Judicial Review of CARS and MAS Determinations: Recent Decisions in NSW

A paper written by Mark Robinson SC and Jnana Gumbert, barrister and delivered by Mark Robinson SC at the Legalwise Personal Injury conference held in Sydney on 22 March 2019

I am asked to speak to you today about 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)). I 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 SIRA is "*suitably qualified*" and who may be a member of the SIRA staff and who is "*appointed*" as a claims assessor by the SIRA 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. He or she is important, thus the Act provides for the PCA to have capital letters in the 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 <u>exemption</u> 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 <u>many</u> judicial review cases in regard to each of these decisions. Some recent decisions are summarised below.

***IAG Limited t/as NRMA Insurance v Mohammed Khaled & Ors* Supreme Court of NSW, Common Law Division, Administrative Law List SC No 2018/00323821 (21 March 2019) (Bellew J)**

In this case (decided *ex tempore* this week – published reasons to follow) the Court considered the insurer's challenge to the legal validity of a statutory "discretionary exemption" decision pursuant to section 92(1)(b) of the Act. The claims assessor (Helen

Wall) heard the insurer's formal application seeking an exemption of the hearing of the claimant's personal injury damages claims from being assessed by the Authority pursuant to Part 4.4 and Chapter 5 of the Act. It was sought that the matter be finally determined by a Court. The application was brought on several bases, including that the insurer had made a formal and particularised allegation to the claimant that he had made false or misleading statements in a material particular in relation to the injuries, loss or damage it was alleged he had sustained in the subject motor vehicle accident. The insurer alleged that the claimant had made false or misleading statements about the number of people in the car at the time of the accident, and that he falsely stated that he was well before the accident with minimal complaints of back pain, whereas in fact he suffered from heart problems and he had significant back pain.

The Court held that the claims assessor misunderstood or misconstrued the scope and nature of her power pursuant to s 92(1)(b) of the Act and she incorrectly applied that power to the application. She wrongly approached the question to be determined on the basis that the exemption sought "can" or "could" be dealt with at CARS. The claims assessor's repeated statements in her reasons that the matter "can be dealt with at CARS" indicated that the claim assessor was applying the wrong legal test.

The question the claims assessor was required to ask herself was whether the claim "is not suitable for assessment" under Part 4.4 of Chapter 4 of the Act: Act, s 92(1)(b); *Abiad* at [76]-[77]. The word "suitable" was held to have its natural and ordinary meaning in accordance with general interpretative principles (*Alcan (NT) Alumina Pty Ltd v Commissioner of Territory Revenue (NT)* (2009) 239 CLR 27 at 31-32 [5] and 47 [48]). That is "such as to suit; appropriate; fitting; becoming" (*Macquarie Dictionary Online*).

The applicable principles and relevant considerations have been well set out in a few cases:

- *Insurance Australia Ltd (t/as NRMA Insurance) v Banos* (2013) 65 MVR 312 at [43];
- *Insurance Australia Ltd (T/as NRMA Insurance) v Taylor* (2017) 80 MVR 190 at [32]-[33]; and
- *IAG Ltd t/as NRMA Insurance v Abiad* (2018) 85 MVR 371at [76]-[77].

The claims assessor referred to *Banos* and selectively quoted from it. However, the Court held that she failed to "engage" with the legal principles set out there (merely listing them without comment or consideration) and her reasons were thereby bad in law.

Significantly, the Court held that the claims assessor had an implied duty to give proper and lawful reasons for her decision under section 92(1)(b) of the Act (notwithstanding that there was no express statutory duty for her to do so in the Act). It was held that where there was a statutory duty to provide reasons or a monetary assessment of damages and for a decision to exempt a matter from CARS, the court should infer a duty on the hearing and dismissal of an important interlocutory application (such as an application for an exemption from CARS).

Also significant is that the first defendant (the claimant) was ordered to pay the insurer's costs of the judicial review case.

He had put on a submitting appearance (not endorsed with the words "save as to costs" – see rule 6.11 UCPR) and done so very late – just days before the final hearing. The Court held, following *Kisimul Holdings Pty Ltd v Clear Position Pty Ltd (No 2)*(2014) 86 NSWLR 645 at [12] and *Commissioner of Taxation v Warner (No 2)* (2015) 244 FCR 498 at [21], that the general rule is that costs follow the event and there is no exception where a party files a submitting appearance: UCPR, r 42.1. Costs were in the Court's discretion under section 98 of the *Civil Procedure Act 2005* (NSW). Costs should be approached according to an appraisal of the circumstances of the case: *Kisimul Holdings* at [14].

Zurich Australia Insurance Limited v Drca **[2018] NSWSC 1945 (Johnson J)**

This was an insurer's challenge to a claims assessor's determination on damages. The assessment was set aside for lack of lawful reasons and non-compliance with section 126 of the Act.

On 17 April 2012, the claimant was injured in a motor vehicle accident when his vehicle was struck from behind on the Cumberland Highway at Canley Vale. Zurich was the Compulsory Third Party ("CTP") insurer of the vehicle at fault. The claimant lodged a claim for compensation and liability was wholly accepted by Zurich. Mr Drca was 28 years old at the time of the accident. He was born in Croatia of Serbian extraction and moved to Australia in 2001. He is a trained mechanic and has worked as a formwork carpenter within the Croatian Serbian community in Sydney.

The claims assessor (Gary Patterson) heard the claim at an "assessment conference" (a non-

curial informal hearing) and awarded $767,395.44. It was undisputed that Mr Drca had suffered soft tissue injuries to his cervical spine, lumbar spine, right shoulder and both knees as a result of the accident. It was also agreed that he had suffered some psychological injury. It was agreed between the parties that Mr Drca had no entitlement to non-economic loss. The award of past economic loss ($334,185.28) and future loss of earnings ($331,168.16) was challenged in the Supreme Court.

