IN THE DISTRICT COURT
AT WELLINGTON

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

[2023] NZACC 103 ACR 206/21

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

Hearing: 20 June 2023
Held at: Hamilton/Kirikiriroa

Appearances: A Carlyle for the Appellant
J Sumner for the Accident Compensation Corporation ("the Corporation")

Judgment: 28 June 2023

RESERVED JUDGMENT OF JUDGE P R SPILLER
[Claim for mental injury caused by physical injury - s 26(1)(c), Accident Compensation Act 2001 ("the Act")]

Introduction

[1] This is an appeal from the decision of a Reviewer dated 4 August 2021. The Reviewer dismissed an application for review of the Corporation's decisions dated 14 January 2020 declining Ms Thomas cover for Somatic Symptom Disorder, and suspending her entitlements, including weekly compensation, on the basis that her current condition was no longer caused by covered injuries sustained in an accident on 21 January 2013.

Background

[2] Ms Thomas was born in 1985. Her career involved work as an optometrist assistant.

[3] On 21 January 2013, Ms Thomas was involved in a car accident in which her vehicle was rear-ended by another whilst waiting at traffic lights. Ms Thomas was wearing a seatbelt and reportedly hit her head on the steering wheel and bounced back and hit the head rest. Ms Thomas did not lose consciousness during the incident.

[4] Later, on 21 January 2013, Ms Thomas was seen at Accident Healthcare. She reported pain in the left shoulder blade area, stiffness in the shoulder, some numbness in the fingers, pain/stiffness in the neck and feeling sleepy. Her arm was placed in a sling, and she was discharged. Dr Murray Hay, GP, lodged a claim for concussion and whiplash injury.

[5] On 22 January 2013, the Corporation accepted claim for cover for head injury (concussion) whiplash and sprain of the shoulder and upper arm. Ms Thomas was initially referred to the Corporation's Concussion Service for treatment. In due course she received weekly compensation.

[6] On 23 January 2013, an x-ray was done of Ms Thomas' cervical spine and left shoulder by Dr B Chisholm, Radiologist. No acute bone damage or joint injury was seen.

[7] On 19 June 2013, Ms Thomas' GP notes recorded:

> Recent string of illness: gastro and cold and now unwell again. Still has a bit of a cough from her previous illness.
>
> Wants cough checked out but primary reason for appt is dizziness and light-headedness. Had a concussion earlier this year in February feels has been setback. Car was nearly written off, was treated for whiplash. Had 3 weeks off work.
>
> Discussed concussion earlier this year has probably affected her ability to recover from setbacks recently.

> Feels constantly dizzy - right through Fri/Sat/Sun, felt OK yesterday morning but worse after her walk. Is a light-headedness, worse on head movement, very much like she felt just after her concussion. Not nauseous but feels a bit seasick at times. Has on and off nausea prior to this.
>
> Last decent holiday was 10 months ago.
>
> Has just finished studies for the year and had no break.
>
> Chest clear.
>
> A: multiple contributing factors
>
> ?slow gastric emptying
>
> recurrence of concussion symptoms
>
> P: rest, aim to have a holiday
>
> Try domperidone
>
> Shown brain injury assoc advice
>
> Rx: 3 – Cholecalciferol 1.25 mg Tab (50,000 IU) – one monthly
>
> Rx: 100 – Domperidone 10 mg Tab – 10 mg 3 – 4 times daily, half an

[8] On 31 July 2013, Ms Thomas was discharged from the Concussion Services with a recommendation for further treatment. Ms Hollie Mawson, Occupational Therapist, made the following recommendation:

> Leasa has a range of symptoms persisting past the average mild TBI recovery timeframes, and which appear to be getting worse. A full Neuropsychological assessment will help establish what could be brain damage. ...

[9] Ms Mawson also recommended a neurological review to rule out other pathology.

[10] On 16 September 2013, Ms Thomas was seen by Ms Karen Mitcheson, Neuropsychologist. Ms Mitcheson conducted formal cognitive testing, noting that no cognitive impairment was found, with Ms Thomas' test scores broadly consistent with premorbid estimates. Ms Mitcheson reached the following conclusions:

> The information provided is not clearly consistent with post-concussional sequelae to the index accident. I note here that: Ms Thomas did not sustain a loss of consciousness, retrograde amnesia or PTA; the difficulties she reports are non-specific and could equally be attributable to other factors such as pain or depression; and the course of her difficulties is not consistent with what would normally be expected following a concussion.
>
> I note that Ms Thomas has a premorbid vulnerability to depression and I think the most likely explanation is that Ms Thomas's physical injury (whiplash/pain

> etc) has triggered a depressive episode. That is, I think that the physical injury has triggered a mental injury.

[11] As far as further treatment was concerned, Ms Mitcheson suggested input from a Clinical Psychologist, along with discussing the possibility of alternative antidepressant medication with her GP.

[12] On 20 December 2013, Ms Thomas saw Dr Gil Newburn, Neuropsychiatrist, from a referral from her GP. Dr Newburn stated that a detailed cognitive assessment was not carried out, but Ms Thomas showed "significant slowness in functions when attentional processes were stressed". Dr Newburn stated that Ms Thomas presented with a "mild neurocognitive impairment secondary to brain injury".

