFERON-TB Gold test on 5 December 2011. The appellant advised Dr Antoniadis that she had been experiencing lethargy from approximately January 2014 and then began to feel unwell with chills in May or June 2014, with rhinitis and a cough. She indicated in July her mother, a dentist in Malaysia, came to see her, to look after her, but within two weeks of visiting, she herself became unwell, developing a cough, and on return to Malaysia, a CT scan confirmed TB. Dr Antoniadis noted Dr Lane, Respiratory Registrar's support of 2014 when she stated:

> Aside from her mother, she has had no other TB contacts and has not worked on a TB ward. Her mother was a dentist in Malaysia, and as explained to her, was more likely to be coming in contact with TB cases than [the appellant] has been. She did have BCG at the age of 12 years.

[23] Dr Antoniadis confirmed that the appellant was off work during 2014 and through to May 2015, but evidently because she was both "mentally and physically unwell". The appellant then left New Zealand in February 2015 and except for short visits, has not returned. Dr Antoniadis thought that the probable diagnosis was latent TB. There was in his view, no clear support for active TB at the time of the presentation in 2014. He also thought it likely that the appellant had suffered an upper and possibly mild lower respiratory tract infection during June and July 2014. He did not think there was any support for active TB and did not think there was any support for the assertion that the appellant's work environment, or employer tasks, caused latent TB.

[24] Dr Antoniadis also said this:

> Therefore, one can conclude that as a doctor, in active practice, including in a field of anaesthetics, would be at significantly greater risk of tuberculosis than those who do not. However, I do reiterate that [the appellant] has not contracted active TB in this case.

[25] On 5 June 2019, the Corporation declined the claim again on the basis that there was not enough evidence to change the original decision and still no evidence that the appellant was exposed to TB at work.

[26] On 1 July 2019, the appellant applied for a review of the Corporation's decision. She reiterated her belief that she contracted TB at work.

[27] In a review decision of 29 October 2019, the reviewer, Ms Reddy, concluded that latent TB was not an identifiable and discrete physical injury, explaining:

> I find that by definition latent tuberculosis means that individual with the condition does not suffer from physical harm or damage to the body until it manifests and becomes active tuberculosis. I accept that a diagnosis of latent tuberculosis means that the person is at risk or has a pre-disposition to developing active tuberculosis in the future. This is not the same as having tuberculosis.

[28] Prior to the hearing of this appeal the respondent obtained a report from Dr Obele, its principal medical adviser dated 6 December 2022 that included the following:

> **<u>Quantiferon-TB Gold (QFT)tests:</u>**
>
> - QuanteFERON-TB Gold tests should never be considered alone.
> - QFTs are a diagnostic aid intended for use in conjunction with risk assessment, radiography and other medical and diagnostic evaluations.
> - QFT manufacturers state the test sensitivity is 99 per cent, which means, they say that the test is highly accurate.
> - Some studies suggest that QFTs can be positive for other reasons, such as possible previous BCG vaccinations (as reported by [the appellant], at age 12 years) or with other infections.
> - These are called false positives.
> - QFTs can sometimes be discordant, going from positive to negative, the reasons are complex, conversion or treatment factors.
> - The World Health Organisation indicates that the incidence of TBC and positive QFTs in Malaysia remains a leading health concern.
> - So, QFT can be a marker of TBC infection, but is probably not a perfect test.
> - QFTs do not tell us when possible exposure to mycobacterium occurred.

- Positive QFTs can indicate that the person is at low risk of developing TBC in the future, but the chances of that are low.

…

(The appellant) may have latent TBC, but that is not absolutely proven:

- (The appellant) advised that she had one positive QFT, which then became negative.

- The public health team decided to treat with isoniazid and rifampicin according to their expert protocols.

- On 23 March 2019, Dr Antoniadis appears to have concluded that one QFT somehow indicated that (the appellant) had latent TBC.

- Other causes do not appear to have been ruled out, eg. systemic inflammatory or connective tissue disorders, adenovirus, pneumococcal disease, HIV, illicit drugs, etc.

The significance of (the appellant's) mother infection is unknown

- (The appellant) advised that her mother visited her and developed respiratory symptoms, and, at some time was diagnosed with TBC. This was not corroborated, her results were not available.

