Judicial Review in Motor Accidents Cases in NSW

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This paper deals with administrative law (judicial review) challenges to decisions of the Claims Assessment and Resolution Service (CARS) and the Medical Assessment Service (MAS) of the State Insurance Regulatory Authority (SIRA) (formerly known as the Motor Accidents Authority of New South Wales (MAA). We will speak on:

- The role of judicial review in motor accident compensation in New South Wales;
- Recent challenges to CARS, MAS and Proper Officer decisions; and discuss
- Key lessons from the recent cases.

As you know, the *Motor Accidents Compensation Act 1999* (NSW) ("**the Act**") does not provide for an "appeal" from these decisions. Furthermore, there is (most regrettably) no provision in the Act for any merits appeal or review by way of internal or external review, say in an independent tribunal such as the New South Wales Civil and Administrative Tribunal (NCAT).

The only way to set these decisions aside or have them reviewed (after exhausting the internal review processes – in the case of MAS decisions) is to seek to quash them or set them aside by judicial review in the Supreme Court of NSW. This invokes the Supreme Court's ancient judicial review (or supervisory) jurisdiction derived from section 69 of the *Supreme Court Act 1970* (NSW). The section provides for the making of orders "in the nature of" the former prerogative writs, such as the former *writ of certiorari*. This jurisdiction is important as it enables the judicial supervision of executive and administrative decision making in New South Wales. The Court's jurisdiction is constitutionally recognised and protected by section 73 of the *Commonwealth Constitution* (see, *Kirk v Industrial Court of NSW* (2010) 239 CLR 531 and "*The Centrality of Jurisdictional Error*", Hon JJ Spigelman AC (2010) 21 Public Law Review 77).

JUDICIAL REVIEW OF CARS DECISIONS

CARS Assessors or Claims Assessors

As you know, there is no "*appeal*" or review of claims assessors decisions provided in the Act. A "*claims assessor*" is a person who, in the opinion of the MAA (SIRA) is "*suitably qualified*" and who may be a member of the MAA staff and who is "*appointed*" as a claims assessor by the MAA pursuant to section 99 of the Act. A claims assessor is empowered to assess claims under Part 4.4 (claims assessment and resolution) (ss 88 to 121) and also in accordance with Chapter 5 (award of damages) (ss 122 to 156).

The Principal Claims Assessor is appointed by the Minister and must be an Australian lawyer. She is important, thus the Act provides for her to have capital letters in her title, unlike claims assessors, who do not. Section 105 provides that a claims assessor is, in the exercise of his or her functions, "*subject to the general control and direction of the Principal Claims Assessor*". But the PCA is not empowered to overrule or interfere with any decision of a claims assessor

"*that affects the interests of the parties to an assessment in respect of any such assessment*" [s105(3)].

There are two main types of judicial review challenges here:

1. challenges to the assessment of monetary damages (ss 94 & 95); and

2. challenges to a decision to grant the parties exemption from having to go to a claims assessment at all (and to thereby be permitted to go straight to a court). Exemption can be "*mandatory*" (section 92(1)(a)) or "*discretionary*" (section 92(1)(b)). Extensive guidelines are set out in the Claims Assessment Guidelines.

There are many judicial review cases in regard to each of these decisions. Some recent decisions are summarised below.

***NRMA Insurance Limited v Buckley* [2016] NSWSC 475 (Rothman J)**

The claimant was injured in a motor accident on 1 February 2011. He made a claim against NRMA. The matter was referred to claims assessor Elyse White, who awarded the claimant $1,292,777.61 plus costs.

The insurer sought judicial review of that decision, on the basis that the award for future economic loss was affected by legal error. It was alleged that the claims assessor had failed to give proper reasons, failed to comply with s126 of the Act, and had made a finding that the claimant would retire early in the absence of evidence on that issue and without indicating to the parties that such a finding may be made.

Rothman J noted that the awarding of damages for "future economic loss" was a misnomer and that in fact damages are awarded for diminution of earning capacity, not earnings lost (at [39] – [44]).

His Honour found that there was ample evidence before the Claims Assessor to support a finding that there would be early retirement, and such a finding was open to her (at [53]). His Honour found that sufficient reasons for that decision had been given. As to the argument that there was a denial of procedural fairness in failing to notify the parties of the intention to make that finding, it was noted that the insurer had conceded that the claimant had a diminution of earning capacity. His Honour noted that procedural fairness requires only that the party should have reasonably apprehended that the point had been opened up or might become a live issue and that in this case the insurer should have reasonably apprehended that the claims assessor was required to assess the working life into the future of the claimant (at [57]). Therefore, there was no denial of procedural fairness.

The insurer's summons was dismissed.

***Allianz Insurance Limited v Larriera* [2016] NSWSC 441 (Campbell J)**

The claimant was injured in a motor accident on 4 May 2012. The matter was referred to claims assessor David Ford. The claims assessor awarded $1,812.727 in damages, plus costs. Included in this award was an amount of $155,997 for past loss of earnings and $888,423 for future loss of earnings.

The insurer sought judicial review on the grounds that the awards of past and future economic loss were affected by legal error. The errors alleged were: *"the Claims Assessor's reasons for his assessment for these heads of damages are legally inadequate; when assessing future loss of earnings he failed to comply with the requirements of s 126(3) of the Act; the insurer was denied natural justice because the Claims Assessor failed "to consider, take into account and engage with" its submissions about the quantum of past and future economic loss; and finally it is said that his assessment of these heads "was irrational and illogical" lacking "any intelligible justification"* (at [5]).

It was accepted by Campbell J that the claims assessor's reasons were not perfect, but that in applying a beneficial construction to the reasons it is permissible to fill caps in expression as a matter of necessary inference on a fair reading of the reasons (referring to *Zahed* – discussed further below). His Honour found that the claims assessor had complied with the requirements of s126.

The insurer argued that the assessor failed to consider the insurer's argument about the calculation of past economic loss. His Honour found that it was clear from the assessor's reasons that he had accepted the claimant's approach, and had implicitly rejected the insurer's approach, and that no more was required of his to discharge his duty of fairness to the insurer ([34]).

The insurer's summons was dismissed.

***Zahed v IAG Limited t/as NRMA Insurance* [2016] NSWCA 55 (24 March 2016) (Meagher, Leeming JJA and Emmett AJA)**

The claimant was injured in a motor accident on 27 October 2010. She sustained soft tissue injuries.

An application was made to CARS for General Assessment. The claims assessor awarded total damages of $114,979.45, of which $36,280.38 was for past care and $50,000 was for future care. The insurer sought judicial review of the decision, arguing that there were a number of errors of law in the way the assessor had dealt with the awards of past and future care.

Prior to the CARS Assessment, the claimant had been assessed by MAS. It had ben determined by MAS that none of the specific hours of care that were referred for assessment were reasonable and necessary. However, the medical assessor had expressed the opinion that 6.76 hours of care per week had been reasonable and necessary for the first year after the accident, and thereafter 3 hours of care per week had been necessary, reducing to 1 hour in the future and then to zero. It was common ground between the parties that the MAS assessor's findings were not binding, as they were not answers to the questions that had been referred as part of the dispute.

There was also other evidence before the claims assessor regarding the plaintiff's care needs, including evidence from the claimant, her alleged carer, and medical opinions.

In his reasons for decision, the claims assessor made the following findings in relation to care (at [11]):

> *"Dr Maniam, who was well aware of the Claimant's needs having treated her over the years on a number of occasions, considered that her requirement for domestic assistance (including child minding which is not now claimed) was 4 hours a day 2 days per week (including, however, an unapportioned time for child care). Judith Davidson summarised the care that she considered as reasonable and necessary for the initial period at 6.76 hours and from 9 November 2011 at 3 hours per week.*
>
> *Taking into account all the expert opinions as well as the opinions of both Assessor Davidson and Dr Maniam (who considered that the need for care 4 hours a day 2 days a week was continuing at the time he saw her) and making some allowance for the deduction of time spent on childcare and with the assistance of the summary recommendation of Assessor Davidson at p 35 I allow an amount of 6.76 hours per week for past gratuitous care from the date of the accident to date of assessment as reasonable and necessary."*

In relation to future care, the claims assessor had stated (at [13]):

> *"I cannot determine the Claimant's future care needs with precision but I am satisfied that, on the balance of probabilities, there is a need which will result in damages, initially in respect of gratuitous care at the current rate of 6.76 hours per week and, at some stage in the future, on the balance of probabilities, for commercial care at the rate of $35.00 per hour. The authorities permit me to assess a buffer which I do in the amount of $50,000."*

The plaintiff argued that the claims assessor had either failed to have regard, or given genuine consideration, to the evidence that was before him (particularly the evidence of the MAS Assessor who had opined that 6.76 hours of care per week was only reasonable and necessary until November 2011) and further and in the alternative that the claims assessor had failed to give proper reasons for his decision.

In *IAG Limited t/as NRMA Insurance v Zahed* (2015) 71 MVR 86; [2015] NSWSC 657 (RS Hulme AJ), RS Hulme AJ determined that there was error of law on the face of the record of the decision of the claims assessor, mainly on the grounds that the claims assessor had failed to give adequate reasons. His Honour cited *Wingfoot Australia Partners Pty Ltd v Kocak* (2013) 252 CLR 480, and stated (at [28]) that there is no reason to think that the obligations to give reasons are any different to the obligations that the High Court outlined in that case. His Honour stated (at [29]):

> *"It may be accepted that the reasons of an assessor should not be scrutinised over-zealously Allianz Australia Insurance Limited v Moo Ok Park [2015] NSWSC 122 at [28] and the reasons required are not those which may be expected of a judge – Allianz Australia Insurance Limited v Kerr [2012] NSWCA 13; 83 NSWLR 302 at*

> *[53]. Nevertheless, the fact remains that Assessor Stern revealed no reasoning process, and provided no reason why he selected the figure of 6.76 hours per week and, although it might be possible to infer he simply adopted Ms Davidson's figure, he provided no reasons why he did so, or why he adopted that figure for the whole of the period of past care, or why he rejected Ms Davidson's view that the figure should be 3 hours per week for some of that time."*

Accordingly, the decision of the claims assessor was quashed and the matter was remitted to the Motor Accidents Authority for determination by another claims assessor.

The claimant appealed this decision.

