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 11 **ACR 291/18**

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

Hearing: 20 November 2023

Heard at: Wellington / Whanganui-A-Tara

Appearances: Ms H Armstrong, Amicus Curiae
Mr C Light for the Respondent

Judgment: 1 February 2024

RESERVED JUDGMENT OF JUDGE C J MCGUIRE
[Payment or Contribution to Costs of Treatment, Clause 1 and 2, Schedule 1, ACC Act 2001]

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[1] The issue on appeal is the decision of the Corporation of 17 April 2018 declining to fund further costs of treatment by Dr Gil Newburn and the costs of travel to attend treatment.

[2] In the decision letter of 17 April 2018, the case manager said:

> ACC have considered the information held on your file for your injuries as well as the treatment plan report that was completed by Dr Gil Newburn on 22 March 2018. ACC considers, based on this information, that the treatment that is being offered by Dr Newburn is not necessary and appropriate and is not the generally accepted means of treatment for your covered injuries.

Background

[3] On 21 January 1992, at age 34, the appellant was injured when she fell off a horse. The first ACC medical certificate relating to this injury appears to be dated 11 February 1992, completed by Dr Newman, her GP, records the following:

> Fall from horse – head injury.

[4] The diagnosis is shown as:

> Post concussion syndrome – has been assessed by Dr Gavin, Neurologist – has put her off work.

[5] At the time the appellant was employed as a newspaper journalist. She was highly regarded with a reference dated 24 April 1992 noting:

> … [the appellant] proved to be very professional and thorough in her duties of reporting and investigating stories for the newspaper.
>
> Her excellent personality held her in the highest regard by both her colleagues and contacts.

[6] Also included in the documents before the Court are earlier academic and work records. They paint a picture of a person who is highly intelligent and motivated and highly regarded by those for whom she worked.

[7] Dr Newman referred the appellant to consultant psychiatrist, Gil Newburn, who in his report of 17 May 1992 included the following:

> As you know, she had a fall from her horse on 21 January 1992, and a further injury five weeks ago when she was kicked in the head by a horse. Following the first injury, she noted that she was aching all over, and that she was extremely sleepy.
>
> She now notices a number of problems best summarised as follows:

1. She is disinhibited and socially slightly inappropriate, for example, giggling inappropriately.

2. She suffers from “head pains” all over her head that are constant. However on closer questioning, she can define two primary sites, with one being from the back of her eyes through to the temporal, and the other occipital.

3. Nausea, more so after the second blow to the head.

4. Reduced concentration.

5. Cognitive disorganisation.

6. Memory impairment.

7. Photophobia.

8. Reduced noise tolerance.

9. Reduced frustration tolerance and impaired impulse control.

10. Ready fatiguability.

11. Reduced language processing.

12. Reduced tension.

13. Distractability/sensory inattention.

As a result of her impairments, she has left a job. She felt under significant stress there and saw the need to take herself away from this.

…

She has started on amitriptyline by Bob Craven, and has noticed some reduction in headaches as a result of this.

On cognitive assessment, she demonstrates a normal level of consciousness. She shows impairment in digit span reversal, verbal fluency, verbal and visuospatial memory, some slowing in processing of complex calculations and impaired visuospatial sequencing. She also has a positive glabella tap, a positive Romberg sign and a impaired postural reflexes. These findings are consistent with bifrontal and bitemporal cortical impairment, as well as problems with basal ganglia functioning and in cerebella mid-brain pathways.

It is also of some concern that she has shown a propensity for more minor knocks since the head injury, arising probably from impaired attention.

…

She is also going to need significant assistance with cognitive re-training, and I imagine there will be a need to continue treatment for some considerable length of time. I have arranged to see her again in the near future.

[8] The appellant commenced a rehabilitation programme with the Rotorua Rehabilitation Service in July 1992 "to retrain and compensate for cognitive disfunction to maintain her viability in the workplace".

[9] On 28 August 1992, she had a ceretec brain scan. The report on this noted:

> There are a couple of discrete zones of reduced cerebral perfusion seen, one in the left posterior parietal/occipital region quite inferiorly, and a further discrete perfusion defect in the right occipital region. Elsewhere cerebral perfusion is within normal limits.

[10] The appellant continued with rehabilitation provided by the Rehabilitation Service which included vocational rehabilitation.

[11] She suffered a further accident on 12 January 1993 when she slipped and "landed on my back and back of head".

[12] On 8 March 1993, Dr Newburn provided a report to ACC under ss 78 and 79 of the then Act. Amongst other things, he noted that it was clear she was significantly impaired as a result of her injury and using the AMA Guides, he concluded an impairment of 61 per cent of the whole person.

[13] A report from Occupational Therapist, Joanne Smith, of the Rehabilitation Service dated 15 March 1993, stated:

> Although [the appellant] has recommenced a structured paced home programme to date, she has had very little improvement in her symptom levels and her primary treatment from myself remains supportive, under medical fees until such time as [the appellant] has the capability to be considered for continuation of a vocational programme.

[14] On 1 February 1995, she was admitted to Rotorua Hospital, having presented to an Emergency Outpatient appointment with an inability to cope and extreme anxiety. In the discharge report of 20 February 1995 her DSM IV diagnosis was recorded as follows:

> Axis I: Organic brain disorder with anxiety secondary to life stresses and coping ability.
>
> Axis II: Borderline personality disorder (pre-head injury).

Axis III: Head injury with frontal lobe signs.

Axis IV: Stresses moderate to her:

1. Loss of relationship.
2. Coping with children.
3. Too many people involved.
4. Family psycho pathology.
5. Running the household alone.
6. Feeling alone.

Axis V: Poor functioning presently.

[15] She was discharged from Rotorua Hospital on 16 February 1995. Her discharge summary also included the following:

> In summary [the appellant] is considered as a woman who received a head injury which has impaired her ability to process cognitively, especially with too many things happening at the same time. She gets bombarded by sensory information and personal conflict and any ambivalent situation, and responds with a confidence crisis, overwhelming escalating anxiety, indecisiveness to the point of paralysis of action, impulsiveness, regression to a dependency state where others must take care of her, and then becomes very regretful when she realises how dependent she has become, and then she gets angry and tearful. Her treatment plan is that of:
>
> 1. **Biological:**
> Tegretol 600mg nocte.
> Imovane 7.5mg nocte.
> Serepax 90mg mane, 15mg midday and 6.00pm, 30mg nocte.
> Melleril 25mg BD; 100mg nocte.
> Propanolol 40mg mane, 40mg midday.
>
> **Psychosocial**
> Was to give [the appellant] leave from the ward, returning to be seen in the morning for several days and then discharging her when she became more stable. This worked very well, and [the appellant] appeared to be coping much better in the community.
>
> 2. Supportive Psychotherapy with Ann Beets.
>
> 3. Rehabilitation course with Joanne Smith. Her GP continuing care, Rose Pedley, home help – Raewyn. Consider in the future a stress management course, and also a meeting with all people involves in [the appellant's] situation. It was also decided in consultation with [the appellant] that the social worker, Alex Tupou, would action a report to Social Welfare … [the appellant] was aware of our overall plan and seemed happy with this.

[16] Over the years that followed, the appellant continued a relationship with the Rotorua Rehabilitation Clinic with Dr Newburn noting in a report of 17 May 1996 that "objectively she was making good progress". Dr Newburn further reported twice in

1997: on 15 October 1998, in which he noted two further brain injuries; and on 5 July 1999.

[17] On 10 October 1999 she was referred to Clinical Neuropsychologist, Denyse Kersel, for a neuropsychological assessment. Ms Kersel noted that she presented as a very complex case and said:

> Her rehabilitation needs to firmly encourage and support her in becoming more independent in her daily functioning.

[18] An independence allowance assessment report was carried out by Dr Collier, specialist Psychiatrist and Psychotherapist on 29 June 2000. He concluded:

> She has a significant disability as a result of her head injury and that this should be included in her whole person impairment for independence allowance.