[13] On 28 January 2014, Ms Thomas was assessed by Dr Andrew Chancellor, Neurologist. Dr Chancellor noted the temporal profile to her illness, which she had referred to as a "relapse". Dr Chancellor advised:

> The temporal profile of this type injury is, in most but not all circumstances, rapidly towards recovery - in Leasa's case there was a deterioration, rather than improvement in the mid 2013, with a fatigue syndrome. It is the fatigue and associated daytime sleepiness that are of concern to her. This is associated with some mild emotionality and possibly mild depression, but this is not, of itself, holding her back in life.
>
> Leasa's symptoms are of a non-specific nature, there is a significant prevalence of such symptoms to various degrees in the population at large and the factors which perpetuate, promote or sustain illness in individuals after accidents in some but not most individuals are poorly understood. …
>
> I said to Leasa and her mother that in my view her major current limitations – i.e the fatigue syndrome and sleepiness, were not explained by the index accident. Post hoc ergo propter hoc (after this therefore because of this) should not apply…

[14] Dr Chancellor arranged an MRI scan of Ms Thomas' brain, but noted that he expected it to be normal. Dr Chancellor also recommended a graded exercise regimen, and that Ms Thomas complete an Epworth sleep score and present this to her GP.

[15] On 18 February 2014, Dr Chancellor produced a supplementary report, responding to questions raised by the Corporation. He reported that he could not identify any pathology other than described symptoms; Ms Thomas' symptoms were

entirely subjective with no correlation to physical examination; and Ms Thomas was not incapacitated for work by the whiplash injury.

[16] On 10 February 2014, Ms Thomas had an MRI carried out by Dr Guy Mason. The results showed no acute intra-cranial abnormality.

[17] On 10 April 2014, Ms Thomas underwent a psychiatric assessment with Dr John Vickers, Psychiatrist, at the request of the Corporation. Dr Vickers noted the initial opinion of Ms Mitcheson but did not consider Ms Thomas to have any DSM IV personality disorders, including depression, or to be in need of any psychiatric treatment. Dr Vickers agreed with Dr Chancellor that there was likely a non-accident-related reason for Ms Thomas' fatigue problems, and there was no psychiatric illness or disorder present.

[18] On 5 May 2014, Ms Erin Eggleston, Clinical Psychologist, recommended that the Corporation seek clarification from Dr Newburn on the present status of clinically significant symptoms that made up the Mild Neurocognitive Disorder, and whether he agreed with Dr Vickers that there was no present clinically significant depression.

[19] On 28 May 2014, Dr Newburn provided a report at the request of the Corporation. Dr Newburn confirmed his earlier diagnosis, of mild neurocognitive impairment secondary to traumatic brain injury (DSM V). Dr Newburn agreed with Dr Vickers that Ms Thomas did not meet the criteria for major depressive episode. Regarding diagnosis, Dr Newburn stated there was clear alteration in function based upon Ms Thomas' history, with slow information processing and disturbance in complex attentional function.

[20] On 4 February 2015, the Corporation approved cover for Ms Thomas' head injury, added to cover for concussion and whiplash.

[21] On 13 February 2015, the Corporation approved cover for sprain of left shoulder and upper arm.

[22] On 24 March 2015, Ms Thomas was referred to Dr Roderick Douglas, Occupational Medicine Specialist, in the context of an initial Vocational Independence Medical Assessment. Dr Douglas noted that Ms Thomas was still experiencing symptoms of fatigue. Dr Douglas advised:

> At most her brain injury was mild and 2 years on from the injury I would not expect there to be any persisting effects. The initial improvement in symptoms and return to normal activity followed by worsening of symptoms four months later also suggest a non-injury related cause for her current symptoms. Her ongoing fatigue and other symptoms are not likely to be injury related and are most likely secondary to factors. Her mother's very supportive nature is probably enabling the condition. ...
>
> There are no cognitive or physical barriers to return to work. The main ongoing problem is fatigue. This has improved recently, but Leasa still finds it limited. I suspect she is more capable that [sic] she realises. She has not worked for some time, so it is difficult to know what her tolerance limits would be. I would suggest a work trail [sic] with graduated increases in hours as an ideal way to help transition her back to regular working hours and help establish her tolerance for full time work.

[23] On 28 May 2015, Dr Douglas provided a follow-up report with clarifications. In his opinion, the injury had fully resolved and there were no specific functional limitations. Ms Thomas was able to undertake all aspects of pre-injury role safety, and could perform all tasks required of the role. No further investigations or specific treatments were required, and she should be encouraged to return to normal activities gradually.

[24] On 11 August 2015, the Corporation declined cover for mental injury due to lack of evidence that Ms Thomas developed a clinically significant mental condition as a result of a covered physical injury.

[25] On 12 October 2015, Ms Jacqui Clark, Physiotherapist, reported that Ms Thomas had a mix of headache symptoms, some neck specific and some "similar" to classic concussion signs. Ms Thomas had fatigue-aggravated headaches, not typical in concussion; however, these might be central pain headaches provoked by concentration and fatigue, associated with concussion. She scored 48 on central sensitisation inventory. Ms Thomas's headaches became minimal but had deteriorated in the last 2-3 months since becoming sick with infection.

