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

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We are asked to speak to you today about administrative law (judicial review) challenges to decisions of the Claims Assessment and Resolution Service (**CARS**), the Medical Assessment Service (**MAS**) and the Dispute Resolution Service (**DRS**) 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 DRS, CARS, MAS and Proper Officer decisions; and discuss
- Key lessons from the recent cases.

As you know, the *Motor Accidents Compensation Act 1999* (NSW) ("**MACA**") and the *Motor Accidents Injuries Act 2017* (NSW) ("**MAIA**") do not provide for an "appeal" from these decisions. Furthermore, there is (most regrettably) no provision in the Acts 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).

MOTOR ACCIDENTS INJURIES ACT 2017 (NSW) CASES

So far, there is just one judicial review judgment in relation to decisions under the new Act.

AAI Limited v Singh [2019] NSWSC 1300 (Fagan J)

Mr Singh was injured in a motor accident where he was the driver of a truck that rolled while turning a corner, due to the contents of the truck being insecurely stowed.

The claimant was entitled to statutory benefits for a period of 26 weeks under MAIA. The issue was what happened after that 26 weeks expired. Section 3.11 of the Act relevantly provides:

(1) An injured person is not entitled to weekly payments of statutory benefits under this Division for any period of loss of earnings or earning capacity that occurs more than 26 weeks after the motor accident concerned if:
(a) the motor accident was caused wholly or mostly by the fault of the person…

Section 3.28 contains a similar cut-off for statutory benefits in respect of treatment and care expenses.

Section 3.2(5) of the Act provides:

(5) For the purposes of this Act (including any motor accident insurance cover in respect of a motor vehicle) a liability that the relevant insurer has to pay statutory benefits under this Part in respect of death or injury is deemed to be a liability in respect of death or injury caused by the fault of the owner or driver of a motor vehicle in the use or operation of the vehicle (being a motor vehicle for which the insurer is the relevant insurer).

The insurer purported to cut off the claimant's statutory benefits after 26 weeks, arguing that by virtue of section 3.2(5), the claimant was deemed at fault and that therefore the termination provisions in 3.11 and 3.28 were engaged.

The claimant applied for internal review, but the decision was not altered. The claimant then applied to DRS, where it was determined that for the purposes of 3.11 and 3.28, the motor accident was not caused by the fault of the claimant. The insurer then commenced judicial review proceedings, seeking review of the decision of the DRS assessor.

Fagan J found (at [12]) that *"Section 3.2(5)is concerned with deeming where financial liability lies, not with deeming that any person is at fault, in any situation."* Therefore, the claimant's entitlement to statutory benefits was not terminated by virtue of 3.2.

There was also an issue as to the effect (if any) that Part 5 of the Act, dealing with "no fault accidents" had on the entitlement to statutory benefits. The insurer relied on section 5.2(1) which provides that in a no fault accident, fault is deemed on the part of the owner or driver. However, Part 5 is also complicated by the insertion of section 5.6, which provides that the owner or driver that is deemed at fault in a no-fault accident can recover from the person actually at fault. In any event, the claimant in this matter said that the accident was not a "no-fault" accident because there was fault on the part of someone, namely, the person who had negligently loaded the truck.

In the judicial review proceedings, the insurer argued that "any other person" should be read down so as to mean something less than <u>any</u> other person, *"to leave open that a motor accident could still be within the definition of "no-fault" if it was to some degree caused or contributed by a person who is outside the class of "any other person"* (at [21]). The court found that this was an impossible task, and that the words "any other person" in 5.2 mean just what they say, thereby rendering 5.6 redundant.

However, Fagan J also found that even if this were a “no-fault” accident within the definition of 5.2, it would not have the effect of terminating the claimant’s statutory benefits. His Honour held that Part 5 has no bearing on the entitlement to statutory benefits (at [23] – [24]).

Accordingly, the insurer’s Summons was dismissed. His Honour also recommended that Part 5 should be re-drafted, having regard to the inconsistencies between the provisions.

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 tas NRMA Insurance v McBlane **[2019] NSWSC 1789 (Lonergan J)**

In this case, the Supreme Court set aside a decision of a claims assessor on a final assessment of damages. Apart from some very small amounts, the insurer and the claimant were very far apart on the proposed quantum of damages. The Court said (at [12]) this provided “critical context” for consideration of the summons here. The plaintiff’s case was that necessary reasons were absent or insufficient in law. The defendant’s case was (at [14]) that necessary findings could be “sticky-taped” together to qualify as sufficient.

The Court held (at [27]) that “findings on material questions of fact, mention of the applicable law and an articulation of the reasoning processes that led to the conclusions

reached would clearly be essential matters to comprise a brief statement of reasons as required by section 94(5) of the MACA.”

In his reasons, the claims assessor failed to make any findings of injury. The Court held (at [37]):

> “Nowhere in any of this material is there anything that resembles a finding by the assessor as to what parts of the body of the complainant the assessor has accepted are impaired, let alone the nature and extent of the impairment”

For this reason, the Court held (at [39]) that the claims assessor’s reasons were “fatally inadequate”.

