**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**

**[2024] NZACC 004 ACR 23/23**

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| UNDER | THE ACCIDENT COMPENSATION ACT 2001 |
| IN THE MATTER OF | AN APPEAL UNDER SECTION 149 OF THE ACT |
| BETWEEN | HM |
| AND | ACCIDENT COMPENSATION CORPORATION<br>Respondent |

| | |
|---|---|
| Hearing:<br>Post Hearing joint memorandum provided by leave of the Court: | 12 December 2023;<br>20 December 2023 |
| Held at: | Auckland District Court/Tāmaki Makaurau |
| Appearances: | P Schmidt for the Appellant<br>P McBride for the Accident Compensation Corporation ("the Corporation") |
| Judgment: | 8 January 2024 |

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**RESERVED JUDGMENT OF JUDGE P R SPILLER**
**[Claim for personal injury - s 26,**
**Accident Compensation Act 2001 ("the Act")]**

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## Introduction

[1] This is an appeal from the decision of a Reviewer dated 29 December 2022. The Reviewer dismissed an application for review of the Corporation's decision dated 12 August 2022 declining the appellant cover for a suicide attempt in September 2000, as not meeting the criteria for being a personal injury.

## Background

[2] On 15 July 2021, Dr Grant Galpin, Consultant Psychiatrist, commented on the appellant's suicide attempt as follows:

> With respect to [the appellant's] suicide attempts I note that she described that she first attempted suicide in the year 2000 in the context of separation from her husband, difficulty coping with the demands of her children, coping with adjustment of a nursing job to becoming a school nurse, not being in a good space mentally and being unable to talk about what she had been through with Dr Gluckman or others. She felt that her life had been reduced to living in a room by herself in somebody else's home. She took her second overdose in 2010 and received follow-up by psychiatric services. Dr Pamela Bennett noted that she had dreams and flashbacks of the suicide attempt of November 2000, that she was the middle of three children being sent away on holiday to a relative's farms, that she had been married to a violent man and a demeaning interaction with an ACC appointed psychiatrist. Dr Bennett noted that she was anxious, noted the impact of clonazepam on the onset of frequent, random suicidal thoughts without feeling depressed and felt that the clonazepam could have been a source of original medical misadventure.

[3] On 26 July 2022, the appellant's counsel wrote to the Corporation:

> Please regard this letter as a claim for cover for the suicide attempt in September 2000 caused by the disinhibiting effects of clonazepam in a vulnerable individual.

[4] On 12 August 2022, the Corporation declined cover for the suicide attempt, as that event did not comprise a personal injury:

> Broken down into its two parts (i.e., 'the Personal Injury' and 'the causative Event') the claim for cover being made is for "the suicide attempt in September 2000" (i.e., 'the Personal Injury') and being "caused by the disinhibiting effects of clonazepam in a vulnerable individual." (i.e., 'the causative Event').
>
> Section 26(1) sets out what 'Personal Injury' means in relevance to the claim being made. The claimed injury of "the suicide attempt in September 2000" does not meet the criteria for being a 'Personal Injury' in terms of section 26(1)(a) or (b) or (c) or (d) or (da) or (e). On that basis the claim for cover in your letter dated 26 July 2022 must be declined.

[5] On 16 December 2022, review proceedings were held. The appellant gave evidence about her suicide attempt:

> 1. … I make this statement for a review regarding ACC's decision declining cover for the suicide attempt in September 2000.
>
> 2. It was during the school holidays, so I wasn't working. On Monday, 25 September 2000, I decided that I could no longer continue living. I felt as if I

was fighting a losing battle to get counselling in relation to my claim for medical misadventure, I was in pain – both physical and mental – and I was dealing with suicidal ideation from the clonazepam I had been prescribed.

3. I was boarding following my marriage breakdown. I went to my room and took 200 amitriptyline 10mg tablets out of their foil packets and put them into bottles. I only ever admitted to taking 100 but I know it was 200 as I counted every tablet. I put the bottles of amitriptyline tablets, plus the clonazepam that I had, into my small backpack with a bottle of water. I then drove out to Muriwai beach.