The Court of Appeal upheld the decision of the primary judge. Emmett AMA stated (with Meagher and Leeming JAA agreeing), at [42]:

> *"It may be that the Assessor adopted Dr Davidson's assessment of hours and then projected that number by reference to the opinion of Dr Marsh (that domestic assistance from 27 October 2010 and continuing for the balance of Claimant's life expectancy related to the injuries she suffered in the accident). However, Dr Marsh simply makes no assessment of the extent of the domestic assistance that was reasonable and necessary. It is not possible to discern from the Assessor's reasons the actual path of reasoning by which he arrived at the result stated in the Assessment. It does not explain the actual path of reasoning in sufficient detail to enable a court to determine whether his decision does or does not involve an error of law. The Assessor did not comply with the requirement of s 94(5) that he set out his reasons for the Assessment. He did not comply with s 106 in so far as the Assessment was subject to the provisions of clause 18.4 of the Guidelines in requiring that his statement of reasons attached to his certificate set out, albeit as briefly as the circumstances of the assessment permit, the reasoning process that led the Assessor to the conclusions made."*

Leeming JA made the following additional observations (with Meagher JA agreeing), at [4]:

> *"Plainly enough, there may be a tension between the obligation to explain and the obligation to be concise. That is a familiar tension (for example, pleadings must "contain only a summary of the material facts on which the party relies", and be "as brief as the nature of the case allows": see now UCPR Pt 14 rr 14.7 and 14.8). The resolution of the competing obligations imposed by s 94(5) and cl 18.4.3 ought not to result in an unduly demanding burden of providing reasons. It is to be borne in mind that the objects of the Guidelines are "to provide a timely, fair and cost effective system for the assessment of claims" and "to assess claims and disputes fairly and according to the substantial merits of the application with as little formality and technicality as is practicable and minimising the cost to the parties" (cl 1.14), and the obligation to set out the reasoning process is to be construed accordingly. The obligation thereby imposed is less than that imposed on courts: see eg Allianz Australia Insurance Ltd v Kerr [2012] NSWCA 13; 38 NSWLR 302 at [53]- [59]; Pham v NRMA Insurance Ltd [2014] NSWCA 22; 66 MVR 152 at [29]- [31]. Further, as Basten JA's judgment in Kerr indicates, by reference to authority, the nature of the*

Assessor's task may mean that aspects are insusceptible of any detailed articulation of reasons."

His Honour further stated at [6]:

> *"If the only complaint were the failure to state expressly that the 6.76 hours was derived from the certificate of Assessor Davidson, then there would in my opinion be no breach of the obligations imposed on the Assessor. Although it is undesirable for the statement of reasons to leave important matters to inference, doing so does not necessarily breach the obligation to set out the Assessor's reasons. The question is whether the reasoning process can be discerned, reading the reasons as a whole and applying a "beneficial construction" to which the High Court referred in Minister for Immigration and Ethnic Affairs v Wu Shan Liang (1996) 185 CLR 259 at 271-272. At least where a gap may be filled as a matter of necessary inference on a fair reading of the reasons, I would consider that the obligation to set out the reasons has been discharged."*

Leeming JA found that the certificate of the assessor discloses no reasoning process on the critical integer in the calculation of care at all. He went on to state (at [9]);

> *"I would not regard it as necessary for the Assessor to explain why he disagreed with aspects of each of the practitioners' opinions. However, it is necessary for the statement of reasons to explain why the 6.76 hours per week for past gratuitous care was regarded by him to be necessary to the date of the assessment. The reasons need not be long. Indeed, there will be many cases, of which I suspect this is one, where a single sentence would suffice. But to say merely that all of the conflicting evidence was taken into account is, in the facts of this case, insufficient. The matter may be tested against the parties' rights of review: how are the parties to know whether the reasoning is affected by judicially reviewable error of law?"*

***Mordue v QBE Insurance (Australia) Limited* (2015) 69 MVR 477 (Adams J)** and
***QBE Insurance (Australia) Ltd v Mordue* [2015] NSWCA 380**

Mr Mordue made a claim against QBE in respect of injuries sustained during a motorcar rally in Coopernook State Forest on 1 December 2012. He was a passenger in a car that was insured, via an Unregistered Vehicle Permit (UVP) with QBE Insurance. QBE initially admitted liability for the claim, but subsequently attempted to deny liability (via an "Amended Section 81 Notice"), and also to deny indemnity.

The insurer applied for an exemption from CARS. The matter came before the Principal Claims Assessor (PCA) who found that the "Amended Section 81 Notice" attempting to withdraw the admission of liability was invalid (at least whilst the matter was within the CARS scheme) – following the line of authority of *QBE Insurance (Australia Ltd v Motor Accidents Authority (NSW)* (2008) 50 MVR 152 and *CIC Allianz Insurance Ltd v Erturk* (2010) 55 MVR 224. However, the PCA found that the insurer was entitled to deny indemnity, and that therefore the matter was subject to a mandatory exemption pursuant to s92(1)(a) of the Act, and clause 8.11 of the Claims Assessment Guidelines.

The plaintiff sought judicial review of the decision of the PCA. The plaintiff's primary contention was that an admission of liability incorporated an admission of indemnity, and that therefore indemnity had been admitted in the Section 81 Notice, and could not be denied whilst the matter remained within CARS. In support of this argument, the plaintiff relied on *Smalley v Motor Accident Authority (NSW)* (2013) 85 NSWLR 580, including the following passage from the judgment of Leeming JA (at [48] – [49]):

> *"This is a case, no different from most, where the legal meaning of a term is determined by reading the Act as a whole in its context. Plainly enough, the word "liability" applies in two different cases. An insurer which offers a third-party policy in the terms of s 10 is naturally described as a "liability insurer"; cf D Derrington and R Ashton, The Law of Liability Insurance, 2nd ed (2005) LexisNexis.* ***The insurer indemnifies the liability of its insured as specified in the policy, and is subject by statute to certain rights and obligations in advance of court proceedings when and if it accepts that it itself is "liable" under that statutory policy.*** *In s 10 reference is made to the liability of the insured, and that is the sense in which "liability" is used in (for example) s 77.*
>
> ***However, in the provisions of central importance to this appeal, notably, s 81, the Act refers to the liability of the insurer. The natural meaning of such language is the insurer's obligation to pay under the statutory policy of third-party insurance - ie where the policy responds to the claim so as to give rise to an obligation to indemnify the insured."*** (our emphasis).

Further, his Honour stated at [60]:

> *"In short, it follows that the elements of the CTP insurer's liability to indemnify include:*
>
> *(a) death or injury (noting that "injury" is an elaborately defined term, and that the amendments to that definition effected by the Motor Accidents Compensation Amendment Act 2006 do not apply to Mr Smalley's claim: see item 19 of Schedule 5 to the Act);*
> *(b) "fault": whether the insured driver breached a duty owed to the claimant;*
> *(c) causation: whether the insured's fault caused the death or injury;*
> *(d)* ***the motor vehicle was operated in the Commonwealth (whether or not on a road) unless the motor vehicle was subject to an unregistered vehicle permit, in which case it was used or operated on a road in any part of the Commonwealth.***
>
> *Only if each of those four elements is satisfied will the s 10 policy respond to a claim. If an insurer admits each of them, then it will be liable to pay a sum of money to a claimant. An insurer may admit liability while disputing that it is liable to pay all the amount claimed. This will commonly be the case where there is a dispute as to apportionment between joint tortfeasors or for contributory negligence, or as to whether all of the claimed injuries result from the accident. If and only if an insurer admits liability in the sense of acknowledging an obligation to pay some money to the claimant do the pecuniary consequences in s 82, 83 and 84 apply."* (our emphasis).

It was agreed between the parties that the PCA had been correct in finding that the attempt to issue an Amended Section 81 had been ineffectual, and that the insurer was not entitled to deny liability in the circumstances of the case. However, the insurer argued that the issue of indemnity was an issue between the insurer and its insured and that it therefore a s81 admission could not prevent an insurer from denying indemnity to its insured at a later date.

Adams J framed the issues in the case as follows (at [14]):

> *The crucial question in this case is whether, once admitting liability to a claimant under s 81(1), an insurer can later deny indemnity to the insured who caused the injury and, in that indirect way, later deny liability to the claimant. lt is significant, as I think, that s 81 (4) permits an insurer which has given notice denying liability or otherwise failed to comply with the giving of a Notice (ie, a deemed denial) to subsequently admit liability but there is no obverse provision permitting an insurer to deny liability once it has been admitted. As Basten JA observed in The Nominal Defendant v Gabriel [2007] NSWCA 52 (2007); 71 NSWLR 150 at [39] the procedures, closely regulated by the statute, give rise to the readily available inference "that an admission of liability pursuant to s 81 (1) cannot be 'withdrawn' except as provided by s 118" - in this case irrelevant. lt is conceded by QBE that the Act provides no mode of varying, let alone completely reversing, the admission of liability made under s 81 (1) and that the purported amended s 81 notice was ineffectual. This concession is correctly made. But can QBE now deny liability on the ground that, as the policy does not respond to the claim, it is not bound to indemnify the insured and, by that circuitous route, deny liability to the claimant? The answer to this question depends on the effect of the initial admission of liability.*

His Honour applied the reasoning in *Smalley* that an admission of liability implicitly includes an admission that the CTP policy responds to the claim, stating (at [18] – [19]):

> *"Here, QBE did not, in its Notice, deny it was obliged to make any payment to the claimant and, although its admission of liability was said to have followed from its explicit admission of fault, this did not imply or suggest that it was not admitting all the other elements giving rise to its liability (ie those specified by Leeming JA in para [60] above quoted) including, in particular that the policy responded to the claim. Smalley thus does not resolve the problem in this case. lt may readily be accepted that an admission of liability necessarily implies the admission that the policy responds to the claim. The question is what is the effect of that implied admission.*
>
> *On the face of it, if an admission of liability cannot be withdrawn, neither can any of the corresponding implicit admissions. The effect would be to do indirectly what cannot be done directly, usually regarded as an unattractive proposition…"*

His Honour found (at [20]) that given that the admission of liability could not be withdrawn, and that indemnity was implied in the admission of liability, the assessor could not decide that the claim should be exempted from determination by CARS. He also noted that, given that BE

was bound by its admission of liability, there would be no room for discretion to exempt the claim, since the issue of indemnity is no longer a live issue (at [21]).

The insurer filed a Notice of Appeal in respect of this decision.

The Court of Appeal (per Beazley P and Ward JA, with Simpson JA dissenting) set aside the decision of the primary judge. The majority stated (at [42])"

> *"We consider that the lack of an express exclusion from s 92 of cases in which a s 81 admission has been made is a recognition of an insurer's entitlement to deny indemnity to an insured and, for that reason, to have the claim determined curially. In any such curial proceeding, it will be for the court to determine, as a matter of evidence, the import of and weight to be given to the statutory admission. This approach gives recognition to the difference drawn by the Act between liability for a claim and liability to indemnify the insured. The reason for this is obvious: the statutory assessment process is directed towards the assessment of claims for compensation for injuries sustained in motor vehicle accidents. It is not concerned with the interstices of insurance law."*

The majority further stated, at [47]):

> *"Nevertheless, the reasoning of the majority supports the conclusion that the giving of a s 81 notice does not preclude a later application to withdraw the admission (and implied admission) contained therein."*

The majority held that the primary judge erred in determining that QBE was bound for all purposes by its s81 notice admitting liability (at [50]).

