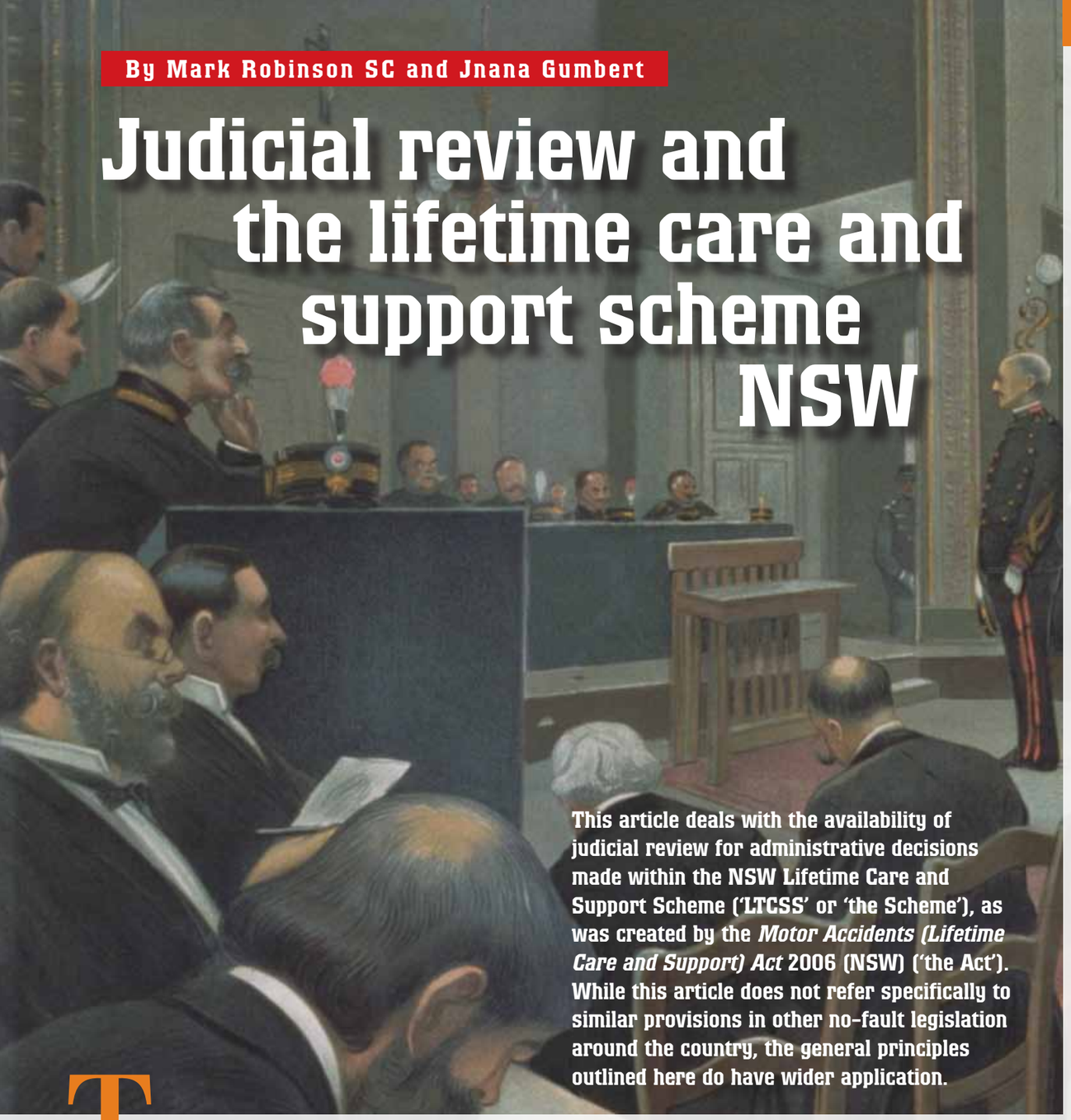
By Mark Robinson SC and Jnana Gumbert

Judicial review and the lifetime care and support scheme NSW



This article deals with the availability of judicial review for administrative decisions made within the NSW Lifetime Care and Support Scheme ('LTCSS' or 'the Scheme'), as was created by the *Motor Accidents (Lifetime Care and Support) Act* 2006 (NSW) ('the Act'). While this article does not refer specifically to similar provisions in other no-fault legislation around the country, the general principles outlined here do have wider application.