4. It was a particularly stormy day and every step forward down the beach I was pushed back by two paces. Once I got to the vehicle entranceway up the beach I went inland and up into the forest. I kept walking, looking for somewhere that I would not be found. Once I found a spot, I proceeded to take the tablets. Then, pulling the labels off the bottles and burying them, I lay down to sleep. I remember waking through the night because it was cold, reaching out to pull up my blankets and then realising that I was in the forest and had not been successful. I fell asleep again.

5. I was told afterwards that they had had a severe storm that night with flooding down the west coast and many trees had been blown down. People were really surprised I had survived two nights in the cold and wet.

6. My next memory is of waking up in the daylight. Every time I tried to stand up, I fell over. I was very shaky on my feet and very dizzy and thirsty. I remember falling and hitting my head on a stone. My next memory was the sound of what I thought was weed eaters. I was convinced they were just outside of my hollow and wondered why they didn't hear me calling them. When I eventually found my way out, I realised there was no one there. I was obviously hallucinated and what I had thought was weed eaters was just grass. I found it very hard looking for a way out of the hollow as I was so dizzy and shaky. I eventually found a way out. For some reason I knew if I didn't get out then I wouldn't get out at all.

7. I stumbled down the forestry road and when I eventually got to where people leave their vehicles instead of going on the beach, I asked some men if this was the way to Muriwai. They answered yes. It was a long way to the store at Muriwai near the carpark where my car was. I was extremely thirsty and dizzy. They looked at me really oddly. Later I found out it was because my face was so red and scratched and swollen on the right side. When I got near another track, I asked some more people if the track was a quick way to the store and they answered yes. When I got to the store, I managed to ask them for some water. They looked at me oddly but gave me some.

8. I then proceeded to walk to the carpark, but my car wasn't there. While I was looking absolutely lost one of the men from the store had followed me into the carpark and he asked me if I was the lady the police had been looking for for the last two days. I answered no I had only been gone one night. He then asked me if I knew what day it was. I answered Tuesday. He then told me it was Wednesday. Somewhere I had lost a whole day and night and I felt totally lost. I only remember one night. He told me that the police had removed my car. He then helped me back to the store and gave me orange juice and chocolate to help bring up my blood sugars. I then rang my girlfriend …, who left work and came out to get me.

> 9. When she arrived, I rang my family. I felt so ashamed and lost. The right side of my face was all swollen up, red and scratched and so was my right arm. [My girlfriend] took me to the local A&E where I admitted to taking only 100 tablets. I was then admitted to North Shore Hospital. My feelings of shame were strong, and I was devastated by the effect of my suicide attempt on my children. They put me under suicide watch in hospital. I had terrible headaches, and my head was really sore, probably from when I fell in the bush and hit my head on a rock.
>
> 10. I was seen by the psychiatric team. They said I wasn't depressed, and they didn't know why I had tried to commit suicide. Because of being turned down for counselling for my ACC claim I never told them about anything about it. After two nights of no sleep and knowing that they were going to discharge me after the CT scan of my head, which came up clear, I went home as I couldn't face another night of no sleep and they wouldn't let me take my medication in hospital.
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> 11. I had had a very mentally fragile start to the year at school as their nurse and following this attempt I knew that I wasn't going to be able to continue with the school nursing. Following discussions with the school, I decided to do a computing course so I could transition into administration. I simply couldn't cope with the pressure of the job and deal with my own mental health, all with no help from anyone.
>
> 12. The school had realised that something wasn't right with me, but I never told them about my suicide attempt. It had been in the paper that the police were looking for me. My name wasn't released but I think one of the Deans realised it was me and joined the dots. I was terrified that if the school found out I would lose my job; it was easier if it wasn't talked about. There was so much shame. Attempted suicides are seldom talked about, but in 2000 it was even harder. It had a huge effect on my children. Their relationship with me was damaged and is still damaged today, and to this day no one talks about my attempts or why they happened.