***AAI Ltd v Feng* [2019] NSWSC 535 (Adamson J)**

In this case, an insurer made both mandatory and discretionary exemption applications to a claims assessor under s 92(1)(a) and (b) of the Act so that the personal injury matter could be heard by a court. The Principal Claims Assessor refused the mandatory exemption application and a claims assessor refused the discretionary exemption application. The insurer challenged the two decisions in the Supreme Court.

Unusually, SIRA appeared and took part in the proceedings to argue some questions of statutory construction. As to the mandatory exemption application, the Principal Claims Assessor claims assessor refused the application stating that she accepted that the insurer had expressly denied *liability* in writing but rejected the insurer’s argument that it had denied “fault” on the part of the driver in the use or operation of the vehicle within the meaning of cl 8.11.1 of the Motor Accidents Claims Assessment Guidelines.

The Insurer had contended in its submissions to the Principal Claims Assessor that the word “fault” in the Guidelines required not only that there be a breach of duty by the driver in the use and operation of the vehicle but also that personal injury had been suffered by the Claimant as a result (which was wholly denied here). The Principal Claims Assessor decided that the word fault in cl 8.11.1 of the Guidelines did <u>not</u> incorporate the concept of personal injury. For these reasons, she did not consider that the Insurer had made out an entitlement to mandatory exemption under s 92(1)(a) and cl 8.11.1 of the Guidelines and dismissed the application.

The discretionary exemption application was based on false and misleading conduct by the claimant and complexity. It was refused by a claims assessor, holding that the matter was suitable for assessment at CARS.

On the construction question on the mandatory exemption application, the Court held (at [39]):

> “The tort of negligence has three elements: duty of care owed by the alleged wrong-doer to the alleged injured party, breach of duty and damage caused by the breach of duty. The elements are commonly referred to in summary form as duty, breach and causation. In court proceedings these matters must be separately pleaded. Although liability in the tort of negligence depends on proof of all three matters, the second element is commonly also referred to as “negligence”. Thus a party who is *negligent* will not be *liable* in negligence if its negligence caused no loss.”

The Court said (at [41]):

> "The wording of cl 8.11.1 makes it clear that it is not any fault that is relevant: it is only "fault of the owner or driver of the motor vehicle in the use or operation of the vehicle". These qualifying words tend to suggest that the word fault is used in the sense of "negligence" (or other wrong) rather than "liability in negligence" or "tortious liability"

It was held that the legislative intention for mandatory exemptions was (at [42]) "to exempt from CARS assessments disputes about whether the conduct of the owner or driver was wrongful, either because the owner or driver was negligent or because the owner or driver was guilty of a deliberate act, such as intentionally colliding with another car."

Her Honour said, at [46] – [47]:

> "In *Smalley v Motor Accidents Authority of New South Wales*, which was decided after *Axiak v Ingram*, Leeming JA, at [60], set out the four elements of a compulsory third party insurer's liability to indemnify which included, relevantly:
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> "(c) "fault": whether the insured driver breached a duty owed to theclaimant;
>
> (d) causation: whether the insured's fault caused the death or injury;"
>
> This extract from the reasons in *Smalley v Motor Accidents Authority of New South Wales* indicates not only that the statute differentiates between fault and causation but that the passages in *Axiak v Ingram* relied on by the Insurer did not alter the principles expressed in *Sivas v Government Insurance Office*: that fault is not synonymous with liability, but is merely one integer which is required to be established before the Insurer is liable. Although the wording of cl 8.11.1 of the Guidelines was amended after *Smalley v Motor Accidents Authority of New South Wales*, nothing turns on the amendment in the present case."

Her Honour said (at [48]) "In my view, "fault" in cl 8.11.1 is, when the relevant tort is the tort of negligence, synonymous with breach of duty *simpliciter*. Fault in this context does not include the element of damage caused by the breach of duty."

The Court held (at [52]) that the Principal Claims Assessor's decision was correct.
As for the claims assessor's discretionary exemption refusal the Court held (at [57]) that when read fairly and as a whole, the claims assessor did address the correct test (of suitability of CARS). Her Honour said, at [58] – [59]:

> "In paragraph [13] of the reasons, the Claims Assessor posed the question whether it was "appropriate having regard to the claims made, the claim can be properly assessed within CARS". The word "appropriate" suggests a discretionary consideration of relevant factors and is consistent with the application of a test of suitability. Although the word "can" implies capacity, the addition of the qualifying adverb "properly" is sufficient, in my view, to indicate that the Claims Assessor

realised that he was making a qualitative assessment of *suitability* rather than determining whether CARS had the *capacity* to hear and determine the dispute.