In her dissenting judgment, Simpson JA stated that she would dismiss the appeal, finding:

> *"85. Resolution of the issue, in my opinion, turns upon what is meant by the words "admits ... liability for the claim" as they appear in s 81(1). It is therefore best to set out the whole of that sub-section. It is as follows:*
>
> *"(1) It is the duty of an insurer to give written notice to the claimant as expeditiously as possible whether the insurer admits or denies liability for the claim, but in any event within 3 months after the claimant gave notice of the claim under section 72."*
>
> *Three questions of construction emerge: whose liability? liability to whom? and liability for what?*
>
> *86. There are good reasons for answering that the liability is that of the insurer; it is liability to the claimant; and it is liability for the claim that the claimant makes (that is, for damages for personal injury). One of the reasons is that, by ss 77 and 78, the insured owner or driver is entirely excluded from the decision to admit or deny liability, from negotiation in respect of the claim, and, by s 88(1), from the assessment process that follows. By s 72(2) the claim*

is made directly to the insurer. The parties to the assessment process are the insurer and the claimant; there is no role for the insured to play. Yet an admission of liability necessarily implies an admission of fault on the part of the owner or driver, and this was expressly contained in QBE's initial s 81(1) Notice.

87. The language of s 81(1) does not, in my opinion, admit of an interpretation that involves an admission of liability on the part of the insurer for the claim but does not involve indemnifying the insured. I find it impossible to understand what the purportedly admitted liability could be if it is not liability of the insurer to pay the claim. As a matter of plain statutory construction, admission of liability for a claim encompasses liability to pay the claim (after assessment or determination by a court). As is clear from Erturk, a mistaken admission of liability cannot, as the legislation presently stands, be rectified.

88. Section 81(1) does not expressly, and, in my opinion, does not impliedly, differentiate between liability to a claimant, and liability to indemnify an owner or driver who is at fault in the use or operation of the vehicle insured. The phrase "the insurer admits or denies liability for the claim" is a composite one, encompassing the insurer's admission of its own liability to meet the claim made in respect of the injury.

89. Senior counsel for QBE acknowledged as much when pressed during the course of argument. He said:

"It is clear that when one looks at what follows that the effect of that admission for the claim, of liability for the claim in whole or in part, immediately gives rise to financial obligations imposed by statute on the insurer and of course that is redolent of an obligation to indemnify. It can only be seen as consistent with that, that there are other logical possibilities, does not matter. (T7, 15-20)

...

It is either an admission on behalf of the insured ... that there was fault and all the other matters which would render the driver liable to the injured person, or it is that plus the operation of the terms of the policy so as to render the insurer liable to indemnify for that liability. It has been held below of course that it was the second, and as you have seen from our submissions, it is extremely difficult to contend against that, because an insurer admitting liability for the claim and the partial denial of liability is of course suggestive that there can be by reasons of the scope of indemnity, non liability of the insurer while still liability of the driver thus admission of liability by an insurer would appear to carry with it statements about the state of the indemnity." (italics added) (T7, 29-40)

90. No provision of the MAC Act which drew any distinction between liability to meet a claim, and liability to indemnify an owner or driver was identified. The only such provision, to which this Court was referred, in which such a distinction appears to be drawn, is to be found in sub-cl 8.11.5 of the Claims

Assessment Guidelines:."

Her Honour concluded:

> *"95. The view I take is in accordance with the general tenor of Ch 4 of the MAC Act. It is hardly to be thought that the legislature intended that the holder of an insurance policy could be prohibited from being involved in any way with the resolution of a claim (s 77), that an insurer could admit liability on behalf of its insured (without consultation) (s 81), conduct and control negotiations in respect of the claim to the exclusion of the insured (s 78(1)(a)), compromise the claim (s 78(1)(c)), and exercise any function conferred on the insured in respect of a claim (s 78(1)(d)), but nevertheless deny the insured indemnity.*
>
> *96. The consequence of the above is that, in my opinion, once an insurer has admitted liability for a claim, it cannot be given exemption from the assessment process under sub-cl 8.11.5. Whether that applies also to an allegation, made after an admission of liability for the claim, that the claim is fraudulent (sub-cl 8.11.6) does not arise for consideration. Once it is accepted – as it was on behalf of QBE – that a s 81(1) admission of liability is final and irreversible, and encompasses an admission of liability to indemnify the policyholder, sub-cl 8.11.5 cannot be used to exempt the claim from the assessment process."*

The claimant has applied for special leave to the High Court of Australia to appeal the decision of the Court of Appeal. The matter settled before the application was heard.

Allianz Aust Insurance Ltd v Habib **[2015] NSWSC 1719 (**Beech-Jones J)

The insurer challenged the decision of a claims assessor (specifically the awards for future economic loss and future care). The claims assessor had awarded $160,000 for future economic loss and $36,500 for future commercial care. The award for future economic loss was calculated at the rate of $200 per week for the remainder of the claimant's working life.

The insurer argued that the claims assessor's award did not conform with section126 of the Act because the assessor had used a buffer to determine one component of economic loss and then calculated the loss using that component, and because the assessor had not stated the assumptions on which the award was based.

Beech-Jones J dismissed the former argument but upheld the latter. His Honour also rejected the remainder of the insurer's argument regarding inadequacy of reasons.

Referring to the insurer's reliance on *Allianz Australia Insurance Ltd v Sprod* (2012) 81 NSWLR 626, his Honour stated (at [31] – [34]):

> *31. ... It was submitted that Sprod precludes an Assessor from adopting an approach whereby one of the integers or components of future economic loss is in effect a buffer, but the balance is a calculation. In support, Ms Poljak referred to the following passage from Sprod (at [37]):*

> *"There was, in my opinion, a failure of the assessor in these respects to engage with and perform the tasks prescribed by s 126. Once the assessor embarked on a process of calculation, the duties imposed by s 126 were enlivened (they would also have been enlivened, but required potentially very much less by way of explanation of assumptions, had the circumstances exhibited such uncertainties and imponderables as to justify the broad evaluative 'buffer' approach)".*

> *32. I do not accept that either this passage or any other part of Sprod precludes the approach adopted in this case of utilising a buffer to reflect the uncertainties associated with one component or integer of a calculation of economic loss. If a component or integer of an award for future economic loss answers a description of a buffer then the assumptions that support it must still be stated although they can be "generalised statements" (Sprod at [30]). If other components or integers do not answer that description then more precisely expressed assumptions must be stated. In the end the ultimate question is whether s 126 has been complied with, and no strict dichotomy of the kind asserted is to be found in the section. Sprod speaks to the obligations imposed on an Assessor within the area of uncertainty that arises in relation to an award of future economic loss but it does not establish a strict demarcation between awards that involve the use of a buffer and awards that utilise calculations.*

> *33. The true vice of the assessment in Sprod was that there was a figure calculated by reference to a notional weekly loss that relied on calculations, but the connection between that approach and the underlying rationale for the making of the award was not explained by any statements of the kind required by s 126(3). Given that the rationale for the award was the potential loss of the claimant's employment and his impaired prospects of finding work if that occurred, it is difficult to see how there could be a statement of the assumptions on which an award that used a calculation of a weekly amount was based. It is difficult to see how that type of potential loss has any connection to a weekly amount.*

> *34. However, by contrast in this case, the awarding of a weekly amount can be seen to have a connection with the two aspects of loss that were accepted as having been suffered, namely a loss of commission and a loss of prospects of promotion. Further the figure chosen could also be seen to have some connection to the assessment of past loss. In this respect the award of future economic loss conformed with s 126 of the MAC Act. I reject ground 4 of the summons so far as it concerns the awarding of future economic loss.*

However, his Honour found that the Assessor had failed to set out the assumptions that underpinned his award, stating (at [37]):

> *"There is no doubt that an assumption as to the age at which Mr Habib would have and will cease work underlay the Assessor's award. There was also a deduction adopted for vicissitudes being the percentage possibility that Mr Habib might have*

> *suffered an affectation of his earning but for the injuries in any event (s 126(2); cf Penrith City Council at [5]). Those assumptions are not expressly stated in the award but they can be deduced from examining the "Claimant's calculations" referred to in [30] of the award as noted above (at [17]). Mr Romaniuk submitted that in circumstances where the opposing party received those calculations that is sufficient to constitute compliance with s 126(3). I disagree."*

In relation to this point, his Honour concluded:

> *"These statements suggest that it is not sufficient for the Assessor to simply refer to a set of calculations provided by one of the parties which in turn contains the assumptions on which the award is based. Such an approach would not "ensure transparency" of the kind referred to by Barrett JA. Without the assumptions being expressly stated the task of determining whether they accord with the claimant's "most likely future circumstances but for the injury" as specified in s 126(1) is either impossible or at least rendered that much more difficult."*

Allianz Australia Insurance Limited v Habib (No 2) **[2015] NSWSC 1870** (Beech-Jones J)

The insurer sought costs in respect of *Allianz Aust Insurance Ltd v Habib* [2015] NSWSC 1719, in which the insurer had been successful in setting aside a decision of a claims assessor.

Beech-Jones J held that part of the case that the insurer had put up was unanswerable, and that the claimant should have recognised this at an early stage. However, his Honour held that the insurer had been ultimately unsuccessful in relation to a large part of its case (although they did ultimately obtain the relief sought).

His Honour ordered the claimant to pay only 40% of the plaintiff insurer's costs.

Allianz Australia Insurance Ltd v Gonzalez (No 2) **(2015) 71 MVR 124; [2015] NSWSC 693** (Campbell J)

The claimant was injured in a motor accident on 23 September 2008. Her claim was referred to CARS for General Assessment, and was allocated to claims assessor Margaret Holz. There were significant issues in the case regarding the causation of the claimant's psychological injuries. The plaintiff had been assessed by MAS, with the finding being that her psychological injuries were not causally related to the car accident, but instead were related solely to intimidating conduct by the driver of the other vehicle (and his companions) immediately following the accident and the next day.

Following the issue of the medical assessment certificate by the MAS Assessor, the claimant obtained further evidence from the claimant's treating psychiatrist, who proffered an opinion as to the cause of the claimant's injuries (being that her injuries were caused by both the accident and the intimidating conduct immediately afterwards).

The claimant asked the claims assessor to refer the matter for a further assessment at MAS.

During the course of preliminary conferences, the claims assessor referred the matter for a further medical assessment at MAS, pursuant to s62(1)(b), largely on the basis of the additional evidence of the treating psychiatrist.

The insurer applied for judicial review of the claims assessor's decision. It was argued that the factual basis for the decision was grossly illogical. It was further argued that a claims assessor was not empowered to ask the proper officer of MAS to refer a number of questions to the medical assessor who would conduct the further assessment (set out at [35]. It was said to be impermissible.

