Matters relating to ACC and survivors of abuse in care (as defined in the Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions Order 2018)

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About the author

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Introduction to ACC

Personal injury cover and entitlement is governed by a complex piece of legislation, the Accident Compensation Act 2001. It has been through at least six significant legislative changes since 1972.[1] The scheme itself is unique in the world because of its no-fault coverage of diseases sustained in the workplace, accidental injuries which have occurred at work, at home, during treatment, at leisure, on the roads, or as a result of certain criminal acts. In return for a comprehensive no fault scheme which is administratively efficient, there is a social contract whereby there is no right to sue in negligence for injuries covered by the scheme.

The scheme is administered by the Accident Compensation Corporation – an independent crown entity. It is funded by way of levy. The Crown has allowed ACC to build up a significant fund to pay for the life time cost of claims. The scheme is now fully funded.

The levies are low by international standards, and the Crown has had an interest in keeping the levies low. This has led to some administrative practices that have not been considered desirable from a claimant perspective, although cost-effective to the scheme.

Therefore, in preparing this report, it is necessary to traverse issues relating to the legislation, the administration of the scheme, and the gaps in the scheme. The Royal Commission of Inquiry into Abuse in Care and Faith-Based Institutions (the Inquiry) is focused on abuse that occurred between 1950 and 1999. The Accident Compensation Act 2001 does not confer cover for any injury suffered before 1 April 1974.

The Criminal Injuries Compensation Act 1963 introduced the first state-funded scheme to provide compensation to some crime victims for personal injury. In 1975, this scheme was subsumed within a new accident compensation regime, which provided much more comprehensive compensation.[2]

[1] The legislative changes include the definition of personal injury, and the way permanent impairment is assessed. We will briefly cover these changes in the Appendices.
[2] Accident Compensation Act 1972.

Abuse in care

The Inquiry's terms of reference defines abuse as "*physical, sexual, and emotional or psychological abuse, and neglect, and—*

> *(a) the term 'abuse' includes inadequate or improper treatment or care that resulted in serious harm to the individual (whether mental or physical):*
>
> *(b) the inquiry may consider abuse by a person involved in the provision of State care or care by a faith-based institution. A person may be 'involved in' the provision of care in various ways. They may be, for example, representatives, members, staff, associates, contractors, volunteers, service providers, or others. The inquiry may also consider abuse by another care recipient."*

ACC is relevant to the Inquiry as abuse can result in physical injuries, mental injury caused by physical injury, mental injury caused by certain criminal acts; all of which are potentially coverable by ACC.

In this paper, we have included anonymised case studies of sensitive claims[3] to illustrate the processes, benefits and gaps within the scheme. Not all of the sensitive claims occurred in a state or faith based care setting, however they are relevant and illustrative of the points being made, because of the consistent way the scheme is administered by injury type rather than where or how the injury occurred.

[3] ACC defines a sensitive claim as a claim for mental or physical injuries caused by certain criminal acts.

ACC Cover: significant issues survivors face when applying for cover

Types of cover under the Accident Compensation Act 2001

To access entitlements through ACC (treatment, rehabilitation, and compensation), a survivor must first apply for and have cover accepted for their injuries. Survivors of abuse can apply for cover for the consequences of the abuse under three sections of the Accident Compensation Act 2001:

Section 20 Covered Personal Injury

A person can receive cover for any physical injury they have suffered caused by an 'accident', and any mental injury suffered by a person because of their physical injuries. Accident is defined in section 25 of the Accident Compensation Act and includes a specific event or a series of events, that involves the application of a force or resistance, external to the human body. Assault, physical violence, and sexual violence is included in the definition of an accident as it meets the definition of an application of force external to the human body.

For the claimant to receive cover for mental injury caused by their physical injury, they must be able to show a causal link between the physical injury and the mental injury. Many survivors who have been abused or neglected in state care may find themselves having to argue that their subsequent mental injury was directly caused by the physical injuries they sustained.[4] That is, if a survivor was suffering from depression prior to receiving their physical injuries, which was merely exacerbated or 're-triggered', the survivor may be unable to get cover.[5] However, sometimes because of the factual matrix of the claim, the distinction between a direct and indirect link to the physical injuries is not easily distinguished. In cases where the physical injury cannot rightly be separated out from the surrounding events cover may still be granted– a mental injury may have several operative causes as long as the physical injury is a real and significant or substantial cause of their mental injury.[6] Supportive medical evidence will be required to prove the causal link (discussed further below).

Cases considering the use of ECT and the administration of anti-depressant or anxiety medications show how difficult it can be to show that a physical injury has occurred, particularly where informed consent was obtained prior to the treatment being given.[7]

Section 21: Mental injury caused by certain criminal acts

A person can also receive cover for mental injury in the absence of a physical injury, if that mental injury was caused by certain acts being performed on, with, or in relation to that

[4] The test for causation is set out in *W v ACC* (2008) NZHC 937.
[5] *Hornby v ACC* HC, CIV-2008-485-763, 10 September 2008.
[6] *Woodd v ACC* DC Wellington, 54/2003.
[7] *Blackmore v ACC* DC Wellington, 38/2006, and *Hughes v ACC* DC Wellington, 109/2004.

person. The particular act must come within the description of a Crimes Act 1961 offence listed in schedule 3 of the Accident Compensation Act. The acts listed in the schedule include sexual violation, sexual connection with a child or young person, and indecent assault. Consistent with ACC being a no-fault scheme, it is irrelevant whether a person can be, or has been charged with or convicted of the offence, or the alleged offender is incapable of forming criminal intent.

To obtain cover, both the survivor and the treatment provider must identify the criminal act as a real or significant cause of the mental injury.

Definition of mental injury

A survivor of abuse can only get cover for mental injury if they have sustained a physical injury or has been subjected to one of the listed criminal acts (above). Examples of what would not be covered could include where a person suffers mental injury after witnessing abuse or being threatened. In both instances, neither physical injury nor a specified criminal act has occurred to that person.

To attract cover for mental injury under either section 20 or section 21, the mental injury must be a *"clinically significant behavioural, cognitive or psychological dysfunction*" – this sets a threshold for cover for mental injury. It has been ACC's practice to require that a mental condition be diagnosable by a psychiatrist under the DSM-IV[8] before cover is granted. However, this has been criticised by the Courts. The District Court has held that the threshold is lower; the DSMIV is only an aid to interpreting the inclusive and broad definition of mental injury,[9] and a claimant must only have to show more than "transient emotional trauma".[10]

However, the burden of proof is on the survivor to establish that they should have cover and that they meet the definition of mental injury. This will often require a psychological or psychiatric evaluation (discussed further below).

Section 33 Treatment injury

For the purposes of the Royal Commission, State Care has been defined to include health and disability settings, including psychiatric hospitals or facilities, residential or non-residential disability facilities, non-residential psychiatric or disability care, and health camps.[11]

A person can receive cover for personal injury (including both physical and mental injury caused by physical injury) if that injury was suffered by a person seeking treatment from a

[8] American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, American Psychiatric Association, Arlington, 2000).
[9] *OCS Ltd v TW* [2013] NZACC 177 (DC).
[10] *Public Trust v ACC* [2012] NZACC 229 (DC).
[11] Terms of Reference, clause 17.3(c)(ii).

registered health professional, and that injury was not a necessary part or ordinary consequence of the treatment. "Treatment" includes a failure to provide treatment in a timely way.