In paragraph [14] the Claims Assessor outlined the jurisdiction and experience of CARS as a "specialist Tribunal" and what, in his experience, had occurred in such assessments. Although this paragraph was relied upon by the Insurer as an indication that the Claims Assessor had fallen into the same error as the claims assessors in *Khaled* and *Lou*, I do not consider this paragraph to have that effect in the present case. Although the ultimate question turns on suitability (or lack thereof), capacity will commonly, if not invariably, be a relevant factor in determining suitability. In paragraph [15], the Claims Assessor again used the words "properly determined", which, in my view, is sufficient to indicate that he was addressing suitability rather than purely addressing capacity. The reference in paragraph [15(ii)] to the potential for the issue of suitability to be *revisited* implies that the question of suitability was being addressed in the reasons. The words "particularly complex" in paragraph [15(v)] also imply that an evaluative judgment is being made. The highlighted words in paragraph [17] in the passage from the reasons extracted above suggest that the Claims Assessor was not engaged in a rudimentary exercise of determining whether CARS had the capacity to determine the dispute but rather that the Claims Assessor had not been persuaded by the Insurer's arguments that the claim was unsuitable for CARS assessment."

***Insurance Australia Ltd tas NRMA Insurance v Gurbuz Aslan* [2019] NSWSC 1587 (Harrison AsJ)**

The claimant suffered physical and psychiatric injuries in a motor vehicle accident in NSW. Liability was admitted. The insurer made an application for discretionary exemption of the matter from CARS. The insurer said that the claimant made false or misleading statements in relation to both his pre-accident employment at Westpac and the reasons for his dismissal from that employment. It was further asserted that the claimant made false or misleading statements as to his pre-accident history of psychological symptoms. In particular, the first defendant failed to disclose that he saw a psychologist only seven weeks before the accident for ongoing management of [his] anxiety and depressive symptoms. Further, it was said he made false or misleading statements as to the <u>cause</u> of the psychological symptoms he had prior to the accident. In particular, the claimant failed to disclose that he suffered anxiety and depression as a result of work performance and disciplinary issues at Westpac before the accident.

The claims assessor determined that it all could be determined at CARS and that issues of credit could be adequately tested there.

The Court applied (at [41]) *IAG Limited t/as NRMA v Khaled* [2019] NSWSC 320 and held that the claims assessor misdirected herself and asked the wrong question, which was whether she was satisfied this claim was capable of assessment in CARS. The Court said (*ibid*):

"The claims assessor applied the wrong test. By so doing, she misunderstood or misconstrued the scope and nature of her power pursuant to s 92(1)(b) of the MAC Act, and incorrectly exercised that power in determining the insurer's application.

This constitutes a constructive failure to exercise jurisdiction and it is an error on the face of the record."

***IAG Limited v Phonphasadu* - decision of Fagan J on 25 November 2019**

The claimant had been assessed by MAS as having WPI of 11% (including 5% for the lower back). The matter was referred to a claims assessor for determination. At the first preliminary conference, the insurer indicated that it had arranged medical appointments for the claimant, and there were directions made in relation to the insurer putting on its submissions after the reports from those examinations were received.

The assessment conference was listed for 26 November 2019. Approximately 3 weeks prior to the preliminary conference, the insurer received the report from its medico-legal Neurosurgeon. That doctor had seen radiological images that were not before the MAS assessor, and he opined that there was no whole person impairment in the lower back.

The insurer immediately served the report and sent it to the claims assessor and requested that the assessment conference date be vacated, as it intended to lodge an application with MAS for further assessment. The claims assessor called a further preliminary conference. The claimant opposed the adjournment of the assessment conference. The claims assessor called for written submissions from the parties.

The insurer lodged its application for further assessment with MAS, and put on written submissions to the claims assessor to the effect that the claims assessor could not proceed to assess the claim with an allowance for non-economic loss, as the insurer was now disputing the entitlement to non-economic loss. The following sections were relevant to that argument:

Section 132 relevantly provides:

> *(1) If there is a dispute about whether the degree of permanent impairment of an injured person is sufficient for an award of damages for non-economic loss, the court may not award any such damages unless the degree of permanent impairment has been assessed by a medical assessor under Part 3.4 (Medical assessment).*

Pursuant to s57, "medical dispute" simply means a disagreement or issue to which the Part applies.

Section 62 relevantly provides:

> *(1) A matter referred for assessment under this Part may be referred again on one or more further occasions in accordance with this Part:*
>
> > *(a) by any party to the medical dispute, but only on the grounds of the deterioration of the injury or additional relevant information about the injury*

The argument was that because there was a disagreement as to the claimant's permanent impairment (which is a matter set out in s58 to which the Part applies), there was therefore a medical dispute, and pursuant to s132 (which applies equally to claims assessors by virtue of s122), the claims assessor could not proceed to determine the claim and award damages for non-economic loss.

The claims assessor issued a decision at 10.31am on Friday 22 November, determining that the matter would proceed to hearing on 26 November, and that there would be no postponement of the hearing date. A central basis for the decision was a finding that there was no "dispute" about non-economic loss because it had already been determined by MAS and the insurer's further application had not gotten past the proper officer's gatekeeper function yet.