[19] In 2004, Gil Newburn reported to the appellant's case manager as follows:

> I understand you are now [the appellant's] case manager since she has been resident in Manawatu. As you will be aware, she has significant neurobehavioural issues arising from recurrent mild brain injury. This has created significant difficulties for her emotionally, behaviourally, cognitively and socially, all of which have been added to by difficulties in managing two difficult children, and issues with disruption of intergenerational boundaries. She has been seen by a number of psychiatrists over the years, and a process of trial and error has led to a degree of poly-pharmacy with which none of us have been happy, but where there has been a significant worsening of symptoms every time we have tried to withdraw medication. In addition to the above, she probably presents with a type two bipolar disorder secondary to brain injury. Prior to her injuries, she was a competent and high functioning individual.
>
> She is very much in need of ongoing psychological and social support in this region and I would appreciate it greatly if you could facilitate referral to a psychologist who has expertise and experience in the management of those with brain injury for assessment and development of such a support programme. This should also involve assessment by an occupational therapist for further assistance. She may also require social work intervention. As I only visit this region two monthly, I can only see her briefly, which places great limits on time availability unless other systems can be established …

[20] On 20 March 2004, Clinical Psychologist, Ms Heath, provided ACC with a psychological assessment report. In the summary section, Ms Heath says:

> Based on the detailed reports from those treatment providers who have worked with [the appellant] over many years, her current presentation has occurred

> numerous times in the past, and generally when she is experiencing an increase in stressors. These periods also appear to be more likely to occur when [the appellant] is living with her children. Advice from therapists who have treated [the appellant] in the past would indicate a need for increased support and structure in order to help [the appellant] move towards a more stable state, [the appellant]'s situation is extremely complex and there appears no easy solution.

[21] Registered Psychologist, Gail Russell, provided a neuropsychological assessment report dated 15 May 2004. She diagnosed post-concussional syndrome resulting from a succession of minor traumatic brain injuries.

[22] On 3 June 2004, a serious injury assessment - follow up medical report was completed at the Palmerston North Hospital Rehabilitation Centre. The report concluded:

> As per the rehabilitation planning report dated 12 May, [the appellant] will continue to work with Juanita Heath and Angie Hartshorn from the Brain Injury Association as part of her community-based rehabilitation programme and for her to continue to attend the Stuart Centre two half days per week.

[23] The report also commented:

> In terms of her psychotropic medication, I prefer to await Dr Armstrong's report. She remains on a high dose of citalopram, 80mg mane, and this could be responsible for some of her manic features …

[24] An impairment assessment report was carried out on 13 July 2004. A final whole person impairment rating of 57 per cent was reached. Then followed two serious injury assessment follow-up medical reports dated 20 August 2004 and 26 November 2004. The recommendation in the latter report was for the appellant to be reviewed by Dr Louise Armstrong, neuropsychiatrist.

[25] She was seen by Dr Armstrong, who reported on 3 March 2005. Dr Armstrong reported:

> The whole tenor of the conversation suggested to me that she was unable to see me as anything other than a person who would undermine treatment already set up by Dr Newburn. She seemed to have the view that I was someone trying to assess what was and was not a brain injury. I was unable to convey to her that I was trying to assist with the difficulty and distress which she is articulating, but that to do so I needed to look at all the factors – biological, psychological and social, which interplay for any person.

[26] Dr Newburn saw the appellant again on 2 May 2005 and in his report to her GP included this:

> As you know, she has had a number of assessments over time and people have continued as I have been previously, to be concerned about the levels of medication she was taken. However, she has been seen by a significant number of people over the years, all of them have tried to reduce medication, and found a return of significant symptoms when this has been done in other than an extremely judicious fashion.

[27] Dr Newburn reported to the appellant's ACC case manager again on 15 February 2006. His report included the following:

> As you are aware, [the appellant] has long-standing and enduring issues arising from her recurrent brain injuries. She clearly has a complex group of neuropsychiatric consequences of this, requiring ongoing management by a neuropsychiatrist, clinical psychologist and at times input from others, including occupational therapy and social work. She will require long term specialist neuropsychiatric input, although hopefully at relatively infrequent intervals.

[28] Dr Newburn reported to the appellant's new case manager on 23 September 2006 as follows:

> She presents with the consequences of a series of mild brain injuries which have left her with anything but mild outcome. There has been a significant personality change, and the development of significant impulsivity, recurrent mood problems, reflecting bipolar disorder (no familiar pre-disposition), and significant impulsivity in the absence of mood abnormality. She has over the years by a trial and error process, ended up with significant polypharmacy. I note that the current regime is a rationalisation of what she was previously on from other specialists, but does remain a significant loading of medication.

[29] On 29 January 2007, the report from Senior Clinical Psychologist, Juanita Heath, to the appellant's case manager included:

> [The appellant] has also wondered about referral to another psychiatrist, as Dr Newburn is not always readily available, however would need to consider this carefully as appointments with other psychiatrists have not gone well in the past.

[30] On 26 July 2007, Dr Greenblatt, Consultant Psychiatrist with Mid-Central District Health Board, saw the appellant. Under the heading "Impression" he said:

> 1. Cluster B personality disorder with borderline personality disorder as a working diagnosis …

2. I am not convinced she has bipolar disorder, at least from the information I have thus far.

3. I think it very unlikely that there will be further progress in respect of her head injury after all these years following the head injuries.

[31] Dr Greenblatt also observed the appellant was on a lot of medication and he was not convinced it was helping that much. He suggested changes.

[32] Dr Greenblatt reported again on 23 August 2007 and noted:

> I don't see significant worsening in the clinical presentation, despite reducing some of her medication and I think this is a step in the right direction. I know that she believes that her problems primarily relate to her head injury and I have no doubt that the head injuries that she has had has significantly affected her. We had some discussion regarding her psychiatric diagnosis and she did indicate she was unhappy with my considerations of personality difficulties for her, although clearly these can occur with head injury patients as well.

[33] On 27 September 2007, in a letter to Dr Greenblatt, Dr Newburn included the following:

> I note the diagnoses around borderline personality disorder which has clearly been considered by yourself, but also Louise Armstrong. When [the appellant] was seen early, there was no suggestion of a pre-morbid history, prior to her brain injuries, or symptoms consistent with borderline personality disorder. It is clear that she may now present with a range of features consistent with this diagnosis, but the longitudinal history is clearly that these are consequent on the brain injuries rather than any pre-disposition to a personality type. She seemed to be a highly functional, competent and coping individual prior to the injuries when assessed at that time.
>
> I note that she has over the years been on what might be considered creative pharmacotherapy. This is what it has taken to maintain some consistent function in the community. She was seen for approximately two years by psychiatrists other than myself at Rotorua Hospital. They had attempted to alter treatment, with severe deterioration, and eventually over a two year period returned to a level of chemotherapy very similar to what she had earlier been on.

[34] It is noted that the appellant gained employment in 2006 as a Health Care NZ support worker. The evidence is she was highly regarded in that role.

[35] Dr Newburn reviewed her again on 20 March 2009. His report included:

> I reviewed [the appellant's] progress today after an interval of a year. I note that she has again had significant issues with overload with her attempts to

> work beyond her capacity. She presents with typical ongoing issues of recurrent mild traumatic brain injury, with these having had a markedly cumulative effect.

[36] The appellant saw Dr Greenblatt again on 16 July 2009 on referral from her GP. Dr Greenblatt noted:

> She has had some contact with her past psychiatrist, Gil Newburn, but she informs me that ACC will only pay for very brief visits (10 minutes) with her previous psychiatrist. The essence of her problem since I have seen her, she reports, are ongoing difficulties related to her physical health. She reports chronic pain from several different problems including fibromyalgia, headache pain and arthritis.
>
> …
>
> **Impression:**
>
> I have no doubt this patient gets stressed and develops anxiety and depressive symptoms, secondary to the disability she suffers from her health related issues and this seems to be the main problem for her. I don't believe that a significant change in her psychiatric medication will affect this significantly. She finds benefit from the medicine and therefore I have not suggested a change in her psychiatric medication.

[37] In 2010, ACC obtained a psychiatric assessment report/treatment plan from psychiatrist, Dr Gary Cheung. Dr Cheung noted at the end of the report that a specific treatment plan was not sought in the referral plan. Dr Cheung then says:

> However the two main forms of intervention [psychological treatment and pharmacotherapy] will be discussed. Due to the pre-existing diagnosis of somatization disorder, I will leave ACC to decide whether [the appellant's] treatment should be funded by ACC or the public mental health services.

[38] Dr Cheung reported again on 24 May 2010 to ACC's case manager after obtaining psychiatric records from 1992 to 2003 from the Rotorua Hospital.

[39] In his report, Dr Cheung refers to a letter of Dr John Fletcher dated 10/01/1995 in which he says:

> All that can be said with certainty presently is that [the appellant] has an underlying borderline personality, as well as major depression, which has largely resolved, and a severe, generalised anxiety disorder. She also has neurological sequelae to her head injury documented by Dr Gil Newburn and Joanne Smith. The extent to which her head injury has played a part in the genesis or exacerbation of symptoms related to her personality disorder is unknown. The exacerbation of symptoms certainly coincided with the head injury. While I suspect that her personality disorder to some indetermined

> extent pre-dated the head injury, this would not be able to be stated as an opinion with any certainty and under the present circumstances, she should be given the benefit of the doubt regarding ACC compensation, and her current psychiatric state regarded as being long term sequelae of a head injury. ACC will need to be informed of the current position as it has funding implications.