Process for lodging a claim

To 'get in the door' and receive cover and entitlements from ACC, a survivor must first lodge a claim for cover. Claims are generally lodged by a person's treatment provider (general practitioner, physiotherapist, A&E doctor). However, for sensitive claims, a registered or contracted counsellor under the ACC's "Integrated Services for Sensitive Claims contract" can lodge a claim.[12] Claims can be lodged at any time, including years after the injury occurred.[13] This is relevant as events that occur later in a survivor's life may trigger the latent effects of earlier abuse and neglect. This does not prevent cover from being granted as long as there is "sufficient untainted evidence"[14] and a causal link can be established.

However, there are some barriers to making a claim. First, it requires a medical practitioner to know that the survivor is able to lodge a claim for the events that occurred. Not all medical practitioners have knowledge of the intricacies of the ACC system, particularly when it comes to historical, complex, or sensitive claims.[15]

Second, any delay in lodging a claim may create practical barriers to receiving cover, as it is upon the survivor to provide evidence of the injuries they are claiming for and their cause. The relevant standard of proof is the civil standard, that is, the balance of probabilities or "more likely than not". Some medical practitioners are not always comfortable dealing with the civil standard, particularly where claims relate to historical events or injuries are multifactorial. In their normal course of work, medical specialists generally search for something closer to scientific certainty (especially when making decisions on courses of treatment), and to give an opinion on "more likely than not" may not always come naturally. This may pose a barrier to survivors seeking and obtaining cover where there is little contemporaneous and/or objective evidence to support their claim.[16]

Third, often survivors are required to access and collate their full medical and care records. This may require the survivor or their representative to contact hospitals, the general practitioners they have seen across their lifetime, WINZ, counsellors, and others to be able to prove their claim. This can be a significant barrier to seeking and obtaining cover as it can be very time consuming, challenging, often requiring access to technology and a strong grasp of written English, and re-triggering. This can be a difficult process for lawyers

[12] https://www.acc.co.nz/for-providers/lodging-claims/lodging-a-claim-for-a-patient/
[13] However, ACC can decline a claim if the delay in lodging a claim is more than 12 months and the delay prejudices ACC's ability to make decisions: section 53.
[14] *Clouston v ACC* (10/2003) (DC).
[15] Please refer to recommendations 10 and 11.
[16] Please refer to recommendation 11.

representing survivors, and it is burdensome and difficult for a survivor; particularly if they are unsupported and under the stress of suffering from physical and mental injuries.[17]

Legal aid is not available to assist or advise a survivor at this point; legal aid is only available once an adverse decision has been made.[18] Other issues with legal aid are discussed further below.

Case study: Historical abuse

This person is suffering anxiety and major depression from the abuse.

The process of obtaining cover and lump sum entitlement from ACC, getting a WINZ benefit, obtaining legal aid, means that they have to reveal intimate details about the abuse and their sexuality multiple times to multiple agencies.

At a minimum, the person is required to describe the abuse and impact of the abuse to their GP, a psychiatrist, an impairment assessor.

The person is also aware that their file is viewed by several agencies: internal ACC staff; legal services staff within Ministry of Justice who processed their legal aid claim; MSD staff who processed their WINZ benefit.

First Issue: Lost documents and failure to report

The person was abused while at school, by a person in authority in that school. As an adult they wished to hold the institution accountable. The institution arranged for them to be interviewed about the abuse which they had alleged had taken place.

The person thought that the interviewer was an independent medical practitioner. Therefore they revealed intimate details to the interviewer about the abuse and the psychological impact it had had on them. The person had assumed that a record of this interview would have been given to ACC.

But subsequent enquiries with ACC could not unearth a report. This led to a further erosion of trust in the institution as it appeared the interview had taken place on behalf of the institution, but not to assist the person in their desire for accountability.

Second Issue: GP lodges a claim for cover with ACC

The person had a GP who lodged a claim with ACC.

Third Issue: Assessment by a psychiatrist

[17] Please refer to recommendation 12.
[18] Please refer to recommendation 12.

In order for ACC to consider cover, the person had to be assessed by a psychiatrist. The psychiatrist diagnoses the mental injuries that they suffered from because of the abuse.

Fourth Issue: Cover

Having received the psychiatrist's report, it is reviewed internally by ACC's specialists and they form an opinion on cover. This is conveyed to the person by way of a written cover decision. In this case, ACC agreed to cover major depression and anxiety.

Fifth Issue: Reassessment by an impairment assessor for lump sum

Once cover was granted, ACC arranged for an impairment assessment for lump sum. This meant another assessment taking place. Following this assessment, the assessor's report is peer reviewed. ACC then issues a decision on the percentage of impairment that the person suffers from due to their covered injuries.

Sixth Issue: Ineligible for weekly compensation

They were ineligible for weekly compensation as when they first sought treatment and became incapacitated they were on a WINZ benefit. They were at school when the abuse took place. But the impact of the abuse came later. They had managed to hold down work episodically. They were on the WINZ benefit when the major depression and anxiety afflicted them. Since then they have not been able to return to work.

ACC entitlements: significant issues survivors face when seeking entitlements

One purpose of the Accident Compensation Act 2001 is to ensure that, where injuries occur, the "*primary focus should be on rehabilitation with the goal of achieving an appropriate quality of life through the provision of entitlements that restores to the maximum practicable extent a claimant's health, independence, and participation.*"[19]

When cover is granted, a survivor may seek to receive entitlements from ACC. ACC must provide entitlements in accordance with the Act. The Act sets out the different types of entitlement that are available, including treatment, weekly compensation for survivors who are unable to work because of their injuries, lump sum/independence allowance for permanent disability caused by their covered injuries, vocational rehabilitation, and social rehabilitation.

Treatment

ACC provides treatment to survivors on the advice of the survivor's treatment providers. With the exception of acute treatment, the ACC must give prior approval before the treatment occurs. However, our firm does not encounter many issues in this regard; when treatment is requested and there is a clear causative link between the treatment requested and the covered injuries, it is typically approved.

However, occasionally treatment is requested that is considered 'novel' or 'experimental' by ACC, such as cannabis treatment for pain management or anxiety.[20] This is not always approved; the Act states the treatment must be 'of a type normally provided by a treatment provider', and 'a generally accepted means of treatment for such an injury', taking into account 'the other options available in New Zealand for the treatment of such an injury'.[21] The provision of treatment will almost entirely depend on the support of an appropriate treatment provider.

If treatment is approved, the amount ACC is liable to pay is set out in the Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003. Some forms of treatments require the survivor to pay a co-payment, such as physiotherapy.

In sensitive claims, some counselling is made available to survivors before the claim is approved.

[19] Accident Compensation Act 2001, s3.
[20] Please refer to recommendation 6.
[21] Accident Compensation Act 2001, sch 1, cl 2.

Rongoā Māori

ACC has recently improved access to kaupapa Māori services to ensure services that are by Māori, with Māori, and for Māori are available for injured New Zealanders. ACC's website describes its Rongoā Māori service as:[22]

> Rongoā Māori is the traditional healing system used in te ao Māori. It includes the use of plant-based remedies, spiritual and physical therapies, and has a deep connection for Māori with the natural world. Traditionally, rongoā Māori was taught within whānau under the guidance of a tohunga (Māori knowledge expert).

ACC's Rongoā Māori service is guided by the Waitangi Tribunal's definition from the Ko Aotearoa Tēnei report to define rongoā Māori. This definition covers various traditional Māori healing methodologies, including:

- mirimiri (bodywork)
- whitiwhiti kōrero (support and advice)
- karakia (prayer).

