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IN THIS EDITION

Crime Doesn't Pay in Insurance Law

Equity provides a rule of public policy known as the "Forfeiture" Rule by which a person forfeits his or her entitlement to property of a deceased person where the first person materially contributed to the death of the deceased and is criminally responsible for it.

For instance, a person convicted of murder is not entitled to inherit or otherwise obtain property of the deceased that would have passed to the person so convicted by reason of that person's criminal responsibility for the deceased's death.

What if the person was convicted of manslaughter (not murder) by reason of the person's diminished responsibility due to a mental illness suffered at the time of the offence being committed?

Does the Forfeiture Rule apply to persons convicted of manslaughter?

These issues were recently considered by Chief Justice Allsop in the Federal Court decision of *Swiss Re Life & Health Australia Limited v Public Trustee of Queensland (No. 3)*.

The background facts of the case involved tragic circumstances.

Mrs Melanie Perks took out a life insurance policy with Swiss Re for her benefit as policy owner. Mrs Perks nominated two beneficiaries, namely her daughter, Ebonie Perks and her son, Mitchell Perks, who would each receive 50% of a Life Benefit Amount upon her death.

In 2014, Melanie and Ebonie were stabbed to death by Mitchell when he was 16 years old. Mitchell was schizophrenic and had suffered mental illness for some years.

The Public Trustee of Queensland was the executor of the estates of Melanie and Ebonie.

In 2016 Swiss Re paid to the Public Trustee 50% of the Life Benefit Amount being Ebonie's share of the policy proceeds.

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The Court noted there was no doubt about the right of Ebonie's estate to receive those funds.

Ordinarily, the remaining 50% of the Life Benefit Amount was payable under the policy to Mitchell but in the circumstances Swiss Re considered it could not sufficiently discharge that amount to Mitchell by reason of his involvement in the death of his mother.

After Mitchell was initially charged with murder and before his subsequent plea of guilty and sentencing for the charge of manslaughter, Swiss Re filed an application at the Federal Court seeking a declaration pursuant to Section 215 of the *Life Insurance Act 1995* (Cth) to pay the remaining 50% of the Life Benefit Amount into Court. Allsop CJ made orders in that regard.

Further, his Honour made orders permitting Swiss Re to have its costs reimbursed from the monies paid into Court. However, as those costs did not eat up all of the monies paid into Court by Swiss Re, an unspecified amount remained as a balance for which no orders had been made.

Mitchell was subsequently sentenced for manslaughter by reason of diminished responsibility noting he suffered from a mental illness at the time of the offences. He was sentenced to a term of nine years full time imprisonment.

In separate proceedings filed at the Queensland Supreme Court, the Public Trustee sought a declaration that the estate of Mrs Perks be distributed to her mother and father. Under her Will Mrs Perks nominated her parents as beneficiaries if her children were unable to obtain the benefit of any gift or other property under the Will.

Justice Boddice granted the Public Trustee's application and, while his Honour made no reference to the Forfeiture Rule in his decision, the submissions of the Public Trustee addressed that issue.

Therefore, in respect of the remaining monies paid into the Federal Court by Swiss Re, the Public Trustee subsequently applied for an order permitting those monies to be paid to the parents of Mrs Perks in accordance with the orders of Boddice J in the Queensland Supreme Court proceedings regarding the distribution of Mrs Perks' estate.

That application proceeded before Allsop CJ on the papers but his Honour sought assistance from *pro bono* Counsel from the Queensland Bar on behalf of Mitchell who was in custody at the hearing of the application.

The Chief Justice said he was interested in obtaining assistance to see whether the funds might yet be able, despite the Forfeiture Rule, to be used for the benefit of Mitchell, for instance, for the funding of psychiatric treatment given his mental health and the burden of the guilt that may now lie upon him.

His Honour observed the traditional view was that the Forfeiture Rule applied in all cases of manslaughter. However, the Victorian Court of Appeal had recently held that the Rule did not apply inflexibly and ought to be approached on a case by case basis in manslaughter cases.

Having reviewed the legal authorities, Chief Justice Allsop held that Mitchell was not entitled to benefit from his mother's estate by reason of the Forfeiture Rule. His Honour made the following observations:

> *"It is unnecessary for me to come to a view as to this apparent conflict in the Intermediate Appellate Courts. Even if there is a discretion to be exercised in relation to whether the Rule applies to manslaughter cases, for the reasons that follow such discretion cannot be exercised in favour of Mitchell.*
>
> *If a discretion exists in a case by case approach, the central question must be whether the criminal culpability of the offender requires the application of the Rule or permits its non application.*
>
> *Culpability and the relationship between the purpose of the Rule and its application in particular circumstances can be debated. Here, however, although Mitchell's culpability was diminished by his mental illness, it was not such as to remove completely the criminal culpability and responsibility for the violent killing of his mother and sister by repeated stabbing.*
>
> *In these circumstances, the criminal culpability for the violent death of Mrs Perks must attract the operation of the Forfeiture Rule."*

Accordingly, the Court made the orders sought by the Public Trustee for the funds to be distributed to Mrs Perks' parents.