The main statutory duties of a claims assessor in assessing damages is to comply with section 94 (and also to give brief reasons – section 94(5)) and section 126 – (to state the assumptions for future economic loss). Both were challenged here.

The Court said (at [74]) that in cases of alleged bad (in law) reasons it was "appropriate to take a practical approach" and "to read fairly, and as a whole, the reasons of the Claims Assessor" There were (at [75]) "statutory requirements for both brevity and sufficiency in reasons to be given as part of the assessment process".

The Court said (at [76] to [77]):

> "It should be kept in mind as well that, in a case such as this, the sums involved are substantial so that there ought be a transparent explanation of the basis upon which conclusions have been reached with respect to past economic loss and future economic loss.
> The "actual path of reasoning" [*Wingfoot Australia Partners Pty Limited v Kocak* (2013) 252 CLR 480 at [55]] should be apparent in the reasons, although this requirement can be achieved by incorporating by reference to a source document such as an expert accountant's report containing calculations, which the assessor states has been accepted: *Mulcahy v NRMA Insurance Limited* (2018) 85 MVR 337 at 348-349 [36]-[42]. That is not what occurred in this case."

One of the big errors found here by the Court was that the claims assessor simply adopted a figure for past and future economic loss put forward by the claimant's counsel. No explanation no rationale – it was just adopted. Also the figure used for the past was different from the figure for future economic loss (again) without any explanation.

The court also held, applying *Allianz Australia Insurance Ltd v Sprod* (2012) 81 NSWLR 626, that the necessary assumptions in any future economic loss award must be identified and they were not here. The claims assessment was quashed.

***Mulcahy v NRMA Insurance Limited* [2018] NSWCA 189 (Beazley P, Meagher, White JJA)**

This appeal was allowed and Adamson J's decision was overturned. It concerned an insurer's challenge to the legal validity of a claims assessment. The main issues concerned the award of future economic loss. The total damages award was $1,504,870.

The assessor (Gary Patterson) sought to incorporate an expert financial report into his reasons (without expressly saying so). Adamson J set it aside, but on appeal, the Court of Appeal considered that it was tolerably clear that the claims assessor meant to include all of the convoluted calculations and figures (see [17] to [21]) as were contained in the expert report in his actual reasons for decision.

In fact, the statutory requirement for "brief reasons" (in section 94(4) of the Act) meant that a claims assessor could seek to incorporate another document by merely mentioning it in his reasons for decision – *Mulcahy* at [37].

***Insurance Australia Group Ltd tas NRMA Insurance v Abboud* (2017) 82 MVR 353; [2017] NSWSC 1571 (Walton J)**

This matter concerned an appeal against the assessment of damages in regards to future medical costs, past loss of earnings and future loss of earnings.

The insurer had submitted surveillance footage which showed evidence contradicting the claimant's claim of incapacity and alleged inability to perform light duties.

In determining the claimant's past loss of earnings, the assessor gave reasons on the basis of a 20% loss of earning capacity and awarded a buffer of $50,000. However, this contradicted an earlier finding that the claimant's pre-accident earnings *"were closer to $400 net per week"*. As such, it could not be reconciled how the assessor arrived at the figure of $50,000.

In making an award for future medical treatment costs in the form of a $25,000 buffer, the assessor had stated:

> *'It is not possible with any degree of accuracy to predict the required level of treatment the [first defendant] will require over the remainder of his life consequent on the relatively minor injuries he sustained in the motor vehicle accident. There will be periods when he may require some physiotherapy or reviews by medical practitioners. It is equally likely there will be substantial periods of time when he will require no treatment at all."*

His Honour held that such reasoning was inadequate and the reasoning for such an award is *"unexposed by those reasons"*.

Future economic loss was also dealt with by way of a substantial buffer of $350,000, with the following making up the entirety of the reasons:

> *"There was no real dispute [that] the [first defendant] was undertaking physically arduous work, is at the beginning of his working life and did not suffer any pre-existing injuries and disabilities. That said, and as I have outlined above, I do not find the injuries sustained by the [first defendant] in the motor vehicle accident have ended his working life, nor have they had the devastating effect on the [first defendant] which he contends. They have interfered with his ability to pursue his employment options. They have left him with some minor ongoing physical difficulties and some psychological problems which will have an adverse effect on his ability to perform work in an unrestricted matter and interfere with his capacity to work in the physically arduous profession he has chosen in the future.*

It was held that such reasons were insufficient, particularly when such an award was in the form of a buffer. Furthermore, his Honour found that the award itself was inconsistent with earlier findings of the Assessor, particularly his finding that the physical and psychological injuries were *"not particularly disabling"*. It was also inconsistent with the finding in regards to past economic loss which found that the claimant had a 20% loss of earning capacity. Such a buffer amounted to approximately $450 a week for the remainder of his working life, despite the assessor accepting that he was earning approximately $400 a week at the time of the accident.

The insurer had also invoked *Cervantes,* submitting that the sum of the award was itself indicative of an error.

Ultimately it was held that the reasons for the award of future economic loss did not comply with or even reference section 126 of the Act.

> *[58] The transparency in the path of reasoning that s 126 of the Act was designed to ensure was, therefore, lacking and, in the result, the third defendant failed to engage with and perform the task prescribed by s 126 of the Act.*
>
> *[59] On this basis, the reasons for the award of damages for future economic loss are inadequate. The failure to comply with the requirements of s 126 of the Act also amounts to an error of law on the face of the record.*

***IAG Limited v Sleiman* (2017) 82 MVR 1; [2017] NSWSC 1346 (Fagan J)**

In this matter the insurer sought judicial review of a decision of a claims assessor to award $929,516.01, specifically, the award of future economic loss. The insurer argued that the assessor had applied the wrong legal test in determining the claimant's 'potential earning capacity' and had provided inadequate reasons. The assessment was also deemed unreasonable.