Weekly compensation

Weekly compensation is designed to compensate those who have been rendered incapacitated for work by their covered injuries. However, to be eligible for weekly compensation, a survivor must be able to prove that they were an "earner" immediately prior to the (1) date of injury, **and** (2) the date of their incapacity to work. This was confirmed by the High Court in *ACC v Vandy.*[23] If a survivor was not an earner at the date of injury, but was an earner at the date of incapacity (or vice versa), the survivor cannot be eligible for weekly compensation. This requirement often leads to unjust results.[24]

In many cases, a survivor would not have been an earner at the date of injury. For physical injuries that are covered, the date of injury will be the date the injury was sustained.

For mental injury under section 21B, the date of injury is considered the date the claimant first sought treatment for the mental injury.[25] A survivor will need to provide evidence of the treatment they have received. In the case where a survivor has already received significant counselling or treatment, the notes of this treatment will be required.

Survivors who have sustained multiple injuries over time may have multiple claims and therefore many different dates of injury: the dates the physical injuries were sustained, and

[22] https://www.acc.co.nz/im-injured/what-we-cover/using-rongoaa-maaori-services/
[23] *ACC v Vandy* [2011] 2 NZLR 131 (HC).
[24] Please refer to recommendation 5.
[25] *Palmer v ACC* (104/2008) (DC).

also the date they sought treatment for mental injury. This can further complicate the analysis of whether they were an earner at the date of injury.

A person in receipt of weekly compensation must attain medical certificates certifying that they have an on-going incapacity on a regular basis. ACC generally accepts medical certificates provided electronically from a GP every three months.

Potential earners

For most survivors of abuse in state care and faith-based institutions, they will not have been in paid employment when they sustained their injuries. The Act provides that where a person was a "potential earner" at the date of their injury, they may be eligible for weekly compensation. A potential earner is a survivor who suffered their injury before turning 18 years, or suffered their injury while engaged in full-time study or training that began before they turned 18 years old and continued uninterrupted. A potential earner remains a 'potential earner' for the life of their claim. Potential earners that are subsequently incapacitated by their covered injuries can receive weekly compensation in two ways:

1. The minimum weekly adult rate under the Minimum Wage Act, or 125% of the rate for a single person without dependent children under the Social Security Act 2018. There is a standdown period of six months before a potential earner can receive weekly compensation in this way, or
2. If, in addition to being a potential earner, they were working at their date of injury and also at their date of incapacity (e.g. they had a paid paper run while they were a child, and were working later in life when they suffered their incapacity), they will receive weekly compensation at a rate based on the permanency of their work and the earnings they were receiving at the time of their incapacity.

To determine whether a potential earner is considered 'incapacitated' and therefore eligible for weekly compensation, they must undergo an occupational assessment and a medical assessment under section 105 of the Act. These assessments will determine the level of training, experience, and education the survivor has, and whether they are medically capable of working 30 hours a week or more in jobs that match their training, experience, or education (or any combination of these things). It is therefore harder for a person who was injured when they were a potential earner (who was unemployed at their date of injury) to demonstrate that they are incapacitated, than it is for a person who was injured when they were an earner.[26]

Social rehabilitation

Consistent with ACC's obligations to restore a survivor's independence to the maximum practicable extent, ACC also provides social rehabilitation such as aids and appliances, home care/home help, and personal care. In our firm's experience, a survivor with a sensitive

[26] Please refer to recommendation 8.

claim usually has to ask for this help; ACC is not particularly forthcoming with social rehabilitation in the absence of the survivor knowing about it and subsequently requesting it.[27]

Like other areas of rehabilitation, before a survivor is provided with social rehabilitation, they must undergo yet another assessment: a needs assessment. This assessment is generally done in the survivor's home and focuses on their deficits: what are they unable to do because of their covered injuries. It requires a survivor to be openly vulnerable and reveal their suffering and limitations that they are having with actions such as personal cares.

Vocational rehabilitation

In addition to providing compensation for a person's injuries, ACC must (as far as possible) provide rehabilitation to return them to the workforce. If a survivor is incapacitated and in receipt of weekly compensation, they will be eligible to receive vocational rehabilitation from ACC. There is no specific definition of vocational rehabilitation in the Act and the rehabilitation that is offered to a person is generally determined by undergoing a two step process of assessments: an initial occupational assessment and an initial medical assessment.[28]

The rehabilitation recommended in the initial occupational assessment and initial medical assessment is generally tailored towards returning the survivor to work in a job that is suitable for them based on their skills, experience, and education. It may include job trials or computer skills training. In our firms' experience, meaningful retraining is envisaged by the Act but is rarely provided. Even though the Act allows funding for retraining for up to three years (for example, a degree, diploma or apprenticeship), the needs assessors very seldom recommend this. The funding can include course fees, equipment, and payment of weekly compensation while undergoing the training.[29]

The rehabilitation needs are included in an Individual Rehabilitation Plan, which is agreed to between the ACC and the survivor. This is similar to a contract; the ACC agrees to provide the rehabilitation in the plan, and the survivor agrees to participate in the rehabilitation. A survivor can be disentitled by ACC for unreasonably failing to comply with their agreed Individual Rehabilitation Plan. In our experience, there are many reasons why a survivor may choose to deviate from the agreed Individual Rehabilitation Plan. For example, they may perceive that the rehabilitation measures are exacerbating their injury(s), they have concerns about the rehabilitation providers. ACC's responses to deviations from agreed Individual Rehabilitation Plans can be quite haphazard, and largely depends on the case manager that the survivor has.

[27] Please refer to recommendation 11.
[28] While the assessments are called "initial", in reality, survivors may have already undergone multiple medical or needs assessments by this point.
[29] Please refer to recommendation 7.

Once the rehabilitation in the Individual Rehabilitation Plan has been completed, the ACC must consider whether the rehabilitation has been successful and whether the survivor is able to work 30 hours or more in a suitable job. If so, the ACC then sends the survivor for a Vocational Independence Occupational Assessment and a Vocational Independence Medical Assessment. These are not always with the same assessors that completed the Initial assessments, and therefore survivors are once again required to repeat the history of their covered claims.

If the survivor is deemed able to work 30 hours or more per week in a suitable job type, they are no longer considered incapacitated for the purposes of the Act and are no longer eligible to receive weekly compensation. They are still entitled to receive treatment and social rehabilitation.

The vocational independence process has historically been subject to significant criticism, largely relating to the way ACC interprets and applies the legislative process. Criticisms include: claimants being removed from the scheme on the basis of being able to work in jobs that do not exist in reality, or are far removed from the claimant's training, experiences and education.[30]

Once a survivor is made vocationally independent, to become eligible for weekly compensation again, they must show that their covered injuries have 'deteriorated'.

Case study: Historical sexual abuse

Cover

The client was sexually abused by their father while still a school aged child. The mother did not acknowledge that the abuse had occurred, and therefore there was no mental health intervention arranged by the family or social welfare.

When they left school they worked intermittently in low paid part time work.

They severed the relationship with the family.

They had problems with concentration, patience and used cannabis daily. Their mental health problems deteriorated and they went onto the sickness benefit. A GP referred them to Community Health, where a psychiatric assessment found they suffered PTSD and cannabis dependence caused by sexual abuse as a child.

A claim was lodged with ACC and cover was granted for PTSD and cannabis dependence. These are mental injuries covered under section 21 for mental injury caused by certain criminal acts.