The insurer applied for an urgent injunction to prevent the matter from proceeding to hearing until its further assessment had been determined. The necessary papers were prepared on the day that the decision was handed down and were sent to the Court and the claimant just after 5pm that day, with an indication that the insurer would seek a hearing before the Duty Judge on the Monday morning (25 November). The application prepared by the insurer was a Summons seeking judicial review of the decision of the claims assessor, together with a Notice of Motion seeking the urgent injunction, submissions, and an affidavit in support.

On 25 November the insurer did indeed seek an urgent hearing before the Duty Judge. The claimant was also represented and therefore the matter did not proceed Ex Parte (as it might have done).

The Duty Judge, Fagan J, heard the matter and gave ex tempore judgment that afternoon, finding that the claims assessor's decision was affected by legal error, particularly in relation to the finding that there was no dispute in existence (having regard to the statutory framework set out above). His Honour made orders in the nature of a stay of the decision to refuse to postpone the assessment conference, and a further order retraining the claims assessor and SIRA from conducting an assessment conference, or issuing a certificate pursuant to s94 of the Act, until the MAS 4A application has been finally determined.

A transcript of the *ex tempore* judgment is available.

***IAG Limited v Priestly* [2019] NSWSC 1185 (Fagan J)**

The insurer sought judicial review of a decision of a claims assessor on the basis that the awards for past and future economic loss were affected by legal error. It was alleged that the award for past economic loss, which was given by way of a buffer, was in error because an actual calculation could have been made, and further that there were inadequate reasons given for the buffer. In relation to future economic loss, it was alleged that the assessor had failed to adequately state his assumptions pursuant to s126 and had failed to give adequate reasons.

The insurer relied on a number of authorities to support the contention that it was a legal error to award a buffer when a calculation was possible. In in *Allianz Australia Insurance Ltd v Kerr* (2012) 83 NSWLR 302, McColl JA said at [9]:

> *"The foregoing should not be seen as a license to award buffers indiscriminately. Where the evidence enables a more certain determination of the difference between the economic benefits the plaintiff derived from exercising earning capacity before injury and the economic benefit derived from exercising that capacity after injury, recourse should not ordinarily be had to the award of damages for future economic loss by way of a buffer. Each case must turn on its own facts."*

In the same case Macfarlan JA said (at [72]):

"[A]wards in respect of future economic loss should wherever possible result from evidence-based calculations or estimates that are exposed in the decision-maker's reasons. The award of a buffer that is not supported by an explanation of how and why the amount was arrived at should remain a last resort where no alternative is available.

Fagan J held that the constraints on awarding buffers apply to both past and future economic loss. His Honour held that the findings that the claims assessor had made in respect to past economic loss would have permitted an evidence based calculation, and that it was impermissible for the assessor to then find that it was not possible to calculate any particular loss. His Honour held that the assessor's approach constituted an error of law, namely, applying a buffer when this was not warranted in principle (at [21]). However, given that judicial review relief is discretionary, his Honour would not have granted relief on this ground alone because in this case the difference between the buffer and the evidence-based calculation was very small.

In relation to future economic loss, the assessor had awarded a buffer of $400,000. Fagan J held that the decision to award a buffer was devoid of explanation, and that the assessor had failed to explain important matters such as which career trajectory was likely, what the claimant's likely income would have been, what the claimant's weekly hours would be reduced to as a result of her impairment, or whether the overall length of her working life would be reduced. His Honour further said, at [36]:

"The future economic loss component of the total award was substantial. It is not possible to say whether $400,000 is within or outside a reasonable range in the absence of any delineation of what the actual future circumstances of employment are expected to be. It is unacceptable that there should be awarded against an insurer under the motor accidents compensation scheme a sum of $400,000 without either a statement of the actual future earnings that have been assumed in the award or an explanation of why it is considered not possible or too difficult to draw conclusions in that regard. The inadequacy of these reasons leaves the affected party with an impression of arbitrariness. This case illustrates why the legal requirement of adequate reasons is important to public confidence in administrative decision making under the Act."

The decision was quashed.

***IAG Limited t/as NRMA Insurance v Mohammed Khaled* (Bellew J) - [2019] NSWSC 320**

In this case 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 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].

***IAG Limited t/as NRMA Insurance v Qianxia Lou* [2019] NSWSC 382 (Wilson J)**

This case was very similar procedurally to *Khaled*. The reasons were found to be demonstrably erroneous. The first defendant filed a submitting appearance (early) but then, based on the application from the plaintiff, had a costs order made against them. This was despite the fact that the first defendant had not made the erroneous decision or opposed judicial review relief in any way. The judge also refused to grant a certificate under the Suitors Fund Act.

***Lou v IAG Limited t/as NRMA Insurance* [2019] NSWCA 319**

The first defendant appealed the decision in relation to the question of costs only. The Court of Appeal granted the appeal and substituted an order that there be no order as to costs in relation to the insurer's summons, and that the insurer pay the claimant's costs of the appeal.