[40] Dr Cheung, in the same report, then refers to the collateral history of the appellant's pre-morbid personality from her older sister as recorded by Dr John Fletcher on 1 February 1995:

- *From a disfunctional family, middle sister married and it helps. Other sister severe (?? writing difficult to read)/medication 18 years.*
- *Always been anxious/easily angered or agitated, guilty, poor self-esteem/ self worthless.*
- *Became worse after accident.*
- *Can't cope with any exams. Had to take med (medication) to write exams.*
- *Difficulty being left alone always.*
- *Always labile mood.*
- *History of hitting herself with hammer after head injury.*
- *Scratch and bruise herself.*

[41] Dr Cheung concludes:

> In summary, it became more certain that the presence of personality disturbance pre-dated [the appellant]'s head injuries and the most important collateral history to support this was provided by [the appellant's] oldest sister, who was supportive through [the appellant's] multiple psychiatric admissions to Rotorua Hospital. The collateral history suggests features of borderline personality traits, identity disturbance, affective instability and inappropriate anger.

[42] Pages 14 to 20 of the bundle of documents prepared by the Amicus contain the notes of the appellant's GP from 1987 through to the accident on 21 January 1992, and

beyond. I was unable to find any entry during that period that is supportive of what Dr John Fletcher recorded from the appellant's sister as to the appellant's pre-morbid personality.

[43] In a further report to ACC dated 21 July 2010, Dr Cheung said:

> On the balance of probability, I believe some of [the appellant]'s ongoing incapacity (from her depressive and anxiety problems) is caused directly from the reported head injuries. However, due to the chronicity of her symptoms and the interplay of other non-injury factors (including her pre-morbid personality style and somatization), it is difficult to determine the proportion of her depressive and anxiety symptoms which is caused directly from the reported head injuries.

[44] It appears that the appellant sustained another head injury on 23 Match 2012, when she fell and struck her head and that this resulted in a brief loss of consciousness. Dr Newburn saw her on 12 April 2012, 12 July 2012 and 11 October 2012.

[45] On 19 December 2012, Dr Antoniadis completed an initial medical assessment which identified a number of work roles that may or may not be suitable for the appellant. Some roles were recommended, others not. Dr Antoniadis concluded:

> At the completion of my assessment today, which took over one and three quarters of an hour, both [the appellant] and her son,… shook hands and thanked me for my assistance and left seemingly satisfied with the consultation.

[46] In a review decision dated 15 May 2013, the reviewer quashed ACC's decision declining to fund the provision of Sandomigran, a prophylactic treatment for the management of migraine headaches.

[47] On 18 July 2013, ACC obtained a psychological assessment of the appellant from clinical psychologist, Matthew Manderson. Mr Manderson did not see any clinical reasoning for further assessments to take place.

[48] The appellant saw Dr Newburn again on 1 October 2013.

[49] The appellant saw Dr Newburn on 15 April 2014. In his report, he refers to the fact that ACC has withdrawn its opposition to the funding of Zopiclone.

[50] Dr Newburn reported further to the appellant's GP on 18 December 2014 and 7 April 2015. In the latter report, Dr Newburn acknowledged that the appellant remained on a significant amount of medication. He noted:

> Those (medications) at least in the neuropsychiatric area, have been arrived at by a trial and error process over a long period of time. Eight medications were listed.

[51] The appellant's GP referred her to Dr Singh, Musculoskeletal and Pain Specialist, for her left arm and neck pain.

[52] Dr Singh concluded:

> Given her longstanding psychotropic medication and possible side effects, I do not believe I can help her any further. I have a different approach which also focuses on reducing the medication and in her situation, unfortunately I cannot advise.
>
> In my view, she has a complex situation, which is difficult to deal with in a private solo practice setting. It is my suggestion that she be referred into the public hospital system or privately where an integrated multidisciplinary approach can be adopted in her treatment, or you may wish to refer her to an orthopaedic colleague who has seen her in the past. I will leave it to you to make that call.

[53] In June 2017, the Corporation convened an external medical multi-disciplinary panel to undertake a review of the claim history and the medical treatment and opinion over the years. The panel met on 2 June 2017 and completed a report, dated 7 June 2017. The report commences:

> [The appellant] is a 59 year old woman who has been involved in 48 recorded accident events, from which 63 injuries have (been) incurred. Of these, 12 involved her upper limbs, 13 her lower limbs, 33 her head, neck or spine, and five involving "other" body injuries, of which two are concussion related and two dental related.

[54] As to diagnoses, current symptoms and disability, the panel had this to say:

> [The appellant's] appropriate primary diagnosis is unquestionably borderline personality disorder. Contributing factors are narcissistic traits and somatic symptom disorder (an update from the previously noted somatisation disorder).
>
> The diagnosis of borderline personality disorder was suggested or declared by her own voluminous reports that contain numerous episodes of feeling abandoned; black/white thinking; chronic suicidality with at least two

> overdoses, cutting her wrists and driving nails into her head when under stress. Her idealisation/devaluation of case managers and clinicians in her letters – particularly notably were the attacks on Dr Newburn and Mrs Smith on two occasions when she felt abandoned by them. Overall there is a profound instability of mood, function and behaviour that is best explained by her personality structure.

[55] The panel then listed the psychiatrists and psychologists who noted this diagnosis, namely:

- John Fletcher, Psychiatrist, 1994;
- Louise Armstrong, Psychiatrist, 2004-2005;
- James Greenblatt, Psychiatrist, 2007-2008;
- Susan Shaw, Neuropsychologist, 2009;
- Gary Cheung, Psychiatrist, 2009-2010; and
- Matthew Manderson, Psychologist, 2014.

[56] The panel report continued:

> Opposing this is Dr Gil Newburn, Neuropsychiatrist, who has seen her since 1992. His consistent argument is that her pre-morbid functionality was intact and therefore she cannot meet the criteria of a personality disorder. This unfortunately was due to the failure on his part to obtain any collateral evidence regarding her pre-morbid functionality outside her self-reporting.

[57] As to the relationship between her current diagnoses and the accident of January 1992, the panel said:

> Both the diagnosis of borderline personality disorder and somatic symptom disorder clearly pre-date the index events of 1992, much less the subsequent reported head injury.

[58] The next question answered by the panel was: Are any of the identified pre-1992 incidents or diagnoses contributing to the current incapacity?

> Her current incapacity is almost entirely due to her pre-morbid diagnosis of borderline personality disorder and the secondary manifestation of somatic symptom disorder. While the fall in 1992 may have resulted in a mild concussion based on the reported symptoms, multiple assessments showed no ongoing cognitive impairment consistent with any modern clinical understanding of traumatic brain injury or even common sense. By any measure (clinical assessment, psychological testing, functional capacity) the concussive symptoms as they were, dissipated long ago.

[59] In answer to the question: What advice and/or recommendations would the panel suggest for her future treatment and/or rehabilitation options, in particular, her medication regime? The panel had this to say:

> The evidence based therapy for borderline personality disorder is dialectical behavioural therapy. This is a therapy that would offer [the appellant] enormous benefit through the modules on mindfulness, distress tolerance, and interpersonal skills, among others, but she would have to engage willingly. With her somatic focus and the enmeshment with Dr Newburn, it is very unlikely that this will happen. It would be worthwhile for this to be presented to her as the therapy is very patient centred and fundamentally the goals are that the patient learns to control their environment so they get what they need more often, especially from contentious and conflict-ridden situations. It can be described as a form of martial arts for the mind.
>
> This therapy is a combination of individual therapist and a therapy group and is only offered by the Community Mental Health Service as it is an intensive therapy that requires highly skilled and trained therapists working together with the patient. The therapy typically requires a significant commitment and occurs over a period of over six months to two years.

[60] In Dr Newburn's letter to the appellant's case manager of 22 March 2018, he noted:

> … It remains my view that [the appellant] presents with the consequences of recurrent mild traumatic brain injury, although clearly the consequences are more than mild. She has chronic health problems, and this must be treated as a chronic health condition, as would be recommended by the Lancet Neurology Commission, eg. *MAAS et al* (November 2017). She requires ongoing assistance in maintaining a stable living environment with pragmatic approaches to this.