This interesting decision confirms the Forfeiture Rule will generally apply even in cases where a person is convicted of manslaughter by reason of diminished responsibility.

That is because the person's criminal culpability for the offence has not been extinguished even though the offence for which a conviction is recorded has been reduced from murder to manslaughter.

The Rule is a sound protection measure to prevent individuals obtaining a profit by reason of their heinous acts. In the life insurance industry this protection measure is especially important given the large benefit amounts under some life insurance policies that would otherwise be payable to beneficiaries in the absence of the Forfeiture Rule.

As the old adage states, crime doesn't pay!

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Liability Policies: The Insurer's Duty to Defend

Liability policies of insurance ordinarily operate on two fundamental premises.

First, the policy provides indemnity to the insured in respect of any amount which the insured becomes legally liable to pay to a third party as a result of personal injury or property damage caused by an occurrence in connection with the insured's business.

Second, the insurer agrees to defend any Court proceedings brought against the insured and pay all defence costs.

Such policies will often have an excess or deductible where the insured is liable to pay the insurer a specified amount under the policy.

Some policies require the deductible to be paid towards any damages for which the insured becomes legally liable to pay to a third party in respect of which indemnity is extended under the policy.

Other policies require the deductible to be paid towards the costs of defending Court proceedings even in circumstances where the insurer has successfully defended the lawsuit against the insured.

What if the lawsuit against the insured contains claims that are covered and claims that are not covered by the liability policy?

In that event, is the insurer nevertheless under a duty to defend the insured?

Further, where the lawsuit against the insured is unsuccessful, must the insurer pay all of the defence costs or is insured to pay a proportion of such costs where the allegations include claims that were not covered under the policy?

These issues arose for consideration by Chief Justice Allsop in the Federal Court decision of *Australasian Correctional Services Pty Limited v AIGA Australia Limited*.

Australasian Correctional Services Pty Limited ("ACS") and the GEO Group Australia Pty Limited ("GEO") contracted with the government to operate immigration detention centres from 1998.

For the period 31 May 2001 to 31 May 2002 American Home Assurance Company issued a general and products liability policy to ACS and GEO which gave cover in the insuring clause for:

> *"... all amounts which the Insured shall become legally liable to pay by way of compensation by reason of Personal Injury ... caused by an Occurrence in connection with the business."*

In 2011 AIGA Australia Limited ("AIGA") assumed American Homes' responsibilities under a scheme of arrangement confirmed by the Federal Court.

In 2013 a former detainee in the Woomera Immigration Detention Centre, operated by ACS and GEO on behalf of the Commonwealth, sued the Commonwealth in the NSW District Court for damages in relation to personal injuries allegedly sustained during his detention.

In 2014 the Commonwealth filed a cross claim against ACS and GEO for contribution or indemnity.

The personal injury proceedings including the cross claim were listed for trial for five weeks at the NSW Supreme Court after having been transferred there from the District Court. On Day 1 of the trial the proceedings were settled on terms involving a judgment for the Commonwealth on the Statement of Claim and judgment for ACS and GEO on the cross claim, with each party bearing its own costs.

AIGA had refused to undertake the defence of the cross claim, requiring ACS and GEO to fund their own defence.

One month before the Supreme Court hearing in the personal injury proceedings ACS and GEO filed a proceeding in the Federal Court's Insurance List seeking a declaration that AIGA was obliged to defend the cross claim on behalf of ACS and GEO in the NSW Supreme Court proceedings. Following a case management hearing in the Federal Court, AIGA accepted it was responsible for undertaking the defence of the cross claim but on conditions that were not accepted by ACS and GEO.

Those differences between the parties were the subject of two separate questions which fell for determination by the Federal Court, namely:

- whether AIGA was liable under the policy to pay or bear the whole of the defence costs relating to the defence of the cross claim or only a proportion of those defence costs relating to allegations that were capable of falling for cover under the policy;
- whether the deductible of $200,000 applied to those defence costs.

The matter proceeded to hearing before Chief Justice Allsop. His Honour noted the primary liability in the insuring clause to indemnify for all amounts which the insured shall become legally liable to pay was to be interpreted as indemnity for legal liability ascertained by judgment, award or settlement.