The Court of Appeal determined (per the headnote):

> "Other than UCPR rr 6.11 and 42.1 and s 98 of the *Civil Procedure Act 2005* (NSW), there is no rule of court or provision dealing with the costs consequences of the filing of a submitting appearance, whether or not expressed to be "save as to costs". There is no prima facie rule that a submitting party will never be ordered to pay costs. What is called for, in all cases, is the principled exercise of the s 98 costs discretion: [41]-[43]. The primary judge fell into *House v The King* error by failing to take into account relevant considerations:
>
> (a) that the appellant did not cause the errors the subject of the proceedings before the primary judge; and
>
> (b) that these proceedings could not be resolved by consent.
>
> In re-exercising the costs discretion, it would not be appropriate to order that the appellant bear the NRMA's costs of the judicial review proceedings: [44], [46].

Perhaps more importantly in terms of ongoing impact from the decision were the unanimous findings of the Court on the issue of the Suitors Fund. The Court held (per the headnote):

> "The decision of a claims assessor under the *Motor Accidents Compensation Act* is a decision of a "court or tribunal". The conclusive nature of the proceedings before the claims assessor helped characterise the nature of the claims assessor's decision as one that falls within the relevant definition of a "court or tribunal" for the purposes of the *Suitors' Fund Act*. A judicial review pursuant to s 69 of the *Supreme Court Act 1970* (NSW) constitutes "an appeal" for the purposes of s 6 of the *Suitors' Fund Act*. The judicial review proceedings had the relevant characteristics of the losing party below seeking to have the decision overturned and the recontesting of the matter before a different body exercising a statutory power of review. The consequence of the exercise of jurisdiction was that the decision below was quashed and the matter remitted to be re-determined. The terms "court" and "an appeal" for the purposes of the *Suitors' Fund Act* should be given a broad and beneficial construction in keeping with the subject matter, scope and purpose of that Act: [63], [66].

This clarifies some confusion arising from earlier first instance judgments and obiter dicta comments in earlier Court of Appeal decisions.

***Zurich Australia Insurance Limited v Drca* (2018) 87 MVR 100; [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 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) 85 MVR 337; [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 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].

<u>JUDICIAL REVIEW OF MAS RELATED DECISIONS</u>

***Transport Accident Commission (Vic) v Kaddour* [2019] NSWSC 1738 (Basten J)**

In this case, the Supreme Court dismissed a summons of an insurer seeking to challenge a decision of a medical assessors review panel. The panel assessed the claimant as 15% WPI for "major depressive disorder with anxious distress". The insurer's summons was attacked (at [10]) for its failure to specify grounds of judicial review "with specificity" and for pleasing administrative error when legal error should have been pleaded (the merits/legality distinction).

The review panel had sought medical records from the parties. They were not provided. The crux of the judicial review case was that it was an error of law for the panel to go on to determine the review without those documents. There was nothing in the Act that pointed to a duty of the panel to secure the missing documents. The guidelines were suggested as a source of the duty, but the Court considered (at [21]) the guidelines to be "implausible source of legal duties".

The Court held (at [24]) that act of making the request (and at least in legal terms it was no more than that) did not impose a duty on the Panel not to proceed further until the documentation had been produced. It was also held (at [47]) not to have constituted a denial of procedural fairness to the insurer.

***Coventry v Insurance Australia Ltd T-as NRMA Insurance* [2019] NSWSC 1096 (Campbell J)**

In this case, Justice Campbell quashed a decision of a proper officer refusing a section 63 request for a review panel review of a decision of a medical assessor. The claimant was

diagnosed with Post-Traumatic Stress Disorder and Major Depressive Disorder. About a year after the motor vehicle accident, the claimant had an argument at work and he felt bullied. His symptoms worsened. The Court said (at [15]) the medical assessor:

> "… assessed the degree of whole person impairment caused by the workplace incident as 22 percent. He assessed the whole person impairment as it was immediately prior to 18 January 2016 as 5 percent. He then went on determine the degree of whole person impairment caused by the events of 18 January 2016 by deducting the whole person impairment as at 18 January 2016 of 5 percent from the current whole person impairment of 22 percent and attributed the difference of 17 percent to the subsequent event. He carried out an inverse calculation by deducting the difference of 17 percent from "the current whole person impairment of 22 percent, "thus the degree of whole person impairment caused by the subject accident is 5 percent". This is clearly circular reasoning."

The proper officer determined that the medical assessor was not wrong on his approach to apportionment - clause 1.36 of the Permanent Impairment Guidelines which provides:

> "The evaluation of permanent impairment may be complicated by the presence of an impairment in the same region that has occurred subsequent to the relevant motor accident. If there is objective evidence of a subsequent and unrelated injury or condition resulting in permanent impairment in the same region its value should be calculated. The permanent impairment resulting from the relevant motor accident should also be calculated if there is no objective evidence of the subsequent impairment, its possible presence should be ignored. (My emphasis)."