[6] On 29 December 2022, the Reviewer dismissed the review, on the basis that there was no evidence that the suicide attempt caused a discrete physical injury and so there was no personal injury that could attract cover. On 25 January 2023, a Notice of Appeal was lodged.

[7] On 18 April 2013, Dr Pamela Bennett, Consultant Psychiatrist, provided an opinion on the causes and impact of the suicide attempt by the appellant:

> [The appellant] had a knee operation in 1980 for chondromalacia of the patella. Postoperatively she had a drug reaction to duloxene (dextropropoxyphene) which is a commonly prescribed medication with pain relief. She was judged allergic to this drug and this was duly noted on her hospital medical chart.
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> In 1982 she was again admitted to hospital to have a screw removed from that knee. In the hospital she was offered capdex which is another generic name for dextropropoxyphene, which [the appellant] knew as duloxene. On this occasion

she is reported as having an anaphylactic reaction with loss of consciousness. These hospital notes are now missing. As a result of this episode [the appellant] was left with chronic pain which is well documented. She then applied to ACC for medical misadventure. Initially this was declined as she was reviewed by psychiatrist Dr Gluckman who according to [the appellant] said that the pain was psychological in origin. I note Dr Gluckman's report is not available. However in the notes made available to me the review which included lawyers, the professor Gavin Calloway from Auckland judged that in fact the chronic pain was a result of the abnormal posture The appellant had been lying in for some time due to her anaphylactic reaction from the duloxetine and the claim was subsequently accepted by ACC. Following this [the appellant] was judged to have a disability of 42%.

[The appellant] had various treatments for the chronic pain over the years. None of these was very successful. She attended the pain clinic at ACH and, in 1997, was prescribed clonazepam 0.5 milligrams BD, as well as 30mg of amitryptilline which is a recognised dose for pain relief. She said she remained on this medication for the next 15 years until her General Practitioner suggested that she stop it which she did in February of 2011.

[The appellant] said in the first year after starting the clonazepam she began to have constant thoughts of suicide but she said she was not feeling depressed at the time. In 2000 she said she walked into the ocean because of these thoughts but nothing came of this. She never sought help for the suicidal thoughts because she said that her one and only interview with a psychiatrist which was Dr Gluckman back in 1982 was very traumatic. She said she was pregnant with her twins at the time and was initially greeted with his saying “I do not like seeing pregnant women”. She had to take her clothes off so that he could see her shoulders bare. She is aware that he said that her chronic pain was simply psychological in origin. She said as a result of this she did not want to ever see a psychiatrist and the thought of going to anyone about her suicidal thoughts or telling anyone about her suicidal thoughts was simply not an option she could seriously contemplate.

In November of 2000 [the appellant] said that she took an overdose of 200 amitriptyline tablets each of which she popped out of her individual container and an unknown amount of clonazepam. After taking these pills [the appellant] said that she drove her car to the Muriwai Beach steps. She said it was very stormy and strong winds. The winds were so strong that as she walked along the beach she felt as though she was being pushed in the opposite direction. She left the beach and walking into the bush and she found a sheltered hollow off the track where she lay down. She said she remembers at some point waking up and realising that she was still alive which she wasn't pleased about and then she went back to sleep. Finally she woke up and walked out of the beach and down to get her car from the car park. She said she went into the shop and bought some fruit juice and chocolate and thought that the man in there looked at her strangely. When she was at her car park an older man had followed her and came up to ask her whether she was the lady who Police had been looking for for two days. He told her that the Police had come and taken her car away. She subsequently made contact with her family. She was taken to the Accident & Emergency Department at North Shore Hospital. Here she was examined physically and she was seen by a psychiatrist who said she was not depressed. These notes are unfortunately not available to me. The appellant said she stayed overnight and then went home with no follow-up. She said when she arrived at the Hospital she was met by her separated husband … who had the children