In finding that the assessor failed to provide adequate or lawful reasons, it was noted:

> *[21] The assessor's reasons say nothing as to how she arrived at a figure for future average weekly earnings, but for the accident, which would be nearly double his average for the four and a half years leading up to the date of injury. On the face of the reasons the conclusion is irreconcilable with the findings stated at [67] that the first defendant "would have continued" to work in construction and printing with "periods off work in between jobs from time to time". The finding that his employment "would have continued" as in the past could only support an inference of future average weekly earnings of $545, unless some other finding or calculation or justification should be introduced to support the higher figure for the future.*
> *The assessor's reasons do not identify any such additional finding, calculation or justification. No path of reasoning from the pre-accident average of $545 per week to a post assessment forecast of $1,000 appears anywhere in the reasons. Ground (3) must be upheld and the certificate of assessment must therefore be set aside.*

Furthermore, it was found that assessor's determination of the likely earnings was demonstrably unreasonable:

> *[28] It is inconsistent, internally, with the evidence recorded by the assessor and which she states she has relied upon. Notably, the four and a half years past earnings disclosed in the first defendant's tax returns. It is inconsistent with the assessor's stated assumption and reasoning that the first defendant's pattern of employment would have continued as before.*
> *On a reading of the whole of the reasons it is evident that the unexplained leap to a future earning capacity of nearly double the first defendant's demonstrated capacity over the years for which figures were available would deliver to him not compensation for lost capacity but a very considerable windfall. The resulting calculated figure of $497,503.98 for future economic loss in the assessment lacks "evident and intelligible justification" and the certificate must, on this additional ground, be set aside.*

In this regard, his Honour held that the certificate must be set aside. The plaintiff had submitted that the certificate must be set aside in its entirety. His Honour took the approach of Hidden J in *Allianz Insurance Ltd v Ward* (2010) 79 NSWLR 657:

> *[30] In the absence of any argument to the contrary before me I will take the same approach as Hidden J. The assessment must be remitted to the third defendant for reassessment but, as a practical matter in view of the plaintiff not having contested any part of the assessor's reasons except that relating to future economic loss, it would be expected that the re-assessment would be concerned with that component*

> *only. I have concluded that the reassessment should be assigned to an assessor other than the second defendant. If the matter were to be considered again by the second defendant on being remitted from this Court there would be a justifiable apprehension on the plaintiff's part that she may have prejudged the matter and that she would revisit the assessment of future economic loss with a tendency to justify the quantum at which she previously arrived.*

Insurance Australia Ltd (t/as NRMA Insurance) v O'Rourke **(2017) 80 MVR 175; [2017] NSWSC 494 (Davies J)**

This case concerned a review of the amount awarded by a claims assessor for past and future economic loss. It was alleged that the assessor had made two errors in her decision. The first with regards to applying the incorrect legal test when calculating damages by failing to take into account the claimant's earnings following the accident and secondly, the finding that she had no residual earning capacity despite earning $648 per fortnight as a carer. The plaintiff argued that this amounted to a denial of procedural fairness and/or a failure to take into account relevant material as it was submitted specifically the carer's pension should be taken into consideration.

The Assessment Conference took place on 14 April 2016 and at this time, there was no evidence concerning the claimant's Centrelink pension. Following the conference, in a letter dated 27 April 2016, the Assessor adjourned the matter for 14 days to allow the plaintiff to provide the Assessor with the Centrelink guidelines on the carer's pension. The plaintiff sent a letter to the Assessor dated 3 May 2016 containing the relevant information and making the following request:

> *"The insurer seeks a direction the claimant provides an authority to Centrelink to enable the claimant's assessment for Carer Payment and the Medical Report that was lodged with her application to Centrelink to be produced to assist you in making your determination.*
>
> *The insurer notes Section A of the carer payment identifies the day to day need cares and cognitive function of the care receiver.*
>
> *The Medical Report of the Care receiver identifies in paragraph 14 the physical needs of the care receiver in determining qualification for a Carers Payment.*
>
> *The insurer submits there is nowhere in the Medical Report or Assessment for Carer Payment for purely 'emotional' support as explained at the General Assessment by the claimant.*
>
> *The insurer submits such evidence will allow a fair, independent and proper determination of the basis upon which the claimant is receiving the carer's payment and services provided by the claimant to the care receiver."*

His Honour dismissed the plaintiff's argument, referring to the Gaudron J in *Re Minister for Immigration and Multicultural Affairs; Ex parte Miah (2001) 206 CLR 57; [2001] HCA 22 at* [81] noting at [53] that the *"substance of the Plaintiff's claim was addressed in determining whether the First Defendant had residual capacity, and in that regard the*

requirements under the carer's allowance were taken into account by the Assessor. The Assessor said that she had not identified in the Centrelink material any requirement that care was only physical care."

Furthermore, Davies J held that the Assessor had examined the evidence supplied and reached a different conclusion that the receipt of the carer's pension did not constitute a residual earning capacity. His honour noted at [55] that *"there can be no error of law in a finding of fact where there is some evidence to support the finding*: *Australian Broadcasting Tribunal v Bond* (1990) 170 CLR 321 at 355-356; *R L & D Investments Pty Limited v Bisby* [2002] NSWSC 1082 at [13]."