His Honour said (at [47]) "As can be seen, guideline 1.36 does not in express terms require any subtraction, deduction or apportionment. All that is required is the calculation of the value of the subsequent and unrelated permanent impairment. And a calculation of the permanent impairment resulting from the relevant motor accident."

His Honour said (at [56]):

> "And it will be sufficient if the motor accident has made a material contribution, provided it is a necessary condition of the occurrence of the impairment. A subsequent event may also be a separate cause of the same impairment which is a result of an injury caused by the motor accident without severing the chain of causation."

He held (at [61]):

> "The principles of law I have discussed above, demonstrate that it is not the occurrence of every subsequent injurious event or condition which should be taken as disrupting the causal connection between impairment, injury and motor accident. It is only those which are unrelated which may have this effect. It is notable, as has been remarked in earlier cases, that guideline 1.36 does not in its terms call for a reduction or apportionment, but as Hoeben J pointed out in General Insurance v Smith, its language is such that a reduction or apportionment may be called for in appropriate cases. But it will only be appropriate to make such a reduction or apportionment by

> reference to Guideline 1.36 where the subsequent degree of impairment, or a portion of it, on objective evidence is unrelated. I repeat not every subsequent injury or condition is unrelated to the relevant motor accident. I am satisfied that in determining whether he was satisfied that there were reasonable grounds to suspect that the medical assessment of Dr Anderson was incorrect in a material respect having regard to the particulars set out in the application, the proper officer misdirected himself as to the principles of causation established by the general law, s 58(1)(d) of the Act and guideline 1.36."

He held that the medical assessor did not have to apportion in the circumstances and set aside the proper officer's decision.

***Insurance Australia Limited t-as NRMA Insurance v Warren* [2019] NSWSC 1126 (Harrison AsJ)**

The insurer sought judicial review of a MAS decision and a proper officer's decision refusing to refer the matter to a review panel.

The main issue was whether there had been an error in the way that pre-existing impairment was dealt with.

Firstly, it was found that the medical assessor had failed to respond to a "substantial and clearly articulated argument" bases upon evidence, made by the insurer, in relation to the claimant's pre-existing impairment in his cervical spine. Her Honour found that the claims assessor had failed to respond to the insurer's argument and that this was a denial of procedural fairness.

Further, in relation to the issue of pre-existing impairment, the medical assessor had simply stated "not applicable" and the insurer submitted that this was a failure to give adequate reasons, particularly in circumstances where the insurer had specifically put pre-existing impairment in issue (see *Allianz Australia Insurance Limited v Francica* [2012] NSWSC 1577; (2012) 63 MVR 1 and *Campbelltown City Council v Vegan* (2006) NSWCA 284). This argument was accepted.

Her Honour also considered the recent case of *Chahoud* (see below) and noted that "As the recent case of *IAG Limited t/as NRMA Insurance v Chahoud* [2019] NSWSC 767 ("*Chahoud*") makes clear, cl 1.31 does not require the *evidence* of injury to be dated at the time of the accident."

There was also an argument that the assessor had failed to apply clause 1.41 of the Permanent Impairment Guidelines, in failing to to put inconsistencies in earlier medical reports, to the claimant. In considering the requirement to bring inconsistencies to the attention of the injured person in order to provide procedural fairness, Her Honour stated;

> *"It is conceivable, and even expected, that a claimant might present to a medical assessor with a variation in range of movement from the presentation months or as in this case, years earlier. In my view, read as a whole and fairly, it can be implied from the medical assessor's reasons that he did not believe there was an*

inconsistency in the severity of Mr Warren's injuries which was not explicable, such that it needed to be brought to Mr Warren's attention."

This passage tempers the position in *Dominice* (see below), providing that the question will be whether it could be reasonably implied that the decision maker did not believe there was an inconsistency in the severity of the injured person's injuries which was not explicable.

The decisions of the medical assessor and proper officer were quashed.

IAG Limited t/as NRMA Insurance v Chahoud **[2019] NSWSC 767 (Bell P)**.

The insurer sought review of a proper officer's decision, refusing to refer a matter for further medical assessment. The issue was whether or not the evidence that showed that the claimant had impairment approximately 4 months prior to the accident was evidence sufficient to constitute evidence of pre-existing impairment for the purposes of clause 1.31 of the PI Guidelines. The proper officer had found that as this evidence was not dated at the time of the accident, it was not evidence of pre-existing impairment at the time of the accident.

In that matter, Bell P summarised the plaintiff's argument as follows (at [68]):

> *"In its written submissions, IAG emphasised the lack of any temporal element in what it described as the "prohibition" in cl 1.31, which states that "[i]f there is no objective evidence of the pre-existing symptomatic permanent impairment, then its possible presence should be ignored." It submitted that, accordingly, if objective evidence of a pre-existing impairment exists, a medical assessor is not required to ignore it, even if it is not temporally connected to the accident."*

His Honour further stated (at [70]):

> *"IAG submitted that in so finding, the proper officer wrongly construed cl 1.31 as requiring that the evidence itself be dated "at the time of the accident". It submitted that the clause should instead be read as requiring that there be "evidence of pre-existing impairment at some time prior to the accident, that likely still existed at the time of the accident." What was "likely still to exist", in other words, were not records of any pre-existing impairment, but the pre-existing impairment itself."*

His Honour found (at [73]):

> *"The statement "[e]ven if I were satisfied that the record was close enough in proximity to the accident to make a deduction" (emphasis added) makes clear that the proper officer was previously concerned with the timing of the* record*, as distinct from the injury. In this regard, the proper officer erred."*

The proper officer's decision was quashed.