[30] Please refer to recommendation 7.

ACC also determined a date of injury. Under section 36, ACC determines the date of mental injury (for section 21 cases) as the date when the person first receives treatment for that mental injury. ACC determined the date of injury as occurring when the claim was lodged, which was when the person was in their 20's (i.e. not a potential earner).

They remained on the sickness benefit. The client had no knowledge of entitlements under the ACC scheme, nor the implications of the decision about date of injury. At this point they sought legal advice.

First dispute: Potential earner

ACC did not consider whether the claimant was a potential earner. A potential earner is a person suffering personal injury before turning 18 years (section 6).

The first dispute concerned the date of injury.

This matter went to review and the person was assisted by a lawyer. Evidence was adduced at a review hearing that the client had first sought assistance and received treatment from the school counsellor without parental knowledge. The counsellor provided evidence at a review hearing. ACC's decision was overturned. The reviewer agreed that the date of injury should be linked to the date that they obtained treatment from the counsellor while at school, not the date when the claim was lodged. This meant that the claimant was a potential earner.

ACC did not act on the review decision at the time so the lawyer acting for the person laid a complaint with ACC. ACC then issued a decision with the correct date of injury.

Second dispute: Extent of cover

The second dispute concerned the extent of cover. This is relevant both for the purposes of assessing lump sum as only covered injuries are able to be assessed for lump sum, and also it is relevant in relation to whether the person is incapacitated from the covered personal injuries.

The claimant obtained a further psychiatric report which identified further injuries including major depressive disorder. It also confirmed the PTSD and cannabis dependence disorder as coverable injuries.

ACC issued a fresh cover decision which replaced their earlier cover decision.

Third dispute: Loss of potential earnings

Having established at review that the claimant was a potential earner, ACC did not immediately turn its mind as to whether the person was entitled to Loss of potential earnings (LOPE). It required the person's lawyer to know of the availability of LOPE and then request it.

Under clause 47 schedule 1 the ACC is liable to pay weekly compensation for loss of potential earnings capacity, if the person has an incapacity resulting from a personal injury, and was a potential earner immediately before the incapacity commenced and is over 18 years and not in full time study. Weekly compensation is payable when the claimant has been incapacitated for at least 6 months.

ACC decided that further assessments were needed to establish whether the client had been incapacitated and therefore eligible for LOPE, and if so, when would backdated loss of potential earnings commence.

The section 105 test is whether they were unable because of the personal injury to engage in work for which they are suited by reason of experience, education, training or any combination of those things. This required an assessment to determine what work types the client may have been suited to in the period in question. Secondly, whether they were unable to engage in those roles because of covered mental injuries. The onus is on the client to provide evidence of incapacity. Evidence is needed of the nature and consequence of the covered injury and in sufficient detail to reach a conclusion as to whether the claimant could work.

There was minimal evidence on file about incapacity in the years following their leaving school. Their work history was sporadic.

Following the 2 assessments commissioned by ACC, it issued a decision granting LOPE with a six month stand down. In other words, ACC accepted that the client had been incapacitated by the sexual abuse causing mental injury, and that weekly compensation would be paid at the LOPE rate.

LOPE did make a difference to the client's wellbeing as the LOPE amount is 125% of the rate for a single person over the age of 18 under the Social Security Act or the minimum weekly adult rate under the Minimum Wage Act (clause 42(3), whichever is the higher.

Fourth dispute: Date of incapacity

The next issue was the relevant date for backdating purposes. ACC considered there was sufficient evidence of incapacity, but it decided that the date of incapacity was the date of the ACC assessment.

Following submissions, ACC reconsidered and adjusted the date of incapacity but not far back enough (from the client's perspective), so the date of incapacity was subject to a review.

Fifth Dispute: Review

The ACC submitted at review that as there was no contemporaneous medical evidence of incapacity no inference could be drawn until the ACC's own medical assessors assessed the client.

The reviewer found that a date of incapacity is when there is sufficient evidence of incapacity as a result of the covered personal injury. This date was set not as far back as the claimant would have liked, but several years earlier than ACC had originally thought. The client received backdated LOPE.

Sixth dispute: Interest on arrears

ACC was requested by the person's lawyer to pay interest on arrears of the backdated LOPE. It did make the payment. The client would not have known to make the request.

WINZ/ACC:

As the client had been on a sickness benefit, and received the accommodation supplement and disability allowance, ACC advised the client to sign a form agreeing that these amounts would be deducted from his backdated weekly compensation. The ACC would pay the sum deducted to WINZ, and they would receive the remainder. Following submissions, ACC agreed that it would not deduct the accommodation supplement that had been paid to them, and leave the collection of the debt for the accommodation supplement (if any) to WINZ to collect. This meant that the client received more of their backdated weekly compensation, and enabled them to negotiate a payment arrangement with WINZ to pay them back (if that was required).

Lump sum:

The client had been assessed for lump sum and when further injuries were identified, a reassessment was requested under clause 61 of schedule 1.

Treatment and vocational rehabilitation:

The client was eligible to receive treatment and vocational rehabilitation.

In summary, this was a long and exhausting process for the claimant over a 3 year period. It was stressful. Often months would elapse without progress seemingly being made. There were times when the client would be unwell and homeless. There was limited information available on the ACC web site on these issues. There was no consistent case management or case manager.

Independence allowance and lump sum compensation

A survivor may also be entitled to apply for an independence allowance or a lump sum compensation payment. These entitlements are to reflect permanent impairment caused by the survivor's injury(-ies). This entitlement does not require the survivor to have been an earner at any point. The level of payment the survivor will receive is intended to directly reflect the survivor's level of permanent disability resulting from their covered injury(-ies).

Once more, the accepted date of the survivor's injuries becomes important as this is what determines whether a person is entitled to receive an independence allowance or a lump sum payment. A history of lump sum and independence allowance payments is included as Appendix A.

Similar to social rehabilitation, the survivor must request this entitlement and a medical practitioner must fill in a medical certificate certifying that the survivor's injury(-ies) are permanent and stable (or two years has passed since the injuries were sustained) before the application can proceed. In our experience, the entitlement is not widely advertised by ACC or its case managers.[31]

Once the ACC receives the application, ACC arranges for the survivor to undergo an impairment assessment. The ACC uses contracted impairment assessors to determine the survivor's level of permanent "whole person impairment" (WPI). These assessors must use the American Medical Association Guides to the Evaluation of Permanent Impairment (Fourth Edition), and the ACC User Handbook to the AMA Guides.[32],[33],[34]

The AMA Guides set out a prescriptive and rigid approach to determining the survivor's WPI. If the survivor has both physical injuries and mental injuries, they must undergo two WPI assessments: an assessment of their WPI arising from their physical injuries, and a Chapter 14 Mental Injury Assessment. There are very few assessors who are trained in both the physical impairment assessment and Chapter 14 Mental Injury assessments. Therefore, the survivor is likely to have to undergo two different assessments and describe their injury history to two further assessors. Because of the limited number of assessors available, survivors are not given a genuine choice of assessor.