[26] On 24 November 2015, Dr Newburn provided an addendum to his report of 28 May 2014. Dr Newburn stated that Ms Thomas presented with symptoms matching "modern literature" of mild traumatic brain injury (TBI) with less than mild consequences, "and then has had an exacerbation with an infective process … reflecting issues around an abnormal immune reaction…". Further, Dr Newburn critiqued Dr Douglas's opinion that Ms Thomas's injuries had "fully resolved" in spite of enduring symptoms.

[27] On 19 May 2016, Dr Douglas confirmed that he remained of the opinion that Ms Thomas had the medical capacity to work in a number of roles, including her preinjury role as optometrist assistant.

[28] On 23 August 2016, Ms Thomas was seen by Dr Geraldine Hancock, Clinical Psychologist, for psychological assessment of chronic fatigue related to the accident on 21 January 2013. Dr Hancock noted that Ms Thomas reported with ongoing severe impairment from fatigue and poor concentration which impacted her cognitive, social, vocation and personal activities. Dr Hancock recommended 10 weekly sessions for treatment of fatigue and cognitive management.

[29] On 4 July 2017, Dr Hancock provided a completion report. The report noted Ms Thomas had made some good process in managing anxiety and indicated reduced interference of fatigue on enjoyment of life, however, that fatigue remained an ongoing issue. Dr Hancock noted that Ms Thomas was motivated to continue to address underlying psychological issues. Dr Hancock stated:

> Leasa evidenced some good progress in her understanding of anxiety. She understands the rationale for graded exposure to avoided stimuli and has made good progress; driving frequently and for longer periods. She has progressed to driving herself to therapy appointments. She was also communicating directly with ACC related personal regarding her case, rather than through her mother as previously. Leasa has also engaged a local community event which she planned for and enjoyed. Lastly, Leasa has committed to taking a trip to Japan to visit a friend. She plans to travel independently and was apprehensive yet excited about her trip. She was crying less frequently and was feeling increased self-esteem making plans on her return. She notes some episodes of feeling panicked or distressed most weeks, although these episodes are becoming shorter in duration. These episodes are usually in response to Leasa wanting things to be 'perfect' or feeling angry in response to others implying that she 'should' be doing better. Leasa has become better able to recognise her feelings of guilt and shame in response to her perception of others view of her. She is

> better able to call to mind her long-term goals and direct her behaviour in that direction. At the conclusion of sessions Leasa's symptoms of depression on the BDI-11 fall within the 'minimal' range (1/63). Her symptoms of anxiety fall within the 'mild' range (15/63). She also completed the Brief Fatigue Inventory indicating reduced interference from fatigue on her enjoyment of life, mood and physical activity. However, fatigue was still present in her 'work' outside the home and general activity.

[30] On 27 October 2017, the Corporation sought advice on whether Ms Thomas' request for acupuncture was clinically appropriate. The BMA's opinion/ recommendation was:

> the client has received an extensive and prolonged course of acupuncture treatment, with little objective evidence of sustained symptomatic or functional improvement to date. As such, it would seem further acupuncture treatments are neither necessary nor appropriate at this stage.

[31] The BMA also noted that there was evidence on file indicating non accident-related factors might be contributing to the ongoing symptoms.

[32] On 15 November 2017, Ms Penny Louw, Psychology Advisor, reported:

> The course and progression of symptoms is not consistent with mild traumatic brain injury. Formal neuropsychological and psychiatric assessment has established that there are no ongoing cognitive or psychological effects from the injury.
>
> The majority of medical, psychiatric and psychological assessors have not found a plausible link between the injury and persisting symptoms, and have postulated that noninjury factors are the cause of ongoing disability.
>
> Given that there is one provider, Dr Gil Newburn, who has provided a contrary opinion, and to address Ms Thomas's ongoing assertion that her fatigue and other concerns are injury-related, I support referral for an MCR [Medical Case Review] to provide a final opinion on causation prior to making a decision regarding ongoing entitlements.

[33] On 18 December 2017, Dr Newburn advised that the Corporation's process did not address brain issues, did not review real world application of function, did not take account of Ms Thomas' significant pain, and was inaccurate.

[34] On 22 February 2018, Ms Susan Shaw, Neuropsychologist, completed a neuropsychological assessment report on referral from the Corporation. Ms Shaw reported that Ms Thomas had developed Somatic Symptom Disorder (SSD) with predominant pain and fatigue following the mild concussion injury in 2013.

Ms Shaw did not agree with Dr Newburn that Ms Thomas suggested TBI in the index accident of sufficient severity to produce incapacitating and enduring cognitive impairment. Ms Thomas had a predisposition prior to injury to poor outcome post injury due to pre-existing mental health issues including depression and social anxiety. Ms Shaw advised:

> My opinion at this stage is that Leasa has some real difficulties, which developed following an accident and concussion, and which have impacted upon her ability to move forward with her life. It seems that prior to her injury she was an individual who was vulnerable to a poor outcome post injury due to pre existing mental health issues including depression in teenaged years, self-esteem issues, relationship issues and perhaps also a degree of social anxiety. She appears to have adopted a 'boom/bust' approach to life, and suffering a concussion led to psychological decompensation."