The Act was substantially amended in 2012. This article deals with the Act as amended.

The Lifetime Care and Support Authority ('the Authority') has the power to issue 'guidelines' under s58 of the Act. The guidelines are a form of delegated legislation.

The Authority administers the scheme under the Act and the guidelines.

The Scheme is designed to provide no-fault care and medical treatment (and, in some cases, some ancillary benefits) for people who have been catastrophically injured in motor accidents since the date of the Scheme's enactment.

The Scheme is funded by a levy on all compulsory third-party (CTP) policies in NSW.

IMPORTANT LEGISLATIVE PROVISIONS

Section 8 of the Act outlines the process for applying to participate in the Scheme. There are three ways to enter the Scheme:

(i) The injured person can elect to become a participant in the Scheme.
(ii) The insurer can nominate an injured person for inclusion in the Scheme.
(iii) The State Insurance Regulatory Authority ('SIRA' – formerly the Motor Accidents Authority) can direct an insurer to nominate an injured person for inclusion in the Scheme. The insurer must comply with this direction.

Section 5A contains the definition of '*treatment and care*'.

'(1) For the purposes of this Act, the '*treatment and care needs*' of a participant in the Scheme are the participant's needs for or in connection with any of the following:
  (a) medical treatment (including pharmaceuticals);
  (b) dental treatment;
  (c) rehabilitation;
  (d) ambulance transportation;
  (e) respite care;
  (f) attendant care services;
  (g) aids and appliances;
  (h) prostheses;
  (i) education and vocational training;
  (j) home and transport modification;
  (k) workplace and educational facility modifications; and
  (l) such other kinds of treatment, care, support or services as may be prescribed by the regulations under this paragraph.
(2) Despite subsection (1), the treatment and care needs of a participant do not include any treatment, care, support or services of a kind declared by the regulations to be "*excluded treatment and care needs*".'

Section 11A sets out the expenses that must be paid by the Authority.

'(1) The Authority is to pay for all of the reasonable expenses incurred by or on behalf of a person in relation to the assessed treatment and care needs of the person while the person is a participant in the Scheme.
(2) The "assessed treatment and care needs" of a person who is a participant in the Scheme are those treatment and care needs that are assessed by the Authority, in its treatment and care needs assessment, to be treatment and care needs that:
  (a) are reasonable and necessary in the circumstances; and
  (b) relate to the motor accident injury in respect of which the person is a participant.
(3) No expenses are payable in respect of:
  (a) excluded treatment and care needs; and
  (b) treatment and care needs that are not assessed treatment and care needs.
(4) As an alternative to paying the expenses for which it is liable under this section as and when they are incurred, the Authority may pay those expenses by the payment to the participant of an amount to cover those expenses over a fixed period pursuant to an agreement between the Authority and the participant for the payment of those expenses by the participant.
(5) The LTCS Guidelines may make provision for or with respect to determining which treatment and care needs of a participant in the Scheme are reasonable and necessary in the circumstances and relate to the motor accident injury in respect of which the person is a participant.'

These provisions give the Authority the power to determine *for itself* what the assessed treatment and care needs of a participant are: the decision as to the assessed treatment and care needs of a person is not subject to any objective criteria. However, under general law principles, the Authority is required to make its decision reasonably and lawfully.[1]

Section 11B of the Act sets out the circumstances in which the Authority is not required to make a payment.