Allsop CJ observed in policies of this character the nature of that primary liability can give rise to practical difficulties for insureds given that the legal liability of the insurer is not engaged until there is an event of liability by judgment, award or settlement. An insured may be left to fund a defence or to settle the case without the involvement of the insurer.

His Honour noted these types of policies deal with this difficulty and related problems differently. Some

solutions are more favourable to the insured and some are more favourable to the insurer.

In this case Chief Justice Allsop noted the solution to the problem was to require the insurer, in this case AIGA, to undertake the defence of the lawsuit in which the relevant claims were made against ACS and GEO.

The relevant wording in this regard was as follows:

"With respect to the indemnity afforded by this policy [AIGA] will:

(a) defend in their name and on their behalf any suit against the Insured alleging such Personal Injury ... and seeking damages on account thereof, even if such suit is groundless, false or fraudulent; and [AIGA] may make such investigation, negotiation, and settlement of any claim or suit as it deems expedient; but [AIGA] shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of [AIGA's] liability has been exhausted by payment of judgments or settlements;

(b) pay all expenses incurred by [AIGA], all costs taxed against the Insured in any such suit and all interest accruing after entry of judgment until [AIGA] has paid, tendered or deposited in Court such part of such judgment as does not exceed the limit of [AIGA's] liability thereof ..."

A further policy provision capped AIGA's liability for the costs of defending any lawsuit against the insured at 50% of the limit of liability stated in the policy schedule (in this case, 50% of $5 million).

Further, the policy contained a deductible of $200,000 which was described in the policy exclusions to be in the following terms:

"The Insured shall bear the first $200,000 of each and every claim inclusive of costs associated with settlement of such claims."

AIGA argued that whilst it was liable to undertake the defence of the suit in the names of ACS and GEO, it did not accept it was liable for all of those costs. The insurer asserted some occurrences and some injuries fell outside and after the policy period and some fell within the policy exclusions. However it also accepted that some occurrences and injuries fell within the policy period.

AIGA therefore contended there should be some allocation of the costs of defending the cross claim between insurer and insured.

Further, AIGA contended the $200,000 deductible should be applied towards those defence costs even in circumstances where the insureds (ACS and GEO) were successful on the cross claim.

In respect of the first issue Chief Justice Allsop rejected the arguments of AIGA. His Honour observed:

"It is a not unusual feature of liability litigation that claims against the insured in a suit may contain claims that are covered and claims that are not covered by relevant liability policy. One response to the difficulties that can arise from such circumstances can be to place the contractual responsibility on the insurer to defend the suit and pay all expenses of that defence of the whole suit. That is what occurred here. In such a clause, the duty to defend is broader and differently expressed to the obligation to indemnify."

Further, Allsop CJ stated:

"The duty to defend arises and attaches until there is no basis for considering that the cover responds to any claim. The duty to defend is the provision of a service, not the granting of indemnification of third party liability. For that reason it is not necessarily logically connected with, or limited by, the structure of the indemnity for liability. It is controlled by the words of the contractual responsibility to defend."

His Honour concluded there was no justification to read into the operation of the duty to defend and cover available to the insured for costs of defending the lawsuit a limitation of apportionment of those costs. The protection afforded by the provision was to protect against the cost of litigation. Therefore His Honour found that any suit in which a claim covered by the indemnity coverage clause can be found triggered a liability to defend and pay all expenses incurred by AIGA in the defence of the whole of that claim, with a 50% liability for indemnity in respect of those costs.

AIGA was held liable for the whole of the costs of the defence, being all expenses incurred by AIGA in defence of the lawsuit with no apportionment to be made between insurer and insured.

In respect of the second issue, His Honour referred to legal authority which established the usual meaning of phrases such as "costs included" or "inclusive of all costs incurred" is a reference only to the costs of the claimant against the insured (including any costs ordered to be paid to the claimant) and do not include expenses incurred in the defence of a claim by the claimant against the insured.

Here, the payments to defend the lawsuit were described as "expenses incurred by AIGA". Chief Justice Allsop noted the words and structure of the policy appeared to keep broadly distinct the liability on the one hand, including liability for any costs payable to a third party, and the expense of funding the defence of the lawsuit.

Accordingly, the deductible did not apply towards the costs of defending the lawsuit and that AIGA was liable to bear the first $200,000 of any such cost.

This interesting decision highlights that an insurer's duty to defend an insured under a liability policy is triggered as soon as any claim against the insured contains allegations which may fall for cover under the

policy. That duty is separate and distinct from the liability to indemnify the insured against any liability to pay compensation to third parties including those third parties' costs.