[35] On 26 February 2018, Ms Louw advised the Corporation that consideration needed to be given to whether the SSD might be considered mental injury due to physical injury which had not been previously considered for cover.

[36] On 6 March 2018, Ms Thomas was seen by Dr Peter Wright, Neurologist, in the context of a Medical Case Review. Dr Wright canvassed the specialist reports produced for Ms Thomas. Dr Wright stated that "at most" she could have suffered a mild TBI at the accident. Dr Wright stated that her current symptoms were nonspecific, and there was no strong reason to argue that they were directly caused by the accident. Dr Wright stated that the symptoms linked to mild TBI dramatically settled, and residual symptoms were associated with changes to Ms Thomas' lifestyle and work commitments. Dr Wright found no neurologic diagnosis relating to ongoing nonspecific symptoms. He did not agree with Dr Newburn that there was enough evidence to show any link to initial mild TBI. Dr Wright found no evidence to support a causal link between the accident and current symptoms.

[37] On 16 June 2018, Dr Wright provided follow-up comments following a request for clarification from the Corporation, noting that he did not consider that whiplash was the likely cause of Ms Thomas' headaches, as the predominant headache was cervically (neck) based and associated with non-neck related triggers and exacerbations.

[38] On 26 September 2019, Ms Thomas was seen by Dr Jane O'Dwyer, Psychiatrist. Dr O'Dwyer diagnosed Ms Thomas with Somatic Symptom Disorder (SSD), and advised:

> The claimant … has excessive thoughts, feelings and behaviours related to Somatic Symptoms. These are disproportionate and persistent thoughts about the seriousness of the symptoms. She has high levels of anxiety relating to this and excessive time and energy devoted to these symptoms. These have been present for more than 6 months. The claimant therefore meets the criteria of having a Somatic Symptom Disorder. …
>
> Aetiology
>
> … By the time of the accident, she already had significant pain issues both in her knee and back. Since the accident, the pain issues have become worse. She appears to have little faith in conventional medicine. She seems to consider her injuries are somewhat more serious than what one would expect with medical investigations. This may allow her to subconsciously justify her very patterns of behaviour which have been present since childhood. In my opinion, the aetiology of the Somatisation Disorder is unclear. However, in my opinion, it is not totally related to the accident as it appears to have predated that. However, the accident may well have worsened the condition. …

[39] On 25 November 2019, Dr Annie Maillard, Psychology Advisor, issued a file report referring to the two recent specialist reports that had been consistent in opinion there being no significant ongoing injury-related pathology. Dr Maillard recommended that Ms Thomas' original covered injury was now "spent".

[40] On 7 January 2020, Dr Paul Noonan, BMA, recommended that the reports of Dr Shaw and Dr O'Dwyer, together with PA comments, were sufficient evidence to conclude that Ms Thomas had SSD not resulting from the accident. He noted that there was now no incapacity resulting from the accident, with any current incapacity being the result of the pre-existing SSD.

[41] On 14 January 2020, the Corporation declined Ms Thomas cover for SSD on the basis that there was insufficient evidence to show that this condition was caused by her physical injury suffered on 21 January 2013. In a separate decision, the Corporation suspended Ms Thomas' ongoing entitlements including weekly compensation. This was on the basis that medical information showed that her current condition was no longer the result of her personal injury of 21 January 2013. Ms Thomas applied for review of the decisions.

[42] On 19 March 2020, Dr Newburn provided a further neuropsychiatric report in which he confirmed that he had seen Ms Thomas on 20 occasions over a seven-year period. Dr Newburn reiterated his earlier opinion that Ms Thomas continued to suffer from a chronic health condition consequent on traumatic brain injury.

[43] On 28 May 2020, Mr Brenton Clark, Optometrist, provided Ms Thomas a report in which he stated:

> You appear to be suffering a number of symptoms (many of which are visual) as a result of your whiplash sustained in a motor vehicle accident in January 2013. The BIVSS score is significant (64 points) compared to any visual symptoms you had prior to the whiplash (19 points). A whiplash injury is a form of mild traumatic brain injury (although the term "mild" is a misnomer). Most mTBI/concussions resolve quickly, but a significant percentage do not, and post-concussion syndrome may persist for many years, especially if no effective rehabilitation is offered or available post-injury.

[44] On 17 September 2020, Dr Newburn provided a further report in which he rejected any suggestion that Ms Thomas was suffering from SSD and reiterated his opinion that she was suffering ongoing physical issues, emotional, behavioural and cognitive consequences of brain injury. Dr Newburn provided a DSM-V diagnosis of: (i) mild neurocognitive disorder due to traumatic brain injury; and (ii) personality change due to a general medical condition (traumatic brain injury). Dr Newburn noted that Ms Thomas had suffered a deterioration in symptoms during July 2013, following what appeared to be a gastrointestinal illness ("leaky gut"), and advised:

> …It can be hypothesised that this was associated with leaky gut issues, increasing cytokine levels, which would have then caused issues by crossing the blood/brain barrier, further activating microglia. This is now an understood pathology, and Leasa is a good example of the consequences of this. Thus, the second event acted as an exacerbating factor on what were consequences of the first injuring event, leading to an increase in symptoms and the course which we now see…