In regards to the letter of 3 May 2016, Davies J stated:

> *[57] Nor can it be said that what was put forward in the letter of 3 May 2016 was a "substantial, clearly articulated argument relying upon established facts" except insofar as it was a submission on the documents that were forwarded with that letter…*
>
> *[58] In my opinion, a fair reading of the final paragraph of the letter of 3 May 2016 shows that it is directed to the submissions in the three preceding paragraphs relating to the material enclosed with the letter of 3 May 2016. Nowhere is an argument put, as was put at the present hearing, that the material that Centrelink would provide in response to the direction might be able to be used in relation to the First Defendant's credit or to analyse what she was in effect undertaking to do in terms of providing physical care in exchange for receiving the carer's allowance. If that was what the last paragraph intended to do it did not say that or it did not say it clearly.*

It was suggested that the plaintiff ought to have made the evidence available at the Assessment Conference *"so appropriate cross-examination could have taken place and appropriate submissions made"*.

***Insurance Australia Ltd (t/as NRMA Insurance) v Taylor* (2017) 80 MVR 190; [2017] NSWSC 507 (Davies J)**

In this matter, the insurer had applied for a discretionary exemption from CARS. The application was opposed and the matter came before the assessor with submissions being made by both parties.

The insurer sought an exemption on the basis of, among other things, clause 14.16.11 of the *Guidelines* and the power granted by s92 of the Act.

The insurer in their application had claimed that the claimant had provided 'false and misleading' information in their claim form, had failed to disclose treatment received contemporaneously to the accident, changed his GP following the accident and given incorrect histories to medico-legal doctors. It was suggested by the insurer that the claimant had a long history of receiving treatment for back pain as well as shoulder pain.

The Assessor had rejected the application claiming that the matter was suitable for assessment and that no fraud has been alleged. In regards to the alleged incorrect histories,

the Assessor noted that this can be put to the claimant in cross examination and that the 'correct' history could be provided to the doctors affected to see if this alters their conclusions.

The insurer sought judicial review, alleging three errors with the Assessors decision:

- The assessor misconstrued her power;
- There was a denial of procedural fairness and a failure to take into account relevant considerations;
- Lack of reasons.

The crux of the appeal centred around the Assessor's determination that as the insurer has not alleged fraud, that there could not be an allegation of false and misleading statements.

Referring to the decisions in *Allianz Australia Insurance Ltd v Tarabay* (2013) 62 MVR 537 and *Insurance Australia Limited t/ as NRMA Insurance v Banos* (2013) 65 MVR 312, his Honour found that the Assessor had fallen into error by answering a question that should not have been asked. It is the Assessor's duty to determine whether or not the matter is suitable for exemption and not whether or not the claimant has committed fraud or provided false and misleading statements.

His Honour noted:

> *[34] First, it is of significance that all that is necessary for the Assessor's discretion to be triggered with regard to an exemption on this ground is an allegation by the insurer. Subject to the requirement by an assessor to provide particulars pursuant to cl 17.13 of the Guidelines that is all that the insurer needs to do for the Assessor to be required to determine whether the claim is not suitable for assessment. Indeed, cl 17.13 when dealing with a requirement that a party give particulars in writing of the general nature of any such allegation, the clause adds "but not necessarily the evidence or proof of same".*
>
> *[35] Secondly, it is significant that there is a corresponding provision for an allegation by the insurer in cl 8.11.6 in relation to a fraudulent claim. Such an allegation results in a mandatory exemption of the matter from an assessment. The matter referred to in cl 14.16.11 can on one level be seen as the corresponding provision to cl 8.11.6 in respect of damages, although without the mandatory exclusion when such an allegation is made. Although the use of the phrase "tantamount to fraud" by the insurer in the present case might be thought to deflect the proper enquiry, what might be being alleged in any given case under cl 14.16.11 could be as serious as a fraudulent claim: e.g. Tarabay at [57] and [66].*
>
> *[36] It can be reasonably inferred from the mandatory exemption in relation to a fraudulent claim that the absence of sworn compellable evidence with a right of cross-examination in the CARS process meant that neither truth nor fairness to the parties was likely to be achieved other than in a court hearing where, additionally, the rules of evidence apply. That is a relevant consideration where it is alleged a false or misleading statement has been made.*

His Honour further stated:

> *[40] In my opinion, error is established in the present case either because there has been a constructive failure on the part of the Assessor to exercise her jurisdiction or because she has not correctly dealt with the question that she ought to have asked. The question she was required to answer was whether the claim was not suitable for assessment on the basis that there was an allegation that the First Defendant had made a false or misleading statement in a material particular in relation to his injuries.*

Ultimately the insurer was successful on all grounds. Davies J held [at 53] that there had been a failure by the Assessor to respond to a substantial, clearly articulated argument and alternatively the Assessor failed to address the substance of the insurer's application.

Lastly, it was held at [54]:

> *"In my opinion, error is established in the present case either because there has been a constructive failure on the part of the Assessor to exercise her jurisdiction or because she has not correctly dealt with the question that she ought to have asked. The question she was required to answer was whether the claim was not suitable for assessment on the basis that there was an allegation that the First Defendant had made a false or misleading statement in a material particular in relation to his injuries."*

IAG Ltd (t/as NRMA Insurance) v Al-Kilany **(2017) 80 MVR 388; [2017] NSWSC 342 (Beech-Jones J)**

The first defendant in these proceedings was awarded damages $137,579.25 at CARS. Proceedings were commenced by the plaintiff, arguing that there was a jurisdictional error, or error of law the face of the record. The appeal centred on the assessor's award of both past and future economic loss.

The first defendant ran his own motor mechanic business. It was accepted by the assessor that if not for the accident, the first defendant's business would have continued to grow and that as a result of the accident the first defendant was restricted to *"light vehicle repair work"*.

The appellant argued that the assessor's award did not reflect the first defendant's true loss of income due to the evidence that the first defendant's income had actually increased since the accident.