'(1) The Authority is not required to make a payment in relation to the following:
  (a) any treatment, care, support or service provided to a participant in the Scheme on a gratuitous basis (that is, anything provided to a participant for which the participant has not paid and is not liable to pay); and
  (b) any treatment, care, support or service that is required to be provided by an approved provider but is provided by a person who is not, at the time of the provision, an approved provider.
(2) However, the Authority may elect to make a payment in relation to any treatment, care, support or service referred to in subsection (1) if the Authority is of the opinion that special circumstances exist that justify such payment.
(3) The LTCS Guidelines may make provision for or with respect to determining whether special circumstances exist that justify payment in relation to any treatment, care, support or service referred to in subsection (1).
(4) To avoid doubt, this section applies even if the treatment, care, support or services concerned are provided in connection with the provision of the assessed treatment and care needs of a participant in the Scheme.
(5) This section has effect despite s11A.'

Section 11C provides that the Authority is only required to pay for services provided by 'approved providers':

'(1) The following treatment, care, support or services (provided in connection with the provision of assessed treatment and care needs of a participant in the Scheme) are to be provided only by an approved provider of the treatment, care, support or service:
  (a) attendant care services; and
  (b) any other treatment, care, support or services (other than the services of a medical practitioner) identified in the LTCS Guidelines as treatment, care, support or services that are to be provided by an approved provider.
(2) An "approved provider" of a service is a person, or a person of a class, approved by the Authority (or by any other person specified in the LTCS Guidelines), in

accordance with the LTCS Guidelines, to provide the treatment, care, support or service under the Scheme.

(3) The LTCS Guidelines may also make provision for or with respect to the standards of competency of approved providers.'

Sections 11A and 11B were introduced to override the early Scheme decision of *Thiering*[2] by making it abundantly clear that the Authority does not have to pay for:

- excluded treatment and care needs (defined in s5A(2) as being treatment, care, support or services of a kind declared by the regulations (that is, the Guidelines) to be excluded treatment and care needs);
- treatment and care needs that are not assessed treatment and care needs;
- gratuitous care; and
- any treatment or care that is not provided by an approved provider (except if the Authority determines that special circumstances exist).

Section 141A of the *Motor Accidents Compensation Act* 1999 (NSW) provides:

'No damages relating to treatment and care needs for Lifetime Care and Support Scheme participants

(1) No damages may be awarded to a person who is a participant in the Scheme under the *Motor Accidents (Lifetime Care and Support) Act* 2006 in respect of any of the treatment and care needs of the participant, or any excluded treatment and care needs, that relate to the motor accident injury in respect of which the person is a participant in the Scheme and that arise during the period in which the person is a participant in the Scheme.

(2) This section applies:

(a) whether or not the treatment and care needs are assessed treatment and care needs under the *Motor Accidents (Lifetime Care and Support) Act* 2006; and

(b) whether or not the Lifetime Care and Support Authority is required to make a payment in respect of the treatment and care needs concerned; and

(c) whether or not the treatment, care, support or service (provided in connection with treatment and care needs) is provided on a gratuitous basis.

(3) In this section "treatment and care needs" and "excluded treatment and care needs" have the same meanings as they have in the *Motor Accidents (Lifetime Care and Support) Act* 2006.'

This section confirms that there is no entitlement to recover compensation from the CTP insurer for damages which fall within the scope of the LTCS Scheme.[3]

DISPUTES (INTERNAL REVIEW)

Disputes about eligibility for inclusion in the Scheme

Part 2 of the *Lifetime Care and Support Guidelines* (latest version July 2015) ('the Guidelines') deals with disputes about eligibility.

Any dispute application about eligibility must be made within six months of receiving the Authority's decision regarding eligibility.

On receiving an application for a dispute regarding eligibility, the Authority will convene a panel of assessors to determine the dispute (Guidelines, Part 2, clause 4). The panel can arrange medical examinations if necessary, and will ultimately issue a certificate regarding the injured person's eligibility in the Scheme (Guidelines, Part 2, clause 11).