D'Ament v Allianz Australia Insurance Ltd **[2019] NSWCA 201**

The claimant sought judicial review of a MAS review panel decision. A central issue was whether the review panel had erred in focusing on whether there was a direct injury to the

claimant's shoulder, as opposed to whether there was restriction caused by the cervical spine injury (and in failing to respond to an argument made by the claimant regarding the referred injury). It was also argued that the review panel had made findings of fact for which there were no evidence.

The claimant was unsuccessful before the primary judge, Lonergan J, and appealed to the Court of Appeal.

The Court of Appeal, per Simpson AJA with whom Macfarlan and Leeming JJA agreed), found that the review panel had addressed the issue of shoulder impairment being referred from the neck.

It was further held that a finding of fact for which there is no evidence does not necessarily constitute an error of law on the face of the record:

> *[74] It may be accepted that a finding of fact for which there is no evidence constitutes an error of law: Kostas v HIA Insurance Services Pty Ltd (2010) 241 CLR 390; [2010] HCA 32 at [90]. That is not the same as saying that such a finding constitutes an error of law on the face of the record. The parameters of "error of law on the face of the record" have not been authoritatively defined. There is no clear line that marks out an error of law as one that is "on the face of the record". ...*
>
> *[77] The appellant's submissions trawled through the medical and physiotherapy evidence in order to establish the proposition that there had been complaints by the appellant of pain in the left shoulder prior to March 2011. The argument also required interpretation of that evidence – for example, the physiotherapy note of "left shoulder pain again" and of the pictogram in the notes. That exercise is beyond the scope of a determination of whether there has been "error of law on the face of the record". I am satisfied, however, that the error of law for which the appellant contends (even if it is error of law) falls on the wrong side of the divide referred to in [74] above. No error of law on the face of the record has been established."*

The appeal was dismissed.

***Insurance Australia Limited v Salvadori & Ors* [2019] NSWSC 1470 (Johnson J)**

The insurer sought to challenge the MAS assessor's reasons based on an alleged unlawful direction to the claimant.

The direction was;

"All measurements done with a goniometer and inclinometer. All measurements repeated three times for consistency, if required. A tape measure was used. The active range of motion, ROM, was measured with the passive range of motion reserved for clinical and diagnostic verification. <u>The claimant was advised that examination would be with all measured movements within a pain-free range and that there might be some discomfort at the upper</u>

limit of movement which should be reported immediately and the movement will be discontinued.”

It was submitted that the instruction, to cease at the onset of discomfort, was not supported by either the PI Guidelines or the AMA4 Guides. In fact the Guidelines require maximum effort and cooperation with the assessment.

Johnson J stated:

> *66. “I do not consider that the direction given by the Medical Assessor to Ms Salvadori was contrary to anything contained in the MAC Act, PI Guidelines or the AMA4 Guides.*
> *67. It is, of course, not sufficient for the Insurer to assert that some other verbal formula could be used by a medical assessor during an examination. It is for the Medical Assessor, using his clinical judgment and experience to formulate the explanation or direction to be given to an examinee for the purpose of clinical examination as part of the assessment.*
> *68. To succeed in these proceedings, it is necessary for the Insurer to demonstrate a legal obligation on the part of the Medical Assessor to have said something else to Ms Salvadori and to refrain from saying something which he did say during the examination. In my view, the Insurer has fallen far short of demonstrating error in that respect, let alone error which could justify the grant of prerogative relief in judicial review proceedings.”*

***Cahill v Insurance Australia Ltd* [2019] NSWSC 564 (Campbell J)**

The plaintiff argued that a MAS review panel had erred in treating the absence of contemporaneous evidence of shoulder injuries as decisive, and in failing to appreciate that there was a reference to shoulder injuries in the medical certificate attached to the claim form.

It was found that the review panel had not erred, and that it was entitled to have regard to the contemporaneous records, and did not view them as determinative of the issue. Further, that the medical certificate did not necessarily show shoulder injuries, and that if there was any error, it was an error of fact (not reviewable in judicial review proceedings except where there was “no evidence” for the finding (see *ABT v Bond*).