The AMA Guides are gender biased; e.g. vaginitis is not assessable (despite it being a significant impairment for some), but erectile dysfunction is assessable. The AMA Guides

[31] Please refer to recommendation 11.
[32] Injury Prevention, Rehabilitation, and Compensation (Lump Sum and Independence Allowance) Regulations 2002, reg 4.
[33] Please refer to recommendation 9.
[34] The ACC handbook should not take precedence over the AMA Guide and suitably qualified medical opinion.

make no specific allowance for suffering, unless the suffering is demonstrably resulting in functional impairment. The ACC Handbook states that:[35]

> *"Pain isn't separately rateable, unless it's specifically noted in the AMA Guides. In general, the AMA Guides' percentages for organ systems already allow for accompanying pain. Pain may be separately rated for physical injuries involving specific nerves or where there is cover for Complex Regional Pain Syndrome (CRPS).... Where there is cover for a mental injury such as Pain Disorder, pain may be rated for its effect on mental and behavioural functioning using Ch 14 by a suitably qualified and trained assessor."*[36]

The assessor(s) write a report setting out the survivor's WPI. The WPI is expressed as a percentage figure and any non-injury related impairment must be deducted from the total WPI. To receive any payment at all, the survivor's WPI resulting from their covered injury(-ies) must be at least 10%. The higher the WPI percentage, the higher the amount of compensation the survivor will receive.

The base scale for lump sum compensation is contained in the schedule to the Injury Prevention, Rehabilitation and Compensation (Lump Sum and Independence Allowance) Regulations 2002. The current entitlement for a 10% WPI for a lump sum payment is $3,595.09, rising to a maximum of $143,803.50 for a WPI of 80% or more. In our experience, ratings of 80% or more are typically only seen where a person's covered injury or illness is terminal (e.g. the person has mesothelioma or cancer covered as a treatment injury). The current quarterly entitlement for a 10% WPI for an independence allowance is $205.79, rising to a maximum of $1,234.61 for a WPI of 80% or more.

Because of the limitation on who can undertake an impairment assessment, it is particularly difficult for a survivor to challenge the resulting decision that ACC makes. If a survivor disagrees with the WPI rating, the survivor must find an ACC contracted assessor who is willing to give a second opinion. This is very difficult for our law firm, and it would be even harder for a survivor who is unrepresented as they may not necessarily know or have been told about the required qualifications for an impairment assessor. The survivor will have to fund the cost of the second opinion, and (as below) may not be able to recover the full cost of the assessment.

Moreover, it is not enough for the survivor to provide an alternative or second opinion. It is incumbent on the survivor to show that ACC's original decision was somehow wrong or flawed. In the absence of obtaining a full reassessment of their WPI by a suitably trained/qualified assessor, the best outcome of an ACC review/appeal of ACC's decision is ACC being directed to redo the assessments and make a fresh decision.[37]

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[35] https://www.acc.co.nz/assets/provider/ama4-handbook-acc716.pdf
[36] Please refer to recommendations 1 and 9.
[37] Please refer to recommendation 1.

Suspension of entitlements

ACC is empowered to suspend, cancel or decline a survivor's entitlements under section 117 of the Accident Compensation Act 2001 in certain circumstances. Section 117 is one of the most important sections of the Act. It is one of the main mechanisms whereby a survivor's entitlements will cease or otherwise be declined. It also provides ACC a mechanism to suspend or decline entitlements to 'recalcitrant' claimants who are not complying with what ACC considers as a reasonable request.

Reasons a survivor's entitlements may be cancelled or declined include:

- The survivor has recovered from their covered physical and mental injuries
- Non-covered factors have wholly or substantially 'overtaken' the initial covered injury(-ies) as the cause of the survivor's symptoms
- On-going causation between the survivor's physical and mental injuries cannot be proven
- Failure to provide a medical certificate certifying on-going incapacity.

Before ACC can suspend entitlements, it must be "not satisfied" that the ongoing entitlements are justified. The leading case is *Ellwood v ACC,* which requires clear evidence that continuing entitlements are not justified.[38] Uncertain or unclear evidence will not be enough for ACC to suspend entitlements. It is incumbent upon ACC to obtain sufficient evidence before it makes its decision.

If the survivor's injuries were covered under the Accident Compensation Act 1972 or the Accident Compensation Act 1982, ACC cover applies unless a condition was *exclusively* caused by a non-covered condition.

Imprisonment

If a survivor is in prison, the ACC must not provide any weekly compensation to the survivor. Moreover, the ACC is not required to make any payments or undertake any assessments for lump sum while the survivor is in prison. The survivor remains entitled to treatment and rehabilitation while in prison.[39]

[38] *Ellwood v ACC* [2007] NZAR 205 (HC).
[39] Accident Compensation Act 2001, section 121.

Declined claims and suspended entitlements: the review and appeals process, and legal aid

Claims being declined on technicalities

The level of proof required to have a claim accepted is more than whether or not the survivor is believed/credible. Objective or contemporaneous evidence is generally required to support a claim. This can be particularly re-triggering for some, particularly those who have a distrust of institutions.

Three-month time frame to lodge an application for review

When a claim is declined, a survivor has the option to lodge an application for review of ACC's decision. This must be lodged within three months of a written decision being made. There are limited exceptions to this rule, but include where a decision was made orally or does not inform a claimant about their ability to review the decision, or where a claimant was so affected or traumatized by the personal injury giving rise to the review that they were unable to consider their review rights. This must also be proven on the balance of probabilities before the late application for review is accepted, and is likely to require evidence of the affect or trauma the person was experiencing within the relevant three-month time frame.

The review process

Although an ACC review is legislatively intended to be a low-level investigative disputes resolution process, in reality it is litigation. It is incumbent on the survivor to prove their case on the balance of probabilities.

As part of the lead up to the review hearing, almost every case sees the exchange of additional medical reports and other supportive evidence (e.g., briefs of evidence). As previously discussed, it is incumbent on the survivor to prove their case. Therefore, where there are any gaps or questions about the evidence on file, these must be covered off. This can be costly for a claimant. Psychological or psychiatric reports can cost upwards of $2000. While a small portion of the costs of these reports can be recovered at the end of the review process (whether the survivor is successful or not),[40] it requires the survivor to have the money to cover the cost of the report upfront. It also requires the survivor to undergo yet another assessment.

During the review, the survivor typically attends and gives evidence in person to support their claim. They may be subjected to cross-examination by an ACC representative and/or the Reviewer. Often the ACC representative at a review is not legally trained. Our firm has previously seen aggressive and otherwise inappropriate cross-examination techniques being

[40] The costs recoverable at the end of the review process can be found in the Accident Compensation (Review Cost and Appeals) Regulations 2002: https://legislation.govt.nz/regulation/public/2002/0081/latest/DLM117426.html

used by ACC's representatives. This process is out of step with moves in other Courts to have a specified process for victims of crimes of sexual violence, such as the Sexual Violence Pilot Court, where designated Judges preside over sexual violence cases and take an active role to intervene where inappropriate questions are being asked of complainants and/or witnesses.[41]

Once the evidence is adduced, the survivor then listens to the legal arguments about how their evidence may or may not meet the legal tests and definitions for cover or entitlement. Our firm has seen survivors struggle with the clinical nature of this part of a review hearing. Some survivors choose to leave the room at this point, which is allowed.

Issues with legal aid

Given the standard of proof required and complexity of an ACC review or appeal, a survivor may wish to be represented by a lawyer. However, being privately represented by a lawyer can be a costly process for a survivor. Some survivors may be eligible for legal aid, however, there are very few specialist ACC legal aid providers in New Zealand. The low level of fees available for ACC reviews and appeals (set out below) discourages the entrance of new legal aid providers:

- Legal aid is granted in 'stages'. A provider is given an initial grant of $780 to meet with the claimant, lodge an application for review (if not already done), obtain and review the file and seek further evidence if required ($140 available for writing the referral letter to a specialist).
- This low fee does not acknowledge the reality of working with survivors; processes cannot be rushed. Simply obtaining a survivor's full file can take significant time and work. Care and significant attention on dates and history taking is required. The lawyer will need to develop a history of the abuse and neglect the survivor suffered, and all of the consequent effects that abuse has caused.
- The provider is given a second stage of $880 to cover the full costs of preparing submissions and preparing for a hearing (including drafting briefs of evidence if required), and only receives $60 per half hour for attendance at the hearing.

