IN THE DISTRICT COURT
AT WELLINGTON

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

[2023] NZACC 124 ACR 327/17

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPEAL UNDER SECTION 151 OF THE ACCIDENT COMPENSATION ACT
BETWEEN	ESTATE OF F BARRY Appellant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Hearing: 16 June 2023
Heard at: Wellington/Te Whanganui-a-Tara

Appearances: Ms B Barry on behalf of the Appellant
Ms L Hansen for the Respondent

Judgment: 1 August 2023

JUDGMENT OF JUDGE C J MCGUIRE
[Causation, Treatment Injury s 32
Accident Compensation Act 2001]

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[1] This is an appeal against a decision by the respondent of 4 February 2016 declining cover for a treatment injury.

Background

[2] On Tuesday, 12 April 2005, Mr Barry collapsed at his home and was admitted to Hutt Hospital in the afternoon. The ambulance first responder report recorded that Mr Barry was conscious and alert to time and date, that he had good strength – good coordination and handgrips but was very weak in the legs and unable to stand.

[3] No obvious cause for the collapse was identified at Hutt Hospital. However, the doctor did not consider that Mr Barry was safe to return home. He was assessed as hypotensive on his arrival and received intravenous fluids which resulted in some improvement.

[4] At the time of his admission, Mr Barry was aged 90.

[5] On assessment the Medical Registrar Dr Grainger recorded that Mr Barry was normally independent with activities of daily living. Examination identified fresh blood in Mr Barry's rectum.

[6] On 13 April 2005, Physician Dr Carroll assessed Mr Barry noting that he was oriented in time and space but the specialist questioned whether Mr Barry may have sustained a stroke. It was determined that Mr Barry should remain 'nil by mouth' pending further assessments.

[7] Blood transfusions were provided and arrangements made for a gastroscopy and colonoscopy, given that Mr Barry's haemoglobin had dropped. A gastroscopy was subsequently performed and identified a severe haemorrhagic oesophagitis. Further blood was transfused.

[8] On 14 April 2005, Mr Barry had a fall. That was unwitnessed and Mr Barry was returned to bed. Mr Barry's intravenous fluids were continued and regular assessments made.

[9] On 15 April 2005, Dr Carroll reassessed Mr Barry noting that he was orientated in time and place and that his chest was clear. Dr Carroll questioned whether there had been a stroke and a CT scan was booked.

[10] Speech Language Therapist Ms Wilson assessed Mr Barry, finding him to be alert and orientated. Ms Wilson recommended that Mr Barry continue with a soft diet and normal fluids as tolerated.

[11] Later that afternoon, Mr Barry was found to be "shaky" and "dyspnoeic", that is, having breathing difficulties. Mr Barry advised that and felt as though he had fluid in his chest.

[12] An assessing house surgeon questioned whether Mr Barry had received too much intravenous fluid or was developing pneumonia. A chest X-ray was arranged to assess the situation.

[13] CT scan on that date reported findings of brain atrophy.

[14] Mr Barry continued to have difficulties with breathing and developed a fever. Aspiration pneumonia was diagnosed with urinary retention and possible gastrointestinal bleeding. Anti-biotics were administered.

[15] Unfortunately, Mr Barry's respiratory situation significantly worsened, and the treating clinicians considered the prognosis to be poor. This was discussed with the family.

[16] Morphine was prescribed and administered for comfort. Unfortunately, his condition deteriorated.

[17] Mr Barry died on 19 April 2005 shortly before midnight.

[18] A claim for treatment injury was not made until 2015. ACC obtained an independent expert opinion from General Physician, Dr Richard Lennane, dated 30 January 2016.

[19] Dr Lennane found that there were significant failings in Mr Barry's care, particularly in the areas of communication and provision of information to relatives. He said that while these were regrettable, he did not believe that these failings had any definite effect on the final outcome. He concluded in summary that Mr Barry received medical care of an acceptable standard throughout his admission. He said:

> His aspiration pneumonia was recognised and treated in a timely and appropriate fashion including treatment for possible sepsis. Morphine was not used until the terminal phase of his illness and then solely to alleviate his very great distress. I do not think it reasonable that his family should have sought to deny him that relief.

[20] On the basis of Dr Lennane's report, ACC issued a decision declining cover for the claimed treatment injury. The decision said:

> [Mr Barry] had haematemesis and reflux of blood from the lower oesophagus, blood aspirated to his lungs causing pneumonia/damage to the lungs, there was sepsis, respiratory function reduced and this condition alongside his aging heart and

cardiovascular system meant the organs of the body could not cope and he succumbed from general organ failure.

Morphine prescribed was a very modest dose to ameliorate severe respiratory distress, and was administered after the pneumonia was present. The morphine was not causative of Mr Barry passing away on 19/04/2005.

This claim is declined for cover because the aspiration pneumonia leading to death on 19/04/2005 was not caused by treatment.

[21] In a separate process, Ms Barry had made a complaint to the Health and Disability Commission which resulted in a mediated agreement. As part of that process, a report was provided by Dr Stewart Tiller, Clinical Advisor, for the Health and Disability Commissioner.

[22] Dr Tiller concluded his report by saying:

Mr Barry was 90 years old, was independent with activities of daily living, required minimal medication, attended day care and lived at home with his daughter Bernadette. It is my impression that Bernadette, as primary care giver for her father at home, had significant personal involvement in the wellbeing of her father as his care giver. The sudden change in his condition from independent functioning to acutely unwell, then critically ill with aspiration pneumonia, was a difficult adjustment for Ms Berry. She had many questions for the clinical staff, and it is my opinion, that they did, with the exception of a Friday evening 15 April, give her time and explanation of the clinical events as they unfolded.