His Honour took issue with this first ground of appeal noting that the plaintiff was seeking a merits review. He went on to note at [26]:

> *"Properly analysed, these submissions do not raise any grounds for reviewing the assessment that can be considered by this Court. I discussed the basis upon which findings of fact similar to those made by the Assessor might be reviewed for jurisdictional error in Australia Ltd v O'Shannessy Insurance [2015] NSWSC 1047 at [56ff] ("O'Shannessy"). The most favourable basis upon which IAG could review these types of findings is by contending that they are not supported by probative*

> *material or logical grounds as stated by the Assessor (see O'Shannessy at [79]). This basis for review is quite distinct from "Wednesbury unreasonableness" of the kind considered in Li which concerned unreasonableness in the exercise of discretionary powers (see Li at [63]). In particular, the power exercised in Li was the power to adjourn the hearing. The determination under challenge here, being one made under s 94(1)(b) of the MAC Act concerning future economic loss, does not involve the exercise of any discretionary power but is instead concerned with fact finding (see Allianz Aust Insurance Ltd v Habib [2015] NSWSC 1719; 73 MVR 412 at [45]; "Habib")."*

In any event, his Honour rejected this ground noting that the assessor's award did in fact appear to be based upon the material and the findings were open to be made by the assessor.

The second ground of review concerned reasons in that the appellant alleged that proper reasons were not provided by the assessor in regards to past and future economic loss.

While it was held that the Assessor's reasons for the award of past economic loss were *"clear and logical"* at [32] as required by *Wingfoot,* the Court took issue with the award of future economic loss:

> *[34] In his reasons, the Assessor did not express any misgivings about the adoption of the figure of $500 per week, as he did when he awarded a "buffer" of $25,000 for past economic loss. Instead, the Assessor appears to have made a finding that has a degree of exactitude without stating any assumption upon which that figure was based. All that was stated was that the figure was "submitted by the claimant's counsel". In the absence of any statement of the assumptions upon which the figure of $500 net per week was based, as required by s 126(3), it cannot be determined whether any assumptions that supported that figure accorded with Mr Al-Kilany's most likely future circumstances as required by s 126(1). Given that the finding of past economic loss of $25,000 was referable to the period in excess of two years immediately prior to the assessment, and given the absence of anything that is said to have altered the position, there are substantial reasons to believe that the $500 did not in fact accord with any assessment of Mr Al-Kilany's most likely future circumstances.*

His Honour goes on to offer guidance as to how the award could have been dealt with:

> *[39] For the sake of completeness I add that, in this case the Assessor was not precluded from awarding an amount as a buffer for future economic loss and that such a buffer could potentially have been calculated by reference to a weekly amount (see Habib). However, that does not obviate the need for the Assessor to identify the assumptions upon which the award is based, even though, as stated, they may be only "generalised statements"(see Sprod at [30]; Habib at [32]). In this case the Assessor did not state that the amount of $500 net per week constituted a "buffer", that is, the Assessor did not explain whether there were various uncertainties that had led him to adopt that figure and, if so, what those uncertainties were. Moreover, the Assessor did not state any assumptions, generalised or otherwise, that supported the adoption of that amount.*

It was ultimately held that the Assessor had failed to comply with section 126(3) of the Act and the award was quashed.

JUDICIAL REVIEW OF MAS RELATED DECISIONS

Iedam v Insurance Australia Ltd ta NRMA Insurance **[2018] NSWSC 1810 (Adamson J)**

The claimant here challenged the nature of the discretion conferred on a proper officer under section 62 of the Act to refer matter for further assessment when there is new material. The court found no error was established. Interestingly, the Court held that no relief was warranted in any event as it was open to plaintiff to make fresh application – the judicial discretion in judicial review maters was exercised against the claimant.

Boyce v Allianz Australia Insurance Ltd **(2018) 83 MVR 403; [2018] NSWCA 22 CA**

The claimant (appellant) in this matter had been assessed as having 10% whole person impairment however upon application for review by the insurer and subsequent "on the papers" review by a Review Panel, she was found to have 2% impairment.

The claimant sought judicial review of the review panel arguing that the Review Panel's failure to perform a clinical examination constituted a failure to discharge its statutory function.

The claimant had written to the Authority noting her objection to the review being conducted on documentary material alone, however no response was made and it became apparent that the letter had been mislaid.

The review panel determined that a re-examination of the claimant *"was not necessary"*.

The claimant's solicitor in her affidavit noted that had she been advised of the review panel's intention to determine the matter without examination, further material would have been provided to assist. Furthermore, as part of the certificate, it was noted:

> *"The Panel considered the matters cited in the Reply to the Application for Review*

and noted that:

- *The respondent agreed with the application"*

On appeal the Court of Appeal noted:

> *[56] By parity of reasoning, given that the Panel was required to consider subjective as well as objective criteria, which could only be assessed upon examination of the appellant and considering her description of her condition, the circumstances in which it can be legitimate to reject an application for examination will be rare. The decision not to examine in such circumstances cannot properly be exercised on a false belief that the claimant does not seek an examination.*
>
> *[57] The decision of the Panel to rely entirely upon the description given by the original assessor of the complainant's condition, while concluding that his assessment should be reduced by 80%, was flawed. The Panel was required to carry out the whole process of assessment afresh; to accept all the findings (it made no finding of its own as to permanency) of the original assessor, whilst rejecting his conclusion, was to run perilously close to the error identified in Allianz Australia Insurance Ltd v Rutland, [34] namely to reassess only that aspect of the original assessment which the proper officer had found reasonable cause to suspect was incorrect in a material respect.*
>
> *[58] Whether the Panel would have refused to allow an interview and clinical examination had it known that the appellant sought one cannot be known. All it decided was that a re-examination "was not necessary." It reached that conclusion on a false premise. The conclusion was an essential element of the assessment process, which accordingly miscarried.*
>
> …
>
> *[66] The decision of the Review Panel not to interview and clinically examine the appellant was fatally flawed. Given the criteria which they were required to address, the failure properly to address that issue involved a constructive failure to carry out their statutory function of conducting a new assessment. The fact that it occurred without fault on the part of the Panel is immaterial.*

It was also determined that the claimant was denied procedural fairness by the authority's failure to advise her that she would not undergo a clinical examination.