- It is possible that (the appellant) was infected with TBC by her mother, and that her prior symptoms were an upper respiratory infection.

- That cannot be proven from the available information.

- There seem to be differing accounts of the timelines, and it is not possible to comment with any degree of certainty.

(The appellant) is unlikely to have contracted TBC from her work as an anaesthetic registrar

- Anaesthetic registrars must always wear full, appropriate PPE when doing aerosolised procedures (when they are exposed to respiratory droplets) – there are strict protocols in place. The chances of getting infected by a patient are not zero, but they are low.

- If there had been any suspicion or questions of a work related TBC infection, the public health team would have investigated this thoroughly, because naturally, there could have been a risk to other patients and staff too. There was no evidence of a public health investigation at [the appellant's] place of work; instead the public health response seems to have indicated that her symptoms were related to her mother's illness.

- There is no objective evidence of any patients with TBC (if there had been, their details could have been provided in an anonymised manner) and the appellant did not recall any such patients.

Adjourned Hearing

[29] The hearing of this appeal commenced at 2.15pm on 14 December 2022. The hearing was adjourned at 5.15pm, with the appellant not having completed her submissions in reply. The hearing was resumed and completed on 31 January 2023.

Appellant's Submissions

[30] Prior to the commencement of the hearing on 14 December 2022, the appellant had filed submissions and 18 appendices referring to documents, medical records, medical articles, medical opinions and comments. Subsequent to 14 December 2022, the appellant filed two further appendices, 19 and 20.

[31] In her submissions on 14 December, the appellant noted these issues:

- Did I contract TB infection in 2014?
- Is it an injury?

[32] She submits that there is a possibility she had active TB, which was missed because the focus was on her mental injury back in 2016. She said, if active TB had been missed, that could have caused or contributed to her current throat diagnosis of a chronic cough and hypersensitive throat.

[33] She says that before 2014, she was a relatively healthy woman and that she generally has a very resilient immune system.

[34] She said that in the four years prior that she was in New Zealand, she had no symptoms of this kind. She said she had no GP appointments at all in New Zealand before 2014.

[35] She said that at about December 2013, she was the victim of breaches of confidentiality and that from about 2014 the work environment became unwelcoming. She described it as toxic.

[36] She says that TB is a lifelong diagnosis and that it can switch from being latent to active and vice versa at any time. She says it can affect all parts of the body.

[37] She referred to her appendix 12 from the Oxford Handbook of Clinical Medicine, which notes that it kills nearly three million people a year worldwide. It also notes that primary TB is often asymptomatic and there is no fever, lassitude, sweats, anorexia, cough, sputum, erythema, nodosum or phlyctenular conjunctivitis.

[38] She notes that:

> Any form of immunocompromise may allow reactivation, eg. malignancy, diabetes, steroids, debilitation.

[39] She says she was "really unwell in July 2014".

[40] She refers to a consultation on 2 July 2014 with Dr David Chee. He recorded:

> Impression – flu-like symptoms
>
> Must be seen if worsening symptoms, ie. stiff neck/any rash/worsening cough/ dyspnoea/dizziness.

[41] She refers to the QuanteFERON-TB result dated 22 September 2014 being a positive test for TB infection.

[42] She said that her mother always tested negative for TB until her mother visited her in New Zealand.

[43] She referred to a report of Dr Randhawa, a registered general medical practitioner (GP) specialist in Malaysia.

[44] Dr Randhawa proposed and answered the following questions:

> 1. Diagnosis? Could she have had active TB for the first two weeks in July 2014, when she was symptomatic with cough, fevers and chills?
>
>   Yes, it would have been active TB in July 2014, because she was not tested for TB at that time.
>
> 2. Does latent TB still mean she had TB infection, but it is under control within her body by her active working immune system? Is there evidence of physical injury?

