IN THE DISTRICT COURT
AT DUNEDIN

[2016] NZACC 164 **ACR 418/13**
ACR 261/14

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

Hearing:	14 October 2015
Appearances:	W A Forster and T M Barraclough for the appellant A Douglass for the respondent
Evidence Completed:	22 January 2016
Judgment:	1 June 2016

RESERVED JUDGMENT OF JUDGE L G POWELL

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[1] These two appeals require consideration of two separate issues. The first (ACR 418/13) requires a determination as to whether a decision of the Corporation dated 30 August 2012 to suspend Mr Anderson's entitlements to weekly compensation was correct, the Corporation having determined that Mr Anderson's condition was no longer the result of a covered injury suffered on 9 December 2003. The second appeal (ACR 261/14) requires consideration of what cover Mr Anderson is entitled to, and in particular whether he has, or should have, cover for post concussion syndrome as a consequence of his 2003 injury. As the two issues involve completely different legal tests they stand to be considered separately, but while ACR 261/14 arose after ACR 418/13, because the extent of cover is a central

consideration to the suspension decision of 30 August 2012 it stands to be considered first, before addressing the suspension decision.

Factual Background

[2] There is no dispute that Mr Anderson was involved in a serious motor vehicle accident on 9 December 2003. The vehicle he was driving collided with a truck and trailer unit at high speed. After being air lifted to hospital Mr Anderson, who could not remember the accident, was treated for a variety of injuries including lacerations to his left temple and right wrist, and cover was granted by the Corporation for:

- Flexor tendon of hand – right;
- Concussion – head (except face);
- Open wound of scalp head – left (except face).

[3] Although the initial focus was on treating Mr Anderson's physical injuries within a short time other issues were identified as significant. In an ACC18 medical certificate filed by Mr Anderson's general practitioner, Dr A E Adam, in addition to Mr Anderson's laceration injuries, the diagnosis is noted as "also fatigue, headache, poor concentration, concussion". Indeed by the end of January 2004 the primary diagnosis on the ACC18 was noted as being:

> Ongoing post concussion symptoms,
>
> Impaired concentration and fatigue.

[4] From that point onwards post concussion syndrome became an almost constant feature of medical certificates as giving rise to a need for ongoing entitlements for Mr Anderson, although at different times the terms "head injury" and "traumatic brain injury" were also used.

[5] Although by this point Mr Anderson had returned to work at varying hours. Ongoing issues with "mental function and fatigue" led Dr Adam to write to the Corporation noting that in his opinion these were "a consequence of [Mr Anderson's]

head injury sustained ... in [his] motor vehicle accident". As a result he requested a neuropsychological assessment.

[6] The Corporation agreed and referred Mr Anderson to Megan Phillips, registered clinical psychologist and neuropsychologist, for assessment, noting relevantly that with regard to Mr Anderson's injury Mr Anderson was suffering from a "head injury – post concussion symptoms".

[7] In the event the neuropsychological assessment carried out by Ms Phillips followed a psychological assessment undertaken by Nisshi Rai-Parkhill, consultant clinical psychologist, which had noted the same symptoms as identified by Dr Adam including problems with cognitive functioning and fatigue, and who concluded that a neuropsychological assessment would be helpful.

[8] Ms Phillips in her own report in October 2004 noted Mr Anderson's ongoing fatigue issues and the interplay between fatigue and cognitive function. After administering a range of neuropsychological tests Ms Phillips provided the following summary and conclusions:

> Shane Anderson is a 32-year old man referred for neuropsychological assessment in relation to a concussion injury he sustained in a motor vehicle accident in December of last year. A neuropsychological assessment was requested to gain an indication of Shane's current level of cognitive functioning and to identify any rehabilitation needs.
>
> General assessment of intellectual and cognitive functioning has identified that Shane is achieving results well within the range expected across most tasks presented and is not reflective of a generalised impairment of cognitive function. Shane's strengths lie with his perceptual organisation abilities and verbal comprehension skills. He demonstrated good verbal memory skills both with his ability to attend to and learn new information as well as his ability to retrieve information after delay. Very mild working memory difficulties were noted when compared with his abilities across other tasks. Shane's visual memory is a particular strength for him.
>
> Difficulties were noted with Shane's processing speed, particularly with his psychomotor processing and information processing. Problems with distractibility were also evidence. Very mild difficulties were noted with working memory and Shane reported that this is a particular difficulty for him within the work setting where he is required to manipulate information in his head. The mild difficulties noted on the executive tasks may reflect his difficulties with his slowed psychomotor processing speed rather than specific problems with the interference of frontal lobe functioning. As noted above,

those executive tasks were presented in the latter part of the assessment session when Shane was clearly very fatigued.

In terms of emotional functioning, Shane reported a range of difficulties consistent with the ongoing difficulties he has been experiencing in terms of his recovery as he struggles to accept his residual difficulties and manage these adequately.

The difficulties identified on testing, particularly a slowed processing speed, are entirely consistent with the ongoing sequelae of Post-concussion Syndrome. Shane continues to struggle to manage his fatigue and accept the limitations brought about by the impact of fatigue on his cognitive functioning. This was demonstrated clearly during the assessment process as his abilities clearly deteriorated over the course of the afternoon. Shane continues to struggle with accepting this limitation and adequately managing his fatigue in order to gain a balanced lifestyle and improved quality of life. My understanding from Shane and his partner is that he continues to struggle to accept the need to manage fatigue adequately, despite the impact and acknowledgement of having worked too hard initially and subsequently having experienced a "burn out". Clearly Shane is a very able man and intellectually will have no difficulty fulfilling the requirements of his current job. With adequate management, he is likely to make good gains in terms of his recovery but he need to allow time for this to happen.

[Emphasis added]

[9] As well as recommending Mr Anderson have the opportunity to work with a clinical psychologist to, amongst other things "increase his understanding of post concussion syndrome and the impact of fatigue on his cognitive functioning", Ms Phillips also recommended Mr Anderson see a speech language therapist. This assessment took place in December 2004, and was undertaken by Emma Davis, speech language therapist, who noted:

> Shane presents with mild cognitive-communication deficits as a result of a head injury sustained in December 2003. Whilst many of his symptoms have resolved he continues to experience problems with thought formulation and retrieval at discourse level, distractibility from conversation and thought generation when fatigued and slowed information processing. Shane demonstrates a good level of insight into his communication difficulties though reports a lessening perspective on his current communicative abilities as his symptoms resolve. Shane has identified that his fatigue levels greatly impact on his communication performance and he conversely becomes fatigued when communicating for long periods of time. The main area of focus for Shane's rehabilitation is his return to work and the identified areas of communicative need are likely to impact on this.

[10] Mr Anderson's symptoms continued and in May 2005 he was referred to Dr Bill Gordon, consultant psychiatrist. Dr Gordon noted that Mr Anderson's

principal difficulty was fatigue, which he observed in the course of his examination, before providing the following diagnosis:

> **Shane appears to be suffering from a Post Concussion syndrome**, but there is no evidence of any current mental illness. While he has had short periods of depression in the past, at the moment there is no indication that this is present. It is likely in fact to have been a response to the frustration of his post concussion syndrome. He has had some sleeping difficulties, but these appear largely to have reversed and are easily managed. I would wish to recommend to his General Practitioner, Dr Euan Adam, that perhaps the only medication that will be helpful is the occasional us of Zopiclone 7.5mgs nocte. I have explained to him that if he has to use it, he should use it for three or four nights in a row, followed by an equally long period without the drug.
>
> He showed me a number of drugs he had tried, including Citalopram and Amitriptyline and Temazepam, but none of these were helpful for him and I believe that antidepressants are probably contra-indicated in this situation.
>
> I think that really there are no indications for any further psychiatric involvement. **He has no mental illness as such, and no doubt the passage of time will lead to a gradual improvement in his Post Concussion syndrome.** I have explained to him that it will take time to settle and that until the fatigue disappears, he needs to monitor his own progress, not overdo things and accept that he has to rest at various times.
>
> [Emphasis added]

[11] Dr Gordon's assessment was followed by a further neuropsychological assessment in September 2005 by another clinical psychologist, Johanna Yee. Like Ms Phillips and Dr Gordon, Ms Yee noted Mr Anderson's problems with fatigue before administering a battery of neuropsychological tests and concluding:

> Shane is a 33 year old Sales Forester seen for repeat neuropsychological evaluation following a motor vehicle accident on 09/12/03 where he sustained a concussion injury, laceration to the left temple and laceration to his right tendon. **He has been diagnosed as having Post-concussion syndrome.** Assessment was requested in light of persisting significant fatigue, preventing him from working in a full-time capacity.
>
> Estimated to be of superior premorbid ability he continued to present with a range of abilities consistent with this estimate, namely, reasoning skills, new learning and memory functions and visuoperceptual skills. Verbal working memory had returned to near pre-accident level. There was no evidence to suggest presence of major executive dysfunction. Verbal fluency was mildly reduced and possibly reflected reduced efficiency in retrieving stored information under time pressure.
>
> There were two findings of note. Immediate verbal retention span, the amount of information he can take in at one time, appeared largely intact however there was a suggestion span could become overwhelmed with too much information of a complex nature. This difficulty can take on the appearance of a "memory

problem" as the individual seems to have "forgotten" what he has just been told, but it is more an attentional deficit. The information did not get in (become encoded) in the first instance.