> *[58] In considering the sufficiency of this evidence, one should bear in mind the nature of the Review Panel’s function as described by the High Court in Wingfoot (at [43] above). And as the Court of Appeal said in AAI v McGiffen (at [88]), as an expert panel the Review Panel was entitled to make its own assessment as to the adequacy of the evidence proving, or disproving, an “injury”. It cannot be said in the circumstances as this case that there was no material supporting the Review Panel’s conclusion of fact or, as I have said, that the material before it admitted of one correct answer only. If the Review Panel fell into error in regard to the central issue, it was an error of fact within jurisdiction.*
>
> *[59] I accept the argument that this case falls into the category discussed by Adamson J in Bradley where it was open to the Review Panel “to find, as it did, that the plaintiff did not sustain injuries to the areas claimed other than the neck in the motor*

vehicle accident". As her Honour said, the weight given to contemporaneous clinical notes was unexceptional. Here the Review Panel did not fall into the mistake of treating the absence of contemporaneous record as decisive.

***Cahill v Insurance Australia Limited (No 2)* [2019] NSWSC 597**

This concerned costs of the first decision. The unsuccessful plaintiff (claimant) had made an application for a certificate under the Suitors Fund. The judge declined to make an order for the certificate.

Campbell J:

1. *Section 6 of the Act provides:*

(1) If an appeal against the decision of a court:

(a) to the Supreme Court on a question of law or fact, or

(b) to the High Court from a decision of the Supreme Court on a question of law, succeeds, the Supreme Court may, on application, grant to the respondent to the appeal or to any one or more of several respondents to the appeal an indemnity certificate in respect of the appeal. (My emphasis.)

5. *Even if it is accepted that the Review Panel was a court for the purposes of the Act, and judicial review proceedings, an appeal, the "appeal" has been unsuccessful in the Supreme Court and there is no power to grant a certificate. Moreover as the moving party in the proceedings the plaintiff cannot be equated with a respondent to an appeal.*

6. *Finally, the plaintiff makes reference to 6C(2) of the Act. This plainly is not a matter over which the Court has power but rather, is a matter the Director General. This provision therefore does not assist the plaintiff here.*

***McHenry v Insurance Australia Limited t/as NRMA Insurance* (2019) 87 MVR 298; [2019] NSWSC 68 (Harrison J)**

This case canvasses a discussion on what constitutes procedural fairness as well as where a panel may draw inferences in the face of absence of contemporaneous and delayed complaint about injury.

It was found that McHenry was not denied procedural fairness and that the panel was well within its power to draw inferences from an absence of contemporaneous complaint when coupled with a 3 year delay in back complaint regarding the injuries sustained from the subject accident.

One of the interesting things to take out of this matter is that an argument of futility was dealt with at the conclusion of the judgement. It was found that it would not be helpful on those facts to have speculated as to what an alternative panel might or might not have done.

***Iedam v Insurance Australia Ltd ta NRMA Insurance* (2018) 86 MVR 512; [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 decision, 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.

***Partridge v IAG Limited t-as NRMA Insurance* [2019] NSWSC 127 (Harrison J)**

In this matter, the WPI of Ms Partridge was in contention. There was an injury to her wrist, hearing loss, vertigo and her cervical spine.

The cervical spine was the contentious issue regarding causation by the motor accident. Ms Partridge successfully made an application for her assessment to be reviewed by the review panel. In addition, she requested by way of letter that she be examined as she had ongoing neck pain.

The panel did not examine her and gave no prior notice that she would not be examined before the certificate was given by the panel. The assessment was less than 10% WPI.

(at [37])

> *Although Ms Partridge has articulated several ways in which she contends that the Review Panel made errors, it is sufficient in my view to dispose of the appeal by reference to her complaint that it did not examine her in accordance with her request to do so. Whether formulated as an allegation of procedural unfairness or a constructive failure on the part of the Review Panel to exercise its statutory function or a failure to respond to a clearly articulated argument, the significant thrust of her contentions is that the Review Panel should have examined her when asked.*

Harrison then cites Sackville AJA in *Boyce* [130]-[134] in discussing the use of the practice note and where the claimant may need to be re-examined by the review panel.

(also re substantial and clearly articulated argument; see *Dranichnikov v Minister for Immigration and Multicultural Affairs* (2003) 77 ALJR 1088 at [24], [25] and [95]; *Plaintiff M61/2010E v The Commonwealth* (2010) 243 CLR 319 at [83], [84] and [90]; *Rodger v De Gelder* (2015) 71 MVR 514 at [93], *Allianz Australia Insurance Ltd v Cervantes* (2012) 61 MVR 443 at[19]-[22].)

***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*."

***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.*

Can less than 3 members of the review panel conduct the examination of the claimant?

Wolarczuk v NRMA Insurance Australia Limited [2017] NSWSC 1691 - No

Bradley v Insurance Australia Ltd t/as NRMA Insurance [2015] NSWSC 950 - Yes

Mackenzie v Allianz Australia Insurance Ltd (No. 2) [2015] NSWSC 1320 - Yes

Gwyther v Insurance Australia t/as NRMA Insurance & Ors [2018] NSWSC 1441 - Yes

IAG Ltd t/as NRMA Insurance v Tarabay [2018] NSWSC 1836 - Yes

Lu v AAI Ltd t/as AAMI [2019] NSWSC 368 – Yes

Thank you