The insurer argued that as the letter had gone astray there could be no procedural unfairness as there has been no *"practical injustice"* however this was rejected:

> *[94] The present case was not one in which a claimant was dissuaded from making submissions because she was misled by the decision-maker; rather it was a case in which the decision-maker failed to provide an opportunity either for an interview and clinical examination, or for further submissions, because it was itself misled as to the appellant's wishes, through no fault of hers. The result, however, was the same: the*

> *appellant was deprived of an opportunity to put her case fully before the Review Panel, either as to why she "objected" to the Panel proceeding "on the papers", or as to what she might do if her objection were rejected. That constitutes procedural unfairness; she did not have to tell the reviewing court what she would have said if she had been accorded the opportunity by the Panel, not least because the court could not (and should not) assess how the Panel might have responded.*
>
> *[95] Further, given the criteria and the statutory scheme outlined above, including by reference to the Permanent Impairment Guidelines, this is a case where impressions created by a personal interview and clinical examination may well have been of such potential significance that a reasonable review panel could not properly have denied her the opportunity for such a process had it been aware that she sought it. That alone may be sufficient to justify a finding of procedural unfairness. It cannot be demonstrated that the absence of such opportunities "did not deprive [the appellant] of the possibility of a successful outcome", and hence relief should not be refused.*

The review panel's certificate was set aside.

Insurance Australia Limited v Kai **(2018) 84 MVR 439; [2018] NSWSC 958 (Adamson J)**

A MAS Form 1A was lodged by the insurer, seeking an assessment of a "treatment dispute". The treatment dispute was expressed as a range, being 0 and the number of sessions required for treatment: eg: "lodged by the insurer was, among other things, whether the claimant required "0-8 hours" of gratuitous domestic care and assistance in the past, "0-6 hours" of domestic assistance into the future, and "0-6 hours" of psychological counselling as a result of the injuries sustained in the accident.

The proper officer in referring the matter, accepted the insurer's form of a range for the domestic assistance claim but it was not deemed acceptable for treatments.

The court noted that *"the Authority had no right interfere with the parameters of the dispute referred to it,"* and as submitted by the insurer, the Authority was essentially refusing to refer the medical dispute which the insurer had referred it.

At [66], the Court accepted the insurer's submissions:

> *I accept [the insurer's] submissions that "this micromanaging and dictation of the nature and scope of a medical dispute is impermissible." The approach taken by the Authority has deprived the insurer of having its medical dispute result in a certificate which provided conclusive evidence as to what, if any, treatment was required within the range which included at the high end, what the claimant was claiming and, at the low end, what the insurer contended to be appropriate (zero). The Authority's disregard of the express terms of s 60(2) has permitted the Authority (with the assistance of the claimant) to create a situation whereby the medical assessors are entitled to certify, for example, either zero consultations, or ten consultations, but nothing in between and any reference to any other number in the assessors' reasons can effectively be disregarded because, although it is evidence, it is not conclusive evidence. Such tactics ought not be permitted to compromise the right of a party to*

have its medical dispute referred to a medical assessor.

In blunt terms, her Honour noted at [69]:

> *"The Authority does not have discretion whether to refer a medical dispute; it has a* duty *to do so*."

***Wolarczuk v NRMA Insurance Australia Limited* (2017) 82 MVR 504; [2017] NSWSC 1691 (Schmidt J)**

The claimant sought to set aside a certificate of reasons given by a review panel. The review panel had certified that the claimant's injuries gave a whole person impairment of less than 10%.

Prior to the review panel's certificate, a treatment dispute was dealt with by Assessor Wong who found that the claimant's L5 nerve root decompression & microdiscectomy was causally related to the accident and reasonable and necessary. The court considered the issue of the adequacy of the reasons given by the review panel.

It was held that the reasons provided by the review panel were *"inadequate… illogical and contradictory"*.

The review panel had accepted that the claimant had sustained a back injury in the subject accident which carried an impairment of 5%. However, it <u>also</u> found that the claimant had a pre-existing condition which was 5% impairment at the time of the accident and as such, the claimant's assessable impairment was therefore 0%.

> *The Review Panel explained, under the heading "Pre-existing injury", that it had assessed Mr Wolarczuk's whole person impairment prior to the 2013 accident, to be 5%. It considered that post-accident, his impairment remained 5%. Accordingly, when that was deducted from his pre-existing impairment, the Panel concluded that the 2013 accident had resulted in "no new level of percentage impairment".*
>
> *This approach did not accord with the Permanent Impairment Guidelines, which required, in the case of spine impairment, that the current impairment be estimated first; that the impairment from any pre-existing spine problem then be estimated; and that this estimate then be subtracted from the present impairment, "to account for the effects of the former": Clause 1.34.*

The Panel had also found that the claimant had a DRE II injury before the subject accident, however then went on to note that there was *"convincing evidence of a lumbar spine injury with radiculopathy, pre-existing the accident of the 06.08.2013, and therefore was strong evidence for a DRE III 10% whole person impairment of the lumbar spine less than three weeks before the subject motor vehicle accident."*

The Panel also noted as their final conclusion:

> *"Mr Wolarczuk did indeed sustain a new lumbar spine disc injury at a different level*

> *to the pre-existing level, and with a different radiculopathy, which required operative intervention, and all this was the result of the motor vehicle accident of the 6.08.2013, but nevertheless, he now still has a 10% whole person impairment as the result of lumbar spine impairment, and there was a pre-existing 10% impairment".*