The second finding was significantly impaired processing speed, given estimated pre-accident level of functioning. Slowed processing speed and span affect information processing capacity. A compromise in this system is evidenced as an inability to perform more than one task at a time, handle complex tasks and perform quickly enough. **It has been suggested in the literature that such information processing deficits form the basis of Post-concussion syndrome** (PCS).

Shane's presenting and over-riding complaint is of significant fatigue. Symptoms such as fatigue, headache and irritability (and many others) are common in PCS. It has been hypothesised that these symptoms arise from the effort required to cope with persisting cognitive deficits. Additional factors contributing to and impacting upon Shane's presentation are personality style and external pressures.

Shane is receiving appropriate rehabilitation input. He has been taught essential compensatory strategies to employ within the workplace and around home to minimise fatigue, or more accurately, these strategies are aimed at circumventing identified cognitive impairments, having the secondary benefit of conserving energy. However it is very clear Shane is not managing. He is not coping after a typical work day, let alone a week, and his social, leisure and recreational functioning is almost non-existent. It is concerning he has been struggling for over 18 months.

[Underlining in original/Bold emphasis added]

[12] A medical case review conducted by Dr Jonathan Wright, occupational physician, in November 2005 likewise concluded that:

Shane has a typical post concussion syndrome with the predominant features being fatigue and difficulty with concentrating for prolonged periods. He is physically well in terms of coordination and strength but is easily fatigued with physical and mental effort.

Shane commented that he finds socialising quite hard as it is fatiguing having to concentrate on what people are saying and making appropriate comments. When is more fatigued he tends to talk more as it is easier than listening and responding appropriately.

He is less keen on going out as a result of this. Most people other than Kylee can't tell when he is tired.

The prognosis for such a closed head injury and post concussion syndrome is difficult to predict and I think a positive feature with Shane is that he is able to function at a reasonably high level for short periods of the day. Similarly he is able to be active and has even attempted some gym work at times however, he continues to easily fatigue. It is possible that he will continue to gradually improve with time although this may be over many months and even years. I

> am not able to say whether he will get back to a full time management position but would hope that he could eventually do so.
>
> It appears that his job will end at the end of this year and I think it is important for his self esteem that he attempts to rejoin the work force, even in a part time role to maintain a routine of activity, both mental and physical. Work that was not excessively mentally demanding or physically demanding would be appropriate and could be used to 'fill in' the time until further recovery allows return to higher functioning work. I discussed this with him today.
>
> Shane struck me as a very open and honest person in his appraisal of the jobs suggested and commented that he thought he could do most of them but only for a limited period per day due to problems with physical and mental fatigue. I reassured him that trying to force extra hours as not helpful in the long run if this resulted in deterioration and a 'boom and bust' cycle.
>
> He remains surprised about his fatigue levels at the weekend if he is mowing the lawn or chopping wood.
>
> [Emphasis added]

[13] Mr Anderson's problems continued. A further assessment carried out by Dr Gordon in May 2006 confirmed his early diagnosis, noting to Mr Anderson "we were struggling with the same problem as before, namely he has not yet recovered from his post concussion syndrome", and noted Mr Anderson's frustration at the slowness of his recovery.

[14] In October 2006 Mr Anderson began to experience what were described as "syncopic symptoms" which involved collapse episodes as a result of low blood pressure. As a result Dr Adam referred Mr Anderson to Dr Alan Wright, neurologist, noting in the referral letter Mr Anderson's ongoing fatigue symptoms as well as the syncopal and presyncopal episodes which he noted had begun post the 2003 accident.

[15] Dr Wright, who was to see Mr Anderson between October 2007 and June 2010 noted that the syncopal episodes were not his major problem, rather it was the fatigue and as a result Dr Wright trialled various medications to address those symptoms with little or no benefit. Although Dr Wright did not attempt to diagnose the cause of Mr Anderson's fatigue he noted consistently that those symptoms were "secondary to MVA".

[16] Eventually Dr Wright referred Mr Anderson to Dr Andrew Bowers, a physician in internal medicine, who saw Mr Anderson for the first time on 26 February 2009.

After noting Mr Anderson's "very significant fatigue" and consequential "slow processing" Dr Bowers noted Mr Anderson's fluctuating heart rate and posited:

> I wonder whether he does indeed have some ongoing significant dysautonomia. He may meet the criterion for the Postural Orthostatic Tachycardia syndrome or POTS. In keeping with that is a marked abnormality of apparently sinus rhythm and not really any significant hypotension, and additionally a history of peripheral colour change. I cannot find any evidence to confirm structural heart disease as a cause for this. In order to investigate this, I would in the first instance repeat the tilt table test with a view to confirming POTS and I have also organised for a Holter monitor. I have discussed with him possible treatment with either a beta blocker, which has in case histories shown paradoxical improvement in regulation under these circumstances, or of adding in Fludrocortisone. He does meet some of the criterion for the Chronic Fatigue Syndrome but I would be concerned with leaving such a label when he has a significant head injury at the onset.

[17] When Dr Bowers reviewed Mr Anderson six months later he noted:

> You will recall that he had some symptoms suggestive of autonomic disregulation and some symptoms consistent with the Postural Orthostatic Tachycardia syndrome; the full neurophysiological criterion of these were **not** met.
>
> [Emphasis added]

[18] Over subsequent months Dr Bowers tried various medications to address Mr Anderson's fatigue symptoms, but, like Dr Wright, was not able to obtain any improvement in Mr Anderson's overall condition by the time treatment appears to have ceased in July 2010.

[19] Not long afterwards in October 2010 the Corporation undertook a comprehensive file review of the various assessments and treatments provided to Mr Anderson, following which it was noted:

> Under treatment of Dr Bowers currently and must be due for review soon. 3 months since starting new drug trial.
>
> Client appears to be willing and wants to improve his circumstances – evidence of this throughout claim file.
>
> Need to check out what he does on home property – farm, as there are references to him doing farm work.
>
> Seems to be that fatigue is main issue, has been given lost of assistance with how to manage this but nothing has helped so far, while a diagnosis was offered by Dr Bowers of Postural Orthostatic Tachycardia Syndrome (POTS), this has

> not been confirmed. Shane has not been seen by du Plessis – referral to him to confirm that this could be the cause, and that current symptoms are injury related.

[20] As a result Mr Anderson was assessed by Dr L J du Plessis, neurologist and physician in rehabilitation medicine, on 25 March 2011. In a lengthy report Dr du Plessis started by reviewing Mr Anderson's history, and Dr du Plessis noted and did not dispute the conclusions reached by Ms Phillips, Ms Yee and Dr Gordon in particular. With regard to the treatment Mr Anderson received from Dr Wright and Dr Bowers it was Dr du Plessis' conclusion:

> For fatigue to be the major and only symptom constantly present seven years after a mild concussive brain injury would indicate that the fatigue has nothing to do with the injury. Mr Anderson did not report the typical post-concussion symptoms on an ongoing basis but only referred to their presence when he was severely fatigued. Fatigue, although a feature of concussion and post-concussion syndrome does not persist without significant evidence of other symptoms. As an isolated symptom it does not persist after mild concussion.

[21] Dr du Plessis went on to record the results of his own examination before setting out his opinions with regard to Mr Anderson's condition, Dr du Plessis commenting in particular:

> In my opinion Mr Anderson sustained a mild concussive brain injury but I cannot confirm that he has an ongoing post-concussion syndrome for a variety of reasons, the main reason being that post-concussion syndrome does not last this long following a mild concussive brain injury, and secondly that the over-riding symptoms continues to be only fatigue and it is only when he is fatigued that he reports other symptoms.
>
> There was a significant absence of symptoms that might suggest that Mr Anderson was suffering ongoing post-concussion symptoms over a prolonged period of time while under the care of Dr Wright.

[22] After referring to literature in support of this conclusion Dr du Plessis indicated that he was of the opinion "as Dr Bowers has suggested" that Mr Anderson was suffering from POTS. As a result he noted:

> It is also very important to note that when Mr Anderson presented to Dr Wright the issue was not post-concussion syndrome or any head injury related pathology but he had been suffering blackout episodes, which were considered to be due to low blood pressure, and even during today's assessment his systolic blood pressure was found to be low at 94mmHg. His heart rate was also very fast and I am also of the opinion that he has, as Dr Bowers had suggested, a postural orthostatic tachycardia syndrome (POTS). In my opinion Mr Anderson's symptomatology of fatigue is either due to this condition or due to a

non-specific chronic fatigue syndrome. I do not consider that his fatigue is the result of mild concussion, the main reason being that to have an isolated symptom (fatigue, in the case of Mr Anderson) persisting without any indication of improvement, over more than seven years following a mild to even slightly more severe concussive brain injury, is not recognised as indicating that there is a causal relationship. Despite treatment with drugs known to reduce the level of fatigue, Mr Anderson reported no improvement.