Campbell J determined that there was nothing "unreasonable" or plainly unjust in the claims assessor's decision to refer the matter for further assessment (at [55]). As to the ground of legal unreasonableness, Campbell J held that it was not made out. He stated (at [52]–[53]):

> *52. I prefer the arguments advanced on behalf of Mrs Gonzalez. It is difficult for Allianz to succeed on a "relevance" ground when the discretion conferred by s 62(1)(b) is so much at large constrained only by "the terms and subject matter of the statutory instrument": Swan Hill Corporation at 758. In such circumstances, when the statute is silent, it may be a difficult task to persuade a court by a process of interpretation or construction that the decision-maker is bound to take certain matters into account and bound to disregard others: Peko-Wallsend at 39-40. With respect, Allianz did not attempt such a task.*
>
> *53. Nor am I satisfied that the claims assessor's decision to refer again was manifestly unreasonable by dint of a misapprehension of a material fact i.e. there was "more information" available. The question is whether the decision to refer again is manifestly unreasonable. There is, of course, a "close analogy" between this ground of review and the principles discussed in a different context in House v The King [1936] HCA 40; (1936) 55 CLR 499 at 504 – 505: Peko-Wallsend at 41 – 42; Li at 366 [75]. In Li the plurality (367 [76]) said:*
>
> *Even where some reasons have been provided, as is the case here, it may nevertheless not be possible for a court to comprehend how the decision was arrived at. Unreasonableness is a conclusion which may be applied to a decision which lacks an evident and intelligible justification.*

In relation to the "power" argument raised by the insurer, his Honour held (at [58]–[60]):

> *58. ...The power is to refer again. What is referred in the first instance under s 60 of the Act is "a medical dispute". In my view, the word "matter" in s 62 is a reference to this, rather than merely a reference to a medical assessment matter. As I have pointed out, medical dispute is defined as "a disagreement or issue to which" Part 3.4 of the Act applies. Section 58(2) makes clear that Part 3.4 also applies to "any issue arising about" a medical assessment matter "in connection with the assessment of a claim by a claims assessor". The very thing that the claims assessor was seeking to elucidate "in connection" with her assessment of Mrs Gonzalez's claim was an issue about the assessment of the degree of permanent impairment resulting from any psychiatric*

injury that may have been caused by the motor accident itself. Such a matter is a legitimate s 58(2) issue; it was capable of being "referred again" under s 62(1)(b).

59. *Mills stands as authority for the proposition that where the only matter referred again is a "medical assessment matter" it will be impermissible to fragment the relevant composite question. At the same time, other "issues" may arise that may be referred for consideration to enable the s 58(1) matter to be properly assessed: Mills at 141 [98]. Section 58(2) permits this, within the discretion of the claims assessor, limited only by the scope and objects of the Act.*

60. *Reading the 7 questions individually, and as a whole, they appear to me to be capable of standing as "issues" arising about the s 58(1) matter in connection with the assessment of Mrs Gonzalez's claim. There is no impermissible fragmentation; questions (vi) and (vii) more than adequately preserve the integrity of the composite concept. In my judgment the formulation of the questions as proposed by the claims assessor did not exceed the lawful limits of her s 62(1)(b) power. To put it another way, as an exercise of that power, her formulation of the questions was lawful.*

Importantly, his Honour gave some guidance as to the power that is conferred by section 58(2) of the Act, at [62]):

> *"…second or subsequent referrals will almost always involve a significant element of reconsideration. This being so, it will almost always be necessary for the court or claims assessor exercising the power to explain the circumstances that have arisen enlivening the power and identifying the issues arising about the particular medical assessment matter in the proceedings, or in connection with the assessment. To my mind, this is what s 58(2) contemplates. This is what Claim Assessor Holz did with some considerable care in the present case. I do not think it can be properly said that she in some way sought to fetter the exercise by the medical assessor of his or her statutory powers. Clearly, unless some care is taken in identifying the issues arising about a previous medical assessment matter, the medical assessor to whom the medical dispute is referred "again" may be at a loss to understand, and address, what issue arising about the s 58(1) matter the court or claims assessor was concerned about.*

His Honour found that there had been no error demonstrated in the claims assessor's decision, and therefore the insurer's summons was dismissed.

His Honour also made some comments regarding the correct naming of parties in such judicial review matters. He said (at [66]):

> *"…in my view, the correct approach is to identify both the claims assessor and the proper officer by their "official designation". So far as the claims assessor is concerned, I would have thought the appropriate party was the Motor Accidents Claims Assessment and Resolution Service, established under s 98 of the Act. Indeed, the authority itself was at best a redundant party. And rather than naming her, the proper officer should have been joined simply by her designated title: the Proper Officer of the Motor Accidents Authority: s 62(1B). There may be any number of circumstances of life which may lead to the claims assessor, to whom the claim has*

> *been allocated, being unavailable to complete the allocation when this Court's supervisory jurisdiction, and any appeal, is finalised. The same may be said of the proper officer. Indeed, the evidence before me indicates that the person named as the proper officer was "acting" in that position. It may well be that by now, someone else has been appointed. I think it appropriate that I make an order amending the record to reflect these reasons."*

QBE Insurance (Australia) Limited v Thomson **(2015) 71 MVR 97; [2015] NSWSC 650 (R S Hulme AJ)**

The plaintiff was injured in a motor accident on 16 March 2011. She sustained soft tissue injuries to the neck and back. The insurer alleged that the claimant sustained only minor injuries in the accident and that the majority of her injuries were pre-existing.

The matter was referred to CARS for general assessment. The claims assessor found that the claimant had sustained an aggravation of her pre-existing neck and back conditions in the subject motor accident, and awarded damages in the sum of $973,460.18.

As part of the evidence before the claims assessor, there was a report of Dr Spira who opined that the claimant was "not credible" and there was also surveillance footage obtained by the insurer. In relation to that surveillance footage, the claims assessor stated in her reasons for decision (at [5]):

> *"The Insurer relies on Dr Spira. He suggests that Ms Thomson's responses to his physical examination "were not credible". The doctor believes that Ms Thomson "has had a psychological reaction to the accident with gross over evaluation of injuries and the emergence of a behavioural disorder which does not relate directly to the physical trauma she sustained". He considers she has exaggerated her disabilities and the soft tissue injuries have long resolved. I note Dr Spira is a neurologist and not trained in psychiatry. He is the only doctor who has formed the opinion that Ms Thomson is not genuine. Dr Lahz does mention "frequent pain behaviour" during an examination.*
>
> *"In addition to Dr Spira, the Insurer has presented a number of video surveillance discs which show Ms Thomson attending medical examinations. From my observations she appeared to move at times with no restriction and at other times, I observed her to be severely disabled. I could find no reason for the change in her movements. However, nothing in the surveillance leads me to conclude that Ms Thomson is exaggerating her symptoms."*

The insurer sought judicial review of the decision of the claims assessor, arguing a number of errors. RS Hulme AJ found that the claims assessor had erred in failing to take into account relevant considerations (namely, opinions of two medical practitioners) that had bearing on the issue of credibility. In this regard, his Honour stated (at [25]):

> *"Assessor White having chosen to rely on one prior assessment bearing on the Plaintiff's credibility and without providing any reason why it was particularly important or preferred, it behove her to explain why evidence, apparently credible, obviously significant and tending, at least arguably, in the other direction was*

> *rejected or discounted. I would add, although I do not feel it necessary to rely on the fact, that a number of other reports also commented on the apparent inconsistency between symptoms reported by Ms Thomson and other information doctors had. This argues for it being more important for Assessor White to properly consider and refer to matters such as those commented on by Dr Fitzsimons."*

His Honour concluded that the claims assessor had failed to give adequate weight to a factor of great importance and that her decision was legally unreasonable as a result.

His Honour also found that the claims assessor had erred in failing to give adequate reasons for her award of economic loss, stating (at [36]):

> *"Section 94(5) of the Motor Accidents Compensation Act requires a claims assessor to set out the assessor's reasons for the assessment. Clause 18.4 of the Guidelines promulgated under the Act requires that an assessor set out "the reasoning processes that lead the assessor to the conclusions made". In neglecting to state why, despite these indications of an earlier reduction in income, the Assessor calculated Ms Thomson's damages on the basis of her pre-accident income the Assessor has failed to comply with these provisions."*

Accordingly, the decision of the claims assessor was quashed and the matter was remitted to the Motor Accidents Authority for allocation to a different assessor.

***Insurance Australia trading as NRMA v Ural* (2015) 71 MVR 93; [2015] NSWSC 620 (Young AJA)**

The claimant was injured in a motor accident on 9 April 2013. A claim form was lodged with the CTP insurer of the vehicle alleged to be at fault, IAG (trading as NRMA Insurance).

A decision on liability was not made within 3 months, as required by s81. Accordingly, liability was then deemed to be denied, pursuant to section 81(3).

On 3 March 2014, the insurer sent a letter to the claimant denying liability for the accident.

Both before and after the letter of 3 March 2014 was sent, the insurer made some payments for medical services rendered to the claimant. Some of the payments were marked "without prejudice" although there was no evidence that this was communicated to the claimant.

An application for exemption was made pursuant to section 92(1)(a), on the basis of the insurer's denial of liability. The *Claims Assessment Guidelines* had been amended after *Smalley v Motor Accidents Authority of New South Wales* [2013] NSWCA 318; 85 NSWLR 580, so that at the time of the application for exemption, the relevant criterion for exemption was:

> *8.11.1 Liability is expressly denied by the insurer, in writing, but only in circumstances where liability is denied because the fault of the owner or driver of a motor vehicle in the use or operation of the vehicle is denied.*

The Principal Claims Assessor declined to exempt the matter from CARS, on the basis that after the deemed denial of liability came into effect, the payments made by the insurer resulted in an admission of liability, by conduct. This was on the basis of the PCA's interpretation of the Supreme Court's findings in *Allianz Australia Insurance Ltd v Anderson* [2013] NSWSC 1186 and *Allianz Australia Insurance Limited v Harrison* [2013] NSWSC 1211.

The insurer applied for judicial review of the PCA's decision. It was argued that the present case was distinguishable from *Anderson* and *Harrison,* on the basis that in those cases the insurer had admitted breach of duty of care, meaning that the only remaining element of the tort of negligence to be admitted was damage, and that element could be admitted by conduct. In the present case, breach of duty of care had never been admitted, therefore it was not possible to "complete" the admission in the same way. The insurer also relied on section 84(3) of the Act which provides that monies paid by an insurer for rehabilitation cannot constitute an admission of liability.

Young AJA quashed the decision of the PCA, giving reasons as follows:

19. As to the payments themselves, it seems to me that, in the light of the provisions of the MAC Act requiring insurers to be sympathetic towards the payment of the claimant's apparent lawful consequential expenses, it is assuming too much to make a finding, especially in the fact of clear denials, that there has been an admission of liability.