[45] On 2 October 2020, Dr Jamie Macniven, ACC Clinical Advice Manager, provided a report after undertaking a full review of Ms Thomas' claim file. He reached the conclusion that there was nothing to indicate that anything more than a mild concussion was sustained in the accident, and that her symptoms were fully accounted for by SSD pre-dating the accident. Dr Macniven noted that the only clinician who disagreed with this view was Dr Newburn. As far as Dr Newburn's conclusion that Ms Thomas had acquired cognitive impairment, Dr Macniven noted

that Dr Newburn's conclusions were based on subjective self-reporting. In addition, many of these comments were suggestive of a lack of understanding of neuropsychological testing (which understandably was not Dr Newburn's area of expertise). As far as Dr Newburn's hypothesis relating to "leaky gut", Dr Macniven noted that this was based on an idiosyncratic understanding of relevant clinical research and literature. Dr Macniven noted that the overwhelming weight of clinical evidence on file indicated that Ms Thomas' symptoms were due to somatic symptom disorder, which was a condition that predated the index accident.

[46] On 4 March 2021, Dr Newburn responded to the report of Dr MacNiven. Dr Newburn confirmed his diagnosis of TBI as a cause for Ms Thomas' symptoms.

[47] On 26 May 2021, Ms Thomas's review was heard, and the parties sought and were granted leave to file further evidence.

[48] On 28 May 2020, Dr Noonan provided comment on the report of Mr Clark:

> Brenton Clark's report describes "Your current BIVSS score is 64. Prior to the accident, it was 19." This is subjective reporting of symptoms, and presumably the pre-injury score of 19 was assumed rather than documented before 2013. She has pre-existing myopia and astigmatism which corrects with glasses to very good vision of 6/5 in each eye. She also had normal colour vision, ocular movements and visual fields. Her accommodation was said to be reasonable, and there was no significant abnormality of vergence. Her symptoms were considered to be visualvestibular symptoms. It was suggested that she use her correcting lenses indoors more frequently, and that some form of visual – vestibular rehabilitation may be necessary. His report indicates that no ocular damage has been sustained. Her reported symptoms are entirely consistent with her somatic symptom disorder. I consider that there is no further information to amend ACC's previous decisions.

[49] On 26 June 2021, Mr Clark confirmed that Ms Thomas did not sustain ocular damage and that the Brain Injury Vision Symptom Survey ("BIVSS") was a tool used to aid diagnosis of mild to moderate brain injury which required self-reporting of symptoms.

[50] On 4 August 2021, the Reviewer dismissed Ms Thomas' application and concluded that the Corporation's decision suspending entitlements was correct. The Reviewer found that the new diagnosis of SSD did not qualify for cover, as it did not

represent an injury coverable under the Act, nor would it qualify as a personal injury if it was a traumatic brain injury on microscopic level.

[51] On 18 July 2022, Ms Thomas underwent a further MRI. Dr Daniel Cornfeld, Radiologist reported:

> No intracranial haemorrhage or oedema. The ventricles and the sulci are normal size and shape. There is normal distinction of the grey/white matter structures. There is normal signal of the grey/white matter structures. No diffusion restriction. Normal appearance of the pituitary, brainstem, and cerebellum. Normal appearance of the globes, extraocular muscles, optic nerves, optic chiasm, and optic radiations. The appearance of the cavernous sinuses, Meckel's caves, and cerebellar pontine angles. There is a small amount of focal thinning of the anterior horn of the corpus callosum. Normal appearance of the vessels in and around the circle of Willis.
>
> Impression: Anatomically normal MRI of the brain.

[52] On 31 October 2022, Dr Newburn stated that he had reviewed the MRI assessments of Ms Thomas and that there was nothing which altered his previous opinion. He noted that the small amount of thinning recorded in the MRI was entirely consistent with the neuropathology of traumatic brain injury.

[53] On 13 January 2023, Mr Clark recorded that Ms Thomas reported her difficulties to be pain, fatigue, concentration and sensory overload. She completed the self-reporting BIVSS and scored 59 for "visual problems associated with brain injury". Mr Clark noted that her symptoms were similar to those in March 2020. The main clinical measures of visual function were normal. Visual-vestibular functioning were normal. Mr Clark assessed that Ms Thomas' symptoms were likely attributable to the whiplash brain injury from 2013.

[54] On 1 March 2023, Dr Newburn provided a further report. He rejected the diagnosis of SSD, and advised that the absence of clinical imaging did not evidence an absence of pathology.

[55] On 30 August 2021, a Notice of Appeal was lodged.

Relevant law

[56] Section 26 of the Act provides that "personal injury" includes "mental injury suffered by a person because of physical injuries suffered by the person". Section 27 states that "mental injury" means a clinically significant behavioural, cognitive, or psychological dysfunction.