[23] Overall Dr du Plessis recorded his conclusions as follows:

1. What is the current diagnosis(es)? Please discuss the pathology.

In my opinion Mr Anderson has chronic fatigue. I do not consider it trauma related and it is either part of a non-specific chronic fatigue syndrome or it could be related to severe deconditioning, alternatively it is due to postural orthostatic tachycardia syndrome as suggested by Dr Bowers.

2. What is the cause(s) of the above pathology? Please discuss your opinion.

In my opinion the cause of his pathology is not related to the trauma. Looking at my clinical findings and those of Dr Bowers and information in other documents I would suggest that the most likely cause for his ongoing symptomatology is the ongoing postural orthostatic tachycardia syndrome. I think it is reasonable to accept that any person who becomes fatigued irrespective of the cause will show certain symptoms such as those reported by Mr Anderson with impairment of concentration, memory etc.

3. What ongoing effects, if any, is the covered injury having on the current condition? Please explain in detail the reasons for your opinion.

I do not consider that the covered injury is causing any of Mr Anderson's symptoms. The reason for this is that he sustained only a minor head/brain injury from which he should have recovered within a matter of a few weeks or a month or three at most. Furthermore, to have an isolated single symptom, namely fatigue, persisting without any evidence of regression of the severity of the fatigue despite treatment, with no other ongoing symptoms of post-concussion syndrome except when he is fatigued, would not be in keeping with the pattern of recovery following mild post-concussion syndrome. Furthermore McCrea clearly indicates that post-concussion syndrome has been considered to be a "neuropsychological disorder" which, although the initial neuropathophysiological effects may be the result of injury, the persistence of the post-concussion syndrome is more directly the result of psychological, psychosocial and other non-traumatic brain injury causes.

4. Does the client remain incapacitated for work due to the effects of the injury for which they have cover and if so, to what extent/ Please discuss your opinion, while considering any other incapacitating conditions (and their relative significance).

In my opinion there is no indication that Mr Anderson's incapacity is the result of his covered injury. His incapacity is related to non-trauma related pathology. This is explained in more detail above.

5 a) If the client is unable to perform his or her pre-injury work type, please detail any treatment, rehabilitation or investigations you find appropriate.

As indicated, also in the report of Dr Bowers, Mr Anderson has undergone extensive investigations and further investigations are not required. He has also been unsuccessful with regard to return to work programmes and numerous treatment modalities have all been unsuccessful. As I indicated above I do not consider that his fatigue is the result of brain injury and it is more likely to be due to the postural orthostatic tachycardia syndrome or deconditioning, and treatment should be advised by a physician.

5 b) What is the likely outcome, in relation to the incapacity, from the recommended treatment/investigations?

To date the outcome has been dismal and there has been no reported improvement. This clearly also indicates that the pathology is not trauma related, particularly minor trauma, which should have shown at least some improvement over the years if it had not recovered within a short period of time. It is my opinion that his ongoing symptomatology is thus not trauma related but is due to some other form of pathology. Under these circumstances it is not possible to indicate the likely outcome with regard to his incapacity.

To date treatment seems to have been totally unsuccessful.

FINAL CONCLUSION

It is my opinion that Mr Anderson's ongoing pathology, is for the reasons described above, totally unrelated to his index injury. The main reason for this opinion is that fatigue as an isolated symptom and cause of other symptoms which are not there at other times, is completely atypical for what happens following a mild concussive brain injury. Mr Anderson sustained a mild (and at the very most a very slightly more severe than mild) concussive brain injury from which he should have recovered and not had a predominantly single ongoing symptom.

Any ongoing incapacity in Mr Anderson is not considered to be trauma related.

[24] Following receipt of Dr du Plessis' report the Corporation requested further comment from both Dr Bowers and Dr du Plessis regarding POTS. Starting with general information about POTS Dr Bowers noted:

Thank you for your letter requesting further information regarding Postural Orthostatic Tachycardia Syndrome or POTS.

POTS is a relatively new newly recognised syndrome. There are some very clear clinical guidelines and investigational criterion to support its diagnosis. It is probably reasonably common and it is estimated that up to half a million people in the United States suffer from it. It is more typically seen in people aged 14-45 and more common in otherwise highly functioning and well people. It can be slow and insidious in its onset or it can occur suddenly in association with a significant illness. The nature of this illness is usually a viral illness or another very specific infective cause.

The clinical features of this are:

1. Dizziness
2. Lightheadedness
3. General weakness
4. Blurred vision
5. Fatigue upon standing with palpitations and tremulousness.

It is much more commonly associated with cognitive decline and impaired memory which has been clearly demonstrated in Mr Anderson's case. There are additionally some observational and investigational requirements to support a diagnosis.

The course of this disorder can be self-limited mild and lasting as short as six months, but it is also now demonstrated that there is a chronic relapsing and remitting course that can exceed two to three years and can be completely debilitating. Additional considerations or alternate diagnosis could include de-conditioning, depression or progressive autonomic dysfunction, but they are not necessarily exclusive of each other, coexisting.

[25] Dr Bowers then reviewed "whether the diagnosis ... may still be the cause for Mr Anderson's complaints" and stated:

In your letter you have specifically requested me to comment on whether this diagnosis of POTS may still be the cause for Mr Anderson's complaints.

In short the answer is yes, but one also has to consider whether this is associated or caused by his head injury. I consider this one has to consider the original diagnosis, association in time with the head injury and subsequent investigations.

The initial diagnosis included specific criterion that were mostly or fully met, excepting that the tilt-table test did not confirm it early on. The characteristic diagnosis is made by a sustained heart rate increase of >30 beats per minute upon standing or in a tilt-table test and an increase of up to 120 beats within the first 10 minutes of tilt. This is not associated with hypotension. Mr Anderson did meet these in bedside testing and so the diagnosis does appear to fit.

It is clear in the history that I took that the fatigue and other symptoms started at the time of the head injury, not before, and I believe this is consistent with histories offered to other medical staff. The association is clear, but is this casual or not? There is no definitive answer on this. There are a number of case reports of this association. http://www.ncbi.nim.nih.gov/pubmed/20865679. This alone does not represent a definitive answer. But these case reports suggest that there may be an association between traumatic brain injury and POTS. There are several insurance disputes I understand regarding this overseas. At this stage one cannot be sure, that there is at least a reasonable possibility that this condition can be caused by head injury.

It is unusual but not impossible that the condition can exceed three to five years and be refractory to treatment.

It is experience from myself and from other practitioners that people with POTS report subjective declines in cognitive function. These have been objectively measured also with Mr Anderson and confirmed as per the additional reports.

It may be that there is now an additional complicating problem such as de-conditioning or depression associated with this disorder, and I am not in a position to exclude these. It is not my impression from seeing Mr Anderson that he is malingering in any way, or that his history is inaccurate or inconsistent.

So with relatively uncertain diagnostic criterion being the best that we can offer, I would have to say yes it is possible that this is the continued cause for Mr Anderson's condition and that there is at least a good possibility that this relates to his head injury in either a causal or strongly associated fashion.

[Emphasis added]

[26] Dr du Plessis also provided further comment on POTS to the Corporation on 14 June 2011 which advised:

The diagnosis of POTS (Postural Orthostatic Tachycardia Syndrome) had been suggested by Dr Andrew Bowers. This condition has been associated in literature with chronic fatigue syndrome and CFS and also fibromyalgia. I had indicated in my report that based on the information from Dr Andrew Bowers that Mr Anderson was suffering either from POTS or he had a non-specific chronic fatigue syndrome, but I did not consider that his symptomatology was related to the mild concussion.

I have now done a review of the literature and also had a discussion with Dr Andrew Bowers. I enclose a copy of various references to POTS and also a more detailed review which was done in January 2011 with an update of this particular topic in June 2011 which indicates that it is in fact very up to date. This particular review does not indicate that brain trauma is the cause of this condition although I also reviewed another article entitled, Autonomic Dysfunction presenting as Tachycardia Syndrome following Traumatic Brain Injury. This article appeared in the Journal of Cardiology in June 2010 and cites 8 patients, 7 of them being women, who had suffered a traumatic brain injury and then presented with features of orthostatic intolerance stated to be consistent with POTS.

The article does not indicate the severity of brain injuries and as it is known that POTS is more common in females (7 out of 8 patients who sustained a traumatic brain injury) the question of a direct causal link is questioned. Traumatic brain injury being much more common in males and under these circumstances it would have been expected that the condition, if associated with traumatic brain injury, would be much more common in the male population which it was not found to be in this survey.

