COMMON LAW PRACTICE UPDATE 96

Sections 61 and 63 *Motor Accidents Compensation Act 1999* (NSW)

The plaintiff sought to set aside the determination of a three-practitioner panel of the Medical Assessment Service (MAS) in *Averkiou v CIC Allianz Australia Insurance Ltd* [2016] NSWSC 311. She had been involved in successive motor accidents in May and October 2010. She sought judicial review of the assessment of the first injury, which initially found 17% WPI from the first accident. When she disputed this, a review panel substituted a revised assessment of 10%, whereupon she sought a further assessment, which also resulted 10% finding. She then sought a further review, which was referred to a review panel. The plaintiff's written submissions to the review panel argued that the second accident did not result in any further or additional injury. The review panel revoked the previous single reassessment. It determined WPI from the first accident at nil percent, noting that the plaintiff had made "no comment whatsoever" in relation to the second accident. In fact, the plaintiff had referred to the subsequent accident in her statement and had said, "I recovered fully from this accident in a matter of weeks. I did not make a claim in respect of this motor accident."

The review panel attributed the entirety of her injuries to the second accident.

The review panel had erred by assessing the WPI caused by the second accident rather than the first, in circumstances where the latter was its real task. The MAS appeal panel's decision evidenced jurisdictional error. Its decision was quashed and remitted to be determined in accordance with law.

Section 62 *Motor Accidents Compensation Act 1999* (NSW)

An insurer sought judicial review of three decisions in *Insurance Australia Ltd (NRMA) v Melkonyants* [2016] NSWSC 503 (Rothman J). These decisions involved respectively the decision of a MAS assessor finding 15% WPI in respect of urological injuries, the refusal of the Proper Officer to refer the medical dispute for further medical assessment and the decision of the claims assessor to refer that dispute for further medical assessment.

The medical assessor, guided by the reports of the treating gynaecologist, had concluded the claimant was incontinent following the accident. Following a period of remission, the incontinence recommenced. The medical assessor, a specialist urologist with access to all the claimant's recent medical records, concluded that the urinary incontinence was caused by the accident despite the fact that the claimant had previously had two children delivered by caesarean section. It was significant that the insurer did not allege that there was no evidence upon which the medical assessor could have found as he did, and whilst there had been a resolved prior incident of urinary incontinence, urinary incontinence was the immediate effect of the accident. The insurer's case that the claimant's injuries had been caused by the two childbirth occurrences was known by the medical assessor but not accepted. No error was demonstrated in respect of any of the three decisions and accordingly the proceedings were dismissed with costs.

Section 63 *Motor Accidents Compensation Act 1999* (NSW)

An insurer challenged the decision of a medical assessor's review panel not to conduct a further clinical examination of the claimant's shoulder in *AAI Ltd t/as GIO v Cooley* [2016] NSWSC 434.

An assessor had found 5% WPI, then the proper officer granted an application for review under s 63 *Motor Accidents Compensation Act 1999*. The review panel certified WPI at 11%. Counsel for the insurer had accepted that a fresh clinical examination was not required in all cases, and had noted that the review panel identified error in the calculation of WPI based upon the original examination. Neither did the insurer's submissions to the review panel challenge the physical examination or criticise the claimant's submission that the original determination of WPI based upon the assessor's measured range of movements in the right shoulder was incorrect. Nor did it address the issue of whether the claimant should attend for clinical examination.

A fresh assessment was not required in all cases and the review panel's decision was open to it. Procedural fairness did not demand a fresh clinical examination. Even if a legal error had been made, relief would have been refused in view of the insurer's effective acquiescence to the approach taken by the review panel.

In *QBE Insurance (Australia) Limited v Davies* [2016] NSWSC 536 the insurer sought review of a referral by the proper officer of SIRA and the decision made by the medical assessor's review panel following the referral. The claimant was originally assessed at 5% WPI. The proper officer thought there was reasonable cause to suspect material error as the assessor seemed to have only assessed direct rather than indirect injury to the shoulders. The review panel, after a re-examination of the claimant, concluded there was a 13% WPI.