> with him. There was miscommunication at this stage where [the appellant] did not want to talk to the family in front of the doctor and her husband became irate and left with the children. She did not see the children for some time after that.
>
> [The appellant] continued to have random and frequent suicidal thoughts. She said she was not depressed and she continued to work. She had a new relationship, and remarried. She remained married to her present husband ... One night in 2010 after they had an incidental disagreement she impulsively took an overdose again and locked herself in an upstairs room in a sleep out in the back garden. She was found by her husband … the next morning and he took her to Waitemata Hospital. The appellant said she was again seen by a psychiatrist who said that she was not depressed. I do have the notes of this period and there is no note of any depressive symptoms nor is there a diagnosis. I note that the psychiatrist does suggest increasing her tricyclic ie the medication she was on for pain relief from 30 milligram up to 75. This is not a therapeutic dose for depression and it is impossible to see from the notes to see whether that diagnosis could be made. She was, as she said, upset when the psychiatrist told her husband that she could very well get the idea to suicide again and do it. There was no effort at this time to stop the clonazepam and she had continued it for the last 15 years. However later in early 2011 her General Practitioner Dr Herbert Morrison told her that the clonazepam was no good for her. At this time [the appellant] said she looked up clonazepam on the internet and looked at the side effects. She said that suicidal thoughts were listed there and also chest pain. She reported having been hospitalised twice for chest pain with no psychical cause. (These notes are not available to me). She stopped the clonazepam and said she had no detrimental side effects. She said in fact it was though a cloud had lifted from her and she felt suddenly in control of herself and her thoughts. She felt as though her thinking was much more lucid and quite different and she has not had any suicidal thoughts since. She felt so different and she realised that she had missed out on 15 years of her life while she was under the influence of the clonazepam.

[8] Dr Bennett described the psychiatric impact of the September 2000 suicide attempt, which included the appellant experiencing flashbacks, intrusive thoughts, insomnia, anxiety, and dysphoria. Dr Bennett diagnosed PTSD as a result of the September 2000 suicide attempt. Dr Bennett concluded as follows:

> In my opinion this case can be seen as continuing from the original medical misadventure. Clonazepam is a benzodiazepine which is not used for pain relief although [the appellant] reported it was prescribed for her from the Pain Clinic. Clonazepam is a benzodiazepam which is used as an anxiolytic ie for people who have anxiety disorders. Anxiety disorders usually are accompanied by heightened awareness and alertness and overall generally a faster metabolism. In anxiety this would normally be used at this dose in the short-term and then decreased probably to PRN medication, in conjunction with another medication. Benzodiazepines have a disinhibiting effect similar to alcohol, it is understandable that [the appellant] had random suicidal thoughts with the consequences thought not particularly frightening at the time. I think that medication like this would have clouded her overall perceptions making such thoughts into the mundane. The feeling describes she … had when she stopped is quite understandable and with this clarity of thought the full impact of the

realisation of what happened has resulted in [the appellant] having a chronic post-traumatic stress disorder as described.

In my opinion [the appellant] does have a mental injury arising from the [event] of the 26th of November 2000.

[9] On 29 June 2023, Dr Gil Newburn, Neuropsychiatrist, reported:

1. Is amitriptyline poisonous if taken in excessive amounts (an overdose)?

The answer to this is yes. The most significant consequence of amitriptyline overdose is death (Henry et al., 1995). This may arise from a number of pathologies. There can be significant depression of neuronal function to the point that the brain can no longer sustain bodily function. There can be respiratory depression with hypoxia occurring. Seizures can occur, including epileptic seizures. Sodium reduction can cause a broad range of issues including cardiac arrythmias. Blood pressure can drop, reducing cerebral perfusion and perfusion through the remainder of the body. The increase in serotonin can cause serotonin syndrome which is potentially fatal if not managed adequately. There are a range of other peripheral issues. There are effects on gut function with this being dampened. There are similar effects on bladder function with reduced muscle activity. Adult respiratory distress syndrome is reported.