As I indicated above there is no indication as to the severity of the brain injuries in these patients and therefore no conclusion can be drawn whether there is or is not an association with this particular condition and traumatic brain injury. All

> the other articles that I reviewed did not indicate that traumatic brain injury had a causal link with this condition.
>
> As the condition is, according to the authors of the article entitled Postural Tachycardia Syndrome, relatively common with estimated 500,000 Americans suffering from this disorder, it would be very possible to have an association with another very common condition namely traumatic brain injury. The association may thus be only incidental.
>
> Until more definitive literature is available to confirm a definite causal link with traumatic brain injury at the moment I can only be considered that there could be an association.
>
> It is also important to note that, at most, Mr Anderson suffered a mild traumatic brain injury and as indicated in the writing of McCrea, persistent symptomatology is more likely to be related to psychosocial, psychological or non-traumatic brain injury associated factors than to brain injury itself.
>
> In my experience of more than 30 years of dealing with patients with various levels of traumatic brain injury I have not had a patient who had presented following the brain injury with Postural Orthostatic Tachycardia Syndrome.
>
> I enclose all the necessary references and hope this assists you in your decision making in the matter of Mr Shane Anderson.

[27] Upon receipt of this further information the Corporation considered its position under the cover of a decision rationale form for a decision to "suspend weekly compensation". After noting the most recent reports from Dr Bowers and Dr du Plessis, case manager Dawn Grey noted:

> Unsure if documentation needs to go to BMA for advice?
>
> Based on information provided it seems that the client is suffering from POTS symptoms. Dr Bowers states that this could be related to the brain injury suffered by Mr Anderson, however Dr du Plessis states that it is unlikely to be related to the TBI.
>
> Dr du Plessis supports his case by including literature, both specialists indicate that there could be an association between TBI and POTS, but a causal link cannot be established until there is more literature available.
>
> Dr du Plessis does state that a mild concussive brain injury occurred – symptoms since the accident do not follow abnormal TBI pattern, only symptom seems to be fatigue, and then other symptoms appear related to fatigue.

[28] In the event a referral was made to the Branch Medical Advisor ("BMA") Dr Peter Burt who commented:

> The report from Dr du Plessis, is thorough and well referenced. Dr du Plessis suggests that the clients current incapacity is not likely related to the PICBA.

> That the clients ongoing fatigue relates to non covered problems. He suggests the diagnosis of POTS is unlikely related to the clients brain injury. Therefore this report, suggests the client should no longer have entitlements. I recommend workwise comment.

[29] In turn the issue was referred to Workwise and specifically Dr Gerard Walker, a specialist in occupational and environmental medicine and director of the Corporation's Workwise Christchurch office. In response Dr Walker did not endorse suspension of Mr Anderson's entitlements. Instead he recommended:

> ACC is on arguably weak grounds to disentitle given the information available.
>
> No, neuropsychological assessment is advised in the first instance.

[30] As a result the Corporation referred Mr Anderson for a further neuropsychological report, this time from Katy Taylor, registered clinical psychologist, who assessed Mr Anderson on 27 and 28 February 2012. Ms Taylor's report noted the previous assessments and while she noted that Dr Gordon in his first assessment had "thought" Mr Anderson was suffering from post concussion syndrome did not record that Ms Phillips, Ms Yee and Dr Gordon's second report had all in fact identified post concussion syndrome. Instead, after completing her own examination administering a wide range of neuropsychological tests reached the following conclusions:

> Mr Shane Anderson is a 40 year old man who sustained a concussion in a motor vehicle accident on 09.12.2003. He currently presents reporting the primary symptom of persisting fatigue. He also feels nausea when he tries to run. When he is fatigued he finds he struggles to put sentences together, can feel cognitively overwhelmed, feels irritable, gets headaches, is slower to process information, and has noticed visual changes and sensitivity to loud noise. Mr Anderson remains off work and claims full earnings related compensation from ACC.
>
> As seen at previous neuropsychological assessments, this assessment shows no reduction in overall cognitive functioning since the 2003 accident. Many skills remain at premorbid levels above the average range. These skills include verbal skills, visuospatial abilities, attention, working memory, visual memory, verbal memory, abstract reasoning, and executive functioning skills. Mr Anderson shows an isolated low score on one measure of processing speed, however his overall index score still reaches the average range and good ability on other tests dependent on processing speed is demonstrated. Slowed processing has consistently been measured at previous assessments but considerable improvement is now seen. In the past slowed processing speed may have partially accounted for a degree of the fatigue Mr Anderson has experienced.

Mr Anderson sustained a concussion of mild severity (GCS of 13 at the scene; PTA uncertain, up to approximately 24 hours but anaesthetic for surgery administered during that period; normal CT scan). Complete recovery from a mild concussion is expected to have occurred by now. In samples where there is a high motivation to recover quickly (prospective studies tracking concussions in professional sport players for example), effects of concussion diminish by 7-29 days and disappear by 30-89 days, and this is consistent with general population patterns showing complete recovery from mild traumatic brain injury is expected between 2 weeks to 3 months post-injury (Mooney, Speed & Sheppard, 2005). Brain injury diagnosis can no longer explain the level of persisting disability Mr Anderson reports.

Mr Anderson's primary presenting symptom has consistently been fatigue which is not unique to post-concussion. Because post-concussion syndrome or associated cognitive impairment cannot account for his persisting level of fatigue and reported disability, medical cause is likely, whether this is secondary to the accident or independent.

In Mr Anderson's case persisting fatigue may be caused by a chronic fatigue syndrome. Formal diagnosis of the chronic fatigue has not been made and medical opinion remains unclear regarding the relationship of this symptom or such a syndrome to the accident. Research on neuropsychological functioning in patients with chronic fatigue shows many similarities to traumatic brain injury in terms of neurological affective, and cognitive symptoms, and it is possible symptoms of this or a similar disorder/syndrome have been mis-attributed to brain injury. In the absence of brain injury patients with chronic fatigue syndrome commonly show significantly reduced processing speed on testing (Busichio et al., 2004; Deluca et al., 2004; Michiels & Cluydts, 2001; Quillian, 1994; Tiersky et al, 1997). Therefore improved but previously low processing speed scores were not necessarily due to brain injury and could be accounted for by a medical condition.

In response to questions raised in the referral:

1. *Please assess Mr Anderson with a view to documenting any current disability, its relationship to his covered injury, an analysis or diagnosis of any other factors that might be causing, or contributing to his reported disability, and recommendations to assist his rehabilitation, and to facilitate his well being in the future.*

   Current disability as reported by Mr Anderson is outlined in the Current Concerns section. The primary presenting problem remains fatigue, and other difficulties secondary to this. It is difficult to attribute current fatigue to the covered injury which was a mild severity traumatic brain injury sustained over 8 years ago. As outlined in the Summary and Opinion section, full recovery from this is expected to have occurred by now. Longitudinal studies consistently show that following a mild traumatic brain injury levels of fatigue decrease with time (Norrie et al, 2010; Ouellet & Morin, 2006), however Mr Anderson has not experienced this pattern.

   Medical opinion has suggested diagnosis of a chronic fatigue syndrome or POTS, although medical reports indicate that neither diagnostic criteria are exactly met. Previous assessments have shown a slow processing speed but this is commonly seen in patients with chronic

fatigue syndrome. Therefore test results and level of persisting fatigue could be explained by a chronic fatigue type syndrome but are not consistent with mild traumatic brain injury. Dr Bowers and Dr du Plessis advise that the research remains unclear as to whether POTS or chronic fatigue could be attributed to the accident cause.

Without a clear diagnosis treatment recommendations are difficult. Fatigue is the only limiting factor. Current cognitive abilities provide no limitations to work capacity. Mr Anderson's lowest processing speed score was one test in the average range, and all other abilities are above the average range of pre-morbid levels, demonstrating a wealth of strengths. Therefore there are no cognitive rehabilitation needs. It is suggested that chronic fatigue models would provide useful guidance in managing fatigue. This research indicates that chronic behaviour therapy and graded exercise are effective (Times & Chalder, 2005), although Mr Anderson has already received these interventions without success. There is a risk that the length of time Mr Anderson has had out of the workforce at his age becomes a problem in itself. Even very part time participation in some gainful employment is recommended.

1. *Please provide a full neuropsychological assessment and report on any factors, social, medical, psychological etc that are contributing to Mr Anderson's current situation and any difficulties he might be experiencing.*

A full neuropsychological assessment is provided and results are detailed in the Assessment Results section. **There are no identified psychological or social factors contributing to Mr Anderson's current reported fatigue. Mr Anderson presents consistently over time and there are no indications of exaggerated disability on well-validated psychometric measures of cognitive and psychological symptom report.** I am not qualified to comment on medical factors. Fatigue is the symptom limiting function. There are no cognitive impairments from concussion or other cause that could account for the degree of fatigue reported.