[61] In a response dated 12 April 2018, panel member and psychiatrist, Dr Kenedi, said this:

> Dr Newburn makes a number of general claims which appear to support his rigid position which are not accepted by the medical community. He does not address why 19 years of treatment using his set of assumptions has resulted in a deterioration in function and worsened disability for [the appellant]. Certainly, there has been no overall improvement. Although I would not accept that 50% of patients with mild TBI have "enduring symptoms", even in the far less than 10% who do have residual symptoms, their problems do not evolve and worsen after a week post injury, much less years and decades. As importantly, I note that [the appellant]'s symptoms are reported to wax and wane, which is inconsistent with TBI. At some points, she has dismissed issues with TBI related symptoms when she has been distracted by other concerns.

[62] On 17 April 2018, ACC issued its decision stating:

> ACC has considered the information held on your file for your injuries as well as the treatment plan report which was completed by Dr Gil Newburn on 22 May 2018. ACC considers, based on this information that the treatment that is being offered by Dr Newburn is not necessary and appropriate and is not the generally accepted means to treatment for your covered injuries.

[63] The appellant unsuccessfully sought to have this decision overturned on review. She then lodged an appeal to this court dated 19 September 2018.

[64] Following the appointment of Ms Armstrong as Amicus, it was agreed that there would be a report prepared at the joint instruction of Ms Armstrong as Amicus Curiae and Counsel, for ACC to obtain a psychiatric report from consultant forensic psychiatrist Dr Lehany.

[65] The appellant was interviewed on 8 August 2022 by Dr Lehany and in preparation for his report, he read the documentation provided, which included 687 pages of notes, opinions and other documentation.

[66] Amongst Dr Lehany's opinion and recommendations were these:

- This is a complex case, with no single or clear answer or formulation and many professional opinions by qualified individuals are at odds with each other in significant ways.
- The provided notes contain a large quantity of information and divergent opinions.
- Overall, the nature of the conflict within these notes, with overt criticism of professional positions by other professionals, and at times somewhat pejorative language, is unusual in my experience, and the reasons for such emotive language is not entirely clear to me, but seems to me to have a somewhat personal tone.
- That there is ever a single and unquestioned diagnosis in psychiatry is debateable and disagreements between psychiatrists is common and when the proposed unquestionable diagnosis is borderline personality disorder, there is likely to be more to debate.
- There is no significant balancing of possible contrary views from the panel, and no apparent acknowledgement that not all the evidence points to the conclusions reached by the panel and we simply cannot be certain they are correct, in determining the primary diagnosis as being "unquestionably" borderline personality disorder.

- The panel does not appear to weigh opinions such as by Dr Collier, Dr Louise Armstrong, Susan Shaw and Matthew Manderson, who gave more skillfully and carefully nuanced opinions across a decade or so.

- Whilst I broadly disagree with some of Dr Newburn's approaches here, the picture does not seem entirely clear to me and the review panel, in my view, overstated the degree with which we can be certain on the matters in dispute.

- Some caveats and acknowledgement of the complexity of this case and recognition that even the review panel may be incorrect, would better reflect the difficulties we will always have with uncertainty in this case.

- That [the appellant]'s functioning was markedly worse following the injury in 1992 is a matter of record and warrants consideration. It does appear that [the appellant] now presents in a reasonably clear borderline manner of functioning. It is plausible however that at least some of this functioning has developed out of her experience of the sequelae of injuries, and the loss of functioning which resulted, even if that loss of function was relatively short lasting.

- Psychological and psychiatric research is always incomplete, and there are many examples in history of our profession being too confident in our understanding of the science being correct, only for later research to find where we have been wrong.

- The collateral history available that does suggest at least some personality abnormality pre-dating the injuries in 1992/93. It also identifies other social stressors at the time, including conflict and breakdown of a marital relationship. These matters cannot be certain however, and onset of symptoms coincides with injuries. The injury event, even as a precipitant, cannot be ruled out as a significant factor in worsening of [the appellant]'s functioning in the context of pre-existing traits of borderline personality disorder.

- Overall a diagnosis of personality disorder which was worsened by psychological stressors, including the sequelae of relatively mild head injuries, and lead to the development of dysfunctional behaviours and coping strategies which never entirely remitted, is the most likely explanation in my view.

- It must be borne in mind however, that at a distance of around 30 years from the events of 1992, we must be careful to acknowledge that all clinicians here are speculating to a degree, and it would be best if we couch our opinions to reflect that there is inevitably a degree of uncertainty in all of this here.

- It seems unlikely that the entirety of her symptoms are caused by physical sequelae of the head injuries. Onset of her difficulties, at least at the level they maintained, seems to have coincided with the head injuries. It is more likely that the latter disability is a function of pre-disposing and pre-morbid factors, interacting with the consequences of relatively minor head injuries and compounded by psychological factors including sick-role factors.

[67] Dr Lehany answered specific questions directed to him by the Amicus, Ms Armstrong, which included the following:

> 2. *The relationship (if any) between [the appellant's] current diagnosis and the covered personal injuries suffered in the accident on 21 January 1992 and/or personal injuries suffered in subsequent accidents?*
>
> Following the injuries of 1992/3 it is likely sequelae of the injuries included post-concussional syndrome. It is likely these symptoms lead to an exacerbation of [the appellant]'s pre-existing difficulties. This exacerbation further lead to a cycle of problematic problem-solving and behaviours. In short, the borderline functioning displayed by [the appellant] worsened, and in turn the borderline functioning and sickness behaviours lead to further disfunction, worsening the presentation of borderline personality disorder, which has since persisted.
>
> 3. *Do any of the diagnoses pre-date the accident of 21 January 1992, and if so, the extent to which these diagnoses cause or contribute to [the appellant]'s current condition and the need for treatment?*
>
> It is likely the borderline personality disorder pre-dated the accident in 1992, although the level of difficulty was less than it subsequently became following the injury.
>
> 4. *Was the treatment provided by Dr Newburn at the date of ACC's decision (17 April 2018) to decline funding for the costs of treatment by him and travel to the treatment:*
> *(a) For a covered injury?*
>
> It is unlikely the treatment provided on that date would be effective in managing the covered injury unless covered injuries included borderline personality functioning.
>
> *(b) To restore [the appellant's] health to the maximum extent practicable?*
>
> This was the aim of the treatment, but it is unlikely to have improved her health the maximum extent practicable. That treatment may however have been beneficial in providing an ongoing therapeutic relationship which was in its way containing and helpful in managing some of the issues [the appellant] was experiencing.
>
> *(c) Necessary and appropriate and of the quality required for [the appellant]?*
>
> The treatment was not at that time entirely necessary and appropriate, and psychotherapeutic approaches such as DBT would have added considerably to a possible positive outcome. However, the ongoing therapeutic relationship with Dr Newburn was not without value.
>
> *(d) Performed only on the number of occasions necessary for the purpose of treatment for a covered personal injury?*

> In terms of psychiatric review, the frequency of appointments was appropriate. It was not clearly indicated for psychiatric review to continue, however an ongoing follow-up by treatment providers offering alternative options, such as [the appellant] exploring the more borderline aspects of her presentation may have been more useful in the longer term.

[68] In response to a question relating to the description of treatment from Dr Newburn, Dr Lehany noted that the request for pharmaceutical funding from Dr Newburn dated 4 April 2017 focusses on medication, including anti-depressants, anti-psychotics and migraine medication. Dr Lehany noted that the evidence base for this prescribing was unclear but said that medication regimes at times evolve in pragmatic ways and a-typical prescribing can offer stability.

[69] Dr Lehany continued:

> [The appellant] has had periods of marked instability, which at times appears similar to bipolar effective disorder, and the clinicians, including Dr Newburn have worked for lengthy periods to stabilise her presentation in the extent of her childcare responsibilities. Treatment by Dr Newburn is not in my view limited to the prescribing however. It is clear that the ongoing therapeutic relationship here is significant. It can be argued that this was not providing great benefit by 2018, but it is also possible that the stability of this relationship has been a factor in limiting harm from [the appellant]'s mental health difficulties.

[70] He further commented:

> Overall, despite the obvious caveats and concerns, [the appellant] has functioned at a reasonable level for significant periods since 1992, including employment. It is not certain, after the exacerbation of her borderline features following the accident in 1992 what her prognosis may have been. It is feasible that the stable and consistent therapeutic relationship with Dr Newburn has provided containment for [the appellant] and that overall without it she may have utilised inpatient facilities and engaged in self-harming behaviour to a greater extent over the years, which may well have been more expensive.