20. There is however no sense in exploring these matters further because the decision of the Court of Appeal in Smalley v Motor Accidents Authority of New South Wales [2013] NSWCA 318; 85 NSWLR 580 makes the whole argument otiose. Smalley was decided by a court consisting of Meagher, Barrett and Leeming JJA. Leeming JA gave the lead judgment in which the other judges concurred.

21. At [70] on page 599 Leeming JA said:

> *Clause 8.11.1 requires attention to be drawn to a particular document: the S81 notice. Whereas here there is no actual S81 notice, but a deemed S81(3) notice, Cl 8.11.1 will always be satisfied. That is not altered by the fact that the insurer chooses, outside the time constraints imposed by S81, subsequently to admit the fault of its insured. Nor is it altered by the fact that the insurer chooses to describe the letter evidencing that submission as a 'SECTION 81 NOTICE'.*

22. Accordingly, anything that happened after the denial in the deemed S81 notice is apart from Section 81(4), quite irrelevant because, 'there is nothing in the Act to alter the effect of a S81 notice or deemed notice' once it has been given, see Nominal Defendant v Gabriel [2007] NSWCA 52; 71 NSWLR 150,180 [143].

23. Section 81(4) says 'nothing in this section prevents an insurer from admitting liability after having given notice denying liability or after having failed to comply with this section.'

24. In Smalley at [66] – [67] 1598, the Court of Appeal said that apart from Section 81(4), the deeming effect of Section 81(3) could not be displaced. Further Section

81(4) is not an empowering section and 'does not purport to detract from the deeming provision in Section 81(3)'.

25. Accordingly, there was no alternative course open to the Principal Claims Assessor but to issue a certificate of exemption.

26. Accordingly, the plaintiff is entitled to have the decision of the principal claims assessor quashed by way of certiorari.

27. I am bound by decisions of the Court of Appeal and thus I can reach my decision in this case quite easily.

28. However, it must be noted that in Smalley it was assumed that a deemed notice under Section 81(3) must be taken to be a deemed notice in writing.

29. Further, the construction of the MAC Act in Smalley means that as long as the insurer fails to give a Section 81 Notice within three months, it is entitled to an exemption certificate for the asking. If the third defendant wishes to avoid this consequence, it will need to amend its guidelines.

The decision of the PCA was quashed and the matter was remitted to the PCA to be determined according to law.

***Allianz Australia Insurance Limited v Moo Ok Park* (2015) 69 MVR 538 (Harrison AsJ)**

In this case, the insurer challenged a decision of a claims assessor as to his damages assessment. The assessor awarded the claimant $496,457 which included $454,656 in damages for past economic loss. This was the head of damages challenged in judicial review proceedings.

The claimant was self-employed, owning and working in a number of businesses with her husband. The last business was for contract cleaning. Before that business was sold (a few months before the motor vehicle accident) she worked 54 hours a week earning $1,800 net per week. She left the business because the hours were too long. The claims assessor was provided with reams of evidence regarding past and future economic loss, including income tax returns and profit and loss statements from Dolman Bateman, accountants, for the claimant, and from Vincents, accountants, for the insurer. He rejected the claimant's evidence entirely and accepted the insurer's expert accounting evidence (in part only, but without stating which part or why). As to her most likely future circumstances, section 126 of the Act, he determined (judgment at [9]):

> "Had the claimant not been injured her most likely future circumstances are that she would have continued to work as a contract cleaner, either in her own business or as an employee. There was no physical reason, prior to the accident, why the claimant could not have continued to work the hours which she had been working with Jani-King (NSW) Pty Ltd. Her decision to work fewer hours was, in my opinion, a lifestyle choice at the time. She had the retained capacity to increase her working hours, if she so wished and I find that the claimant's most likely future circumstances were that she

> would, in time, have increased her working hours to meet her ongoing financial commitments."

He determined that the claimant was earning $600 net per week at the time of the accident, a figure that was wholly unexplained. He found that there was $1,200 net per week earning capacity. He then awarded past economic loss in stages of $1,200, $600 and $300 net per week based on a percentage of her "retained residual earning capacity". Again, the reasons for this staged award were not apparent.

Four grounds of judicial review were argued for the insurer. Only the ground based on failure to provide reasons was dealt with by the court. The court posed the issue for itself (at [34]) as "did he sufficiently set out the reasoning process that led him to make those conclusions?"

The court considered that the claims assessor should have made some reference at least to the primary documents evidencing past income that were attached to the expert reports (at [35]). The court could not find any support for the findings of $1,200, $600 and $300 net per week. It said that it was "*not satisfactory*" that one should have to "*make a best guess as to why those figures were relied upon by the CARS Assessor*".

The requirement to set out "brief" reasons is contained in s 94(5) of the Act and in clause 18.4 of the SIRA *Claims Assessment Guidelines* ("the Guidelines"). The court held (at [39]) it was not clear how the figures were arrived at and the conclusions were not supported by proper reasons and the decision was quashed. This is similar to the reasons of an earlier Supreme Court case involving tax returns that had not been taken into account (by the same claims assessor) in *CIC Allianz Australia Limited v McDonald* (2012) 61 MVR 382 (Hidden J).

***IAG Limited trading as NRMA Insurance v Tran* (2015) 70 MVR 105; [2015] NSWSC 263 (Hall J)**

The plaintiff, NRMA, sought judicial review of a decision of claims assessor Robert Foggo. The assessor had assessed total damages in the amount of $52,672.12. The insurer sought to challenge the major component of those damages, being the award of future economic loss is the amount of $42,500.

The main ground upon which the insurer challenged the decision was that the Claims Assessor made a finding which underpinned the monetary award which was not supported by the medical evidence given at the assessment hearing. Alternatively, the Claims Assessor denied the plaintiff procedural fairness by making that finding without indicating that such a finding might be made.

The main passage of the claims assessor's reasons that formed the basis for the application for review was as follows:

> *'It is then possible that he will not suffer any actual loss of earnings in the future. However, he may not succeeding (sic) in obtain (sic) these qualifications, or, having obtained them, he may be unable to find employment as an interpreter, or employment sufficiently regular to earn more than that from his present employment. If that is the case, then he will certainly sustain an actual loss of earnings in the future, because in*

> *my view the ageing process when compounded with his injuries will mean that the would be most unlikely to be able to work to normal retirement age as a barman/cellar hand.'*

It was argued that there was no evidence to support the finding that the claimant would suffer any economic loss in the future, and in particular no evidence to underpin the finding that the ageing process would affect the claimant's ability to work as he aged.

The claimant/first defendant relied on the fact that the claim for future economic loss had been in the nature of a buffer, and relied on the judgment of Mason P in *Leichhardt Municipal Council v Montgomery* [2005] NSWCA 432, where his Honour stated at [2]:

> *'a buffer or cushion award is usually reserved to the situation where there is a smallish risk that otherwise secure employment prospects may come to an end, in consequence of the tort-related injury, at some distant time in the future.'*

Hall J found that there was sufficient evidence before the claims assessor to support the assessor's findings as to future economic loss, in particular the evidence of the claimant as to the heavy nature of his employment and the fact that he did suffer from ongoing problems. Even though the medical evidence did not provide much direct support for ongoing economic loss, his Honour found that there was evidence of current restrictions, which provided a sufficient grounding for the finding that the claimant's condition would impact on his ability to work as he aged.

As to the assessor's findings regarding the "ageing process" and its impact on economic loss, Hall J found that the assessor was not expressing a medical opinion, but rather was merely recognising common human experience. His Honour stated (at [118] – [119]):

> *118. Accordingly, the composite statement made by the Claims Assessor at [25] of his Reasons which is impugned was no more than an opinion that was supported by the evidence that Mr Tran's injuries and disabilities in an occupation involving heavy lifting and bending, and working and standing for prolonged periods, were likely to be less tolerable as older age ensues. The restrictions on the plaintiff's physical capacity were well-established at the date of assessment. They had in fact stabilised as at the date of the assessment. The finding of an ongoing physical impairment as at the date of assessment (even putting to one side the issue of the later effects of ageing), well-supported a finding of a present and continuing diminution of Mr Tran's earning capacity: Medlin v State Government Insurance Commission, supra, at p 16. Such a finding was sufficient to justify the award of a "buffer" for the established risk Mr Tran faced – the risk that his otherwise secure employment prospects may end in consequence of the tort-related injury in the future: Leichhardt Municipal Council v Montgomery, supra, at [2].*
>
> *119. In those circumstances it was open to the Claims Assessor to have regard to the evidence that established an impairment of Mr Tran's earning capacity and, in particular, Dr Matalani's opinion referred to at [104] above. The additional finding made by the Claims Assessor that Mr Tran's restrictions*

> *and disabilities would be compounded by the ageing process, was strictly unnecessary as the established impairment and restrictions impacting upon him was sufficient in itself to justify the award of damages in the nature of a "buffer".*

His Honour also found that the insurer was plainly on notice of the type of award that may be made, and therefore the denial of procedural fairness argument was not made out.

Accordingly, the insurer's summons was dismissed.

JUDICIAL REVIEW OF MAS RELATED DECISIONS

Ali v AAI Limited [2016] NSWCA 110 (Basten, Leeming and Simpson JJA)

In *AAI Limited v Ali* (2015) 72 MVR 23; [2015] NSWSC 1068 (Wilson J), the insurer applied for judicial review of the decision of a medical assessor. There were issues regarding the claimant's credibility, and whether the assessor was entitled to rely on the claimant's self-reporting of impairment and disability in circumstances where the assessor accepted the claimant's credibility was in issue.

Wilson J held that it was open to conclude that the evidence pointing to malingering (including tests conducted by the MAS assessor personally) had been passed over without being taken into account by the assessor, and that there was an absence of reasoning in relation to this issue (at [72]). Her Honour also held that the assessor failed to address and resolve a dispute between the parties as to the difference between the pre and post accident impairment (in circumstances where there was clearly pre-existing impairment to some degree) (at [74]). Accordingly, the decision of the medical assessor was quashed.

The claimant has appealed this decision.