[57] In *Ambros*,[1] the Court of Appeal envisaged the Court taking, if necessary, a robust and generous view of the evidence as to causation:

> [65] The requirement for a plaintiff to prove causation on the balance of probabilities means that the plaintiff must show that the probability of causation is higher than 50 per cent. However, courts do not usually undertake accurate probabilistic calculations when evaluating whether causation has been proved. They proceed on their general impression of the sufficiency of the lay and scientific evidence to meet the required standard of proof ... The legal method looks to the presumptive inference which a sequence of events inspires in a person of common sense …
>
> [67] The different methodology used under the legal method means that a court's assessment of causation can differ from the expert opinion and courts can infer causation in circumstances where the experts cannot. This has allowed the Court to draw robust inferences of causation in some cases of uncertainty -- see para [32] above. However, a court may only draw a valid inference based on facts supported by the evidence and not on the basis of supposition or conjecture … Judges should ground their assessment of causation on their view of what constitutes the normal course of events, which should be based on the whole of the lay, medical, and statistical evidence, and not be limited to expert witness evidence …
>
> [70] The generous and unniggardly approach referred to in *Harrild* may, however, support the drawing of "robust" inferences in individual cases. It must, however, always be borne in mind that there must be sufficient material pointing to proof of causation on the balance of probabilities for a court to draw even a robust inference on causation. Risk of causation does not suffice.

[58] In *Hornby*,[2] it was held:

> [28] In terms of the approach to the law, Dobson J considered that this Court's decision in *Accident Compensation Corporation v Ambros* [2008] 1 NZLR 340 did not alter the requirement as set out in *Harrild v Director of Proceedings* [2003] 3 NZLR 289 (CA) for a "degree of connection" that shows the mental injury results from the preceding physical injury: at [22]. His Honour adopted the phrase "results from" as used in *Harrild* as the appropriate means of establishing the connection. …

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1 *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.
2 *Hornby v Accident Compensation Corporation* [2009] NZCA 576.

> [37]… Essentially, the appellant does not get cover because her depression has nothing to do with the injury. This is not a case of susceptibility or eggshell skull but, rather, one where the appellant has a condition which was not brought on by the accident. Even on the approach taken by the appellant's doctor, Dr Mackenzie, the break to her arm has made her symptoms worse but has not caused her depression.

[59] In *Comerford-Parker*,[3] Gendall J discussed the need for a direct causal connection between a physical injury and a mental injury in the context of a post-traumatic stress disorder:

> [21] … it is clear from the legislative history that Parliament has intended there to be some initial physical injury to that person which results, in addition, to a consequent mental injury. …
>
> [25] Whether "perpetuating causes" are outcomes from a physical injury so as to lead to mental injury, may well depend upon the type of mental injury, and type of physical injury under consideration. For example, causes of depression may be continuing perpetuating occurrences. But PTSD is, by definition, caused by the life threatening event and once it exists, later symptoms will be effects which result from it. That is the condition. But Mr Miller's argument appears to be based on the proposition that the effects of injury (pain, and prompting of memory) lead to the resulting mental injury. This may fail to distinguish between "results" of an injury and "effects" of it. The physical effects of the physical injury result from it. But conversely the mental injury, already present, does not result from those physical effects. Results are not necessarily the same as "effects". There will be a causal connection between the physical injury and the alleged outcome (the PTSD) if as a matter of fact, medical and other evidence, there is a resulting, consequential logical connection between the PTSD and the physical injury. …
>
> [35] … It will be a question of fact in every case whether the ultimate condition (the mental injury) is in fact an outcome or result of physical injury, and whether the "perpetuating cause" is but an effect of the physical injury, rather than something that results in a mental injury …

[60] In *Ghosh*,[4] Judge MacLean stated:

> [57] The key issue is that there must be a direct causal link and in that context the severity of the physical injury needs close scrutiny…
>
> [59] Also as explained in *Hornby v Accident Compensation Corporation* where a physical injury simply triggers a pre-existing mental condition so as to exacerbate the condition or cause it to be symptomatic that is not enough.
>
> [60] It is important to focus therefore on the actual injury and not the surrounding circumstances or reaction to it.

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3 *Comerford-Parker v Accident Compensation Corporation* [2011] NZAR 481.

4 *Ghosh v Accident Compensation Corporation* [2015] NZCA 208.

[61] In *W*,[5] Collins J stated:

> [65] The present case illustrates how, in complex cases, there may be multiple contributing causes to a claimant's mental injury. In such cases it may be helpful to assess the extent to which a claimant's mental injury has been suffered because of their physical injuries. 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. This means that to satisfy s 26(1)(c) of the Act, the physical injury must be the cause of the mental injury in some genuine or meaningful way, rather than just in a trivial or minor way. …
>
> [67] …Parliament has, in s 26(1)(c), employed the words "because of" to establish the degree of link required between a claimant's physical injury and their mental injury. The words "because of" fit more comfortably with a test that focuses upon whether the physical injuries materially contributed to the claimant's mental injuries, in a more substantial sense of that phrase than was adopted in Bonnington Casting Ltd v Wardlaw. When Parliament enacted the "because of" test, it is likely to have envisaged that a claimant would need to establish a genuine and meaningful connection between his or her physical injury and his or her mental injury, particularly in the context of the desire to introduce certainty to the boundaries for cover under the Act.
>
> [68] In cases involving multiple contributions to a claimant's mental injuries, the decision-maker should ask if the claimant's physical injuries materially contributed to the mental injuries that they have suffered. This inquiry involves an assessment of the evidence and the drawing of reasonable inferences. If the claimant's physical injuries materially contribute to his or her mental injuries, then the claimant will have established the basis for cover under s 26(1)(c) of the Act. …
>
> [76] In summary, the answer to the first question posed in [5] is that the ambit and meaning of the words "because of" in s 26(1)(c) of the Act depends on the context in which the claim for cover is made. In most cases, s 26(1)(c) of the Act will require that the claimant's physical injuries are both a factual and legal cause of his or her mental injuries. These requirements will usually be satisfied where two tests are met. First, subject to the possible exceptions outlined in [63], the "but for" test must be satisfied. Second, the physical injury must "materially contribute" to the claimant's mental injury.