"Reasonable cause to suspect" is a fairly undemanding threshold and, given that QBE had not demonstrated "irrationality or illogicality", it had not shown that the proper officer's conclusion was not open to her. As to the challenge to the review panel's assessment, QBE's contention that the claimant must establish that the impairment was "directly related" is not a requirement of the Act nor required by law. The insurer's complaints were not made out and were dismissed with costs.

In *Ali v AAI Ltd* [2016] NSWCA 110, the claimant was assessed at 11% by MAS and a subsequent application for review by the insurer was refused by the Proper Officer. The insurer sought to challenge the certificate and the decision of the Proper Officer and the trial judge set aside both the assessment and the decision not to review. The claimant then sought leave to appeal. The NSW Court of Appeal found that incomplete references in the original statement of reasons by the assessor in turn led to incorrect inferences being drawn as to the apparent failure to address relevant material, which led the trial judge into erroneously concluding that the assessor had failed to consider pre-accident psychiatric information. Although an account is

described as unreliable does not prevent some weight being given to it. The assessor's role is not subject to the same principles that relate to judicial function and the brief reasons provided were sufficient to satisfy the statutory provisions. An assessor's determination is not vitiated by a failure to have regard to a matter in the permanent impairment, because those guidelines do not have the status of delegated legislation. The claimant was granted leave to appeal and the appeal upheld.

Section 94 *Motor Accidents Compensation Act 1999* (NSW)

The adequacy of the reasons given by the assessor was at issue in *Zahed v IAG Limited t/as NRMA Insurance* [2016] NSWCA 55. The assessor was required by Section 94(5) *Motor Accidents Compensation Act 1999* to attach a brief statement of reasons to the assessment certificate and clause 18.4.3 of the Claims Assessment Guidelines imposed an obligation on an assessor to set out the statement of reasons "as briefly as the circumstances of the assessment permit". The certificate disclosed no reasoning as to the calculated hours for care, and as a result the insurer was successful at first instance in having the assessment set aside. The claimant appealed. The NSW Court of Appeal agreed with the judge at first instance. While the reasons required of an assessor are not necessarily those which might be expected of a judge, their reasons must demonstrate the path of reasoning that leads to the award. Accordingly the appeal was rejected.

Sections 94 and 126 *Motor Accidents Compensation Act 1999* (NSW)

The insurer sought judicial review of aspects of the assessment of damages by the CARS assessor in *Allianz Insurance Limited v Larriera* [2016] NSWSC 441 under the *Motor Accidents Compensation Act 1999*. The insurer's concern was that was that the reasons for the assessment of past and future economic loss were legally inadequate.

The insurer argued that the claims assessor failed to take its submissions about the quantum of economic loss into account and that the assessment was irrational and illogical, however Campbell J was not satisfied that the assessor failed to discharge the duties imposed by s 126 *Motor Accidents Compensation Act 1999*. Although the assessor had not expressed himself particularly clearly, gaps in expression could be filled by natural inference on a fair reading of his reasons. Although the assessor did not expressly refer to residual earning capacity, that exercise was explicitly undertaken. The assessor allowed for 60% of usual business hours and found particular difficulties in working full-time in the future. In the circumstances Campbell J was not satisfied that the assessor applied fell into jurisdictional error and there was no error of law on the face of the record. The assessor's findings clearly rejected the insurer's submissions, so it could not be said that the assessor failed to engage with those submissions. It was clear, for example, that he preferred named medical practitioners to those upon whom the insurer relied. In the circumstances the reasons for the assessment were adequate in the circumstances and the application for judicial review was dismissed.