If a survivor can find a legal aid lawyer able to represent them, the survivor must then prove that they are eligible for legal aid. The first assessment is a financial eligibility assessment. The criteria restrict who is eligible for legal aid. A survivor must have low earnings per year and cannot have disposable capital of more than $3,500.[42] To be eligible, a survivor cannot have more than $80,000 in equity of their house. Even where a claimant does not have more than $80,000 in equity, if they own a house, a caveat is then placed upon the house to prevent any disposition of the house without the survivor first having paid off any debt they may owe to Legal Aid. Our firm has found that the caveat requirement discourages ACC claimants from continuing with their application for legal aid.

[41] Please refer to recommendation 13.
[42] If a person has a spouse or partner, or 1 or more dependent child, this amount increases by $1,500.

Second, the application also requires a large amount of reading and divulging of personal information. While it is up to the lawyer to draft the 'prospects of success' part of the application, the survivor must detail their lifestyle and spending in significant detail. Often three months' worth of bank statements must be provided to support their application.

Finally, if legal aid is approved, it is in the nature of a loan that is required in most cases to be paid off, even if the case is unsuccessful. Interest can be applied to the loan. If a survivor is unable to pay the loan off, they must apply for it to be written off and once again must provide a detailed breakdown of their lifestyle and spending.[43]

[43] Reviews of the legal aid system have repeatedly noted the barriers and issues with legal aid.

Issues with ACC case management: The "Sensitive Claims Clinical Pathway"

In October 2009, ACC created a set of rules governing claims under section 21 of the Act, "the Sensitive Claims Clinical Pathway", in response to some concern that the scheme was not being administered in accordance with the Act: that cover was being granted to sensitive claims that did not meet the strict legislative criteria. In the months following the implementation of the Pathway, there was a sharp drop in the number of accepted claims and widespread criticism from survivors, treating specialists, and support agencies. In April 2010, the then Minister for ACC established a Panel to review the Pathway. The review found that:

1. The Pathway was discouraging victims of sexual abuse from lodging claims
2. ACC was strictly requiring a survivor to be given a diagnosis under the DSM-IV in order to obtain cover
3. The Pathway was leading to claims being inappropriately declined: requiring the sexual abuse to be more than a substantial or material cause of the mental injury.
4. The ACC requested further information to support a claim in 75% of all sensitive claims, which was causing delays and a rise in concerns regarding privacy and appropriateness.
5. Overall, the Pathway was a claims management regime (i.e. not a problem with the legislation) that resulted in significantly reduced timely and appropriate access to the scheme.

The Panel made a number of recommendations to remedy the issues it found. However, despite the recommendations made, and some being implemented, a further review 18 months later found that the number of sensitive claims lodged and accepted had continued to sharply fall. This trend continued until 2015, when claims began to rise again. This corresponded with an increased spend on each claim.[44]

In 2020, there were 36,270 'active' sensitive claims, and ACC spent $191,482,535 on active sensitive claims. This is a sharp increase in both the number of claims and amount spent on them: in 2015 there were 18,975 'active' sensitive claims and the cost to the scheme was $73,283,511. The average cost per active claim has risen from $3,862 to $5,279: a 36.7% increase per claim.

[44] Please refer to recommendation 15.

ACC Claims Management – other issues

In our experience, there are many practical and institutional barriers operating that prevent survivors from either receiving cover or from accessing their full entitlements.

A key theme throughout this opinion has been the lack of information and knowledge about ACC at key stages: medical practitioners not knowing what claims can be made to ACC, lack of information available about types of entitlements, lack of available assessors, and the difficulties imposed by the review and appeal process. The Office of the Auditor General reviewed ACC's case management in 2014, and again in November 2020. In November 2020, the Office of the Auditor General issued a report titled "Progress on recommendations made in 2014" and notes that ACC acknowledges it must improve its relationship with providers to make it easier to lodge claims, improve claimant care.[45] The Office of the Auditor General also noted:

> *While doing this follow-up work, we noted some performance data that indicates that ACC needs to focus on improving its relationship with the providers it works with. ACC acknowledges this and is working on initiatives to make it easier to lodge claims, improve communications, and simplify the processes related to claimant care.*
>
> *However, ACC acknowledges that it still needs to do more to become truly claimant centred. It told us that building a "culture of feedback" was a critical part of this.*

Survivors are also significantly disadvantaged if they do not have internet access, online/internet banking, and computer literacy. Much of ACC's case management is digitised and done by email, and limits personal contact. The Office of the Auditor General noted this shift to digital services:[46]

> *3.19 In March 2018, ACC introduced a digital service called MyACC. Claimants can access MyACC through their desktop or mobile devices to manage aspects of their claim online. Claimants can now apply for entitlements online, including weekly compensation. They can also check information about their claim and entitlements.*

Despite ACC's Code of Claimants' Rights (discussed further below) specifically stating that the ACC will provide survivors with full and correct information about their claim and entitlements, and that they will give survivors information about how ACC provides services; our firm has found this is regularly not the case. Our firm has created and provides claimants with a fact sheet of the various types of entitlements ACC can provide to fill this gap with our own clients. We also make this available on our own website.

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[45] Office of the Auditor General, ACC's Case Management: Progress on Recommendations made in 2014, page 5. Available online: https://oag.parliament.nz/2020/acc-case-management/docs/acc-case-management.pdf

[46] Please refer to recommendation 14.

The Act sets out specific time frames and steps for making a decision on cover. ACC must make a decision on cover for a sensitive claim within four months' of the claim being lodged. If they cannot make the decision within four months, the ACC must seek the permission of the survivor to extend the timeframe for up to another five months. There are no statutory time limits for making decisions on requests for entitlements, other than the general requirement that ACC must make decisions in a timely manner.[47]

The Office of the Auditor General also noted that ACC has created Customer Advisory Panels made up of people with expert and practical knowledge of the challenges that claimants with complex needs can face. Participants include relevant advocacy representatives and professional sector specialists (including clinicians). Different types of panels cater to specific demographics or situations. Types of panels include the Sexual Violence Panel, the Serious Injury Panel, and the Older Persons Panel. The Office of the Auditor General noted:

> *We encourage ACC to make the feedback and information these panels provide publicly available so that there is transparency on what claimants are experiencing and the issues being raised.*

The Office of the Auditor General also noted concerns when claimants transferred from ACC to another public organisation, such as Work and Income New Zealand. The Office of the Auditor General recorded:

> *Although ACC collects feedback on much of its case management process, we did not see evidence that it collects feedback just before and when claimants leave ACC. Getting this feedback while ACC is still in a position to address any concerns would help case managers to co-ordinate a more seamless transition. It would also enable ACC to assess whether case managers are meeting its expectations to support a seamless transition.*
>
> *One option might be an exit interview or survey carried out by an independent party. This could give people transferring to another public organisation the chance to tell ACC whether they felt case managers had done all they could to prepare them for the move.*

The Office of the Auditor General also noted specific needs for ACC claimants who have sensitive claims:

> *ACC funds providers to prepare claimants with sensitive claims for transition from the care of ACC to other public organisations, or to connect the claimant with organisations that can best meet their needs. This funding is available in situations where other organisations provide support that ACC cannot or when they provide support alongside ACC. It was not clear to us how ACC knows how well these transitions are working in practice. We did not see how ACC seeks and assesses*

[47] Accident Compensation Act 2001, s 54.

feedback from people receiving this support. This type of feedback could help ACC understand how well this support is meeting claimants' needs.