> Yes. She has had a chronic cough since 2014, diagnosed as hypersensitivity of the throat.
>
> 3. Can latent TB become active TB at a later time?
>
> Yes, because she is already infected with the TB mycobacterium.
>
> 4. Could she have contracted TB from her workplace at the DHB due to employment tasks?
>
> Yes, as it is not found in any material extent in her non-employment activities/ environment.
>
> 5. (On the version of Dr Randhawa's report submitted to the Court, item 5 is completely blanked out.)
>
> 6. Is the risk of suffering that permanent injury (TB infection) greater for people performing that employment ask, or who work in that environment, than those who do not?
>
> Yes. Dr Antoniadis has already answered this question and has confirmed that she was performing work as an anaesthesia registrar, which exposes her to patients with active TB. There could be patients anaesthetised that have undiagnosed TB. This characteristic of her work contributed or caused her to be exposed to the TB infection. As a doctor in active practice, including in the field of anaesthetics, she would be at a significantly greater risk of TB than those who do not.
>
> …

[45] She produced a report from Dr Page dated 10 September 2014. Amongst other things, it said:

> Since March 2014, Dr has been very stressed and concerned about her marriage … there has been conflict and fights.
>
> …
>
> From the information available [the appellant] does not currently meet criteria for any DSM5 diagnosis. Although the concern from the Police may have been whether she was paranoid or had other psychotic symptoms, the story presented by [the appellant] and supported by her mother, has plausibility and must be interpreted within cultural constructs. However, [the appellant's] supervisors and colleagues have noticed subtle changes in her behaviour, as well as a reduction in her level of functioning in recent months. It is not clear if this is entirely due to the stress caused by the marital problems, and [the appellant's] cultural beliefs and personality. It is possible that [the appellant] may have undisclosed symptoms and a psychotic process cannot be ruled out.

[46] In her appendix 19, filed after the hearing of 14 December 2022, the appellant refers to a case report entitled "Transmission of Tuberculosis from Patients to Healthcare Workers in the Anaesthesia context. The article is by Doctors DTW Teo and TW Lim from Annals

Academy of Medicine, January 2004, Volume 33, Number 1. The conclusion of the article, according to the abstract, is this:

> … PTB (Pulmonary Tuberculosis) susceptible patients with suggestive CXR (chest x-ray) should be treated as potentially infective. Adequate personal protection should include highly efficient facemasks and shields. Risk of patient to patient transmission of tuberculosis through the anaesthetic circuit is low if effective bacterial/viral filters are used.

[47] The appellant also addresses matters raised by ACC's principal medical advisor, Dr Mary Obele dated 6 December 2022, saying:

> Dr Obele has made many general statements , and just like her previous report, most of her statements are inaccurate, have no basis and have supporting evidence….

Respondent's submissions

[48] Ms Becroft referred to s 26(2) which excludes personal injury caused wholly or substantially by a gradual process, disease or infection, unless it is a personal injury of a kind described in s 20(2)(e)-(h).

[49] Section 20(2)(e) provides that there is cover for personal injury caused by a work related gradual process, disease, or infection suffered by the person.

[50] Ms Becroft notes that the only diagnosis from 2014 is of latent TB and no diagnosis of active TB. Therefore, she submits it is not a disease process causing harm, or in other words, the latent disease is not covered because it is not an injury. There is no physical harm or damage to the body.

[51] She refers to Dr Randhawa's report and submits that at best, for the appellant, there was a diagnosis of latent TB in 2014.

[52] She submits that there is no evidence that this was acquired at work. Nor, she submits, is there evidence of a particular risk at work. Had it been otherwise, the situation plainly would have been regarded as very serious by the health authorities.

[53] Ms Becroft submits that there is no medical evidence to support the proposition that in 2014 the appellant's cough was part of a TB infection, rather it was more likely to be an upper respiratory tract infection.

[54] In summary, Ms Becroft says that at best, the appellant had latent TB, which was not an active process and therefore there was no injury.

Appellant's reply

[55] In reply the appellant said she did not contract latent TB from her mother, nor from non-employment activities. She refers to Dr Obele's report and says that it is not logical for there not to be cover for latent TB, as when it becomes active, it is too late. She reminded the court that she is a non-smoker and that she has no allergies and that her chronic cough was related to a latent TB infection.

[56] She said that Dr Shaw, in 2018 diagnosed a chronic cough and hypersensitivity of the throat.

[57] She says that latent TB cannot cause a chronic cough.

[58] She refers to Judge Beatie's decision in *Fifield v ACC*[1] where nerve damage is considered a personal injury. She says that the hypersensitivity of her throat has been caused by nerve damage on account of the chronic cough.