[71] Dr Lehany acknowledged that it was possible that Dr Newburn unintentionally fostered a dependent relationship with the appellant, which prevented alternative treatment strategies from being acceptable to her and deprived her of alternative approaches that may be beneficial.

[72] Regarding the way forward, Dr Lehany said this:

> A useful approach might be for Dr Newburn to periodically review [the appellant] to provide stability and continuity, but that [the appellant] is encouraged to also pursue additional and alternative treatment approaches such as dialectical behavioural therapy, with the aim of improving longer-term functioning.

Submissions from Ms Armstrong – Amicus Curiae

[73] Ms Armstrong referred to the extensive background of this case and the voluminous records that have been generated as a result, which she, with the assistance of the appellant and Mr Light, had been able to reduce to some 700 plus pages.

[74] Ms Armstrong noted that the appellant had had several head injuries and that they had caused symptoms affecting her functioning as a person.

[75] She noted that Dr Newburn's approach had been to treat the appellant's symptoms and prescribed medications to respond to those symptoms, which had been caused or contributed to by her head injuries.

[76] She contrasts this with what is contained in the external medical multi-disciplinary panel report of 7 June 2017, which said that the appellant's appropriate primary diagnosis was "unquestionably borderline personality disorder".

[77] She notes what she describes as a third approach by Dr Lehany describing a mild personality disorder that pre-dated head injuries, but which deteriorated due to her head injuries.

[78] She acknowledges that the treatment the appellant received has not been entirely appropriate, but it limited the harm from her mental health injury.

[79] She refers to *Ambros,*[1] noting that the Court of Appeal concluded that Courts can infer causation in circumstances where experts cannot.

[80] She refers to *W,* where Justice Collins discussed the proper ambit and meaning of the term "because of" in s 26(1)(c) of the Act.[2] The Court said:

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

> … The physical injuries do not have to be the sole cause of the mental injury. It is sufficient that the physical injury materially contributes to causing the mental injury. That means that to satisfy s 26(1)(c) of the Act, the physical injury must be a cause of the mental injury in some genuine or meaningful way, rather than just in a trivial or minor way.

[81] She refers to Dr Lehany's conclusion that part of the appellant's mental injury is from pre-existing factors and part from the accidents she suffered.

[82] She notes that Dr Lehany went through all of the evidence, concluding that the appellant had a probable borderline personality disorder, but worsened with post-concussion symptoms. Therefore, it was necessary to treat both the head injury and the borderline personality disorder.

[83] Ms Armstrong refers to paragraph 2 of Schedule 1 of the Accident Compensation Act, which provides that the Corporation is liable to pay for the cost of the claimant's treatment if the treatment is for the purpose of restoring the claimant's health to the maximum extent practicable.

[84] She disagrees with the panel that the appellant's incapacity is due almost entirely to her pre-morbid diagnosis of borderline personality disorder and, as Dr Lehany says, the panel was not correct as it cannot rule out a worsened function after the accidents, given the nature and seriousness of the injuries incurred.

[85] She notes that Dr Lehany acknowledges there were other options for treatment, but that Dr Newburn did not harm the appellant and may have "contained" her symptoms.

[86] She notes that Dr Lehany thinks that Dr Newburn should continue some therapy.

[87] She says therefore that ACC exercised its discretion without regard to all the factors in this case. She submits that the panel was combative towards Dr Newburn. She also notes that Dr Lehany was rightly cautious about "absolutism" when it came to analysis of the causes of the appellant's presentation.

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[2] *W v Accident Compensation Corporation* [2018] NZHC 937, [2018] 3 NZLR 859, at [65].

[88] She notes, referring to page 7 of the appellant's own submissions, Dr Lehany agrees with the appellant's statement that depression and anxiety was huge and debilitating and that it took a number of years for her medication regime to be stabilised by Dr Newburn and that no other psychiatrist was able to do this.

[89] She refers to the appellant's comment that Dr Newburn's professional help brought her back from the brink.

[90] She also notes that the appellant acknowledges that dialectical behavioural therapy had been helpful to her.

[91] She notes that in her submissions, the appellant denies that she has borderline personality disorder.

[92] She notes that it is the appellant's position that she had no medical conditions at all during the period preceding the injury of 1992 and this is borne out by the medical records of her GP, Dr Newman, from 1987.

[93] She refers to the fact that it was agreed between ACC and the Amicus Curiae that a report would be obtained from Dr Lehany.

[94] She refers to Dr Newburn's response of 7 March 2023, where he says:

> I note and reiterate the contemporaneous information that I was able to elicit, not elicited by others, which confirm that there were no pre-morbid issues of personality disorder, either clearly evident or developing. It appears that such diagnosis by others was made retrospectively and in the context of some family dynamic issues with siblings … This does not mean that there are not symptoms that are also seen in borderline personality disorder.

[95] She notes that the recommendation of ACC's pharmacist, Ms Jones, from 9 February 2017 was to continue funding the seven pharmaceuticals that were prescribed.

[96] She notes that the multi-disciplinary panel acknowledges that the appellant had 48 recorded accident events, 33 of which were to her head, neck or spine.

[97] Ms Armstrong notes that although the panel appears to have assumed that the appellant did not undertake dialectical behavioural therapy (or similar), she did so with Mid-Central Health back in 2004.

[98] She notes a report from Mid-Central Health of 8 July 2004 which includes the following:

> Initially the focus was on working with [the appellant] and other providers to address her significant social difficulties and health concerns, while providing [the appellant] with ongoing psychological support. The main focus of early sessions was to assist [the appellant] to discuss pressing issues and concerns and problem solve potential solutions.

[99] She also refers to a follow-up medical report from Dr Degroot, Consultant in Rehabilitation Medicine with Mid-Central Health, dated 23 August 2004, in which Dr Degroot says:

> Since I last saw her in June she has continued to derive good support through the Stuart Centre, where she has started doing some cognitive and remedial work, which she appears to be enjoying …

[100] Ms Armstrong then went through Dr Lehany's report. As well as the head injuries in 1992 and 1993, Dr Lehany notes further head injuries in August and September 1997. A further injury is noted by Dr Lehany as having occurred in 2012, when she had fallen and hit her head with brief loss of consciousness. She notes Dr Lehany's comment at page 10 of his report:

> An ACC panel review was undertaken in 2017. The review notes Dr Newburn had seen [the appellant] over 24 years following the initial accident in 1992. The panel expresses strong opinions. Despite the panel not having assessed [the appellant], it writes with very strong categoric statements about diagnosis expressed with a degree of certainty. It opines:
>
> > [the appellant's} appropriate primary diagnosis is unquestionably borderline personality disorder. Contributing factors are narcissistic traits and somatic symptom disorder. …

[101] At page 11 of his report, Dr Lehany notes that the panel is strongly critical of Dr Newburn "in a markedly combative tone". She notes that Dr Lehany acknowledges that this is a complex case, with no single or clear answer or formulation and that many professional opinions by qualified individuals are at odds with each other in significant ways.

[102] She acknowledges that at page 24 of his report, Dr Lehany stated:

> In short, the borderline function displayed by [the appellant] worsened, and in turn the borderline functioning and sickness behaviours lead to further dysfunction, worsening the presentation of borderline personality disorder which has since persisted.

[103] Ms Armstrong acknowledges that psychotherapeutic approaches such as dialectical behavioural therapy would have added considerably to possible positive outcomes. However, the ongoing therapeutic relationship with Dr Newburn is not without value and Dr Lehany also notes that the evidence for dialectical behavioural therapy as a successful treatment approach is variable and outcomes are uncertain. Dr Lehany does not agree that dialectical behavioural therapy should be the exclusive treatment offered to the appellant, as it is possible that the ongoing therapeutic relationship with Dr Newburn has been a factor in limiting harm from the appellant's mental health difficulties.

Appellant's Submissions

[104] Ahead of the hearing the appellant filed written submissions. In those submissions she says:

> Why I have remained with Dr Newburn for some 30 years, from the beginning of seeing Dr Newburn straight after brain injury, is I learnt from him at each appointment what had happened to me after my horse riding accident January 1992 and how it had affected my brain dysfunction with significant cognitive impairments, physical impairments such as balance, depth perception issues, vertigo and memory. Comprehension issues and an inability to process information or learn new information. A significant visual impairment. Visual processing. Dr Newburn, along with Josanne Smith, Neuro-Occupational Therapist in the 90's up to leaving Rotorua in 2003 did an amazing job, Dr Newburn was able to treat my functional disabilities that were causing mental difficulties. Depression and anxiety was huge and debilitating. It took a number of years for my medication regime to be stabilised by Dr Newburn. No other psychiatrist was able to do this. In particular, in 1993 with only a mental health psychiatrist with Community Mental Health in Rotorua, a Dr Fletcher, for a brief time as he returned to South Africa.