There are other more rarely reported incidents. Peripheral neuropathy has been described. Guillain Barre syndrome has also been reported following amitriptyline overdose, at least in an association manner with other factors (Zhang et al., 2022). Genetic factors are seen to interact with overdose, with there being a clear variation in the population of the cytochrome P 450 enzymes that metabolise amitriptyline and nortriptyline (e.g. van de Wint et al., 2022).

2. Could you please describe the likely physiological effects that [the appellant] suffered because of the overdose of amitriptyline? Amitriptyline overdose causes numerous harmful physiological effects. It impacts on many neurotransmitters in the brain including serotonin, noradrenalin, dopamine, acetylcholine, histamine and alpha-adrenergic receptor effects. There are a range of secondary transmitter systems and neurochemical processes triggered by these neurotransmitters which are beyond the scope of this document to discuss. These interact across a broad range of nervous system processes which impact on a wide range of bodily functions.

Serotonin is associated with a broad range of tonic processes that allow the processing of stimuli and coordinating a response, encouraging survival. Excess serotonin causes these systems to malfunction, resulting in a broad range of physiological symptoms such as high blood pressure, increased heart rate, high body temperature, tremor, sweating, seizures, diarrhoea, and loss of consciousness.

Noradrenalin is associated with fight/flight reactivity in the brain, along with a range of other processes that impact on physiological homeostasis. Histamine amongst other processes activates systems which are associated with sedation. Acetylcholine has a direct transmitter effect in pathways associated with memory acquisition and attention. It also has a tonic impact on most cortical cells allowing a greater response

to other inputs. Thus, it keeps them in a state of readiness for response. Dopamine is associated with a range of issues including attention, generation of ideas, initiation, motor coordination and reward processes. These neurotransmitters operate in a coordinated and integrative manner. Amitriptyline overdose disrupts these processes which explains why it impacts on such a wide range of systems.

In terms of the physiological effects of amitriptyline overdose, the quality of the medical record at the time makes it difficult to confirm which symptoms were suffered by the appellant but it is likely, given that she was unconscious for a considerable period of time and had no recollection of two days passing, that she suffered from the usual effects of amitriptyline overdose with coma due to one or more of the expected reactions to the dose taken, which likely include neuronal depression, cardiac arrythmia, hypotension, seizures or factors secondary to any of these, making her fortunate to have survived.

3. Could you please discuss the mechanism (if known) that results in clonazepam increasing suicidal ideation in a patient? Does taking clonazepam cause physiological changes to the neural pathways of the brain?

The specific reasons at a physiological/neuropharmacological level why clonazepam can increase suicidal ideation is not clearly known. We know that clonazepam impacts on gamma aminobutyric acid (GABA) receptors, both via a rapid impact involving chloride channels, and a slower and more prolonged effect with secondary G protein impacts arising from calcium channel alterations. A best guess is that these changes in brain function are involved but we do not know how this comes about.

4. It is accepted that clonazepam likely played a material role in the appellant attempting suicide. Is there statistical evidence for how often this happens – is this an ordinary or relatively rare outcome of taking this medication?

Benzodiazepines are known to be associated with an increase in suicidal ideation. While this is not common, it happens often enough in one's career to need to be aware of it. This is borne out by the literature, with the New Zealand Health Department Medsafe data sheet describing suicidal issues as a potential adverse effect. This is seen in situations where benzodiazepines are added on in patients with major depressive disorder (Dold et al, 2020). It is also seen when benzodiazepines are added in for post-traumatic stress disorder patients, where more suicidal behaviours are seen in patients receiving clonazepam and lorazepam than other benzodiazepine agents (Gilbert et al., 2020). It is seen in individuals where they are treated for epilepsy (Olesen et al., 2010). In summary, an increase in suicidal ideation and suicide attempts is a relatively rare but known outcome of the prescription of clonazepam.

Further Comment.