2. *Comment on the usual severity and cause of recovery in cases of similar to Mr Anderson's. Please state how his case may differ.*

Mr Anderson sustained a mild severity injury to the brain in the accident on 09.12.2003 (GCS of 13 at the scene; PTA uncertain, up to approximately 24 hours but anaesthetic for surgery administered during that period; normal CT scan). Complete recovery from a mild concussion is expected to have occurred by now. In samples where there is a high motivation to recover quickly (prospective studies tracking concussions in professional sport players for example), effects of concussion diminish by 7-29 days and disappear by 30-89 days, and this is consistent with general population patterns showing complete recovery from mild traumatic brain injury is expected between 2 weeks to 3 months post-injury. (Mooney, Speed & Shepperd, 2005). Brain injury diagnosis an no longer explain the level of persisting fatigue and disability reported. Longitudinal studies consistently show that following a mild traumatic brain injury levels of fatigue decrease with time (Norrie et al, 2010; Ouellet & Morin, 2006), however Mr Anderson has not experienced this pattern. It is relevant to note that his primary presenting symptom of

fatigue, and the slowed processing speed at previous testing could both be explained with a chronic fatigue syndrome diagnosis.

3. *Please review and comment on previous assessments, particularly previous Neuropsychological assessments, and relate your findings to those of previous assessments.*

   Mr Anderson underwent an initial neuropsychological assessment with Megan Phillips in 2004 and a second assessment with Johanna Yee in 2005. All assessments have found a strong overall cognitive capacity that remains at premorbid levels above the average range. Previous assessments have reported slowed processing speed. Fortunately improvement across time is demonstrated with his scores on the processing speed index improving from the low average range in 2004 to the average range now, based on only a single average range score. Generally on other processing speed tasks and more demanding timed tasks he shows good processing speed capacity. Since earlier testing working memory ability has returned to pre-morbid levels.

4. *If relevant, please comment on Mr Anderson's neuropsychological profile, and the implications of any difficulties he might have on his ability to drive, engage in the usual activities of daily living, and on future employment.*

   Mr Anderson's lowest processing speed score was in the average range compared to the general population his age, with all his other processing speed scores above that level. Average range processing would not present concerns regarding his ability to drive. He also demonstrates an awareness and care about driving when fatigued and appears to manage this responsibility. His current cognitive abilities would not prevent him from performing any daily domestic or vocational activity. Fatigue is the only limiting factor. In terms of future employment fatigue levels for anyone can be minimised by working in an environment that is quiet, with minimal distractions, and allows regular breaks. The less physically and cognitively demanding a task is, the longer his tolerance for the task will probably be. It should be noted that during testing presence of subjective fatigue did not reduce accuracy or performance on tests so would not be expected to impair work accuracy or performance.

5. *Please provide a comprehensive assessment of symptom validity including use of measures of the new generation of the highest sensitivity and specificity.*

   New generation measures of effort on cognitive testing and psychological symptom validity raised no concerns. These tests indicated that Mr Anderson invested full and genuine effort in testing and was not exaggerating symptom report and disability on self-report measures.

6. *Please comment on Mr Anderson's pre-injury ability and coping. Wherever possible refer to objective sources of information; that is uninterested third parties (such as school reports, GP records from a significant period pre-injury, occupational records) if independent sources were not consulted please state this in your report.*

Uninterested third party account of pre-injury ability was not available. ACC advised they do not hold any pre-injury medical notes. Mr Anderson and his partner (who has been with him since before the accident), report that he was a busy person who worked about 50 hours a week and still enjoyed socialising and the outdoors in his spare time. He reports no significant pre-accident medical or psychological problems.

7. *Please comment on the likely effects of substance use, or medical conditions on Mr Anderson's energy levels, cognitive abilities, and ability to engage in the usual activities of daily life.*

   Mr Anderson does not use illicit drugs and his weekly alcohol consumption is below the recommended maximum level for men (ALAC guidelines). Therefore substance use cannot account for reduced energy levels or reduced test scores, and would not impact Mr Anderson's daily functioning. Pre-accident medical notes are not available for review but Mr Anderson reports no significant pre-accident medical or psychiatric diagnosis. Currently his fatigue may be due to a medical condition but as yet diagnosis remains unclear.

8. *If you believe it is relevant, please conduct a full formal assessment of personality factors that might impact on Mr Anderson's presentation, functioning, and rehabilitation.*

   A formal psychometric assessment of personality factors was conducted. Results are reported in the *Psychological Assessment* section. No validity issues, personality factor, or psychological disorder was identified that would account for current presentation.

9. *Please provide recommendations to assist Mr Anderson in returning to as fully independent functioning as possible given any limitations he might suffer.*

   Mr Anderson does not currently present with symptoms attributable to brain injury, so diagnosis is likely to be medical and specific treatment and rehabilitation would be best advised by medical professionals. In terms of general management of fatigue, Mr Anderson will have a longer tolerance for an activity or job if demanding aspects can be minimised. Reducing cognitive demands could involve reducing background noise, distraction and interruption, doing one task at a time, and developing efficient task organisation systems. These strategies would be unique to a particular job and could be provided by an Occupational Therapist once a workplace is arranged. After this length of time out of routine daily activity any tolerance for new activity would need to be established gradually.

   [Emphasis added]

[31] Comment was then sought by the Corporation from Dr James Hegarty, Branch Advisory Psychologist. It is unclear exactly what reports Dr Hegarty was provided with before he commented as follows:

It should be remembered that processing speed is related to general intellectual ability at near chance level (r=@0.55). As such a professional speed score within the Average range would not be considered out of the norm for Mr Anderson. In addition, it is normal to find scores in the below average range on test of cognitive ability, even among those of superior ability. Therefore previous measures low processing speed may not have been indicative of a true deficit of processing speed ability.

It should also be remembered that problematic fatigue is commonly reported at high rates among the "healthy" population, and is not necessarily indicative of a brain injury, or major physical illness.

My understanding of the relevant reports on file is that there is no evidence that Mr Anderson suffers from POTS, or from chronic fatigue. In any event the literature is clear that there is no reliable or valid evidence that a mild concussion or brain injury would cause either POTS, or chronic fatigue. On the basis of probability Mr Anderson's difficulties could not be attributed to his covered head injury.

I do not see the point of investigating this further, however recommend that this is discussed with your Team Manager.

[32] At this point the issue was referred back to Dr Walker. The referral to Dr Walker by Ms Grey summarised the available evidence as follows:

Summary – Dr Bowers has diagnosed POTS, and Dr du Plessis has diagnosed Chronic fatigue or POTS. **Neither can say if it is or is not related to the accident**, but there is a possibility of an association to the accident.

[Emphasis added]

[33] From that starting point Ms Grey asked the following questions of Dr Walker:

Please review the file to determine if Mr Anderson still has cover from ACC.

Specifically, cover is granted for a head injury, with a probable diagnosis of POTS – does Mr Anderson still have cover from ACC?

Is the POTS related to the head injury and original accident?

[34] In response Dr Walker stated:

The neuropsychological testing conducted in February 2012 did not show any cognitive impairment. All scores were above average except for processing speed but such a finding cannot be linked with the head injury given that such an array of results are said to be a common normal finding.

I note that the client has persisting fatigue, which may or may not be attributable to the accident.

I note that both Dr Bower's indicated that the POTS may be due to the head injury although Dr du Plessis concluded otherwise. Overall, this does not provide enough evidence to support cover for POTS.

ACC needs to consider what responsibility it has for the client's fatigue. I note that Dr du Plessis, as per his report dated 31.03.11, did not think that the fatigue was due to the head injury. Instead, Dr du Plessis attributed the client's incapacity to the postural orthostatic syndrome, de-conditioning, as well as the fatigue. In line with that, Dr Bowers' report dated 05.05.11 stated that fatigue upon standing was one of the clinical features of POTS however Dr Bower could not rule out other causes for the client's fatigue. In line with that Katy Taylor, as per her neuropsychological report dated 28.02.12, stated that the client's brain injury diagnosis can no longer explain the level of persisting disability.

I do not think it is clearly appropriate to cease entitlement, at least at present. Firstly, the client's ability to perform his pre-injury job is unclear. Secondly, the reason(s) for the client's fatigue has not been very clearly established (it is hard to argue strongly that injury is not the issue when the true cause(s) remains less than clear i.e. Dr Bower was not definitive as to the relationship between the client's POTS and his fatigue & whether or not other causes for fatigue might be operating).

[Emphasis added]

[35] The Corporation considered this advice, with the issues summarised in an anonymous undated file memorandum which recorded:

Have reviewed the latest Workwise comment and the comments from Drs du Plessis and Bowers.

The issue of ongoing entitlement is dependent on considering the principles from Ellwood, accordingly ACC has to show the weight of medical evidence shows that ACC can be not satisfied that there is ongoing entitlement.