[105] The appellant's submissions covered the years since 1992 and her efforts to maintain employment and access assistance. She mentions going to the Brain Injury Society in Palmerston North to relearn skills and mix with others socially and that by 2005, she had improved and was able to sustain part time work. She records however,

there was a setback with a workplace trauma incident in 2009. She is critical of her treatment by her case manager in 2009/10, who she said:

> Arranged a barrage of assessments with other psychiatrists and psychologists and that the assessments were invasive and scary and caused severe anxiety to me.
>
> …
>
> As they kept digging and digging and the questions were offensive and I was informed on more than one occasion ACC wanted to tease out any mental conditions that (I) had before brain injury.

[106] She said:

> Without Dr Newburn's medical professional help in neuropsychiatry, I would be dead. Dr Newburn brought me back from the brink of wanting to end my life on more than one occasions because my impairments physically and mentally from brain injury were permanent and the reality of them would not go away, but burden me with disfunction on a daily basis.

[107] She also records that she had dialectical behavioural therapy with Juanita Heath in 2005/06/07 at Star Rehab in Palmerston North under specialist, Durian Degroot. She says:

> It was great and immensely helped me and gave me a further insight into managing my injury and the disabling effects of it that still left me struggling but in a better place.

[108] She said:

> I don't have BPD (borderline personality disorder). There is no evidence and I certainly had no difficulties prior to brain injury January 92 … ACC had fabricated evidence up and twisted the wording of their assessors, in particular the narrator of the medical panel review panel report June 2017 as noted and commented on by Dr Lehany.

Respondent's Submissions

[109] Mr Light asks the question: *Is the appellant getting treatment for a covered injury?* He reminds the court that we are now many years past the accident of 1992. He notes her borderline personality disorder diagnosis which he submits she had before the accident. Therefore that is the answer.

[110] He refers to paragraph 2 of Schedule 1 of the Accident Compensation Act and notes that subparagraph 2 requires the Corporation to take into account:

(a) the nature and severity of the injury;

(b) the generally accepted means of treatment for such an injury in New Zealand;

(c) the other options available in New Zealand for the treatment of such an injury; and

(d) the cost in New Zealand of the generally accepted means of treatment and of the other options, compared with the benefit that the claimant is likely to receive from the treatment.

[111] So, Mr Light submits, that costs are a factor to be considered in deciding the question of the Corporation's liability to pay for the cost of the claimant's treatment.

[112] He refers to the decision of Judge Beattie in *Gurney,*[3] where a professional athlete sought ACC funding for a shoulder surgery. Judge Beattie found that the respondent was correct to decline to approve the payment of costs for surgery, as such surgery could not be said to be necessary or appropriate, but merely more desirable from the appellant's personal perspective.

[113] Mr Light also refers to *GG,*[4] where Judge Spiller said:

> For GG to be entitled to treatment from Dr Newburn, she must establish on the balance of probabilities that her treatment is required in relation to a covered personal injury. GG must therefore establish that her treatment arises as a consequence of (is directly caused by) her covered personal injury by accident. GG must also establish on the balance of probabilities that her treatment is necessary and appropriate and of a quality required for that purpose. Whilst it is accepted as being GG's personal wish to have the treatment in question, there needs to be an objective assessment of necessity and appropriateness, cost and benefit.

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3 *Gurney v Accident Compensation Corporation* [2009] NZACC 179.

4 *GG v Accident Compensation Corporation* [2022] NZACC 132, at paragraph 81.

[114] Mr Light submits that the appellant does not meet the statutory criteria which he describes as quite a high threshold.

[115] He refers to a Rotorua Hospital mental health services record of 20 February 1995 documenting an admission to Rotorua Hospital by the appellant on 1 February 1995 which notes a diagnosis of:

> Organic brain disorder with anxiety secondary to life stresses and impaired coping ability; borderline personality disorder (pre-head injury); and head injury with frontal lobe signs.

[116] Mr Light places some emphasis on the notation in the record that the borderline personality disorder pre-dates the appellant's head injury.

[117] Mr Light refers to two reports from Dr Cheung dated 24 May 2010 and 21 July 2010, both of which refer to the presence of "personality disturbance" that suggested features of borderline personality traits that pre-date her head injury. He does note Dr Cheung saying in the second of the two reports:

> On the balance of probability, I believe some of [the appellant's] ongoing incapacity from her depressive and anxiety symptoms is caused directly from the reported head injuries. However, due to the chronicity of her symptoms and the interplay of other non-injury factors (including her pre-morbid personality style and somatisation) it is difficult to determine the proportion of her depressive and anxiety symptoms which is caused directly from the reported head injuries.

[118] Mr Light refers to a progress note from Consultant Psychiatrist, Dr Greenblatt, of 26 July 2007. Dr Greenblatt says:

> I think it very unlikely that there will be further progress in respect of her head injury after all these years following the head injuries.

[119] Dr Greenblatt also notes borderline personality disorder as a working diagnosis.

[120] Mr Light refers to the multi-disciplinary panel report of 7 June 2017 which says:

> [the appellant's] appropriate primary diagnosis is unquestionably borderline personality disorder. Contributing factors are narcissistic traits and somatic symptom disorder (an update of the previously noted somatisation disorder).

[121] He also notes that the clinical advisory panel says:

> Both the diagnosis of borderline personality disorder and somatic symptom disorder clearly pre-date the index events of 1992, much less the subsequent reported head injuries.

[122] The panel goes on to say:

> The other contributing factor to the causality of her continued distress and impairment is that the ongoing care of Dr Newburn has been misguided and harmful. His care propagated a brain injury hypothesis against all evidence and ignoring the collective assessments of many other experienced and qualified clinicians.

[123] The panel also said:

> The waxing and waning course of symptoms is not consistent with a diagnosis of TBI and the profound high and low functionality does not appear to have any temporal association with the myriad of minor head injuries she has sustained.

[124] The panel notes that:

> The evidence based therapy for borderline personality disorder is dialectal behavioural therapy. This is a therapy that would offer [the appellant] enormous benefit through the modules of mindfulness, distress tolerance, and interpersonal skills amongst others, but she would have to engage willingly. With her somatic focus and the enmeshment with Dr Newburn, it is very unlikely this will happen.

[125] Mr Light submits that she has not had this therapy during her time with Mid-Central Health.

[126] Mr Light notes Dr Newburn's response of 22 March 2018, in which he says:

> It remains my view that [the appellant] presents with the consequences of recurrent mild traumatic brain injury, although clearly the consequences are more than mild. She has chronic health problems and this must be treated as a chronic health condition as would be recommended by the Lancet Neurology Commission … she requires ongoing assistance in maintaining her stable living environment with pragmatic approaches to this.

[127] Mr Light then notes panel member, Dr Kennedi's response, saying that:

> Dr Newburn … doesn't address why 19 years of treatment using his set of assumptions has resulted in deterioration in function and worsening of disability for [the appellant] …

[128] Mr Light notes that Dr Lehany accepts that the appellant has a pre-existing underlying borderline personality disorder. He also acknowledges that dialectical behavioural therapy will not always work.

[129] Mr Light refers to the Court of Appeal decision in *Hornby*,[5] which confirmed that cover cannot be granted for an exacerbation of an underlying and pre-existing mental condition.

Reply by Amicus

[130] Ms Armstrong notes that the index head injury occurred in 1992 and following that the appellant suffered several more head injuries, all of which were covered by ACC up to and including 2016. She submits that any pre-injury (backdated) diagnosis of a personality disorder was at most a mild personality disorder, but after her head injuries she had a moderate personality disorder, therefore her condition deteriorated post-injury.

[131] She refers again to Dr Fletcher's report of 20 February 1995 where he says:

> In summary, [the appellant] is considered as a woman who received a head injury which has impaired her ability to process cognitively, especially with too many things happening at the same time.

[132] Ms Armstrong also notes that Dr Cheung, in 2010, did not have the GP notes and they do not suggest an underlying borderline personality disorder.

Decision

[133] The appellant appeals against the decision of the Corporation dated 17 April 2018 which declined to meet the appellant's costs in attending appointments with Dr Gil Newburn, as well as travel reimbursement for mileage to attend the appointments. In its decision, the Corporation considered that the treatment being offered by Dr Newburn was not necessary or appropriate and was not the generally accepted means of treatment for the appellant's covered injuries.