Each policy wording will be interpreted on its own facts but in this case, the wording did not permit the insurer to seek apportionment from the insured towards defence costs nor did the insurer succeed in applying a large deductible towards those defence costs.

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TPD Claims: the insurer's duty to act reasonably and fairly

In previous editions of GD News we reviewed several court decisions regarding a life insurer's duties with respect to claims for total and permanent disablement ("TPD") when the claim requires the insurer to be satisfied as to the extent of the claimant's incapacity and whether such incapacity falls for TPD cover under the policy.

One of those duties requires the insurer to act reasonably and fairly both in its consideration of the material concerning the claimant's alleged incapacity and in determining whether it was so satisfied.

This has often been described as a "two-stage" approach.

Two recent decisions of the NSW Supreme Court, handed down two weeks apart in the lead up to Christmas, concerned separate and unrelated proceedings brought by former NSW police officers who claimed TPD benefits under the First State Superannuation scheme.

FSS Trustee Corporation ("FSS") as trustee had obtained a group life policy from MetLife Insurance Ltd ("MetLife") for the benefit of its members under the scheme.

MetLife rejected both claims.

The claimants brought proceedings against FSS and MetLife.

FSS took no part in either proceeding.

Both claims involved a consideration of whether MetLife breached its duty to act reasonably and fairly in its treatment of the material before it.

One claimant succeeded. The other claimant failed.

In *MetLife v Hellessey* the NSW Court of Appeal unanimously dismissed the insurer's appeal from a decision of his Honour Justice Robb who found in favour of Hellessey at first instance.

Bernadette Hellessey had been employed as a NSW Police officer for nine years when she ceased work in August 2010.

She allegedly suffered from PTSD and major depressive disorder resulting from her exposure to numerous traumatic incidents at work.

Several letters and supporting materials including statements and medical reports were provided on her behalf to MetLife which the insurer considered. MetLife also obtained its own medical and vocational reports.

Ultimately, MetLife rejected the claim.

A pivotal finding by Robb J at first instance was that MetLife's consideration of the lay written evidentiary material before it was not reasonable or proper because it involved ignoring or not engaging with a substantial body of consistent evidence which provided corroboration for the opinions reached by Hellessey's treating doctors in support of her claim.

According to the primary judge, MetLife did not act reasonably or fairly by rejecting the TPD claim based on medical opinions of doctors who disputed the opinions of Hellessey's treating doctors.

The insurer had obtained information from social media pages which showed Hellessey's association with a regional pony club including her attendance at various horse or pony club events. MetLife's independent medical experts reviewed this material and expressed in their reports that Hellessey's participation in these activities demonstrated she was not suffering from PTSD and was not unable to return to work.

MetLife invited Hellessey to respond to these matters.

Statements by Hellessey and other witnesses addressing these issues were provided to the insurer as well as further medical reports in which Hellessey's treating doctors maintained their earlier opinion she was suffering from PTSD at the relevant time (her pony club activities notwithstanding) and, her participation in those activities, moreover, were not inconsistent with a PTSD diagnosis.

The lay witness material provided a consistent explanation for Hellessey's participation in these activities which was evidently disregarded by MetLife.

Meagher JA (with whom McColl & White JJA agreed) rejected all of MetLife's appeal grounds and upheld the primary judge's reasoning.

Justice Meagher held that MetLife could have given *bona fide* consideration to the lay witness material and that, acting reasonably and fairly in doing so, it might have concluded that the evidence should be given little weight. However, MetLife had failed to do so which constituted a breach of its duty.

White JA also observed:

"An opinion that would not be open to an insurer acting reasonably and fairly will not be binding on the claimant. It is not a corollary of that principle that the insurer's opinion will be binding on the claimant if it is one that would be open to an insurer acting reasonably and fairly, if the insurer in question did not act reasonably and fairly in reaching its opinion.

There is a distinction between the formation of a reasonable opinion and acting reasonably in the formation of an opinion. The primary judge addressed the latter. The primary judge was not in error in doing so, nor in his evaluation that MetLife did not act reasonably in forming its opinion."

Hellessey was therefore entitled to succeed on her claim for TPD benefits.

In *Sargeant v FSS,* handed down nine days after *Hellessey*, his Honour Justice Parker of the NSW Supreme Court dismissed Sargeant's claim for TPD benefits under the policy, finding that MetLife had not breached its duty of reasonableness and fairness in rejecting the claim.

Bronwyn Sargeant had been employed as a NSW Police officer for eight years when she ceased work in February 2010. In November 2009 she sustained a lower back injury at work. A CT scan evidently showed disc bulging but a neurosurgeon reported that an MRI scan was absolutely clear.