It is possible to apply for an internal review of the panel's decision, but only on the following grounds (as set out in s15(1) of the Act):

'(a) a change in the condition of the injured person, being a change that occurred or that first became apparent after the dispute was referred for determination by the Assessment Panel and that is capable of having a material effect on the determination;

(b) the availability of additional relevant information about the injury, being information that was not available, or could not reasonably have been obtained, before the dispute was referred for determination by the Assessment Panel and that is capable of having a material effect on the determination;

(c) the determination was not made in accordance with the LTCS Guidelines; and

(d) the determination is demonstrably incorrect in a material respect.'

Under the Guidelines, any review must be applied for within six months of receiving the certificate from the assessment panel (Guidelines, Part 2, clause 12). However, there is no corresponding requirement in the Act and it is possible that the time limit imposed is *ultra vires* the Act (and therefore invalid). An application for review can be lodged by the injured person, the insurer, or the Authority.

On receiving the application for review, the Authority will consider whether to refer the dispute to a review panel. The review panel may either confirm the original certificate or revoke it and issue a new certificate (LTCS Act s15, Guidelines, Part 2, clause 12).

Under s16, the determination of an assessor or review panel as to satisfaction of the criteria for eligibility to participate in the Scheme is deemed to be '*final and binding*' for the purposes of the Act and any proceedings under the Act. This is a privative clause intended to limit or restrict the availability of judicial review. However, it will be ineffective in circumstances where there is jurisdictional error in the making of the decision – see *Kirk v Industrial Court of NSW* (2010) 239 CLR 531.

Section 18 of the Act provides that no legal costs are payable by the Authority in respect of a dispute regarding eligibility for the Scheme. This would only apply to *internal* disputes and not to judicial review proceedings in the Supreme Court.

Disputes about whether an injury is a 'motor accident injury'

Part 3 of the Guidelines deals with disputes about whether an injury is a '*motor accident injury*' within the meaning of the Act.

A person who has been notified by the LTCS Authority that they are eligible for the Scheme may, pursuant to s20, lodge a dispute as to whether their injury is a motor accident injury within the definition of the Act. Such an application must be made within six months of receiving notice from the Authority as to eligibility.

The Principal Claims Assessor will convene a panel of three assessors to determine the dispute. This is the *only* type of dispute under the Act where the injured person is entitled to recover costs for legal representation for matters undertaken within the Authority.

Section 21 provides that the panel which determines the dispute as to whether an injury is a 'motor accident injury' also determines the amount of legal costs that the Authority has to pay. Section 21(3) provides for the making of regulations in relation to maximum legal costs, but no such guidelines have yet been made. The *Lifetime Care and Support Guidelines 2012* do not specify what costs the Authority has to pay, but simply say that the panel will assess the 'reasonable' costs payable to the injured person's legal practitioner.

Legal practitioners are unable to recover the 'solicitor/client' portion of the costs from the client directly, as s21(4) specifies that a practitioner is not entitled to be paid or recover for a legal service an amount that exceeds any maximum legal costs fixed by the regulations.

Treatment and care disputes

Part 4 of the Act provides for the Authority to conduct treatment and care assessments. Such assessments are required at frequent intervals during the first few years post-accident, especially in brain injury cases. Thereafter, reassessment of a participant's needs may become more periodic.

Section 24 of the Act provides that the Authority will make decisions in relation to future care and treatment.

If an injured person does not agree with an assessment, the Authority must refer the dispute to an assessor for determination. The procedure for these disputes is set out in Part 4 of the Guidelines.

Section 24 also provides that the assessors who determine the disputes will be appointed by the Authority.

The only right of appeal from an assessor's decision is to a panel of three other assessors, also appointed by the Authority. Limited circumstances and strict time limits apply (s25). The application for review must be lodged within 28 days of receiving the initial assessor's certificate (Guidelines, Part 4, clause 12).