In our view, ACC could do more to gather the perspectives of people with sensitive claims to fully understand their experience with the providers that ACC provides funding to. Sensitive claims will be included in Heartbeat surveys from the end of September 2020. ACC told us that it will now also look at whether it can include claimants' perceptions of how well it co-ordinates with other public organisations in those surveys.

We agree with the Office of the Auditor General's recommendations in this regard.

ACC performs well, assists or otherwise provides a good service for survivors

There are some instances where ACC performs well and provides a good service for survivors. ACC provides all sensitive claimants with access to 16 sessions of therapeutic assessment and recovery support with an approved counsellor, even prior to a claim for cover being accepted. The provision of these sessions does not guarantee that cover will be accepted. In some circumstances, the sessions might be provided without a formal claim having been lodged yet. This service is not anticipated by the legislation and it demonstrates ACC's exercising its discretion to prevent further harm from occurring.

Once a survivor has cover, ACC provides treatment a survivor needs mostly in a seamless way. We encounter very few problems in this regard. There have historically been issues regarding a survivor's choice of treatment provider/assessor, but these have largely been resolved (save for the issues highlighted above regarding independence/lump sum assessors). Moreover, the fact that a survivor is able to access treatment whenever it is needed, at little to no cost, is a significant benefit. It is not limited to a number of sessions of counselling or a number of years. The survivor remains entitled to the treatment their entire life if treatment is necessary.

Moreover, ACC has recently significantly increased its spending on harm prevention for sexual crimes. It has put significant resources into partnering with various NGO's and initiatives to assist the prevention but also support survivors of abuse. It has developed a significant online presence and online tools for survivors to be able to seek help and navigate the 'system'. ACC supports the "SafetoTalk" initiative currently being run which provides a 24/7 confidential, free, sexual harm helpline. ACC is also running a sexual violence programme for secondary school children called "Mates & Dates". ACC also runs a website called "Find Support"[48] that hosts an online search tool to see the organisations that have therapists that can support survivors. The therapy is a free service and is funded by ACC. There are currently 1,923 therapists registered therapists on the Find Support website that a survivor can contact for help.

The legislative mandate that a survivor does not have to prove fault, name a perpetrator, or have reported the abuse to the police is important. It provides access to the scheme even when there might be barriers to receiving support or assistance in other ways.

The ACC also has a Code of Claimants rights which confers rights on claimants and imposes obligations on ACC in relation to how ACC should deal with claimants.[49] The Code is comprehensive and requires ACC to treat claimants with dignity and respect, honesty and courtesy, recognising that the claimant may be under physical, emotional, social or financial strain. The Code requires ACC to treat claimants fairly, to listen, and to take into account the impairment the claimant might have. The Code also requires ACC to be respectful of and responsive to Māori, and all cultures. In our experience, the ACC team set up to investigate

[48] www.findsupport.co.nz

[49] Injury Prevention, Rehabilitation, and Compensation (Code of ACC Claimants' Rights) Notice 2002.

alleged breaches of the Code of Claimants rights' is well equipped to deal with complaints. Investigations occur in a sensitive way, and complaints are genuinely considered and responded to. The ACC Complaints Service can sometimes act as a 'circuit breaker' where there has been a deterioration in the relationship between a claimant and an ACC case manager.

ACC has also funded two services to assist claimants with navigating the ACC system. These are called Way Finders and the Workplace Injury Advocacy Service. These services can help with a wide range of claim-related questions and issues. They can help a claimant understand what ACC support is available, or help navigate ACC's processes. These services are free to claimants. They do not represent claimants in ACC review hearings and appeals.

Other significant matters relating to ACC and survivors of abuse in care

ACC's processes

In our view, ACC is quite well geared for traumatic injury from which a person recovers their independence in a specified time frame with specific treatments. The ACC's service delivery model is largely based on a physical injury model. These injuries form the majority of claims made to ACC. ACC is therefore more challenged by complex claims, including historical and sensitive claims. The harm suffered by abuse survivors is such that it can cause long term disability. ACC is less equipped to providing rehabilitation services which may need to be provided over a life time with only incremental change/improvement if any. The drive to run the scheme in the most efficient way possible will inevitably cause tension when a claim requires additional time and care.

The Sentencing Act 2002

Under the Sentencing Act 2002, a victim of crime can be awarded a payment of reparation from the offender by a Judge. However, reparation is only available for harm that is not covered by ACC. Therefore, if a survivor has an accepted claim, they may only receive reparation for economic loss not covered by ACC (e.g., a 'top up' of weekly compensation payments, or for co-payments they may have had to make for treatment), and for non-economic loss that is not covered by ACC (e.g., pain and suffering not covered by an impairment assessment). The quantification of reparation is difficult where there is an accepted ACC claim and often requires an actuarial assessment. Our firm has represented victims of workplace injuries or fatalities, where the prosecutor has attempted to have the victim of the crime or their whanau meet the cost of the actuarial report.

Pain and suffering

The ACC is only able to provide entitlements in accordance with the Act. Reference to pain and suffering was removed from the legislation from 1992 onwards. Prior to this date, a lump sum payment was available to claimants specifically for pain and suffering and loss of enjoyment of life. After this date, pain and suffering was not specifically provided for. The history of lump sum payments is set out in Appendix A.

Under the 2001 Act, it is assumed that a survivor's pain and suffering is compensated through access to weekly compensation and lump sum entitlement for permanent impairment. Symptoms of a persons covered physical and mental injuries are not separately coverable, e.g., incontinence resulting from a pelvic injury. The incontinence is not separately coverable as it is considered a symptom rather than an injury.

Recommendations: Key reforms ACC needs to address

There are numerous legislative changes and changes in practice that could be made that would immediately improve the experience survivors have with ACC, both in terms of case management and in terms of access to entitlements. Our recommendations in terms of amending the legislation include:

1. Impairment assessments for independence allowance/lump sum: the legislation needs to allow for greater independence of the selection and training of assessors from ACC. The important criteria ought to be their qualifications. The Act needs to be amended to allow all those with appropriate qualifications to be able to undertake lump sum assessments, after they have received training in the assessment tools. It also should mandate that the peer review of independence allowance/lump sum assessments should be undertaken by a peer reviewer independent from ACC.

2. The legislation could be amended to extend cover for mental injury without physical injury or without a causative link to a sexual crime if claimant can demonstrate abuse or neglect in State Care and in the Care of Faith-based Institutions (similar to the way work related mental injury caused by trauma is covered in section 21B of the Accident Compensation Act 2001). This may include situations where a survivor has been a witness to abuse or neglect in state care and in the care of faith-based institutions.