When looking at the weight of evidence/comment –

For being Not Satisfied	Favouring continued entitlement
- Neuropsych assessment finds that the TBI doesn't explain his symptoms and a medical cause for the persisting fatigue is likely.	- temporal link. However on its own this isn't sufficient and needs to be substantiated by medical comment.
- du Plessis report, not post concussion syndrome or TBI related, POTS and no evidence to link POTS to trauma.	- Bowers report, POTS is the best we can offer, is possible this is the continued cause for Mr Andersons condition and that there is at least a good possibility that this relates to his TBI in either a causal or strongly associated fashion. → However the test is on balance of probabilities though. → As per District Court decision of Davis (307/2110) Judge Willy

	commented when looking at the issue of multiple chemical sensitivity being caused by gluteraldehyde poisoning – *It may well be that at some time the science will confirm the "common sense", but until it does there remains an unabridged gap evidential gap in the link of causation and the appellant must fail."* As in this case no firm conclusions exist re TBI being a cause of POTS.
- Cover granted for TBI only and reports showing symptoms not TBI related.	
- BAP comment that the literature doesn't show a link with TBI and POTS.	
Onus on ACC is to show we are satisfied the current issues are not linked to the covered injury.	

> As the Workwise comment states "Overall, this does not provide enough evidence to cover POTS". Accordingly as symptoms as not due to the TBI and the likely cause offered is POTS without cover for POTS there can't be continued entitlement. The bits of evidence that possibly support ongoing entitlement as stated above are not without flaws.
>
> Workwise comment is that Dr Gerard[sic] doesn't think it is clearly appropriate to cease entitlement, at least at present as firstly the client's ability to perform his pre-injury job are unclear. However the wrong legal test is being considered when making these comments. These comments would have relevant if a Section 103 clearance was being considered, which it is not. The matter is a section 117 one whereby the medical evidence points to the ongoing symptoms and incapacity being caused by something other than the injury that was covered. While there may be some conjecture re the cause of the fatigue; be it POTS or chronic fatigue syndrome what is clear is there is insufficient information to show there is a link between either two and the injury that cover had been granted for.

[36] As a result the Corporation issued its decision of 30 August 2012 suspending Mr Anderson's entitlement to weekly compensation ("the suspension decision"). Specifically the decision letter recorded:

> Thank you for your patience while we've reconsidered your entitlement to weekly compensation.
>
> We have based our decision on the medical reports from Dr du Plessis, Dr Bowers, and Katy Taylor.

> After looking carefully at all the information available, we're sorry to say we've now suspended your entitlement to weekly compensation under section 117(1) and you will receive your last payment on 30 September 2012.
>
> **Why we can't continue with your entitlement**
>
> We're unable to continue providing you with this support as the medical information received shows that your current condition is no longer the result of your personal injury of 09/12/2003.
>
> The medical reports state that your symptoms are not post concussion syndrome, or Traumatic Brain Injury related, it is likely to be Postural Orthostatic Tachycardia Syndrome (POTS) and there is no evidence to link POTS to trauma. Cover has been granted for Traumatic Brain Injury, and the reports from Dr du Plessis and Katy Taylor show that the symptoms are not Traumatic Brain injury related.

[37] Mr Anderson sought a review of the suspension decision and obtained a report from Dr Gil Newburn, neuropsychologist in support of that application and this report sparked a response from Dr du Plessis and led to a series of further reports between Dr du Plessis and Dr Newburn.

[38] The Corporation's decision was however upheld at review. Reviewer J Wilson concluding that the Corporation "had sufficient evidence to suspend [Mr Anderson's] entitlements and it was correct to rely on the opinions of Drs du Plessis and Taylor to do so". While Review Wilson awarded costs in favour of Mr Anderson, she declined to award disbursements for Dr Newburn's second and third reports on the basis the amount sought was not reasonable and because she considered herself "bound by the Regulations to only award the maximum once". As a result of the review decision, Mr Anderson filed appeal ACR 418/13, the first appeal at issue in this judgment.

[39] In the meantime in early 2013 and following the suspension, Mr Anderson's counsel Mr Forster had sought clarification of the cover held by Mr Anderson, and specifically whether Mr Anderson had been granted cover for post concussion syndrome and, if so, whether it had been revoked. In response Ms Grey confirmed that cover had been granted for concussion and noted that the suspension letter had advised that Mr Anderson's symptoms "are not related to post concussion syndrome or traumatic brain injury, but are likely to be related to POTS, and there is no evidence to link POTS to trauma". Mr Forster then wrote to Ms Douglass, counsel

for the Corporation, summarising the exchange with Ms Grey and seeking the following assurance:

> One of the submissions that we are considering advancing is that the post concussion syndrome is causing the current incapacity. My concern is that this submission will be responded to with a submission that there is no cover for post concussion syndrome and therefore the reviewer has no jurisdiction to consider such.
>
> Can you please advise whether ACC agrees the reviewer has jurisdiction to consider post concussion syndrome.

[40] It is unclear if Ms Douglass responded or not. In any event on 6 September 2013 Dr Adam filed an additional ACC45 injury claim form seeking cover for "E2-A2-post concussion syndrome", suffered in Mr Anderson's accident of 9 December 2003.

[41] The Corporation responded to Mr Anderson on 13 September 2013 and stated:

> **We're sorry, we can't approve your claim**
>
> Your treatment provider has made a claim on your behalf for the following injury(s) which happened on 09/12/2003:
>
> - Post concussion syndrome
>
> After careful consideration, we're sorry to say your claim has not been approved.
>
> **Why we can't approve your claim**
>
> We're unable to approve your claim because it relates to a previous claim you made for the same injury, which we've already declined as the medical information showed there was no post concussion syndrome. Accordingly this letter is not a fresh decision and does not attract review rights.
>
> Enclosed is a copy of our decision letter to you on 30 August 2012 letting you know why we had to decline your previous claim (A1511951679) and advising you of your rights to formally review the decision. A review of this decision was lodged and subsequently dismissed.

[42] In response to a query from Mr Forster, Ms Grey confirmed that the terms of the letter would not be altered and noted:

> As far as ACC is concerned there is no incapacity due to an injury on the 9/12/03 that will attract cover from ACC. Please refer to the Review Decision 1120856 and ACC decision letter on the A151195169 claim, which also refer to Post Concussion Syndrome.

[43] Mr Forster then proceeded to file two review applications in relation to the letter. The first sought deemed cover for the injury on the grounds that the Corporation's letter of 13 September 2013 had specifically not been a decision on the application and if no decision on cover had been made Mr Anderson was entitled to a deemed decision on the cover as sought. The second review asserted that to the extent the letter of 13 September 2013 was a decision it was wrong given its reliance in a decision on cover to a decision on the suspension of entitlements for other covered injuries.

[44] The review applications were dismissed by Reviewer J G Greene on 10 June 2014. Reviewer Greene considered that the matters raised by Mr Anderson's application for cover for post concussion syndrome had been dealt with by the suspension decision and subsequent review hearing. In particular he accepted:

> I accept Ms Douglass' submission that the matters raised by Mr Forster on these applications are governed by the legal principles of res judicata and issue estoppel. Issues arising from a suspension of entitlements decision invariably involve a consideration of cover. So, while the issue before the District Court is the suspension of entitlements the Court will have to consider the broader cover issues as part of it de novo enquiry. Given Mrs Wilson's very clear statement in her review decision to which I have referred above, it would be quite incorrect for me to assume jurisdiction on issues that are now before the District Court.
>
> It follows, therefore, that I do not consider there is any basis for Mr Anderson to argue that he has a deemed decision on cover for mental injury, nor can he require a separate decision on cover on the basis of the medical evidence that was considered at the last review hearing. Simply put, his only avenue to pursue these issues is to the hearing of his appeal in the District Court.

[45] As a result he concluded:

> I dismiss the applications. I find that ACC correctly did not issue a new reviewable decision on cover for post concussion syndrome as a mental injury consequential on Mr Anderson's covered personal injuries. And, I find that Mr Anderson does not have a deemed decision on cover for mental injury.

[46] Mr Anderson appealed the decision which is the second matter now before the Court (ACR 261/14).

Issue One – Was Mr Anderson Entitled to Cover for Post concussion Syndrome?

[47] This issue, which is the subject of the second appeal (ACR 261/14) can be addressed relatively briefly because it is clear from the outset that both the Corporation and reviewer have approached the issue in entirely the wrong way.

[48] It is clear that at the time Mr Forster was preparing for a review of the suspension decision, it was difficult to discern exactly what cover was held by Mr Anderson. While Ms Douglass has now accepted in her submissions on behalf of the Corporation "ACC initially accepted that there was post concussion syndrome arising from the head injury on 9 December 2003", it was unclear at that time as to whether this had even been formally accepted.

[49] As a result the claim for cover for post concussion syndrome was filed by Dr Adam on behalf of Mr Anderson, and it should have been dealt with on its merits. The only reason for the Corporation not dealing with the application would have been if it considered that cover had already been granted, in which case the existence of that cover should have been confirmed. It is not at all unusual to add further injuries to the cover granted for a particular accident over time and indeed such an approach is entirely sensible, as it obviates the need for a subsequent battle over entitlements.

[50] In the event the Corporation's response was quite fundamentally misconceived in stating that the cover sought had been declined in the course of the suspension decision of 30 August 2012, when it is clear that the suspension decision determined only that Mr Anderson was no longer entitled to weekly compensation, and did not consider the issue of cover at all. Nor should it have as there was no actual application for cover at the time, and the Corporation's internal documents, as well as the terms of the suspension decision itself make it clear that the only decision made in the letter of 30 August 2012 was the suspension of Mr Anderson's entitlement to weekly compensation. The fundamental difference between cover and entitlements should have been clear to the Corporation, but by retrospectively purporting to subsume the application for cover for post concussion syndrome into

the decision on entitlements, the Corporation erroneously concluded that it was not making a fresh decision on the application for cover.