Section 29 provides that no legal costs are payable by the Authority for or in respect of legal services provided to a participant in the Scheme in connection with an assessment or a review under Part 4. This effectively cuts off access to legal services for many injured people within the Scheme.

The Guidelines are generally proscriptive in identifying what the Authority will and will not pay for. There is a list of things it will pay for, addressed in broad terms, in the Act and further specified in the Guidelines. The beginning of Part 5, 6, 7, and 8 of the Guidelines provide: 'to avoid requirements that might be unreasonable in the circumstances on any participant, the Authority may waive observance of any part or parts of these Guidelines'. There is a separate and independent right under the Guidelines to ask the Authority to waive the Guidelines if that is what stands in the path of a particular benefit. Such a situation would require independent statutory decision-making by the Authority which might well be reviewable in the Supreme Court.

By way of example, Part 8 (1.7) of the Guidelines provides that attendant care services do not cover personal care if the participant is an inpatient in a hospital. If, in a particular case, there were services that were necessary that the public hospital system could not provide, there would seem to be little point in asking an assessor to award them, as the assessor is bound by the Guidelines. It would be necessary to ask the Authority to exercise its discretion to waive the Guidelines.

As happens every few years, we understand that the Guidelines are presently being re-drafted; whether these general discretions will survive the re-drafting is unknown. Ultimately, any proscriptive 'we will not pay' clause in the Guidelines may arguably be *ultra vires* the plain legislative requirement of the Authority to pay for what is reasonable and necessary. This remains to be seen.

Payment disputes under the Scheme

In 'special circumstances', the Authority may elect to make payments (for treatment or care or gratuitious services) that it is not otherwise required to make – s11B(2). This discretion

would be exercised by the Authority, possibly informed by one of its assessors. Such issues would fall on the Authority directly, unless delegated. In any event, any such decision would be amenable to challenge in the Supreme Court if made unlawfully.

LEGAL REPRESENTATION

The Scheme was plainly set up to minimise the involvement of insurers and lawyers. Its focus is to maximise the provision of treatment and care to the injured, and minimise the involvement of lawyers in disputes. While there is provision for recovery of legal fees in relation to a dispute as to whether the circumstances of an accident fall within the scope of the motor accident regime, there is no recovery of legal fees in relation to a medical dispute over eligibility (s18) or for a dispute about treatment needs (s29).

The restrictions on fees apply only to internal applications and reviews. Once an application for judicial review is made to the Supreme Court of NSW, ordinary costs rules of the Supreme Court would apply.

JUDICIAL REVIEW

Proceedings for judicial review invoke the Supreme Court's judicial review (or supervisory) jurisdiction derived from s69 of the *Supreme Court Act* 1970 (NSW), which provides for the making of orders '*in the nature of*' the former prerogative writs, such as the former writ of *certiorari*. This jurisdiction is constitutionally recognised and protected by s73 of the Commonwealth *Constitution* (see *Kirk v Industrial Court of NSW* (2010) 239 CLR 531).

The remedy that is usually sought is an order in the nature of *certiorari* to 'quash' or set aside an Authority decision. An order in the nature of *mandamus* is often also sought, in effect, to remit a matter back to the decision-maker (perhaps differently constituted) to make the decision in accordance with law. Sometimes, an order in the nature of prohibition or an injunction is needed to prohibit the decision-maker from taking the matter further within the Authority while the court hearing goes on.

Also, the court may make declarations as to the legality or lawfulness of the subject Authority decisions. Costs are usually awarded to the successful party.

There are established discretionary factors that the court will take into account in determining whether a remedy should be granted in judicial review proceedings. In short, a remedy will not normally be granted if:

(i) a more convenient and satisfactory remedy exists;
(ii) no useful result could ensue (futility);
(iii) the applicant has been guilty of unwarrantable delay;
(iv) the application has acquiesced in the conduct of proceedings known to be defective; or
(v) if there has been bad faith on the part of the applicant, either in the transaction out of which the duty to be enforced arises or towards the court to which the application is made (see the decisions of the discretion generally, and citation of some of the relevant cases in *Commissioner of Taxation v Futuris Corporation Limited* (2008) 237 CLR 146).