[62] Section 117 of the Act provides that the Corporation may suspend or cancel an entitlement if it is not satisfied, on the basis of the information in its possession, that a claimant is entitled to continue to receive the entitlement.

[63] In *Ellwood*,[6] Justice Mallon stated:

> [65] I therefore consider that s 116 combined with the requirement in s 62 on ACC to make reasonable decisions requires ACC to have a sufficient basis

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5 *W v Accident Compensation Corporation* [2018] NZAR 829.

6 *Ellwood v Accident Compensation Corporation* [2012] NZHC 2887.

> before terminating benefits. If the position is uncertain then there is not a sufficient basis. The "not satisfied" test is not met in these circumstances.

[64] In *Furst*,[7] Judge Barber stated:

> [13] ACC must have a "*sufficient basis before it is not satisfied that a claimant is entitled to continue to receive the entitlement*". If the position is uncertain, "*then there is not a sufficient basis*" *The "not satisfied" test is not met in these circumstances*". *Ellwood v the Corporation* [2007] NZAR 205. The "*not satisfied*" test requires a positive decision … equivalent to being satisfied that there is no right to entitlements. This test would not be met where the evidence was in the balance or unclear: *Milner v the Corporation* (187/2007).

Discussion

Cover for SSD

[65] The issue here is whether the Corporation's decision of 14 January 2020, declining Ms Thomas cover for Somatic Symptom Disorder (SSD), is correct. The Corporation declined Ms Thomas cover for SSD on the basis that there was insufficient evidence to show that this condition was caused by her (covered) physical injury suffered on 21 January 2013.

[66] In terms of section 26(1)(c) of the Act, Ms Thomas must establish that she suffered mental injury because of a physical injury. This means that, in principle, she must establish that, but for her covered physical injury, she would not have her current mental injury, and that her physical injury materially contributed to her disorder in a genuine or meaningful way.[8]

[67] Mr Carlyle, for Ms Thomas, submits as follows. Ms Thomas has cover for head injury (concussion) whiplash and sprain of shoulder and upper arm, caused by her accident on 21 January 2013. The evidence of Ms Thomas' pre-accident capability is shown by her scholastic level, her social and sport engagement, and her travels and independence. All of this changed after the whiplash injury from the accident. The finding of a somatic symptom disorder, offered as an answer for Ms Thomas' present state of health, emerged many years after the accident, with no specific date, and no specific source. Dr Newburn and Mr Clark have both assessed

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7 *Furst v Accident Compensation Corporation* [2011] NZACC 379.

8 *W, above* note 5, at [65] and [76].

that Ms Thomas has suffered a mental injury caused by the covered whiplash injury, and that her ongoing condition is attributable, not to a diagnosis of somatic symptom disorder, but to an unresolved brain injury caused by the accident.

[68] This Court acknowledges the above submissions. However, in relation to the reports of Dr Newburn, the Court notes that they are heavily reliant on the temporal profile of Ms Thomas' symptoms following the accident and her subjective self-reports. In relation to the reports of Mr Clark, the Court notes that his optometrist assessment relied on Ms Thomas' self-reporting of symptoms, and that he is not properly qualified to offer psychological/psychiatric opinions.

[69] This Court points to the following medical evidence provided before the Corporation's decision of 14 January 2020, declining Ms Thomas cover for SSD on the basis that there was insufficient evidence to show that this condition was caused by her physical injury suffered on 21 January 2013.

[70] First, on 23 January 2013 (two days after Ms Thomas' accident), an x-ray was done of Ms Thomas' cervical spine and left shoulder by Dr B Chisholm, Radiologist, and no acute bone damage or joint injury was seen.

[71] Second, on 16 September 2013, Ms Mitcheson, Neuropsychologist, advised that the information provided was not clearly consistent with post-concussional *sequelae* to the index accident, that Ms Thomas had a premorbid vulnerability to depression, and that Ms Thomas's physical injury had likely triggered a depressive episode.

[72] Third, on 28 January 2014, Dr Chancellor, Neurologist, advised that Ms Thomas' symptoms were of a non-specific nature, and that her major current limitations (fatigue syndrome and sleepiness) were not explained by the index accident. On 18 February 2014, Dr Chancellor further reported that he could not identify any pathology other than Ms Thomas' described symptoms, which were entirely subjective with no correlation to physical examination; and that Ms Thomas was not incapacitated for work by the whiplash injury.