Given the description and the change in state after stopping clonazepam, it should be considered that clonazepam was a material cause in the development of [the appellant]'s suicidality and subsequent suicide attempt. Because the clonazepam was prescribed for an earlier determined disorder, with chronic pain, the suicide attempt is a consequence of treatment for these conditions.

Amitriptyline overdose has an acute physiological impact which is potentially fatal. The wide-ranging effects of amitriptyline overdose illustrate its harmful, life-threatening nature. Here, the fact that the amitriptyline overdose resulted in coma or reduced level of consciousness for approximately two days indicates significant brain or CNS depression.

## Relevant law

[10] Section 3 of the Accident Compensation Act 2001 ("the Act') provides:

> The purpose of this Act is to enhance the public good and reinforce the social contract represented by the first accident compensation scheme by providing for a fair and sustainable scheme for managing personal injury that has, as its overriding goals, minimising both the overall incidence of injury in the community, and the impact of injury on the community (including economic, social, and personal costs) …

[11] Section 20 provides:

> (1) A person has cover for personal injury if—
>
> (a) he or she suffers the personal injury in New Zealand on or after 1 April 2002; and
>
> (b) the personal injury is any of the kinds of injuries described in section 26(1)(a) or (b) or (c) or (e); and
>
> (c) the personal injury is described in any of the paragraphs in subsection (2). …
>
> (2) Subsection (1)(c) applies to—
>
> (a) personal injury caused by an accident to the person:
>
> (b) personal injury that is treatment injury suffered by the person:

[12] Section 26 provides:

> **26 Personal injury**
>
> (1) Personal injury means—
>
> (a) the death of a person; or
>
> (b) physical injuries suffered by a person, including, for example, a strain or a sprain; or
>
> (c) mental injury suffered by a person because of physical injuries suffered by the person; or
>
> (d) mental injury suffered by a person in the circumstances described in section 21; or
>
> (da) work-related mental injury that is suffered by a person in the circumstances described in section 21B; or

(e) damage (other than wear and tear) to dentures or prostheses that replace a part of the human body.

[13] Section 32 provides:

> (1) Treatment injury means personal injury that is—
>
> (a) suffered by a person—
>
> (i) seeking treatment from 1 or more registered health professionals; or
>
> (ii) receiving treatment from, or at the direction of, 1 or more registered health professionals; or
>
> (iii) referred to in subsection (7); 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 condition at the time of the treatment; and
>
> (ii) the clinical knowledge at the time of the treatment.
>
> (2) Treatment injury does not include the following kinds of personal injury:
>
> (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 resource allocation decision:
>
> (c) personal injury that is a result of a person unreasonably withholding or delaying their consent to undergo treatment.

[14] Section 54 provides:

> The Corporation must make every decision on a claim on reasonable grounds, and in a timely manner, having regard to the requirements of this Act, the nature of the decision, and all the circumstances.

[15] In *Ambros*,[1] Glazebrook J, for the Court of Appeal, envisaged the Corporation taking an inquisitorial role, and the Court taking, if necessary, a robust and generous view of the evidence as to causation:

> [64] An important factor that favours the Supreme Court of Canada's approach applying in that context is the essentially inquisitorial role of the Corporation, both when an initial claim is made and in the review function. … The inquisitorial approach should generally mean that, to the extent this is practical, all aspects of the claim (including causation) have been investigated by the

[1] *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.

> Corporation before matters reach the courts. ... In our view, it is in keeping with the non-adversarial nature of the claim and review process that the Corporation should investigate all possible aspects of a claim, at least in a rudimentary fashion and as far as practicable. It would thus be in a position, once the matter comes before a court, to lead evidence on all points that were investigated, whether strictly obliged to or not.

[16] In *Allenby v H*,[2] the Supreme Court stated:

> [66] Where, however, the medical misadventure involves misdiagnosis of a disease, perhaps without any form of treatment being given, it is not a natural use of language to speak of the progression of the disease (say the enlargement of a cancerous tumour and the spreading of the cancer to another part of the body) as a physical injury. Yet it is common ground that the affected person has cover under s 20 if this is suffered as a consequence of negligent treatment or negligent failure to administer treatment.
>
> [67] Paragraph (c) of s 20(2) gives cover to the sufferer of the transmitted infection which is the subject of s 32(6) to which reference has already been made.