[51] Against this background it is not surprising, and entirely reasonable, that Mr Forrester felt compelled to hedge his bets and file two review applications, seeking a deemed decision on the cover application in the event that the Corporation in fact had not made a decision on the application, and an application reviewing the merits in the event that the letter of 13 September 2013 was found to be a decision declining cover.

[52] Unfortunately the distinction between cover and entitlements was not recognised by Reviewer Greene, who concluded that the review decision upholding the suspension decision had addressed the issue of cover for post concussion syndrome, and that the legal principles of res judicata and issue estoppel accordingly applied. This was simply wrong, and this error led Reviewer Greene to conclude that the second of Mr Anderson's review applications, seeking a deemed decision was not reasonably brought. Given my conclusion on the way the application for cover for post concussion syndrome has been dealt with, this conclusion was also wrong and Mr Anderson is entitled to costs on the deemed decision review as well.

[53] How then should the letter of 13 September 2013 be construed? Given its ultimate conclusion, the only sensible interpretation was that it in effect was a decision declining the cover sought. The question then turns to whether Mr Anderson was entitled to cover for post concussion syndrome as sought.

[54] In this regard the distinction between cover and entitlements remains of fundamental importance. In relation to cover the question is whether that at any point the claimant suffered a particular injury as a result of an accident in accordance with the Act. If he or she has, then he or she is entitled to cover. This does not mean that entitlements flow to the claimant at any particular point in time, for example, no entitlements will flow where the injury for which cover has been granted has resolved and entitlements have been suspended, or the claimant otherwise does not meet the test for a particular entitlement, such as for example, the claimant was not

an earner at the date of injury and incapacity, and as a result notwithstanding cover, will not be entitled to weekly compensation.

[55] In this case, with regard to cover, there can in fact be no dispute whatsoever that Mr Anderson did suffer post concussion syndrome as a result of his accident on 9 December 2003. As noted at [47] above, Ms Douglass noted that the "Corporation initially accepted that there was post concussion syndrome arising from the head injury on 9 December 2003". Ms Douglass' acceptance of this point on behalf of the Corporation is, as the factual background section makes clear, entirely consistent with the evidence before the Court. As noted in the factual background section, and in particular at [3] and [4] above, diagnoses of post concussion syndrome were a constant feature of medical certificates provided on behalf of Mr Anderson and it was indeed the primary basis for Mr Anderson receiving entitlements through to the suspension decision. Post concussion syndrome was also formally recognised on numerous occasions, including by Ms Phillips, Dr Gordon, Ms Yee, and Dr Newburn. Even Dr du Plessis did not dispute that Mr Anderson **had** post concussion syndrome, rather the reasons he could not confirm that Mr Anderson continued to have post concussion syndrome when he assessed Mr Anderson in March 2011 were:

> ... the main reason being that post-concussion syndrome does not last this long following a mild concussive brain injury, and secondly that the over-riding symptom continues to be only fatigue and it is only when he is fatigued that he reports other symptoms.

[56] Taken together I conclude there can be absolutely no doubt that Mr Anderson is entitled to cover for post concussion syndrome from the date of his injury. The question now becomes whether he remained entitled to entitlements as a result of that or indeed any of his other covered injuries or whether the suspension decision was correct.

Issue Two – Was the Corporation Correct to Suspend Mr Anderson's Entitlement to Weekly Compensation?

[57] The power for the Corporation to suspend entitlements to clients is set out in s 117(1) of the Accident Compensation Act 2001 which provides:

> **117 Corporation may suspend, cancel, or decline entitlements**

(1) 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.

[58] It is well established, pursuant to the decision of Mallon J in *Ellwood v Accident Compensation Corporation*[1] that before the entitlements of a claimant can be suspended the Corporation must show that it had a sufficient basis on which entitlements should be suspended, with her Honour noting in particular:

> The claimant is not present at the first stage so the obligation must be on ACC at this stage to obtain sufficient evidence … if there is an insufficient basis then the test of "is not satisfied" is not met. If there is a sufficient basis then ACC can be "not satisfied" of the right to entitlements. As the reviewer and the District Court apply the same test the same approach should be taken at each stage.[2]

[59] As a result before the medical evidence adduced by both parties after the Corporation's decision can be considered, this Court must first be satisfied that the Corporation had a sufficient basis to be not satisfied that Mr Anderson had a right to continue to receive entitlements at the time the decision to suspend was made. Only if this can be established does the Court then consider whether there remains a sufficient basis to be not satisfied having regard to all the evidence now before the Court.

[60] With regard to what is required for the Corporation to be satisfied as to whether a claimant remains entitled to an entitlement, the starting point is clearly s 67 of the Act which provides:

> **67 Who is entitled to entitlements**
>
> A claimant who has suffered a personal injury is entitled to 1 or more entitlements if he or she—
>
> (a) has cover for the personal injury; and
>
> (b) is eligible under this Act for the entitlement or entitlements in respect of the personal injury.

[61] As a result the correct approach in determining whether a claimant is no longer entitled to an entitlement or entitlements is to consider whether the two components

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1 [2007] NZAR 205
2 [64] at 221.

of s 67 continue to be satisfied. In other words entitlements can only be suspended under s 117(1) if either of the two requirements in s 67 are not, or are no longer, met.

[62] With regard to the requirement under s 67(a) this is most often manifested when the covered injury is recorded as a sprain or a strain and the entitlement sought is for a more specific injury such as a rotator cuff tear or lumbar disc prolapse. In such situations a causal inquiry is necessary to determine whether the tear or prolapse was indeed related to the injury for which cover was granted or whether the injury for which the entitlement is required occurred independently of the covered injury. Likewise it is well established that a claimant cannot rely upon a non covered injury to support a claim for entitlements, and in the absence of cover no entitlements can therefore flow.[3]

[63] In contrast where there is no dispute over the extent of cover the question becomes whether the claimant is still eligible for a particular entitlement or entitlements pursuant to s 67(b). If the covered injury has resolved the claimant will for example no longer be eligible for weekly compensation as he or she is "no longer unable, because of his or her personal injury, to engage in employment in which he or she was employed when he or she suffered the personal injury" pursuant to s 103(2) of the Act.

[64] As a result the issues to be determined on appeal ACR418/13 are:

[a] Did the Corporation have a sufficient basis as at the date of the decision to suspend on 30 August 2012 to be not satisfied that Mr Anderson should continue to receive entitlements? And

[b] Is the decision to suspend correct in light of the evidence now before the Court?

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[3] See in particular *Medwed v Accident Compensation Corporation* [2009] NZACC 87 at [13] and [26] and my decision in *Newton v Accident Compensation Corporation* [2015] NZACC 22 at [24] and [25].

Whether the Corporation had a sufficient basis to suspend at the date of decision

[65] Ms Douglass submitted on behalf of the Corporation the suspension decision was correct at the time it was made. In particular she submitted "the culmination of medical information before [the Corporation] as at August 2012 and in particular the evidence of Dr du Plessis, Ms Taylor and Dr Bowers provided a more than sufficient basis for the Corporation to suspend and that in contrast Mr Anderson was unable to show his incapacity was causally related to his covered injury.

[66] Furthermore it was Ms Douglass's submission that:

> 46. Whilst ACC had initially accepted that there was post concussion syndrome arising from the head injury on 9 December 2003, it rejected this syndrome as an ongoing cause of the appellant's fatigue.
>
> 47. At the time of the decision letter in August 2012, it was considered likely to be postural orthostatic tachycardia syndrome (POTS) and there was no evidence to link POTS to trauma.
>
> 48. In the event, the differential diagnosis of POTS was excluded. ACC had only granted cover for traumatic brain injury and the reports of Dr du Plessis and Dr Taylor showed the appellant's symptoms were not traumatic brain injury related. ACC considered that there was no causal link between the appellant's current condition and his covered injury.

Discussion and Analysis – Suspension

[67] This is an appeal where a long recital of the factual background is necessary given the wide range of specialist opinion available prior to the suspension decision with regard to Mr Anderson's condition. When all reports available at the time of the suspension decision are looked at carefully I am quite satisfied that the Corporation did not have a sufficient basis to suspend Mr Anderson's entitlements and instead the Corporation's decision-making process was quite flawed at a number of different levels.

[68] First, it is clear as both Mr Forster and Ms Douglass noted in their respective submissions, that post concussion syndrome was identified at an early point as being the cause of Mr Anderson's condition, and that this diagnosis was well supported by specialist opinion and accepted by the Corporation as providing a basis for entitlements including weekly compensation to Mr Anderson for a number of years.