The insurer (NRMA) sought judicial review of a CARS assessment in *NRMA Insurance Limited v Buckley* [2016] NSWSC 475. The CARS assessor calculated damages at $1,292,777.61 and awarded costs of $82,858.72. The NRMA complained about the adequacy of reasons and argued that there had been a failure to comply with s 126 *Motor Accidents Compensation Act 1999*. The

insurer alleged that the assessor failed to calculate precisely when the claimant would retire, made findings about the claimant's need to retire early without indicating to the parties that such a finding was being considered and also failed to apply the requirements for the calculation of future economic loss.

The assessor had provided a brief statement of reasons in accordance with s 94(5) *Motor Accidents Compensation Act*, noting that whole person impairment had been assessed at greater than 10% and set out the claimant's continuing disabilities. Non-economic loss was calculated at $240,000, and an allowance was made for continuing care. The assessor noted that the insurer accepted commercial care of two hours a week and proposed a buffer for the future, however he found this to be inadequate. After considering medical evidence, he allowed five hours per week care for the rest of the claimant's life, amounting to a total $209,996.

The claims assessor also referred expressly to the requirements of s 126 regarding economic loss and noted that NRMA had conceded that he had suffered an impairment of earning capacity productive of economic loss. Although the insurer again suggested a buffer of $150,000 for past and future economic loss, including superannuation and a *Fox v Wood* allowance, the assessor did not believe it appropriate, and instead allowed $890,000 for future economic loss plus superannuation - past economic loss was agreed at $150,000, including workers compensation repayments, past superannuation and *Fox v Wood*.

The assessor found that the evidence supported the claimant's case that, for physical and psychological reasons, he could not continue in his current job, as he now had only a limited capacity to supervise and engage in some activities. The claimant would have worked to 67 years and his calculation was based on 50% of pre-accident earnings less 15% for vicissitudes and with the addition of a buffer of $100,000 for early retirement.

Rothman J noted that that parties often come to the court arguing that it should come to a different conclusion on the evidence when in reality they simply did not agree with the conclusion of the assessor. The court's intervention is only justified by an error of law on the face of the record. Claims assessors are required under the Act to state the assumptions on which the award was based, and in this case the assessor did so. As the insurer must have realised that the claims assessor was required to reach an assessment regarding the claimant's working life in relation to the future of the claimant and that submissions should be made in that regard, there was no denial of procedural fairness. The insurer's submission that allowing a buffer for early retirement was double counting lacked any reasonable basis. It was open to the assessor to reach the assessment, which was based on assumptions which were disclosed. The application was dismissed with costs.

Employment /Causation

The plaintiff in *Eaton v TriCare (Country)* [2016] QCA 139, an administrator in the defendant's nursing home, alleged that her manager allocated her an excessive workload and that the manager's aggressive and belittling conduct caused the plaintiff to suffer psychiatric illness.

The judge at first instance accepted the thrust of the plaintiff's evidence, noting that the evidence supported a finding that her psychological state deteriorated whilst working under the manager. There was no dispute that the plaintiff complained about her workload.

However, the trial judge was not satisfied that the plaintiff had proved that the risk of suffering a recognisable psychiatric illness was reasonably foreseeable in the circumstances. Mere notice of distress was insufficient. Despite the plaintiff's claim that the defendant was vicariously liable for the manager's conduct, that issue was not directly addressed by the judge at first instance.

The plaintiff appealed. The Queensland Court of Appeal noted that the employer owed a non-delegable duty of care and that it was a matter of general knowledge that some recognisable psychiatric illnesses may be triggered by stress. There were sufficient indications in the plaintiff's demeanour (she was clearly upset, shaking and crying) to enable the trial judge to conclude that there was a more than far-fetched or fanciful risk that the plaintiff would suffer a psychiatric illness without the exercise of reasonable care by her employer. As a result, there was a duty of care and foreseeability. There was also was medical support for causation. The conduct constituted a breach of the duty of care on the facts. The defendant was liable for the conduct of its manager.