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5 *Hornby v Accident Compensation Corporation* [2009] NZCA 576.

[134] As the background section of this judgment sets out, the appellant suffered a head injury when she fell from a horse on 21 January 1992. The injury diagnosis at the time was of post-concussion syndrome. The appellant also has cover for later injuries to her head, two of which, in July 2003 and March 2012, included concussion.

[135] Dr Newburn first saw the appellant on 14 May 1992 and reported on 17 May 1992. Dr Newburn, in that report, said that five weeks after her first accident, she suffered a further injury when she was kicked in the head by a horse. No separate claim was made for that injury.

[136] The GP's notes in respect of the 21 January 1992 accident are as follows:

> Fall from horse – thrown over front, landed on back – blacked out briefly – sweats – sore neck front and back – neck hyper extended.

[137] She saw her GP numerous times during the remainder of 1992. Her GP notes include reference to post-concussion and intermittent generalised headaches.

[138] Her GP noted on 1 February 1992:

> Generalised headaches intermittent – still spaced out – that she had problem with short term memory, that she was making silly mistakes.

[139] The doctor also notes that she was still working.

[140] On 7 February 1992, her doctor noted:

> More worried – forgetful/confused – still aches in neck, shoulders, forehead.

[141] On 13 February 1992, her doctor again notes post-concussion.

[142] On 6 March 1992, her GP noted "by lunch time is spaced out". The doctor also noted she was "still fragile, her memory impaired", but he also notes "headaches much better".

[143] On 21 April 1992, the doctor notes:

> Not well again – OK if no pressure, can't tolerate children/working/pressure. Vertigo is mentioned.

[144] On 22 July 1992, the doctor notes she is "headachy, shakey."

[145] On 30 September 1992, the results of a CT scan are referred to in the doctor's notes and a note is also made that initially after the injury there was visual distortion but that had now improved.

[146] She had a further accident on 12 January 1993. The GP note of 13 January 1993 is:

> Head injury. Fell off slide, hurt back of head and neck. No LOC – dizzy, especially on moving since. She was diagnosed with concussion and neck strain.

[147] Also included in the bundle of documents are the appellant's GP records going back to October 1987, that is to say some four years prior to the accident of 21 January 1992. These notes indicate that the appellant saw her GP as required for health issues that arose. In 1989, she was treated for rosacea which appeared to be related to stresses of money lost in a business venture and the end of her marriage. Mention is made of "strong family history of erratic personality and that one sister has drug dependency and her mother is alcoholic". Following this, the doctor notes:

> Think about direction of referral – will contact.

[148] The next entry dated 23 July 1989 relates to a low cervical spine issue after shifting furniture.

[149] There is an entry on 15 October 1990 noting "new back injury 6/10/90 pulling horsefloat around".

[150] In November 1990 she reports mid cycle pelvic pain

[151] On 3 January 1991, there is an entry relating to being "trampled on by a horse" and being treated for an ankle injury at the hospital. On the same date she reports to the GP that life is actually much better and her back is much better.

[152] The entry on 15 January 1991 is that the ankle is not settling.

[153] On 15 February 1991, so far as it is decipherable, is the following notation:

> Messages of a million problems …. abdo pain. Just had … (indecipherable)
>
> Headaches … (indecipherable) … back cant sleep nor will she really talk to me about it. Wound up +++++ requesting Valium …

[154] She next saw her GP on 29 April 1991 regarding her ankle and her back.

[155] In July 1991, there is an entry following a fall from a chair.

[156] On 5 August 1991, there is an entry relating to a fall from a horse on 2 August 1991.

[157] In addition to the above, there are the entries that one would expect to see in a GP's records where following a health related need, a person consults her GP.

[158] The purpose in the above partial summary of GP consultations in the four years prior to the subject accident, has been to identify whether there are GP records over those four years that would support a conclusion of borderline personality disorder having pre-dated her 1992 accident.

[159] Apart, possibly, from the single entry on 15 February 1991, I have been unable to find such support in these four years of GP's notes.

[160] There is the suggestion of a somewhat dysfunctional family. Accordingly, I would be concerned if, as appears to be the case, the primary diagnostic indicator of pre-existing borderline personality disorder was a report to Dr Fletcher from the appellant's sister.

[161] The collateral history obtained by Dr Fletcher on 1 February 1995 from the appellant's sister is as follows:

- From a disfunctional family, middle sister married and it helps. Other sister severe (?? writing difficult to read)/medication 18 years.

- Always been anxious/easily angered or agitated, guilty, poor self-esteem/ self worthless.
- Became worse after accident.
- Can't cope with any exams. Had to take med (medication) to write exams.
- Difficulty being alone always.
- Always labile mood.
- History of hitting herself with hammer after head injury.
- Scratch and bruise herself.

[162] I do note that although the appellant's GP records right through to 1997 are in the bundle of documents before the Court, there appeared to be no GP record supporting the "history of hitting herself with a hammer after head injury" as described by the appellant's older sister.

[163] What we do have included in the bundle of documents are a series of positive references in respect of the appellant from the time she left school in 1973. There are seven of these references, the last dated 20 November 1984. They are all glowing and it is noteworthy that the last of the references from Alawi Enterprises notes:

> Her integrity, honesty and capability to cope under extreme pressure makes her departure a great loss to myself. Accordingly, I most strongly recommend her to any future employer.

[164] That particular company was owned by the Deputy Prime Minister of the Sultanate of Oman and her role was that of Personal Secretary, a role she fulfilled for two years.

[165] As it appears to be the case that the diagnosis of pre-existing borderline personality disorder seems to rely on incomplete reported comments of the appellant's sister, I am driven to conclude after weighing the evidence on this particular issue, that pre-existing borderline personality disorder, is not established and indeed the reported comments of the appellant's sister on which such diagnosis appears to be based, are substantially contra-indicated by the extraordinarily positive employment references that the appellant has provided.

[166] The GP notes of the day of 15 February 1991 excepted, my conclusion is also supported by the unremarkable nature of the GP notes for the four years prior to the index accident, except that the appellant does appear to be somewhat accident prone. This latter trait of the appellant continued with two further accidents in 1998, a fall from a horse on 16 August 1998 and "hit on the head by horse" on 2 September 1998.

[167] It is noted that in a report to the appellant's GP of 17 May 1992, Dr Newburn said:

> She is also going to need significant assistance with cognitive retraining, and I imagine there will be a need to continue treatment for some considerable period of time. I have arranged to see her again in the near future.

[168] On 21 June 1992, Dr Newburn reported that the appellant fatigues easily, which exacerbates all of her other symptoms and that she cannot work full time. Assistance with rehabilitation was requested.

[169] Occupational Therapist, Joanne Smith, became involved. On 16 October 1992, Ms Smith noted "fluctuating in progress and symptoms". On 6 November 1992, Ms Smith reported that the appellant cannot manage rehabilitation, daily activities and parenting without home help and childcare.

[170] Regrettably, on 13 January 1993, the appellant slipped on a water slide onto her back and the back of her head and her GP noted symptoms of concussion.

[171] On 8 March 1993, Dr Newburn produced a report for ACC noting 18 problems affecting the appellant. He noted she was significantly impaired and he diagnosed features of an organic affective disorder. His view was that the appellant warranted full compensation under s 79 of the Accident Compensation Act then in force.

[172] What the narrative thus far establishes is that after the 21 January 1992 accident, the appellant was a different person from the one she was prior to it. I conclude on the balance of probabilities that that accident caused a brain injury to the appellant that was significant.

[173] Furthermore, I conclude that the evidence prior to that accident does not support the diagnosis recorded by Dr Fletcher on 20 February 1995 of pre-head injury borderline personality disorder. In fairness to Dr Fletcher, he does, in the same document, diagnose organic brain disorder with anxiety secondary to life stressors and impaired coping ability, as well as head injury with front lobe signs.

[174] In his report of 20 February 1995, Dr Fletcher also notes:

> In summary, [the appellant] is considered as a woman who received a head injury which has impaired her ability to process cognitively, especially with too many things happening at the same time.

[175] On 15 October 1998, Dr Newburn reported to ACC's case manager that unfortunately the appellant had sustained two further minor brain injuries.

> She had a fall on 16 August from a horse, and she was hit in the head by a horse on 2 September.

[176] On 10 October 1999, Clinical Neuropsychologist, Ms Kersel, reported to ACC following a neuropsychological assessment. Under the heading "Conclusions" she said:

> [The appellant] presents as a very complex case. The anxiety that [the appellant] presents is so extreme that it is difficult to determine the degree of cognitive impairment that she may or may not experience. While it is not uncommon for people to become anxious following a head injury, the severe degree of anxiety that [the appellant] presents with is uncommon.