Accordingly, before seeking judicial review, a party should have exhausted the internal review remedies available, acted without delay and must not have done anything that could indicate that it accepts that the decision is lawful.

Under Part 59 of the *Uniform Civil Procedure Rules 2005* (NSW), the time limit for filing proceedings in judicial review in the Supreme Court is three months from the date of the decision (*not* three months from the date of receiving the decision). Part 59 also contains many other rules and requirements pertaining to the conduct of judicial review proceedings.

An action in judicial review is designed to set aside what would otherwise be valid decisions made by administrative decision-makers (such as the Authority) but which are void by reason of the decisions being made unlawfully or beyond power (*ultra vires*). Ordinarily, the grounds of judicial review would be applied to a decision in order to test and then establish its legal validity.

The grounds of judicial review include, for example:

(i) denial of natural justice or procedural fairness;
(ii) failure to take into account required relevant considerations;
(iii) taking into account irrelevant considerations; and
(iv) applying a policy without taking account of the facts of the application.

Many of the grounds of judicial review overlap. Where a decision-making power contains an element of discretion, the general law has imposed a requirement that any such discretion must be exercised reasonably and lawfully.[4] Accordingly, most decisions made by the Authority are amenable to judicial review, subject to the above discretionary factors for granting relief.

It must be borne in mind that the Guidelines of the Authority are not holy writ. They themselves might travel beyond the scope of the empowering legislation. The stream cannot rise higher than the source.[5] If the Guidelines appear to be invalid, they can also be challenged in judicial review proceedings, and set aside. It follows that decisions made based on invalid guidelines are also invalid.

On our understanding of the Act and the Guidelines, the three types of disputes referred to earlier in this paper (eligibility for inclusion in the Scheme; whether there is a motor accident injury; treatment and care disputes; and payment disputes) are all open to challenge in judicial review proceedings, once all internal review processes are exhausted. They all concern justiciable decisions.

Surprisingly, there have not been many cases in judicial review under this legislation.

There might be many reasons for that situation. One of the main reasons appears to be that because there is no effective right to legal representation *within* the Scheme (in that there are little or no costs available), most participants do not have ready access to legal advice, and are therefore not in a position to be advised as to the availability of judicial review proceedings once internal review has finished. The other reason may be that the Authority's considerable discretion in respect of many of its decisions is perceived as a disincentive to seek judicial review (which it is not).

JUDICIAL REVIEW AND THE LIFETIME CARE AND SUPPORT SCHEME NSW

However, the Authority's discretion must be exercised reasonably and lawfully. Failure to act reasonably when exercising discretion is a jurisdictional error and can be remedied in judicial review proceedings.

In *Minister for Immigration and Citizenship v Li* (2013) 249 CLR 332, the High Court held that where statutory powers contain a discretion, the standard to be applied to the exercise of that power derives not only from the terms of the statute, but from a presumption of law that the statutory power will be exercised reasonably (at [63]). The majority stated (at [76]):

> 'As to the inferences that may be drawn by an appellate court, it was said in *House v The King* that an appellate court may infer that in some way there has been a failure to properly exercise the discretion "if upon the facts [the result] is unreasonable or plainly unjust". The same reasoning might apply to the review of the exercise of the statutory power. 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.'

Three cases of note have been heard and determined by the Supreme Court of NSW in relation to the Scheme.

In *Daly v Thiering* (2013) 249 CLR 381, the High Court considered the issue of whether gratuitous care (pursuant to *Griffiths v Kerkemeyer* (1977) 139 CLR 161 and s128 of the *Motor Accidents Compensation Act* 1999 (NSW)) was payable by the LTCS Authority, the CTP insurer, or whether it had been abolished altogether for participants of the Scheme. Much of the discussion on appeal centred around the interpretation of the words '*providing for*' in s6 of the *Motor Accidents (Lifetime Care and Support) Act* 2006, and '*provided for*' and '*are to be provided for*' in s130A of the *Motor Accidents Compensation Act* 1999 (NSW). It was found that gratuitous care was *not* recoverable from the Authority. Subsequently, the Act was amended to reinforce that result legislatively, and it is now dealt with in ss11A and 11B of the amended Act.