3. The legislation and ACC's case management system should envisage and permit streamlining of the claims and entitlements process. Currently the tests for cover and each type of entitlement are set out with its own legal test and generally each request a claimant makes requires an assessment. Each assessment requires the survivor to repeat their claim history to the assessor; generally a stranger, some who are not trained specifically in sensitive matters (e.g. needs assessors for home help). Our firm has seen this result in contradictions in the recorded history of the survivor's claim. This may or may not seem important to a survivor at the time, but

Case Study Three:

This case study illustrates the limit of entitlements available through ACC. The person may be covered by ACC, but ACC cannot assist them beyond the statutory entitlements. For non-statutory remedies the person must look elsewhere.
The person had been abused within a Church setting. The remedies they were seeking included an apology; counselling for themselves and their family; a healing mass; an ex gratia payment; legal fees; criminal investigation to be launched into the alleged offenders.
The only remedy of those listed above that ACC could address for this individual is counselling for themselves alone (not their family). This person was not eligible for weekly compensation.

is very hard to correct once it becomes part of the survivors ACC records. This can subsequently be held against the survivor if they give evidence at a review hearing particularly if the survivor is not a good historian.

4. ACC is limited in the way it can spend money on harm prevention. All of ACC's spending on harm prevention must show a return on investment. That is, each dollar spent on harm prevention must return a reduction in claims. The required return is set by the Minister. This requirement can result in decisions being made about harm prevention programmes that may not result in the greatest reduction in harm or improvements for survivors. The return-on-investment requirements are not a fit model for controlling and determining spending on harm prevention, particularly when it comes to harm prevention programmes for physical and sexual abuse and violence.

5. As discussed above, given the clarity of the statutory language, and the resolute decision of the High Court in *Vandy*, the "Vandy problem" will require legislative amendment. This is a well-known issue with the scheme and has been the subject of previous papers. The solution to the issue is beyond the scope of this paper, however, one option that would result in fairer outcomes for a survivor would be to amend the legislation to only required a person to be an earner at the date of their incapacity.

6. ACC should have greater discretion to fund novel or experimental treatment when there is a clear link between the treatment and relief of pain or symptoms, even when it is not considered of a type normally provided.

7. The vocational independence process needs significant overhaul. The 30 hour a week threshold is too low and should be lifted to 35 or 40 hours. The jobs a person can be made vocationally independent in should be meaningful, genuinely available, and more robustly linked to the person's training, education and experience. The jobs should better reflect the claimant's pre-incapacity working hours and earnings.

8. The assessment of a person's incapacity under section 105 is a very fluid test. A person can be denied weekly compensation even when there is no doubt they could not work in the job they were doing when they were incapacitated. A potential solution would be, if a potential earner was working at the date of their incapacity, to assess that person's incapacity under section 105 against the work they were doing when they suffered their incapacity.

9. The Act should be updated to require independence allowance/lump sum assessors to use the most recent versions of the AMA Guides (currently the 6th edition).

Our recommended changes in practice include:

10. ACC should provide specific training to treatment providers on cover and entitlements, and the way in which the scheme works. Treatment providers are the messenger for ACC and also the 'gate keepers', and should not be acting as a barrier or imposing their own view of the law or merits of a case. ACC could do this by using case studies emphasizing historical claims.

11. The ACC should widely publicise information how to lodge claims, what entitlements are available, and how to access them. Information should be targeted to different audiences in different languages. ACC should have an active stakeholder engagement plan that covers advocates, community law, Citizens Advice Bureaus, and counsellor/counsellor organisations. Publication of this information should go beyond a spreadsheet on the website; oral communication and engagement is also important.

12. ACC could reconsider its case management model for sensitive claims and align with the historical way gradual process claims were treated. In those cases, ACC would fund nurse practitioners to visit a person in their home, take a full history, and aid a person through the various assessments a person would need to undergo to access entitlements.

13. Reviewers should be required to undertake training specifically on hearing and deciding sensitive claims, including training on cross-examination and evidence gathering techniques.

14. The recommendations of the Office of the Auditor General relating to claims management should be implemented by ACC.

15. The ACC should revisit the sensitive claim pathway recommendations and implement them if not complete.

Appendix 1: History of the definition of personal injury, mental injury, and lump sum and independence allowance provisions

The Criminal Injuries Compensation Act 1963 was the first attempt to provide victims with compensation for injury and pain and suffering. Section 18 of that Act allowed the Tribunal to award compensation for actual expenses incurred as a result of the injury, pecuniary loss as a result of incapacity for work, and for pain and suffering. In the case of pain and suffering, the total amount awardable was £500.

The Criminal Injuries Compensation Act 1963 was subsumed within a new accident compensation regime, which provided much more comprehensive compensation.[50] The Accident Compensation Act 1972 came into force on 1 April 1974, and included a provision for a person to receive a lump sum payment for permanent disability arising from their covered injuries (including mental injuries). The injured person's whole person impairment was assessed against the Second Schedule of the Act, which provided a percentage of impairment based on the type of physical loss of impairment of bodily function that the person was suffering. Up to $5,000 was available for permanent physical loss or impairment of bodily function. In addition, section 120 enabled the ACC to make an additional lump sum payment - As much as the Corporation thought fit - in respect of loss of amenities or capacity for enjoying life, and pain and mental suffering.

The Accident Compensation Act 1982 introduced a definition of personal injury by accident, and included the physical and mental consequences of any such injury or of the accident. This Act came into force on 1 April 1983 and covered personal injury sustained on or after that date. This Act retained the lump sum payment for permanent loss or impairment of bodily function. However, the maximum quantum was increased to $17,000.[51] The lump sum payment for loss of amenities or capacity for enjoying life and for pain and mental suffering was capped at $10,000.[52]

The scheme was amended again in by the Accident Rehabilitation and Compensation Insurance Act 1992, which came into force on 1 July 1992. Personal injury was defined as the death of or physical injuries to a person, and any mental injury suffered by that person which is an outcome of those physical injuries to that person.[53] Mental injury was defined as a clinically significant behavioural, psychological or cognitive dysfunction. A definition of accident was inserted: a specific event or series of events that involves the application of a force or resistance external to the human body and results in personal injury. Impairment was defined as any abnormality of psychological, physiological, or anatomical structure or function.

[50] Accident Compensation Act 1972.
[51] Accident Compensation Act 1982, s 78.
[52] Accident Compensation Act 1982, s 79.
[53] Accident Rehabilitaiton and Compensation Insurance Act 1992, section 4.

Medical misadventure was also inserted into the Act, and included cover for medical error: the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances.[54]

There was no provision under the 1992 Act for lump sum payments for permanent impairment. Section 54 of the Accident Rehabilitation and Compensation Insurance Act 1992 created an entitlement to an "independence allowance" for a person whose personal injury has resulted in a disagree of disability of 10 percent or more. The independence allowance was set at a maximum of $40 per week for a person who had a 100% degree of disability. The amount payable was pro-rated at such lesser graduated rates as were set by regulations. A person's assessment of disability was assessed against the AMA Guides Second Edition.[55] A persons impairment had to be reassessed at intervals not exceeding 5 years. Any percentage impairment assessed under the 1972 and/or 1982 Acts had to be deducted from any independence allowance assessment.

Unlike its predecessors, the 1992 Act did not provide a specific entitlement to independence allowance in respect of loss of amenities or capacity for enjoying life, and pain and mental suffering.

The scheme was amended again by the Accident Compensation Act 2001. This Act reinstated the lump sum payment system for coverable injuries that occurred on or after 1 April 2002. The relevant definitions of personal injury and mental injury are set out in the full text of this paper.

[54] Accident Rehabilitation and Compensation Insurance Act 1992, section 5.
[55] American Medical Association Guides to the Evaluation of Permanent Impairment (Second Edition).