It is my opinion that overall clinical care provided was of an acceptable standard, with the exception of the failure of the Carroll Medical Team to set in place a clear weekend management plan for the end of the day on Friday 15 April. Ms Barry was very upset about care given on "Friday". It is my opinion that care over the weekend of 16/17 April was compromised by the failure to establish an active management plan for the end of that Friday.

[23] Section 32(1) of the ACC Act provides:

(1) **Treatment injury** means personal injury that is –

(a) Suffered by a person

(i) Seeking treatment from one or more registered health professionals

… and

(b) Caused by treatment; and

(c) Not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment, including –

(i) The person's underlying health conditions at the time of the treatment; and

(ii) The clinical knowledge at the time of the treatment

[24] Section 32(2) excludes the following kinds of personal injury from being a treatment injury:

> (2) **Treatment injury** does not include the following kinds of personal injury:
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> (a) Personal injury that is wholly or substantially caused by a person's underlying health condition:
>
> (b) Personal injury that is solely attributable to a resources allocation decision:
>
> …
>
> (3) The fact that the treatment did not achieve a desired result does not, of itself, constitute treatment injury.

[25] While her father was in hospital, Ms Barry was the epitome of a caring daughter. She stayed overnight in hospital to ensure as far as she was able that her father's needs were met.

[26] It seems that on Thursday 14 April, Mr Barry had a fall that was not witnessed. However, the night nurse noted that Mr Barry slept well overnight with his daughter present and that there were "no concerns".

[27] On Friday 15 April, the Speech Language Therapist attended and the speech and language assessment was held. The recommendation was to "continue with a soft diet and normal fluids as tolerated. No further SLT (Speech Language Therapist) was indicated".

[28] On the Friday afternoon, the house surgeon was notified that the patient was shaky and dyspnoeic. It seems that Mr Barry felt he had fluid in his chest and his daughter has seen specks of blood when he vomited. Later that day, the Registrar diagnosed aspiration pneumonia.

[29] Blood tests were taken at 3 pm on Friday 15 April 2005 but these were not reported by the laboratory until 19 April, which the Health and Disability Commissioner Clinical Advisor Dr Tiller said it was "unacceptable and requires further investigation".

[30] Also, there was no entry in the notes so to indicate that a repeat X-ray as suggested by the Radiologist was done.

[31] There was no weekend hand over note of a management plan made on Friday 15 April 2005.

[32] Dr Tiller said:

> … it is my opinion that the level of medical care with Mr Barry on this weekend day (Saturday) was less than was warranted given his condition. My impression is that routine care was 'on hold' for the weekend and only crisis management would be provided. No physiotherapy care had been requested.

[33] Dr Tiller went on to say:

> It is my impression again that Mr Barry was only receiving crisis care on this weekend day. There is no record in the notes of any ward round review. It should have occurred. Nor had there been any arrangement for physiotherapy management of the pneumonia over the weekend. It is my opinion that the failure of Dr Carroll and his team to put in place a weekend management plan and hand over on Friday afternoon led to the provision of only 'crisis care' over the weekend.

[34] On Monday 18 April, Dr Carroll visited on the ward round and noted "daughter very upset about care given on Friday. It feels patient has been set back due to this…" By this time, a morphine was being administered. Mr Barry's condition deteriorated, and he died late in the evening of Tuesday 19 April 2005.

[35] In the "summary" portion of his report, Dr Tiller said this:

> It is my opinion that the overall clinical care provided was of an acceptable standard with the exception of the failure of the Carroll medical team to set in place a clear weekend management plan at the end of the day on Friday 15 April. Ms Barry was very upset about care given on Friday.
>
> It is my opinion that care over the weekend 16/17 April was compromised by the failure to establish an active management plan at the end of that Friday.

[36] Ms Barry notes that her father on one occasion was given 5 milligrams of morphine instead of the correct dose of 2.5 milligrams.

[37] However, it appears that this occurred on 19 April 2005, the day Mr Barry passed away.

[38] Ms Barry also maintains that her father's aspiration pneumonia was caused by food particles and that he was fed food other than soft food prescribed by the Speech Language Therapist.

[39] However, the record shows that when the Speech Language Therapist attended on 15 April, a trial of fruit mince pies and water occurred, and the comment was made "adequate swallow…no signs of aspiration".

[40] It is recognised that aspiration pneumonia could be caused by ingestion into the lungs of food particles, however in this case, the issue relating to causation of the aspiration pneumonia is whether it was caused by food particles or by the aspiration of blood from the patient's internal bleeding.

[41] Given the evidence as it stands, I am bound to find that it is more likely than not that Mr Barry's aspiration pneumonia was caused by the ingestion of blood rather than food particles. When the Speech Language Therapist conducted her examination, and witnessed Mr Barry eating, she was satisfied with what she observed. She noted "adequate swallow…no signs of aspiration" following the eating trial fruit mint pies and water.

[42] I accept that what Dr Tiller said about the absence of a clear weekend management plan for the deceased, satisfies that part of the definition in s 33 where it says that the treatment includes:

> (h) the application of any support systems, including policies, processors, practices and administrative systems that –
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> i a use by the organisation or person providing treatment and
>
> ii directly support the treatment.

[43] However, I am unable to conclude that this 'treatment', or in reality, treatment failure, caused Mr Barry's death. At the time of this treatment failure, Mr Barry had already been diagnosed with aspiration pneumonia and he was gravely ill. Therefore, I am unable to find there was a causal link between his death from aspiration pneumonia and the care he received over that weekend of 16/17 April 2005.

[44] It follows therefore that I must dismiss this appeal. Costs are reserved.

CJ McGuire
District Court Judge

Solicitors: L Hansen, Barrister, Wellington