The Court found that the review panel appeared to ignore the requirements of the SIRA *Permanent Impairment Guidelines*, but ultimately noted:

> *"[57] As the Insurer submitted, the Review Panel was undoubtedly undertaking its assessment at a different time to that undertaken either by Assessor Wong or by Assessor Gliksman. Still, the Panel's findings do not shed necessary light on why it was that the application of the applicable Guidelines to the evidence before it led the Panel to the result it finally arrived at, whichever it actually was, a 5% DRE II or 10% DRE III impairment, both before and after the 2013 accident.*
>
> *[58] It follows that despite all that the Review Panel said in its certificate, its reasoning process cannot be discerned, even reading the reasons as a whole and applying a beneficial construction to them. Nor can the gap in the Panel's logic be filled as a matter of necessary inference, on a fair reading of those reasons.*
>
> *[59] It thus must be concluded that the Panel did not discharge its statutory obligation, to explain the actual process of reasoning by which it in fact formed its opinion. What it did reveal, however, establishes that it did not adhere to the applicable Guidelines.*

It was also found that while the review panel is not bound by the earlier assessment of Assessor Wong, they had failed to consider it and provide its reasons for rejecting his conclusions.

The review panel in its assessment also concluded that the claimant should be re-examined, but by only 2 out of the 3 members of the panel. However the court found error with this:

> *"[88] The Permanent Impairment Guidelines specify in cl 1.20 that a review panel's assessment task involves three stages: review of medical and hospital records; interview and clinical examination; and preparation of a report using the methods there specified. No express provision is made in either the Impairment or Medical Assessment Guidelines, to permit the panel to determine all of its members will not to be involved in each stage of the new assessment it must undertake.*
> *[89] The obvious implication is that all members of the panel must be involved in the entire assessment process. That also accords with the requirement in the Impairment Guidelines that the assessment of spinal impairment be made at the time of examination: cl 4.3.*

Ultimately the review panel certificate was set aside.

***Joseph Elias v Insurance Australia Limited t-as NRMA Insurance* (2018) 83 MVR 325; [2018] NSWSC 33** (Button J)

The claimant in this matter had psychological injuries assessed by MAS three times, going back and for between the injuries being held to be related to the accident, and not related. Following the third assessment in which the claimant's injuries were assessed as being not related to the accident, further evidence was obtained and an application was made for a further medical assessment based on additional relevant information (section 62 of the Act).

The proper officer rejected the application and it formed the subject of judicial review.

In rejecting the application, the proper officer on numerous occasions referred as authority of *Singh (No.2)*, with the only reference to *Jubb* being noted that the claimant's solicitors specifically relied upon it. The proper officer said:

> *"Whilst the report postdates the MAS assessment and is additional to the party relying on it as a ground for further assessment, the report does not contain an opinion of a different kind than the opinions previously expressed and considered."*

Furthermore:

> *"It is clear that the issue of inconsistency in his presentation [that is, the plaintiff] has been previously expressed and considered by Assessor Cassidy [the third medical assessor]. Therefore, the report of Dr Guirgis is a difference of an opinion or a critique of the MAS assessment, which does not form the basis of an application under s 62 of the Act.*

The proper officer also considered a second report supplied by the claimant, but for the same reasons it was not considered additional relevant information.

As such, it was held that an error of law had been established in that the proper officer had failed to the correct legal test.

> *[46] It is also noteworthy that, although the reasons refer to Jubb having been relied upon by the plaintiff in written submissions, there is no analysis of the principles to be found in that decision. Nor is there any recognition in the reasons that, to the extent that Jubb is inconsistent with Singh (No 2), of course it is the subsequent decision of the Court of Appeal that authoritatively states the correct interpretation of the section.*

Counsel for the defendant had conceded that the proper officer had made a legal error but argued that the matter should not be remitted for a review as even though the proper officer had applied the incorrect legal test, the assessment that material was not *'additional relevant information'* was correct.

In declining to exercise his discretion to correct the error, his Honour noted at [53]:

> *Turning now to the first submission with regard to asserted inevitability of outcome, a significant legal error has been conceded to be present in the reasons of the primary*

decision maker. In those circumstances, I think that I should be slow indeed to refuse relief on the basis of my own assessment of what is really a question of fact.

Secondly, the test as whole, bearing in mind its three separate aspects, calls for an evaluative judgment about which minds may reasonably differ. Again, I think that I should be slow to interpose my own judgment about such questions, when statute has reposed the power of making decisions about them in the proper officer.

Thirdly, to the extent that resolution of such questions may call for a degree of expertise with regard to medical matters and the operation of the system of assessments as a whole, a proper officer of SIRA is in a better position than me to make such an assessment.

Fourthly, remitter (as opposed to a peremptory decision by me adverse to the plaintiff, leading to refusal of remitter) is, I consider, the more cautious course. After all, it is possible that, in determining a further application by the plaintiff, a proper officer may nevertheless refuse it, for reasons that are completely legally and factually correct.

For all of those reasons, a fundamental legal error having been established, I consider that the preferable course is for me to exercise my discretion to remit the matter for further consideration within the statutory regime.

***Dominice v Allianz Australia Insurance Ltd* (2017) 81 MVR 249; [2017] NSWCA 171 (Basten and Simpson JJA and Emmett AJA)**

The appellant in this matter was an injured party seeking a review of the proper officer's decision to refer the respondent's application to a review panel.

The proper officer had referred the matter to a review panel on the basis of an argument mounted by the insurer that there were inconsistencies in the MAS report and that the medical assessor had failed to bring inconsistencies to the attention of the claimant. The claimant argued that clause 1.43 of the *Guidelines* existed only for the benefit of a claimant and did not provide any protection to an insurer. The primary judge rejected this argument and upheld the Proper Officer's decision, finding that clause 1.43 was in place to ensure both accuracy and procedural fairness (as stated in the clause) and that it applied to both parties. The claimant appealed from this decision.