[17] In *C*,[3] the Court of Appeal stated:

> [34] As noted, the appellant relies on personal injury of the kind described in s 26(1)(b), that is "physical injuries suffered by a person, including, for example, a strain or a sprain". The appellant has given unchallenged evidence that, had she been given a correct diagnosis following the 20 week scan, she would have chosen to seek an abortion. The question is therefore whether continuation of the pregnancy following the incorrect diagnosis and the consequential inability of the mother to implement her choice to terminate the pregnancy can constitute a physical injury suffered by the mother for the purpose of the definition of "personal injury".
>
> [35] We are satisfied that the answer is yes. In so concluding we agree with Blanchard J in *Allenby* that the expression "personal injury" is used in an expansive way. By analogy with the impregnation of the victim as a physical consequence of rape or of a failed sterilisation treatment, we consider that the continued pregnancy of the appellant following a misdiagnosis in the 20 week scan is capable of being an injury suffered by the appellant for the purposes of the Act. It is true that the appellant fell pregnant by natural process prior to the 20 week scan. But the analytical focus for the purposes of cover must be on the physical consequences to the appellant in the period post the misdiagnosis.

[18] In *AZ*,[4] Cooper P and Collins J, in the Court of Appeal, stated in the context of a claim for cover for treatment injury:

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2 *Allenby v H* [2012] NZSC 33, [2012] 3 NZLR 425.
3 *C v Accident Compensation Corporation* [2013] NZCA 590, [2014] 2 NZLR 373.
4 *Accident Compensation Corporation v AZ* [2023] NZCA 617.

> [21] … the purpose of the Act, … reinforces the appropriateness of erring on the side of allowing cover in marginal cases unless plainly excluded.
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> …
>
> [47] This summary of the way treatment injury came to be incorporated into the Act demonstrates a deliberate intention by the legislature to expand the circumstances which would attract cover under the Act for untoward medical events. Parliament accepted that the comparatively restrictive cover afforded for medical misadventure under the 1992, 1998 and 2001 Acts led to injustices which needed to be remedied. This was achieved by relaxing the boundaries for cover for personal injury arising from treatment injury. Parliament has advocated a generous attitude to cover for those who suffer treatment injury. This in turn reinforces the approach to interpretation we have set out …
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> …
>
> [75] To establish causation between the relevant treatment and the personal injury, s 32(1)(b) uses the simple language of "caused by". The Supreme Court in *Roper v Taylor* used the "material cause" test in situations of "personal injuries that have more than one cause", and we have also followed this test.
>
> …
>
> [91] When Parliament enacted the treatment injury provisions of the Act, it deliberately expanded the scope for cover under the Act for persons who suffer personal injury arising from an untoward medical event. The terms treatment and therefore treatment injury have been cast broadly and encompass injuries arising from medical procedures that extend beyond those that aim to cure a condition …

[19] In *AZ*, Mallon J added the following in support of the above judgment:

> [107] These cases illustrate the need for care in identifying the cause of physical injuries when the claimed basis for cover is treatment injury. When personal injury is caused by treatment injury, the focus is on the physical consequences suffered by the person claiming cover following the treatment. Underlying physical injuries before the treatment that continue after the treatment can be treatment injury if their continuation is caused by a treatment failure (for example, a misdiagnosed scan). A gradual process condition in such circumstances is not the same as an underlying health condition that is wholly or substantially the cause of the personal injury.
>
> …
>
> [127] A restrictive reading of "treatment" would mean AZ is only eligible for care through the public health and social welfare systems. AZ can only access entitlements, such as treatment, therapy, attendant care, weekly compensation, and lump sum compensation if she has cover under the Act. This means that AZ's mother would have been worse off than she would have been under the common law, and AZ similarly would have been worse off to the extent that she would benefit if her mother received compensation for the additional costs associated with her disability.