In 2012, there was a challenge to an eligibility decision, in *Cruse v Review Panel Established under the Motor Vehicle (Lifetime Care & Support) Act* 2006 [2012] NSWSC 507. The plaintiff in that case had sustained amputations to both of his legs, approximately 13cm below the knees, in a motor vehicle accident in 2008. The plaintiff was accepted into the Scheme. He challenged the decision before an assessment panel and then a review panel, and was unsuccessful with each challenge. He then applied to the Supreme Court for judicial review of the review panel's determination.

The issue raised by the plaintiff was whether or not his amputations (which were below the knee transtibial amputations) were 'adjacent to or above the knee' (per clause 2.3 of the (then) Guidelines). Neither the Act nor the Guidelines contained a definition of 'adjacent to or above the knee'. The review panel had determined that because the plaintiff's amputations were nearer to the knee than to the ankle, that was sufficient to satisfy the term 'adjacent' to the knee. Justice Schmidt held that the review panel had erred in its construction of the Guidelines and had applied an incorrect test in considering whether the amputations were nearer to the knee than the ankle. She stated:

> '45 Clause 2.3 of the Guidelines requires one consideration in the case of a below the knee transtibial amputation, that is the proximity of the point of amputation, to the knee. If that point is 'adjacent to' the knee, that is, near or close to the knee, then the criteria is satisfied. If not, the criteria will not be satisfied and the injured person is not eligible to participate in the scheme, unless on the particular facts, it can be concluded that he or she has suffered an "equivalent impairment".
>
> 46 What must firstly be determined in this case, is whether the amputations at a point which left Mr Cruse with tibial stumps of about 13cm in length, were amputations 'adjacent to or above' his knees and if not, whether he suffered equivalent impairments. In the result, the appeal should be upheld and the matter remitted for determination according to law.'

Since *Cruse* was handed down, further legislative amendments have been made to the Guidelines, which mean that Mr Cruse would now most likely be assessed as being eligible for the Scheme.

In *Insurance Australia Limited t/as NRMA Insurance v Milton* [2015] NSWSC 1392, the insurer commenced proceedings to challenge the validity of a decision of a review panel to exclude the participant from the Scheme. The participant strongly objected to being included in the Scheme because he thought he would be better off being compensated under the *Motor Accidents Compensation Act* 1999 (NSW). He had suffered a brain injury and the review panel's decision was challenged on the basis of both its failure to deal with inconsistencies in the participant's presentation and to set out lawful reasons. The Court held that the review panel's reasons were sufficient and there was no error of law. The review panel's decision was upheld and the insurer's summons was dismissed with costs. An appeal to the NSW Court of Appeal has been commenced. ■

The authors acknowledge the kind assistance of Andrew Stone SC who read the draft of this article and made some additional remarks. Any errors in the article are our own.

Notes: **1** *Minister for Immigration and Citizenship v Li* (2013) 249 CLR 332. **2** *Daly v Thiering* (2013) 249 CLR 381. **3** This is essentially the same as the result reached by the High Court in *Daly v Thiering* in respect of the earlier version of the legislation. **4** *Li*, above, note 1. **5** As Fullagar J held in *Australian Communist Party v Commonwealth* (1951) 83 CLR 1 at 258.

Mark Robinson SC practises from Maurice Byers Chambers, Sydney.
PHONE (02) 9221 5701 EMAIL mark@robinson.com.au.

Jnana Gumbert is a barrister at Sir Owen Dixon Chambers, Sydney.
PHONE (02) 8076 6600 EMAIL jgumbert@sirowendixon.com.au.