[73] Fourth, on 10 February 2014, an MRI carried out by Dr Mason, Radiologist, showed no acute intra-cranial abnormality.

[74] Fifth, on 10 April 2014, Dr Vickers, Psychiatrist, advised that there was likely a non-accident-related reason for Ms Thomas' fatigue problems, and there was no psychiatric illness or disorder present.

[75] Sixth, on 24 March 2015, Dr Douglas, Occupational Medicine Specialist, assessed that Ms Thomas' ongoing fatigue and other symptoms were not likely to be injury related and were most likely secondary to other factors. On 28 May 2015, Dr Douglas advised that Ms Thomas' injury had fully resolved and there were no specific functional limitations. On 19 May 2016, Dr Douglas further advised that Ms Thomas had the medical capacity to work in a number of roles, including as an optometrist assistant.

[76] Seventh, on 22 February 2018, Ms Shaw, Neuropsychologist, assessed that, prior to Ms Thomas' injury, she was vulnerable to a poor outcome post injury due to pre-existing mental health issues, including depression in teenaged years, self-esteem issues, relationship issues and perhaps also a degree of social anxiety. Ms Shaw advised that Ms Thomas had developed Somatic Symptom Disorder (SSD) with predominant pain and fatigue following the mild concussion injury in 2013.

[77] Eighth, on 6 March 2018, Dr Wright, Neurologist, found no evidence to support a causal link between Ms Thomas' accident and her current symptoms. Dr Wright found no neurologic diagnosis relating to ongoing nonspecific symptoms. On 16 June 2018, Dr Wright advised that he did not consider that whiplash was the likely cause of Ms Thomas' headaches, as the predominant headache was cervically based and associated with non-neck related triggers and exacerbations.

[78] Ninth, on 26 September 2019, Dr O'Dwyer, Psychiatrist, diagnosed Ms Thomas with Somatic Symptom Disorder (SSD). Dr O'Dwyer assessed that this disorder was not totally related to the accident as it appeared to have predated that, and that the accident may well have worsened the condition.

[79] Tenth, on 25 November 2019, Dr Maillard, Psychology Advisor, recommended that Ms Thomas' original covered injury was now "spent".

[80] This Court also points to the following medical evidence provided after the Corporation's decision of 14 January 2020.

[81] First, on 2 October 2020, Dr Macniven, ACC Clinical Advice Manager, concluded that there was nothing to indicate that anything more than a mild concussion was sustained in Ms Thomas' accident. Dr Macniven noted that the overwhelming weight of clinical evidence on file indicated that Ms Thomas' symptoms were due to somatic symptom disorder, which was a condition that predated the index accident.

[82] Second, on 18 July 2022, Dr Cornfeld, Radiologist, reported on an anatomically normal MRI of Ms Thomas' brain.

[83] In light of the above medical evidence, this Court finds that the Corporation correctly declined Ms Thomas cover for SSD on the basis that there was insufficient evidence to show that this condition was caused by her covered physical injury suffered on 21 January 2013.

Suspension of entitlements

[84] The issue here is whether the Corporation's decision of 14 January 2020, which suspended weekly compensation entitlements, is correct. The Corporation suspended Ms Thomas' ongoing entitlements including weekly compensation on the basis that medical information showed that her current condition was no longer the result of her (covered) personal injury of 21 January 2013.

[85] The Corporation is entitled to suspend Ms Thomas' entitlements if it is not satisfied, on the basis of the information in its possession, that she is entitled to

continue to receive them.[9] Where the available evidence is in the balance or unclear, the "not satisfied" test is not met.[10]

[86] Mr Carlyle, for Ms Thomas, submits as follows. The Corporation was not entitled to suspend Ms Thomas' entitlements because it could not have been satisfied, on the basis of the information in its possession, that Ms Thomas was no longer entitled to continue to receive them. Because the available evidence was at least in the balance or unclear, the "not satisfied" test was not met. Ms Thomas suffered a traumatic brain injury caused by the motor accident, in which a whiplash injury was suffered with concussion, causing a legal requirement for the Corporation to provide cover and weekly compensation entitlement.

[87] The Court acknowledges the above submissions. However, the Court refers to the substantial medical evidence, at paragraphs [70] to [79] and [81] to [82] above, that there was insufficient evidence to show that Ms Thomas' current condition was caused by her covered physical injury suffered on 21 January 2013. The Corporation was therefore entitled to suspend Ms Thomas' entitlements, including weekly compensation, on the basis that it was not satisfied, on the basis of the information in its possession, that she was entitled to continue to receive these entitlements.

Conclusion

[88] In light of the above considerations, the Court finds that the Corporation correctly declined Ms Thomas cover for Somatic Symptom Disorder, and suspended her entitlements including weekly compensation, on the basis that her current condition was no longer caused by covered injuries sustained in an accident on 21 January 2013.

[89] The decision of the Reviewer dated 4 August 2021 is therefore upheld. This appeal is dismissed.

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9 Section 117(1) of the Act.
10 See *Furst*, n 19, at [13].

[90] I make no order as to costs.

P R Spiller
District Court Judge

Solicitors: Ford Sumner Lawyers for the Respondent