[177] Ms Kersel concluded:

> Her rehabilitation needs to firmly encourage and support her in becoming more independent in her daily functioning.

[178] Dr John Collier carried out an independence allowance assessment report on 29 June 2000. He said:

> She has a significant disability as a result of her head injury and this should be included in her whole person impairment for the independent allowance.

[179] Between 2000 and 2017, when the multi-disciplinary panel reported, the appellant had irregular contact with Dr Newburn, the bundle shows that during this

time there were updating reports to ACC and other health professionals. The involvement of Dr Newburn appears to have been quite limited. One reason appears to have been that the appellant shifted to Whanganui for a time and also to Palmerston North. During 2016, there appears to have been no involvement at all with Dr Newburn.

[180] As to psychotherapeutic inputs, it is noted that in a report of 30 August 2002, Dr Newburn recorded:

> Of equal importance is the work done with psychotherapeutic strategies.

[181] The appellant's file indicates that over the years she engaged in psychotherapeutic strategies, however her involvement with these strategies appears to have been at least in part dependent on the availability of the therapy where the appellant was at the time located.

[182] Understandably, the Corporation wished to progress matters with the appellant and indeed follow through with what s 3(c) of the Act requires, namely that its primary focus should be on rehabilitation with the goal of achieving an appropriate quality of life through the provision of entitlements that restores to the maximum practicable extent a claimant's health, independence and participation.

[183] On 5 February 2010, therefore, Dr Cheung completed a detailed psychiatric assessment report and treatment plan, which unsurprisingly provided for pharmacotherapy and psychological treatment.

[184] It is noted that in respect of the proposed treatment plan, Dr Cheung said:

> Due to the pre-existing diagnosis of somatisation disorder, I leave it to ACC to decide whether [the appellant's] treatment should be funded by ACC or the public mental health services.

[185] Again, Dr Cheung's conclusions about a pre-existing somatisation disorder are linked back to the Dr John Fletcher report of 1995, based on information obtained from the appellant's older sister.

[186] Dr Newburn continued to have occasional involvement through to 2017 when the external medical multi-disciplinary panel carried out its case review.

[187] In response to the question "What are the diagnoses of the appellant's current symptoms and disability?" the panel said:

> [The appellant]'s appropriate primary diagnosis is unquestionably borderline personality disorder. Contributing factors are narcissistic traits and somatic symptom disorder (an update of the previously noted somatisation disorder).
>
> The panel notes that Dr Newburn was of the view that her pre-morbid functionality was intact and therefore she cannot meet the criteria of a personality disorder.

[188] In support of its position, the panel referred once again to Dr Fletcher's diagnosis of borderline personality disorder based on "collateral information".

[189] To further bolster its conclusion, the panel said:

> Dr Antoniadis, an occupational physician, who did a very comprehensive 19 day assessment, also noted an occupational history of ten jobs across multiple occupations over 12 years, a bankruptcy of her business, and a tumultuous relationship involving the father of her two children (for which there is little information other than the fact that he abandoned them around the time of the index accident and her initial deterioration).

[190] When the panel referred to her occupational history of ten jobs across multiple occupations over 12 years, it necessarily means that the panel is referring to the period of the appellant's life prior to her accident in 1992. This statement in the panel's review is quite inaccurate. Dr Antoniadis' report in fact records all of the appellant's occupational history from the time she left school in 1975 until the accident (and in fact beyond). Between her leaving school in 1975 and her first accident date of 21 January 1992 (a total of 17 years, not 12 years) she worked for ten employers. Six of those roles involved secretarial work and the first roles she worked at after leaving school involved receptionist and shorthand typing work. During that time, between 1982 and 1984, while in her mid-20's, she worked in London and Oman.

[191] The panel's review also says this:

> Also contributing to the consistent pre-morbid picture are her GP notes which Dr Cheung details in his 16 October 2009 report and which describe chaos,

> stress, dependence and somatic symptoms across multiple years prior to the 1992 events.

[192] I disagree with the review's characterisation of the appellant's pre-morbid GP notes, and I have referred to these earlier in my judgment. They do not on any fair basis at all "describe chaos, stress, dependence and somatic symptoms across multiple years prior to the 1992 events".

[193] On the joint instruction of Ms Armstrong as Amicus Curiae, and counsel for ACC, the opinion and recommendations were sought of consultant forensic psychiatrist Dr Lehany. Dr Lehany reported on 19 October 2022 and as already mentioned earlier, Dr Lehany recognised that this was a complex case with no single or clear answer or formulation, and many professional opinions by qualified individuals which are at odds with each other in significant ways.

[194] Of the opinions expressed by the review panel, Dr Lehany said it was in his experience "unusual in its confidence in its own conclusion and dismissal of Dr Newburn's opinions to the point I find surprising". I agree.

[195] As Dr Lehany said:

> That [the appellant's] functioning was markedly worse following the injury in 1992 is a matter of record and warrants consideration. It does appear that [the appellant] now presents in reasonably clear borderline manner of functioning, it is plausible however, that at least some of this functioning has developed out of her experience of the sequelae of injuries.

[196] Dr Lehany also notes that in terms of psychiatric review, the frequency of the appellant's appointments was appropriate.

[197] My analysis of all of the evidence before the Court in this case is that, as Dr Lehany says, when commenting on whether the treatment provided by Dr Newburn was cost effective:

> It is feasible that the stable and consistent therapeutic relationship with Dr Newburn has provided containment for [the appellant] and that overall without it she may have utilised inpatient facilities and engaged in self-harming behaviour to a greater extent over the years, which may well have been more expensive.

[198] In saying that, Dr Lehany fairly states that as the review panel in 2017 suggested, Dr Newburn may have unintentionally fostered a dependant relationship with the appellant which has prevented alternative treatment strategies from being accepted by her and deprived her of alternative approaches that may have been beneficial. If that has occurred it was not intentional and at least in part, it is an acknowledgement of the fact that for those presenting, as the appellant has, following her injuries, there are limited choices in this country to obtain optimum diagnoses as well as optimum treatment, especially where, as in the appellant's case, her recovery trajectory has been interrupted on several occasions with further head injuries.

[199] It follows, given the circumstances of this case, I find that the decision of ACC dated 17 April 2018 declining the costs of treatment by Dr Newburn and associated travel reimbursement was wrong.

[200] I find that the criteria set out in paragraph 2 of Part 1 of Schedule 1 of the Accident Compensation Act 2001 was met and that within his area of professional expertise, Dr Newburn was providing treatment for the purpose of restoring the claimant's health the maximum extent practicable and that the treatment was necessary and appropriate and of the quality required for that purpose.

[201] That is not to say that the treatment provided was what might be described as the optimum available in 2018. Plainly, for a person with the background of head injuries that the appellant had, optimum treatment would have included not only appropriate medication, but dialectical behavioural therapy.

[202] As Dr Lehany said:

> A useful approach might be for Dr Newburn to periodically review [the appellant] to provide stability and continuity, but that [the appellant] is encouraged to also pursue additional and alternative treatment approaches such as dialectical behaviour therapy, with the aim of improving longer-term functioning.

[203] In all of the circumstances of this case, with all its unusual features, little assistance is to be had from reference to other decided cases mentioned by counsel.

[204] I find on the balance of probabilities that the appellant's need for treatment arises from her head injury of 21 January 1992 and the subsequent head injuries she suffered.

[205] I also find that her borderline personality disorder was caused by these head injuries, or to follow the wording of s 26 (1)(c) she suffered this mental injury because of her physical injuries, and the sequelae of these injuries has not ended.

[206] Also, as mentioned, the number of head injuries that the appellant suffered has indeed been unusual, and so for this reason I conclude that her case is an outlier when compared to other cases with mild head injuries where the expectation is of full recovery within weeks or months.

[207] Accordingly, her appeal is allowed and ACC's decision of 17 April 2018 declining to pay the costs of her appointments with Dr Newburn, as well as her travel reimbursement to attend such appointment is reversed.

[208] Costs are reserved.

[209] Before concluding, I would like to record my grateful thanks to both counsel, Ms Armstrong and Mr Light, for the way in which they have cooperatively worked to bring this long outstanding and complex appeal to a conclusion. That has included the identification and collation of the relevant documents going back over 20 years, which now amount to over 800 pages. I am deeply in their debt.

Suppression

[210] 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 *KI v Accident Compensation Corporation*.

CJ McGuire
District Court Judge

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