However, by the date of the suspension decision the focus was on whether or not Mr Anderson had POTS and if so whether it was causally linked to Mr Anderson's accident, rather than post concussion syndrome, notwithstanding the reference to post concussion syndrome on the suspension decision itself.

[69] While the reason for this change is clear, namely the reports of Dr du Plessis and to a lesser extent Ms Taylor and Dr Bowers, the change is not warranted on the evidence before me. Specifically while Dr du Plessis reached the view that he could not confirm that Mr Anderson had an ongoing post concussion syndrome for a variety of reasons, this was against a background where no less than three specialists, Ms Phillips, Dr Gordon and Ms Yee had all concluded that post concussion syndrome was indeed the cause of Mr Anderson's ongoing problems notwithstanding that they too had assessed Mr Anderson some time after the accident (in Dr Gordon's case some two and a half years later). While as set out at [20] above Dr du Plessis had noted the existence of these three reports at no time did he engage with the diagnosis reached by those specialists let alone did he ever state that they were wrong or why. This is particularly important given the evidence is clear that Mr Anderson has presented consistently since his accident and at no stage has there been any suggestion that his symptoms were other than genuine, on the contrary the neuro psychological testing undertaken by Ms Taylor confirmed that they were.

[70] At best Dr du Plessis was simply a further opinion and notwithstanding it was the most recent did not entitle the Corporation to simply ignore the earlier specialist reports. Furthermore to the extent that Dr du Plessis characterised Mr Anderson's chronic fatigue as a neuropsychological disorder he did not explain why this was not related to the accident, given the temporal connection between the onset of symptoms and the accident itself. Ms Taylor's report in turn does not provide any greater basis for ignoring those earlier reports. While acknowledging that Ms Phillips and Dr Gordon had completed reports, as noted at [30] above she did not even note Ms Yee's conclusions, nor did she acknowledge Ms Phillip's diagnosis of post concussion syndrome. Furthermore Ms Taylor did not directly state that Mr Anderson did not have post concussion syndrome but rather having observed that fatigue was not unique to post concussion syndrome, without any semblance of foundation simply asserted:

> Because post concussion syndrome or associated cognitive impairment, cannot account for his persisting level of fatigue and reported disability, medical cause is likely, whether this is secondary to the accident or independent.

[71] I likewise find that there was no basis for the Corporation to conclude that Mr Anderson was in fact suffering from POTS. As noted at [16]-[17] above the possibility of POTS was first raised by Dr Bowers in February 2009 but rejected in his next report of 20 August 2009 for not meeting "the full neurophysiological criteria". As a result although Dr Bowers continued to treat Mr Anderson until at least July 2010 POTS was not mentioned again as a possible diagnosis. Accordingly the time Dr du Plessis reached the opinion that Mr Anderson may be suffering from POTS it had already been rejected by Dr Bowers. Although Dr Bowers in his final report, following the Corporation's request for further information on POTS, did agree that Mr Anderson could be suffering from POTS ("the diagnosis does appear to fit"), Dr Bowers was quite equivocal noting in particular the "relatively uncertain diagnostic criteria" and even then only agreeing "it is **possible** this is the continued cause for Mr Anderson's condition". Although Dr du Plessis was more certain it must be seen in the context that POTS was clearly outside Dr du Plessis' core area of expertise evidenced by the fact that he felt it necessary to talk to Dr Bowers with regard to the condition, and indeed the fact he undertook a literature review which was clearly intended to find out more about the condition.

[72] Given this background, the failure of Dr du Plessis to engage with the earlier diagnoses of post concussion syndrome, the uncertain conclusions reached by Dr Bowers and the essentially derivative nature of Dr du Plessis' conclusions with regard to POTS, it is difficult to see on what basis the Corporation could move to a decision summary on 23 June 2011 (see [27] above) that did not address the earlier diagnosis of post concussion syndrome directly but instead moved straight to a discussion of POTS and whether or not such POTS was linked to Mr Anderson's accident. Likewise the brief report of Dr Burt (see [28] above) provides no support for the Corporation's eventual conclusions given it simply references Dr du Plessis' report and conclusions.

[73] Despite this, the seemingly inexorable move towards a suspension foreshadowed by both the decision rationale document of 23 June 2011 and

Dr Burt's comment, was abruptly interrupted by Dr Walker's comment on 18 July 2011 when he observed "ACC is on arguably weak grounds to disentitle given the information available", and further, after receiving the final Drs du Plessis and Bowers reports on POTS, Ms Taylor's report, as well as the brief comment of Dr Hegarty which cast even more doubt on the POTS thesis, still concluded that the Corporation should not suspend Mr Anderson's entitlements.

[74] The fact that Dr Walker came to this view not just once, but twice, that it was premature to suspend Mr Anderson's entitlements is significant in this case. Dr Walker is well known to this Court through his robust reports on behalf of the Corporation and he is often used by the Corporation as a final sounding board as to whether suspension is appropriate. While Dr Walker's reports have not always been accepted by this Court they are always deserving of respect and for him to oppose the Corporation's decision where the Corporation must establish a basis to be not satisfied that Mr Anderson remained entitled to receive entitlements is quite unprecedented. In this case it is noted that Dr Walker's views were sought because of his seniority and experience, and the fact he could not support the decision ultimately taken is of great moment.

[75] While it is correct that further evidence was obtained after Dr Walker's first comment, it is quite clear that he did not accept Dr du Plessis' first report provided a basis to suspend Mr Anderson's entitlements, while the second report considered all the evidence then available. While Ms Douglass submitted that Dr Walker had confused the test for suspension, a close inspection of his comment shows that this was not the case. Instead, as the suspension decision ultimately made by the Corporation involved the suspension of entitlements for weekly compensation, the ongoing incapacity of Mr Anderson was clearly relevant (see [63] above). Similarly the cause or causes of Mr Anderson's ongoing incapacity was also relevant, and Dr Walker was clearly not satisfied that the other causes for Mr Anderson's incapacity, including those for which he had cover may "still be operating".

[76] In any event, Dr Walker's analysis compares favourably with the undated, anonymous, memorandum that underpinned the final decision to suspend Mr Anderson's entitlements (see [35] above). Not only did the memorandum clearly

not consider the earlier diagnosis of post concussion syndrome and proceeded on the basis that the issue was ultimately a battle between whether Mr Anderson's POTS was or was not causally linked to his accident, but in going on to suggest Dr Walker had adopted the wrong legal test the author of the report was not only wrong, as noted above, but completely failed to address Dr Walker's other concerns that he was not satisfied as to "whether or not other causes for fatigue might be operating".

[77] Taken together it can be seen that the suspension decision, focused as it was on only the reports from Dr du Plessis, Dr Bowers and Ms Taylor, was significantly flawed across a number of different levels. As a result I conclude that it the date of the decision the Corporation did not have a sufficient basis to be not satisfied that Mr Anderson's symptoms were no longer the result of post concussion syndrome arising as a result of his injury. As a result appeal ACR 418/13 must be allowed and it is not necessary to cover the totality of the evidence now before the Court.

[78] The only issue remaining involves the decision of Reviewer Wilson not to allow disbursements for Dr Newburn's second and third reports at review. As discussed with counsel at the hearing it appears clear that Reviewer Wilson was mistaken in concluding that the additional reports exceeded the maximum payable. Specifically, pursuant to the Injury Prevention, Rehabilitation, and Compensation (Review Costs and Appeals) Regulations 2002, "All relevant and reasonably necessary **reports** for applicant ... by any registered specialists" are entitled to a maximum award of $935.54. Quite clearly, the maximum award must relate to each report prepared rather than the maximum that the specialist is entitled to with regard to the totality of their involvement in a review. While Reviewer Wilson also purported to exercise her discretion that the amounts sought were not reasonable it is noted that she was not aware of the actual costs of the reports and she was not, as a result, in a position to make an informed decision as to whether the amounts invoiced by Dr Newburn were reasonable or not. In the event the correct amounts invoiced by Dr Newburn for his second and third reports were $690.00 and $230.00 respectively, and Ms Douglass has not suggested that such amounts were in fact unreasonable. I accordingly also direct that Mr Anderson is entitled to disbursements for Dr Newburn's second and third reports.

Decision

[79] Both appeals are allowed:

[a] In respect of ACR 418/13 the review decision of 24 June 2013 is quashed and the Corporation's decision of 30 August 2012 set aside. Mr Anderson's weekly compensation is to be reinstated and in addition the Corporation is to reimburse Mr Anderson for the cost of Dr Newburn's second and third reports being a total of $920.00 (including GST) which were not allowed in review 1120856.

[b] In respect of ACR 261/14 the review decision of 10 June 2014 is quashed and the Corporation's decision of 13 September 2013 set aside. Mr Anderson is entitled to cover for post concussion syndrome from 9 December 2003. In addition for the reasons set out in the judgment, Mr Anderson is also entitled to costs on review 2216589.

[80] Mr Anderson is also entitled to costs. In the event that these cannot be agreed within one month, I will determine the issue following the filing of memoranda.

Judge L G Powell
District Court Judge

Solicitors: P J Sara, Dunedin, for the appellant