The Court of Appeal upheld the appeal. It was found that the medical assessor had had sufficient regard to the evidence that was before him. As to the credibility issues, the Court of Appeal held that the medical assessor had at no pint treated the claimant's self reporting as reliable. Furthermore, the Court held (per Basten JA with Leeming and Simpson JJA agreeing) (at [63]):

> *"Even supposing that the assessor had, contrary to the explanation just given, relied upon the claimant's self-reporting, self-reporting adjudged to be unreliable does not thereby become "irrelevant information", which, if taken into account in the assessment process, will invalidate the process."*

Leeming JA made further comments about the status and reliance on Guidelines, noting that it had been submitted in the proceedings that the guidelines were delegated legislation, and that it had been argued that a failure to properly apply the Guidelines led to a breach of statutory duty. His Honour noted the statutory power for making the Guidelines and stated, at [83] – [85]:

> *83. Thus, the Authority is empowered to issue guidelines, which are to be published in the Gazette and which are treated as being disallowable instruments for the purposes of ss 40 and 41 of the Interpretation Act 1987 (NSW): see subss 44(1), (4) and (7). Subsection (7) makes it plain (by providing that ss 40 and 41 apply as if the guidelines were statutory rules) that the guidelines are not statutory rules. (It is unnecessary in this appeal to say anything of the claims assessment guidelines which are dealt with by subss 69(1), (5) and (6).)*
>
> *84. Section 45 contains special provisions relating to the power to make guidelines relating to the assessment of permanent impairment. Such guidelines are subject to limitations which need not for present purposes be summarised. Such guidelines are also treated as disallowable instruments: s 45(4).*
>
> *85. None of those provisions converts a guideline into delegated legislation which binds the parties or an assessor of its own force. Certainly, the requirement of gazettal does not do so. Many, many instruments are required to be published in the Gazette. Nor does the extension of the provisions relating to disallowance to guidelines do so. Many instruments under many statutes are treated as disallowable instruments (examples include a recall order under s 46 of the Stock Medicines Act 1989 (NSW), a scheme under the Professional Standards Act 1994 (NSW), a determination under Part 3 of the Statutory and Other Officers Remuneration Act 1975 (NSW) and a proclamation or order under ss 8 or 37 of the Poisons and Therapeutic Goods Act 1966 (NSW) – see ss 47, 13, 19A and 46 respectively of those statutes). In such cases, the legal consequence of the instrument is determined by other primary legislation. The instrument does not of itself impose a statutory obligation. The central concept of "delegated legislation" is a delegation of legislative power by Parliament: see O Jones, Bennion on Statutory Interpretation (6th ed 2013, LexisNexis) at 219.*

His Honour noted that the Medical Assessment Guidelines contain statements within them to the effect that they are delegated legislation, however, his Honour stated that whether something is delegated legislation depends on what Parliament has done, rather than the language of the instrument (at [92]). Furthermore, his Honour noted that the Permanent Impairment Guidelines contain no such statements purporting to be delegated legislation. His Honour concluded:

> 98. *Further, the foregoing would appear to confirm that there is nothing in the Guidelines – and certainly nothing in those parts of the Permanent Impairment Guidelines which have less than "directive" force – which of itself leads to the conclusion that a failure to have regard to some matter vitiates the assessor's determination.*
>
> *99. In short, I cannot agree that the Guidelines are "delegated legislation" in the sense that they bind of their own force. Instead, if judicial review is sought of a decision of an assessor based upon guidelines, it will be necessary to address the provisions of statute which make the guidelines applicable, and it will be necessary to address the particular clauses relied on, because both the Act and guidelines made pursuant to it proceed on the basis that they are not all of the*

same legal force.

Allianz Australia Insurance Ltd v Rutland **[2015] NSWCA 328** (McColl, Meagher and Macfarlan JJA)

The claimant (Respondent) made a claim for nervous shock in respect of the death of her sister in a motor vehicle accident in 2009. She was assessed by MAS as having whole person impairment of 14%, but a review panel subsequently reduced that to under the "greater than 10%" threshold. The claimant sought review of the review panel's decision.

At first instance, Garling J overturned the decision of the review panel, on the basis that the review panel had failed to undertake a re-examination of the claimant and in doing so had failed to afford the claimant procedural fairness.

The insurer appealed the first instance decision. The Court of Appeal upheld the findings of the primary judge, stating (at [33]):

> *"The task before the Review Panel required that it exercise its collective clinical judgment as to the respondent's impairment at the time of its deliberation on 7 March 2014. The Review Panel had before it Dr Jager's reasons for his certificate, based on his examination of the respondent on 8 October 2013, and the other medical reports which pre-dated that assessment. Notably, the Review Panel did not have the benefit of any transcript or clinical notes associated with Dr Jager's examination. In the circumstances, and recognising that clinical judgment between medical practitioners may vary on the issue which had to be assessed, it would, in our view, be surprising and unusual that a panel of medical assessors seeking to assess a person's degree of impairment due to a particular psychological injury would not interview the relevant individual so as to be satisfied that they have an accurate and complete history of his or her pre-accident lifestyle, activities and habits and the extent to which those may have changed as a result of that injury (PI Guidelines, cl 7.20). That an examination of the respondent did not occur in this case, when considered with the other matters to which we have referred, confirms our view that the Review Panel undertook its task by reviewing the asserted errors in the assessment already undertaken, rather than exercising an independent and contemporaneous clinical judgment on the question of permanent impairment."*

The Court of Appeal held that in failing to re-assess the claimant, the review panel had failed to afford procedural fairness.

Clinton McGiffen v AAI Limited t-as GIO, as agent for the Nominal Defendant **[2015] NSWSC 1530** (Rothman J)

The claimant sought judicial review of a decision of a MAS assessor and MAS review panel. The issue was whether injuries to the spine were related to the accident, when the first symptoms were recorded months after the accident.

Rothman J stated (at [47] – [51]):

> *47. Earlier in these reasons for judgment, I recited the relevant passages in the reasons for assessment of Assessor Crane and of the Review Panel insofar as they deal with the alleged injuries to the thoracic or lumbar spine. As is made clear by Assessor Crane under the heading "Diagnosis and Causation", the Assessor relied entirely on the lack of contemporaneous evidence or notes of an injury to the thoracic or lumbar spine and the fact that the first mention of any symptom in the back occurred nine months after the motor vehicle accident. The Review Panel agrees with the finding as to the lack of evidence and explains that a description of "a plausible mechanism of injury to a spinal region is not a reason to accept that an injury has actually occurred".*
>
> *48. There are two fundamental difficulties with the approach of the Assessor and of the Panel. First, the comment by Assessor Crane as to the lack of contemporaneous evidence to indicate injury to the thoracic or lumbar spine does not deal with the emergency department trauma admission secondary survey note of 2 September 2008 (see [12] above), which recites that there was "tenderness over lumbar-thoracic spine" on examination. The Review Panel repeats the error.*
>
> *49. It is possible, perhaps probable, that the doctors, being Assessor Crane and the members of the Review Panel, took the view that "tenderness over lumbar-thoracic spine" was not "evidence of an injury to the area". If that were the case, that conclusion would need to be expressed.*
>
> *50. Otherwise, plainly there is evidence of an injury (whether or not permanent) to the lumbar-thoracic spine region contemporaneous with the accident itself and noted independently on examination by the emergency department at Westmead Hospital. As a consequence, there is evidence that prevents both Assessor Crane and the Review Panel from coming to the crucial finding of fact that "there was no evidence of any injury" to this area.*
>
> *51. As is well known, a finding of fact for which there is no evidence is an error of law.*

His Honour also stated that it was problematic for the issue of causation to be determined on the basis of absence of contemporaneous evidence (at [51] – [53]). His Honour stated, in relation to the test of causation (at [54]):

> *"As is made clear in Clauses 1.8 and 1.9 of the Guidelines, and as is generally the approach of the common law, causation means "that a physical, chemical or biological factor contributed to the occurrence of a medical condition". In deciding such a question, the issue that must be determined is whether the injury caused "or contributed to worsening" of the impairment; it does not have to be the sole cause, provided it is a contributing cause that is more than negligible. Further, causation can be direct or indirect. Neither of these issues was addressed by either Assessor Crane or the Review Panel."*

The Court set aside the medical assessor's decision and the review panel's decision. The insurer has appealed this decision.

Rodger v De Gelder **(2015) 71 MVR 514; [2015] NSWCA 211** (Macfarlan JA, Gleeson JA, Leeming JA)

The claimant sought review of the decision of a MAS review panel. At first instance, Hamill J quashed the decision. The insurer appealed from the decision of Hamill J. The insurer argued that the primary judge had erred in concluding that the review panel had failed to take into account a number of relevant considerations (ie the evidence that had been provided to the review panel) and that the review panel had failed to provide adequate reasons for its decision.

The Court of Appeal dismissed the appeal. As to the issue regarding relevant considerations, the Court of Appeal (per Gleeson JA) held:

> 84. *It is well established that reference to a "relevant consideration" in judicial review is a reference to a factor which, by law, the decision-maker is bound to take into account: Peko-Wallsend at 39; Allianz Australia Insurance Ltd v Cervantes [2012] NSWCA 244; 61 MVR 443 (Cervantes) at [15] (Basten JA; McColl and Macfarlan JJA agreeing).*
>
> 85. *As Basten JA explained in Cervantes at [15], this ground required the respondent, Mr De Gelder, to identify the legal obligation on which he relied to identify what were mandatory factors to be taken into account for the purposes of the Panel's decision. The identification of relevant and irrelevant considerations is to be drawn from the statute empowering the decision-maker to act rather than from the particular facts of the case that the decision-maker is called on to consider: Abebe v Commonwealth of Australia [1999] HCA 14; 197 CLR 510 at [195] (Gummow and Hayne JJ).*
>
> 86. *It seems that this did not occur before the primary judge. This remained the position in this Court. Although Mr Rodger contended that the Permanent Impairment Guidelines were delegated legislation and4 Mr De Gelder did not submit to the contrary, neither party identified any mandatory considerations the Panel was bound to take into account. Both parties proceeded on appeal on the same basis as they did before the primary judge – that relevant material was the same as a relevant consideration in the sense described in Peko-Wallsend. This approach, which his Honour adopted, was erroneous. The error, as Basten JA said in Cervantes at [15], is that "to describe evidence as 'relevant' to the case of one party is not to identify a 'relevant consideration' for judicial review purposes".*
>
> 87. *As will be seen below, if the matter is approached on this basis, which although erroneous was common ground before the primary judge and in this Court, then in my view no error has been demonstrated in the primary judge's findings that the five items of evidence were not taken into account by the Panel. My reasons for this conclusion appear below when addressing the related question of whether the Panel failed to respond to a substantial argument advanced by Mr De Gelder based on those items of evidence: see below at [101], [105] and [106] - [107].*

As to the related issue of whether the review panel had an obligation to respond to a substantial argument (which first arose in the Court of Appeal), Gleeson JA stated (at [89]):