[59] In further submissions in reply on 31 January 2023, the appellant referred to a medical article, drawing attention to the risks that anaesthetists are exposed to in a hospital context, where if not properly protected, TB can be contracted.

[60] She says that generally the precautions taken back in 2014 at the hospital were not enough to stop the spread of TB. The use of normal masks by hospital staff was not enough to stop the spread of TB.

[61] She says that the QuanteFERON Gold test is 97% accurate.

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[1] *Fifield v ACC* 8/2009

[62] She reminds the Court that once infected with the TB mycobacterium, it is there for life

[63] The appellant seeks a lump sum compensation and weekly compensation backdated until then.

Decision

[64] The ACC injury claim form in this case was completed at the Central Wellington Medical Centre on 27 September 2018, just over four years after the alleged accident date of 22 September 2014.

[65] The description of injury in that claim form is:

> Positive QuanteFERON Gold 22/Sep/2018. Exposure at work resulted in enforced time off work and given prophylactic treatment.

[66] The injury diagnosis in the claim form is "Tuberculosis – suspected".

[67] There is no doubt that in September 2014, the appellant tested positive for TB following a QuanteFERON Gold test.

[68] She had had an earlier QuanteFERON Gold test in March 2013, which was negative.

[69] The appellant's then partner in 2014 also undertook the QuanteFERON Gold test. It was negative.

[70] However, in Dr Antoniadis' report of 21 March 2019, he records:

> [The appellant] indicated she had a QuanteFERON test in Australia approximately two weeks ago and this was negative.

[71] Given the appellant's profession and her heightened awareness relating to tuberculosis following her positive QuanteFERON test in September 2014, it is reasonable to conclude that since then, the issue of TB for the appellant was an ongoing one.

[72] There is nothing before the Court relating to further testing for TB between September 2014 and February 2019, when she tested negative in Australia. The inference that I draw is that in the intervening four and a half years, the appellant, being a doctor and hyper-aware of

transmissibility of disease in general and TB in particular, she would have ensured that she remained up to date with her own status following the positive QuanteFERON test in 2014.

[73] I therefore conclude that the September 2014 test excepted. There have been no other diagnostic indications that she has the TB mycobacterium.

[74] The conclusion I draw, therefore, on the balance of probabilities is that the positive test in September 2014 was amongst the 3% of false positive tests and that she does not have the TB mycobacterium.

[75] It is a notorious fact that once a person has the TB mycobacterium, it cannot be eradicated. Therefore, she would have tested positive since then. She has not.

[76] The appellant's appeal must therefore fail on this ground.

[77] There is a second basis on which this appeal must fail. If indeed the appellant had a latent TB infection in 2014, which I have found she did not, I conclude that a latent TB does not satisfy the statutory requirements of the ACC Act.

[78] I echo what the reviewer said, and reproduce the World Health Organisation definition of "latent tuberculosis", namely:

> Latent tuberculosis infection (LTBI) is the state of persistent immune response to stimulation by mycobacterium tuberculosis antigens without evidence of clinically manifested active TB. Someone has latent TB if they are infected with the TB bacteria but do not have signs of active TB disease and do not feel ill. However, they can develop active TB disease in the future.

[79] That being so, the appellant has been unable to establish that she has suffered a personal injury in terms of s 26 of the Act.

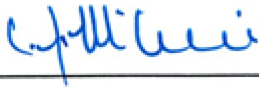
[80] I note that Dr Lane, Respiratory Registrar's record of 15 October 2014 said this:

> The appellant herself initially became unwell prior to her mother arriving in July of this year, with a short illness associated with lethargy and fevers and productive cough. After that illness, she went on to have a chronic cough that continued while her mother stayed for three weeks in Auckland, but has subsequently resolved.

[81] To summarise, I find on the balance of probabilities that the appellant has never contracted TB. All her tests, but for the one in 2014, have indicated that she does not have the mycobacterium. There is no evidence she has sustained an injury as described by the Accident Compensation Act 2021.

[82] Accordingly, her appeal is dismissed.

[83] Costs are reserved.



CJ McGuire
District Court Judge

Solicitors: Medico Law Limited, Grey Lynn