The Court of Appeal upheld the decision of the primary judge, reiterating that it clause 1.43 is not restricted to use by claimants despite the fact that more often than not, it would be to the benefit of claimants.

Basten JA also provided some useful commentary on what types of decisions of proper officers enable openings for an appeal.

> *[7] Where the proper officer refuses to grant a review on the basis of a legal misunderstanding as to the scope of his or her powers, there may well be grounds for judicial review of that decision. Its effect may be to deny a claimant an opportunity to obtain damages for non-economic loss. However, when the error is said to have resulted in the failure of the proper officer to refuse a referral, the legal consequences are quite different. If the basis of her suspicion had been misconceived, one would*

> *expect that misconception to be identified by the review panel, which would dismiss the application and confirm the original certificate of assessment. A judge faced with a judicial review application in such circumstances, at least where the bona fides of the proper officer was not in question, would have strong reasons for rejecting the application on discretionary grounds.*

Furthermore, a warning was sounded as to the propensity of decision makers to adopt language outside the legislative frameworks, arguing that it is best practice to simply follow the statute:

> *"[12] In conclusion, it may be noted that the proper officer identified the state of satisfaction required under s 63(3) as one which "need not rise above anything other than a state of unease", being language adopted by Campbell J in Elliott v Insurance Australia t/as NRMA Insurance. [13] The abandonment of the statutory language in favour of a paraphrase is to be deprecated. It did not lead to error in the present case, but it could well do so in other circumstances. The statutory language is not obscure, nor difficult to apply. Conclusions expressed in accordance with the language of the statute are less likely to invite applications for judicial review.*

Colley v Insurance Australia Group trading as NRMA Insurance **[2017] NSWSC 714 (Fagan J)**

A summons was filed by the plaintiff in this matter seeking judicial review of the decision of a proper pfficer to refuse to have a MAS certificate sent to a review panel.

The claimant had initially been assessed by MAS as having a whole person impairment of 10% and the claimant's injuries to the lumbar spine, left knee and left ankle were not related to the accident.

The plaintiff argued that the assessor had not considered the claimant's complaints during the assessment or her complaints to her general practitioner.

This ground was dismissed and it was held:

> *[41]Whilst the assessor does not explicitly refer to the plaintiff's complaints of injury during the assessment in the passage set out at [38] above, those complaints are clearly recorded in the body of the assessment report. In any event, it is the proper officer's determination that is the subject of challenge. In order to demonstrate jurisdictional error on these grounds, the plaintiff must point to a failure on the part of the proper officer to take into account a relevant consideration, or taking into account an irrelevant consideration.*
>
> *[42] The proper officer's reasons set out at [39] above do not disclose a failure to take into account a relevant consideration or that any irrelevant consideration was taken into account. Essentially, the observations at [32] to [34] above also apply to this aspect of the plaintiff's argument."*

It was also argued that the proper officer had failed to correctly apply the test under section 63(3) of the Act which requires that the proper officer be *"satisfied that there is reasonable*

cause to suspect that the medical assessment was incorrect in a material respect having regards to the particulars set out in the application". Citing *Elliot*, the plaintiff submitted that all that was required upon the part of the proper officer was that they hold a *"state of unease"* and the test that was applied by the proper officer (i.e. *"asking herself whether or not material error [was] demonstrated"*) was too strict.

His Honour dismissed this submission, stating:

> *[48] This submission ignores the proper officer's statements at pages 1 and 4 of the Statement of Reasons, namely, "I am not satisfied that there is reasonable cause to suspect that the medical assessment is incorrect in a material respect." Lest these statements are construed as a mere recitation of the statutory test, rather than a conscious application of it, it is relevant to have regard to the whole of the document.*
>
> *[49] The proper officer addressed the particulars of the application for review. They were the alleged errors in relation to the assessment of the left knee injury and the lumbar spine injury, in particular the alleged failure to have regard to the plaintiff's statements to the assessor in arriving at the conclusion that the left knee and the lumbar spine injuries were not causally related to the accident, and the alleged error in determining that the lumbar spine injury was "atypical".*
>
> *[50] The statements complained of appear in paragraphs 11 and 16 of the proper officer's Statement (see [22] and [39] above). The proper officer was not applying the wrong test simply by addressing the particulars of the application. At no point did the proper officer formulate the test, impliedly or otherwise, in terms of whether material error had been demonstrated. It is apparent that the proper officer immediately followed the statements of satisfaction in regard to clauses 1.8 and 1.20 of the Guidelines with a reference to the test under s 63(3), that is, that she was not satisfied that there was reasonable cause to suspect that the medical assessment was incorrect in a material respect.*
>
> *[51] As a matter of logic, the expression of a positive state of satisfaction that the particularised errors had not been made out is not inconsistent with the application of the correct test under s 63(3). Absent any error of the kind alleged by the applicant for review, it would follow that no suspicion or sense of unease could arise that the medical assessment was incorrect in a material respect.*

Lastly, it was argued that the proper officer failed to provide adequate reasons for the determination and erred in the finding that the assessor provided adequate reasons. His Honour found that the assessor's reasoning was sound:

> *There was no requirement on the proper officer to address every alleged omission on the part of the assessor in determining whether the assessor provided adequate reasons. The assessor's doubts relating to the plaintiff's reliability, particularly with respect to the left knee and lumbar spine injury, were laid bare by the assessment report. The plaintiff's implicit submission, that nothing short of a detailed explanation of the criteria applied to reach the assessor's judgment and the proper officer's determination is required, is not supported by authority. The requirement is to provide adequate reasons, not comprehensive ones."*