> *In Cervantes at [19] - [22], Basten JA addressed the legal obligation of administrative decision-makers to take particular evidence into account. The context in that case was the obligation of a claims assessor exercising power under the MAC Act, s 94. His Honour said:*
>
> > *[19] Although this ground must be dismissed for the reasons given above, it is desirable to return to the first step in the reasoning, namely identifying the legal obligation to take particular evidence into account. No case was referred to which supported a proposition expressed in these terms. In Dranichnikov v Minister for Immigration and Multicultural Affairs (2003) 73 ALD 321; 197 ALR 389; 77 ALJR 1088; [2003] HCA 26 at [24] (Dranichnikov), Gummow and Callinan JJ stated:*
> >
> > *[24] To fail to respond to a substantial, clearly articulated argument relying upon established facts was at least to fail to accord Mr Dranichnikov natural justice.*
> >
> > *[20] A similar point was made by Kirby J at [86] referring to a passage in the judgment of Gaudron J in Re Minister for Immigration and Multicultural Affairs; Ex parte Miah (2001) 206 CLR 57; 179 ALR 238; [2001] HCA 22 at [81] (Miah) where, after noting that it was not always easy to distinguish an error of law which is jurisdictional from one that is not, her Honour continued:*
> >
> > > *[81] However, the present case is, in my view, a clear case of constructive failure to exercise jurisdiction. That is because the delegate failed to consider the substance of Mr Miah's application and could only have failed to do so because he misunderstood what is involved in the Convention definition of "refugee".*
> >
> > *[21] Two propositions may be drawn from these statements. First, although not articulated in these terms, a constructive failure to exercise jurisdiction may arise because the statutory conferral of power has not been exercised according to its terms. Thus, in the present case, s 94 of the [MAC] Act requires that a claims assessor "is, in respect of a claim referred to the assessor for assessment, to make an assessment of ... the amount of damages": s 94(1)(b). It is, therefore, mandatory that the assessor address the claim and carry out the statutory function.*
> >
> > *[22] The second point is that neither Dranichnikov nor Miah went so far as to imply an obligation to consider every piece of evidence presented. Further, to refer to a report, but not to a particular passage in the report, may indicate an implicit preference for some other material which (in the absence of any no evidence ground) must be accepted as existing to support a particular*

> *conclusion. Such a course cannot constitute a failure to take into account a relevant consideration nor a failure to respond to a substantial argument: Minister for Immigration and Citizenship v SZJSS (2001) 243 CLR 164 at [35] (SZJSS).*

His Honour (and the other judges) held that the review panel in this case had failed to respond to a substantial argument raised by the claimant, holding (at [109]):

> *"Here the Panel failed to respond to a substantial argument based on evidence relied upon by Mr De Gelder as to the causation of his thoracic spine injury by the motor accident. It may also be inferred that the Panel failed to apply itself to the real question to be decided in carrying out its statutory function under s 58(1)(d), because it misunderstood a significant body of evidence relevant to its non-medical determination. What the Panel did amounted to a jurisdictional error. The Panel's decision recorded in its certificate is to be regarded as a purported and not real exercise of its statutory function in s 58(1)(d), leaving that statutory function unexercised, and the Authority and the Panel liable to the relief granted by the primary judge by way of judicial review: Ex parte Hebburn Ltd; Re Kearsley Shire Council [1947] NSWStRp 24; (1947) 47 SR (NSW) 416 at 420 (Jordan CJ)."*

Accordingly, the Court of Appeal upheld the decision of Hamill J, but for a different reason, and the appeal was dismissed.

Mackenzie v Allianz Australia Insurance Ltd (No. 2) **(2015) 72 MVR 440; [2015] NSWSC 1320** (Adamson J)

The claimant sought review of the decision of a MAS review panel. The review panel had assessed the claimant's whole person impairment at 0%. The claimant argued that the review panel had erred in finding that the claimant's injuries had resolved within a 2 week period following the accident, following which he had returned to work. The claimant argued that the review panel failed to appreciate that the work that the claimant returned to was different to his pre-accident work and therefore it could not be inferred that the claimant's injuries had resolved.

Adamson J held that the reasons given by the review panel did not reveal any misapprehension about the plaintiff's work history (at [46]). Her Honour noted that the review panel's ultimate finding was that the claimant's injuries had resolved and gave rise to no permanent impairment, and that there was nothing to indicate that the review panel had not performed its statutory task (at [47]).

The claimant had also argued that the review panel was not properly constituted, as not all members of the review panel re-examined the claimant. Her Honour dismissed this argument, finding that although a review panel is comprised of all its members, there is no requirement that all of the members participate in each of the tasks that leads to the assessment (at [59]).

Scott v Insurance Australia Limited **(2015) 72 MVR 300; [2015] NSWSC 1249** (Campbell J)

The claimant sought review of the decision of a MAS assessor and review panel which purported to assess the claimant's past and future care needs pursuant to an application for a treatment dispute which had been made by the insurer.

Campbell J held that MAS did not have jurisdiction to assess the reasonableness or necessity of gratuitous care (as opposed to commercial care) (at [56]). His Honour also found that a genuine dispute did not exist between the parties so as to enable the insurer to refer the matter to MAS in any event. In this regard, his Honour said that he is not of the view that treatment disputes are limited to cases where a specific request for treatment has been made (at [84]), but that it is necessary for the treatment issue to be seriously and maturely considered by the insurer rather than the insurer just going through the motions of setting up the appearance of a dispute (at [85]).

The insurer has appealed this decision, primarily on the grounds that the finding in relation to treatment disputes not including gratuitous care is inconsistent with the decision of the High Court in *Daly v Thiering* [2013] HCA 45, (2013) 249 CLR 381.

IAG Limited t/as NRMA Insurance v Gilshenen **(2015) 72 MVR 214; [2015] NSWSC 1165** (Fagan J)

The insurer sought judicial review of a decision of the proper officer of MAS. The decision was to refer a medical assessment for review. The proper officer had determined that there was "reasonable cause" to suspect a material error in the assessment of the primary MAS assessor. The alleged error concerned clause 1.28 of the Permanent Impairment Guidelines (adjustment for effects of treatment).

Fagan J held that the correct interpretation of that clause permits assessors to allow any percentage in the range 1-3% and that it is a matter for the assessor to choose and apply the percentage taking into account the matters specified in the guidelines. His Honour held that the medical assessor had complied with the guidelines and that the proper officer had erred in finding that there was reasonable cause to suspect that the assessment was incorrect.

His Honour also held that the proper officer could not make a decision under section 63 until the proper officer had determined clause 1.28 of the guidelines in a matter that was both definitive and correct.

AAI Limited v Fitzpatrick **(2015) 72 MVR 97; [2015] NSWSC 1108** (Schmidt J)

The insurer applied for review of the decision of a medical assessor and review panel. The insurer argued that the assessor had failed to have regard to relevant material and had failed to give adequate reasons.

Schmidt J held that the assessor had failed to adhere to his statutory duty to give reasons for his decision. Her Honour also held that the assessor had failed to have regard to relevant material, in that he did not give necessary consideration to the material that was before him (and this was related to the failure to give reasons).

The Court quashed the decision of the proper officer.

Bradley v Insurance Australia Ltd t-as NRMA Insurance **(2015) 71 MVR 496; [2015] NSWSC 950** (Adamson J)

The claimant applied for judicial review of the decision of a MAS review panel. The issue was whether the plaintiff's back injury was caused by the accident. The review panel determined that the lower back injury was not caused by the accident, primarily on the basis that there was no contemporaneous evidence of such an injury.

The claimant argued that the review panel had treated the contemporaneous medical records as being determinative of the issue of causation, rather than merely one piece of evidence to be weighed with all the others.

Adamson J concluded that the review panel had in fact had regard to a number of pieces of evidence, and that the fact that the review panel gave weight to the clinical records was unexceptional (at [54] – [55]).

The claimant also argued that the review panel was not properly constituted ion that only 2 of the 3 assessors actually examined the claimant. Her Honour found that the Act and Guidelines permitted the re-examination to be conducted by 2 out of the 3 members of the review panel (at [73]).

Peet v NRMA Insurance Ltd **(2015) 70 MVR 473; [2015] NSWSC 558 (Hidden J)**

The claimant was injured in a motor accident on 4 December 2007. She alleged that she sustained a psychological injury as a result. The matter was referred to MAS for a permanent impairment dispute. She was ultimately assessed as having whole person impairment that did not exceed 10%.

The matter was then referred to a review panel. The panel also certified that the claimant's whole person impairment was not greater than 10%. The review panel found that the plaintiff had pre-existing psychological problems. It also found that she has sustained psychological injuries as a result of the accident – namely a Specific Driving Phobia. The claimant had encountered workplace issued prior to the accident but had also had further issues following the accident, which the claimant had alleged were causally related to the accident. The panel found that the claimant had developed a recurrence of Adjustment Disorder with Mixed Anxiety and Depressed Mood, but that this was not causally related to the motor accident, and was instead due to workplace issues.

The claimant applied for judicial review of the review panel decision. The main complaint was that the review panel had incorrectly applied the test of causation. The claimant's argument was summarised by Hidden J as follows:

> *18. In written submissions Mr Romaniuk argued that the Panel's reasons demonstrate three, closely related, errors. Firstly, the Panel failed to consider any causal link between the accident, the consequent workplace issues, and the recurrence of the Adjustment Disorder. In failing to do so, it applied too narrow a test of causation. Secondly, the Panel failed to consider whether the*

Adjustment Disorder was caused or "materially contributed to" by the accident, as required by the Guidelines and CLA s 5D. The Panel failed to determine whether the accident was a "necessary condition" for the occurrence of the disorder. Thirdly, the Panel failed to have regard to the stipulation in cl 1.9 of the Guidelines that the accident need not be the sole cause of the condition, provided that it was a "contributing cause" which was "more than negligible."

19. Mr Romaniuk argued that, plainly, the plaintiff's alleged treatment at her workplace, accepted by the Panel to be the source of the recurrence of her Adjustment Disorder, would not have occurred "but for" the accident. In the circumstances, he submitted, the Panel had fallen into error in considering the issue of factual causation, for the purpose of CLA s 5D(1)(a) and the Guidelines. Accordingly, there was an error of law amounting to jurisdictional error and warranting relief in this court.

His Honour outlined the insurer's argument (as summarised in oral argument) as follows (at [24]):

"We say this is a very clear case where, while the 'but for' test may be satisfied because the motor accident was one of a number of factors leading to the situation that occurred, because of questions of intervening acts and remoteness of damage this is certainly not a case where liability should extend to the first defendant in its capacity as the insurer of the driver alleged to be at fault. To the contrary, the Panel appears to have clearly decided that the motor accident had nothing at all to do with the development of the Adjustment Disorder in the presence of a very clear and powerful history as to what did cause that disorder."

His Honour cited *Wingfoot Australia Partners Pty Ltd v Kocak* (2013) 252 CLR 480 and found that the reasons of the review panel disclosed error, stating (at [29]):

"The analysis of the issue of causation which Mr Rewell attributed to the Review Panel may well be available, but I do not accept that it is how the Panel approached the matter. Indeed, one might question whether it would ever be appropriate for the normative judgment required by CLA s 5 D(1)(b) to be made in the medical assessment process. I am satisfied that in the present case the Panel was addressing the issue of factual causation when it found that the plaintiff's Adjustment Disorder was not attributable to the accident. That being so, I am persuaded by the submissions of Mr Romaniuk that its assertion that this was not a "but for" situation discloses explicit error in its reasons. The plaintiff is entitled to the relief she seeks."