> [128] To the extent that there is a gap in cover for AZ on ACC's interpretation of the Act, relative to the common law position, that gap would, as Cooper P and Collins J say, invite civil personal injury claims and that is difficult to reconcile with Parliament's intention and the social contract that the Act entails.

**Discussion**

[20] The issue in this case is whether the Corporation was correct in its decision of 12 August 2022 declining cover for the appellant on the basis that the claimed injury of "the suicide attempt in September 2000" did not meet the criteria for being a personal injury in terms of the 2001 Act.

[21] The appellant's position is that, because treatment for chronic pain in the form of clonazepam resulted in the suicide attempt, this should be regarded as a treatment injury because it caused physical consequences by way of neuronal depression, cardiac arrythmia, hypotension, seizures, and a significant period of unconsciousness. These physical consequences, and the other minor physical injuries suffered by the appellant in the suicide attempt, are collectively a treatment injury.

[22] The Corporation's position is that the issues the appellant seeks to advance do not properly arise from the decision under appeal, and the event of the "suicide attempt" does not amount to "personal injury". Counsel for the Corporation notes that, in its decision of 12 August 2022, the Corporation did not address issues of a treatment injury relating to the appellant's suicide attempt, and therefore submits that such issues are outside the jurisdiction of the review and appeal process.

[23] This Court notes the following considerations.

[24] First, the Corporation's decision of 12 August 2022 was in response to a letter written by the appellant's counsel asking that the letter be regarded "as a claim for cover for the suicide attempt in September 2000 caused by the disinhibiting effects of clonazepam in a vulnerable individual". The Corporation chose to decline cover based upon section 26(1) of the Act, and did not address the claim in terms of a treatment injury claim, in relation to the suicide attempt in September 2000. At

review, counsel for the appellant raised issues in relation to treatment injury, but the Reviewer found such matters to be outside of jurisdiction.

[25] This Court finds that a reasonable interpretation of the appellant's claim was that it encompassed a claim for treatment injury, as being caused by the effects of medication prescribed by a medical practitioner. The Corporation is required to make its decision on a claim on reasonable grounds, having regard to the requirements of the Act, the nature of the decision, and all the circumstances.[5] In doing so, the Corporation is expected to investigate all possible aspects of a claim, at least in a rudimentary fashion and as far as practicable.[6] This Court finds that, in omitting to decide the appellant's claim in the context of a treatment injury, the Corporation did not give a fully reasonable decision.

[26] Second, this Court notes that, only six days before the hearing of the present appeal, the Court of Appeal handed down its judgment on a treatment injury claim. Thus, neither the Corporation nor the Reviewer had the opportunity of addressing the Court of Appeal's latest comments and findings on a personal injury claim in the context of treatment injury.[7] In that this Court finds that the Corporation should address the appellant's claim in the context of treatment injury, the Court considers that this assessment should be done with reference to the Court of Appeal's recent judgment.

**Conclusion**

[27] For the above reasons, the appeal is allowed, and the review decision is set aside. In terms of section 161(2)(b), this Court directs that the Corporation undertake a fresh assessment of the appellant's claim, to include an assessment of whether she is entitled to cover for a treatment injury relating to her suicide attempt in September 2000. In making its assessment, the Corporation must have regard to the judgment of the Court of Appeal in *AZ*, in particular, the statements of the Court of Appeal noted above at paragraphs [18]-[19].

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5 Section 54.
6 *Ambros*, above note 1, at [64].
7 *AZ*, above note 4.

[28] The appellant is entitled to costs. If these cannot be agreed within one month, I shall determine the issue following the filing of memoranda.

**Suppression**

[29] 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 *HM v Accident Compensation Corporation*.

P R Spiller
District Court Judge

Solicitors for the Appellant: Schmidt & Peart Law.
Solicitors for the Respondent: McBride Davenport James.