***McCosker v Motor Accidents Authority of New South Wales* (2015) 70 MVR 280; [2015] NSWSC 434 (Button J)**

The claimant sustained injuries in a motor accident on 4 March 2006. She was assessed by MAS as having 27% whole person impairment of which 25% whole person impairment was in respect of her physical injuries. A large part of this impairment was comprised of impairment from the claimant's thoracic and lumbar spine.

The medical assessor, Assessor Kenna, was not provided with some of the plaintiff's background medical records, including in particular the handwritten notes of her treating chiropractor, Robert Schwager, and a statement from a witness to the accident. There was no dispute that the insurer had been in possession of those documents for years prior to the time of the assessment with Assessor Kenna, but the insurer had not provided them to MAS.

The insurer applied for a further assessment at MAS pursuant to s62(1)(a), on the grounds that there was additional relevant information. The alleged "additional relevant information" including, relevantly, the records of Dr Schwager, the witness report, and two other documents, namely a report of Dr Schwager and a medico-legal report of Dr Spira.

The proper officer determined that the records of Dr Schwager and the witness statement (and the various other documents that the insurer had been in possession of prior to the MAS Assessment but had not provide to MAS) could not constitute additional relevant information, in accordance with *Singh v Motor Accidents Authority of NSW (No 2)* NSWSC 1443, on the basis that the insurer had been in possession of the documents prior to the first MAS assessments.

The real issues were the report of Dr Schwager and the report of Dr Spira and whether these documents could constitute "additional" information. Both of those documents post-dated the MAS Assessments. The proper officer found that these two documents did constitute additional relevant information for the purpose of s 62(1)(a), and she referred the matter for further assessment.

The claimant sought judicial review of the proper officer's decision. The claimant/plaintiff submitted that the report of Dr Schwager was not additional relevant information because in substance it was no more than a shortened transcription of the notes that had been in the insurer's possession prior to the first MAS application. The plaintiff also submitted that the report of Dr Spira could not be additional relevant information because it was derived only from material that was in possession of the insurer prior to the first MAS application.

Button J found that the report of Dr Schwager was largely (though not completely) a transcription of his handwritten notes. This was based on the fact that the material in the report was also contained in the notes (albeit with some changes of expression) and also on the basis that the report was prepared approximately 5 years after the last consultation with the claimant, from which his Honour inferred that the chiropractor must have had little if any independent recollection of his treatment of the claimant and must have relied on his notes when preparing his report. Accordingly his Honour found that the report was not "additional" although he found that if it had been additional, the proper officer would have been correct in finding that it was relevant and that it could have had a material outcome on the assessment.

Referring to *Singh (No 2)*, his Honour said (at [41]):

> *"In short, I consider that the judgment of Rothman J stands for two propositions. The first is that material that was in the possession of a party at the time of the original assessment cannot be relied upon by that party as additional information in support of an application for a further assessment. The second proposition is that material that is*

> *an expert opinion substantially based upon material that was in the possession of the party at the time of the original assessment, even if the expert opinion was obtained after the original assessment, will also fall within the prohibition contained in the first proposition."*

Applying those principles, his Honour found that the report of Dr Schwager, and the report of Dr Spira, were not additional relevant information. The decision of the proper officer was declared invalid.

***QBE Insurance (Australia) Ltd v Jovanovic* (2015) 70 MVR 126; [2015] NSWSC 241 (Garling J)**

The claimant claimed that she had sustained a number of injuries, including a lower back injury, as a result of a motor vehicle accident. The claimant had pre-existing lower back problems and the insurer disputed that she had sustained any injury to her lower back as a result of the motor accident.

The claimant was assessed by MAS in relation to a treatment dispute – for L4/5 decompression surgery plus spinal fusion with internal fixation. It was certified by the medical assessor that the surgery did not relate to the accident. The claimant applied for a review of that decision but the review was rejected.

The matter was then referred to MAS for assessment of a permanent impairment dispute. The MAS assessor certified that the claimant's injured caused by the accident did include a soft tissue injury to the lumbar spine, but that the claimant's whole person impairment did not exceed 10%. There was no application for review.

Thereafter, the claimant underwent the surgery that had been the subject of the treatment dispute. She then applied for further assessments of the treatment dispute and permanent impairment dispute, relying on a report from her treating surgeon, Dr Kohan. Both applications were rejected by the proper officer. The main basis for the rejection of assessments was that the proper officer was not satisfied that the occurrence of the surgery was additional relevant information that had any bearing on the issue of whether the surgery was causally related to the accident.

Although the decision of the proper officer was "rational and appropriate" (in the words of Garling J) there were two obvious errors in her reasons which caused the parties to invite the Proper Officer to re-visit her decision. The Proper Officer considered that application and stated:

> *"There has clearly been an error on my part as Proper Officer. The [judgment in] Minister for Immigration and Multicultural Affairs v Bhardwha (sic) (2002) CLR 597 is relevant to this matter and is authority for the proposition that where a decision can wholly be accepted as invalid by reason of jurisdictional error, a decision maker has, at law, not yet discharged his or her statutory function and may 'revisit' that decision without a court order. In this case there has clearly been a jurisdictional error as I have not appropriately considered all the information provided to me and have denied procedural fairness to the claimant. In view of this it is my intention to*

revisit my determination."

The proper officer did revisit her decision and ultimately referred the whole person impairment dispute for further assessment (with Dr Bodel), but did not refer the treatment dispute for further assessment.

In the meantime, an application was made to CARS for General Assessment, and the matter was allocated the claims assessor Broomfield. Concerned about the possibility of two incompatible causation findings from MAS (in the event that Dr Bodel made causation findings that were incompatible with the previous treatment dispute findings), Assessor Broomfield made referral pursuant to s62(1)(b) that the treatment dispute be further assessed.

The insurer sought judicial review of the decision of the proper officer to refer the matter for further assessment of the impairment dispute, and of the decision of the claims assessment to refer the matter for further assessment of the treatment dispute (on the basis that the latter decision was based on the earlier impugned decision).

Each of the defendants, including the claimant, filed submitting appearances. This meant that there was no contradictor in the proceedings. Nevertheless, despite all the defendants being content for orders to be made by consent, the Court required the case to be run, on the basis that it was necessary for the Court to determine whether it had jurisdiction to make the orders sought, and to give guidance as to what the law required of the decision makers.

Garling J set aside the decisions of the Proper Officer, finding:

> *69. In my view the arguments of QBE are correct.*
>
> *70. Ms Jovanovic claimed an injury to her lumbar spine, and a soft tissue injury to her back. Dr Wong's certificate determined as an essential fact, that there was no spinal injury caused by or associated with the motor vehicle accident.*
>
> *71. Dr Kohan's statement in his report of November 2013 did not contain any additional information which was capable of fulfilling the threshold requirements to justify a rational decision to refer the treatment dispute for reassessment. The decision of the third defendant to decline to require reassessment of the treatment dispute was therefore legally correct. The treatment dispute having been determined, and reassessment lawfully refused, it was not then open for the fourth defendant to refer the treatment dispute for reassessment.*
>
> *72. The issue for the third defendant was then, in light of the legally valid certificate which concluded that there was no causal relationship between the motor vehicle accident and the lumbar spine injury, whether she could lawfully refer the impairment dispute for reassessment, based on Dr Kohan's report. But if, as is apparent from the report of Dr Kohan, the only additional material reported on by him related to the fact of the conduct of his surgery, which was correctly identified as not being causally related to the motor vehicle accident, then such information was not capable of constituting any additional information of the kind required to enable a referral of the impairment dispute to a further medical assessment.*

73. It was thus an error of law for the third defendant, based on the report of Dr Kohan, to refer the impairment dispute for reassessment.

74. In addition, I am satisfied that the decision to refer the assessment of the impairment dispute for a further assessment by a medical assessor was irrational and illogical. That is because, as QBE correctly submits, it was completely illogical to refer only one of the disputes for reassessment. The circumstances were such that the third defendant, acting rationally, could only refer both or neither of the disputes for reassessment.

75. Since there is no challenge to the original non-referral of the treatment dispute, and I am satisfied that that was a legally correct decision, then it follows that the decision of the Proper Officer, the third defendant, to refer the impairment dispute for a further medical assessment is wholly irrational.

76. What then should be made of the decision of the fourth defendant, the Claims Assessor, Mr Broomfield, to refer the matter for further medical assessment?

77. In my view, that decision ought also be set aside because at its heart, it was brought about by, and depended upon, the decision which I have found was wholly irrational, to refer the impairment dispute for a further assessment to a Medical Assessor. It follows that the decision of the fourth defendant also ought be set aside. He should proceed to conduct his assessment based upon the Certificate issued in 2012, and any other relevant information, subject to any lawful decision which may be made in the future about a referral for reassessment.

***Dunbar v Allianz Australia Insurance Limited* (2015) 70 MVR 15 (Fullerton J)**

In this case, the claimant challenged a decision of a medical assessor and a proper officer. The medical assessor certified permanent impairment (orthopaedic injuries) of 1% (assessor Cameron). Another medical assessor awarded 20% for other injuries (assessor Fry). The insurer applied to the proper officer for a review panel and was successful. The review panel determined that assessor Fry's determination should be reduced to 6%.

In the Supreme Court, the claimant challenged the decision of medical assessor Cameron and the decision of the proper officer to refuse to allow assessor Cameron's determination to go to a review panel. The primary attack was on the medical assessment (at [40]).

The grounds of judicial review were wide-ranging. The claimant said (at [54]) the legal errors included legal unreasonableness, failing to properly consider certain documents and issues and that the assessor failed to afford proper weight to some matters. There was a particular report before the assessor (of Dr Mobbs) that the claimant said the assessor had failed to "comment, review or consider".

The court set out the established legal principles it would apply (at [75]), namely:

> There is no equating the evidence that may be relevant to a case that a party may wish

> to advance in curial proceedings with a relevant consideration for the purposes of judicial review. In the context of judicial review, a relevant consideration refers to a matter that a decision maker is obliged by law to take into account. This was identified by Basten JA in *Allianz Australia Insurance Ltd v Cervantes* [2012] NSWCA 244; 61 MVR 443 at [15] as the first of four key concepts inherent in judicial review. The second concept, namely how a particular consideration is to be taken into account, and the weight to be accorded it, are matters within the discretion of the decision maker (see *Minister for Aboriginal Affairs v Peko-Wallsend Ltd* [1986] HCA 40; 162 CLR 2324). Of the remaining two concepts identified by Basten JA, only the third is of present relevance, that being the obligation of the plaintiff to establish on the balance of probabilities that the assessor did not take the identified material into account.

It was held (at [76]) that the claimant had not established as a matter of fact that the medical assessor failed to take relevant information into account on the balance of probabilities. The assessor was held to not be required to have to set out in full his review of every report that was before him (at [77]). Accordingly the challenge failed and the summons was dismissed.