Some doctors then diagnosed piriformis syndrome. Other doctors disputed this diagnosis and considered Sargeant was exaggerating her symptoms.

Subsequent medical evidence confirmed the diagnosis of piriformis syndrome and the onset of depression associated with her physical pain.

However, medical evidence obtained by MetLife questioned her motivation for the claim and that the prospect of financial gain may have been perpetuating her status.

Further, MetLife obtained surveillance which depicted Sargeant's attendance at an iron man or paddling training event with her husband and son. In response to MetLife's questions on this issue, Sargeant stated her children were heavily involved in surf lifesaving and she attended events so as not to let her injury interfere with her children's lives. She claimed to be heavily medicated while doing so.

Sargeant initially brought proceedings at the Industrial Court that were transferred to the Supreme Court in 2015. At this time, MetLife was yet to make a determination of the TPD Claim.

Throughout the proceedings, further material was requested by and provided to MetLife.

MetLife also relied upon documents produced under subpoena in the proceedings before its decision to reject the claim in May 2018, three weeks before the Supreme Court hearing was listed to commence.

The hearing before Parker J proceeded over five days and culminated in an agreed set of questions for his Honour to consider as separate issues before any other issue in the proceeding.

The principle questions concerned whether MetLife's failure to make a decision by September 2015 or alternatively September 2016 was a breach of the insurer's obligation to act reasonably and fairly in dealing with the claim.

Sargeant contended this delay by the insurer was sufficient to establish a breach of the insurer's duty.

The Statement of Claim alleged in substance that MetLife, rather than accepting the claim, sought out contrary material and conducted further investigations in the hope of being able to find a way to refuse it.

Justice Parker disagreed. His Honour noted that Sargeant's lawyers had on several occasions contributed to the delay in providing material requested by MetLife.

Further, those lawyers repeatedly served further medical reports throughout the course of the proceedings. At no time did Sargeant's lawyers ask MetLife to ignore those reports and decide the claim based on the material it already had.

His Honour held that MetLife, in these circumstances, was entitled to proceed on the basis that the ongoing provision of further material on Sargeant's behalf was to be taken into account by the insurer when considering the claim. Further, that MetLife was entitled to test this material by obtaining its own independent medical expert evidence.

Parker J observed:

"It seems to that, in effect, by 2016, MetLife had adopted the approach that Ms Sargeant's claim should be evaluated by reference to the whole of the evidence and the other material which was to come forward in the proceedings. This was never explicitly stated by MetLife or agreed on behalf of Ms Sargeant. But there was no protest about it from her side either.

The fact is that at no stage prior to 3 September 2016 did [the lawyer], on behalf of Ms Sargeant, seek to make 'time of the essence'…It must be borne in mind that the insurer's duty is one of good faith and fair dealing. Such a duty is not breached merely because of inefficiency or mistake in handling the claim. And I do not think it was unreasonable for MetLife to fail to make a formal determination of the claim while the proceedings were continuing and there was no request for it do to so."

His Honour therefore dismissed Sargeant's claim.

These interesting decisions illustrate how a consideration of the nature and content of an insurer's duty to act reasonably and fairly regarding TPD Claims can produce different results.

The difference is that the insurer, in the second case, was held to be acting reasonably and fairly by considering all of the available material presented to it including material produced in the litigation concerning the claim.

Whereas the insurer, in the first case, did not give regard to a large body of material which supported the basis for the claim.

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CONSTRUCTION ROUNDUP

Extension of time for compliance with statutory demand

In our last newsletter we discussed the case of *Grandview Ausbuilder Pty Limited v. Budget Demolitions Pty Limited* [2018] NSWSC 1647, in which a building contractor sought to set aside a statutory demand for approximately $1 million that had been issued by a subcontractor to enforce two payment claims served under the *Building and Construction Industry Security of Payment Act 1999* (**SOP Act**). In applying to set aside the statutory demand, Grandview contended that it had three offsetting claims that together were greater than the amount demanded.

Parker J had rejected two of those offsetting claims, but had considered that Grandview had a potentially viable claim for liquidated damages in the amount of $220,000. However, since at the time of the hearing of the application before Parker J Grandview had not yet commenced substantive proceedings to recover these liquidated damages, his Honour had held that Grandview should be entitled to a reduction in the amount of the statutory demand only if Grandview provided a formal undertaking that it would commence proceedings as quickly as possible, and further if it paid into court the amount of $220,000 pending the outcome of those proceedings.

However, Grandview was not prepared to provide such an undertaking. Instead, it filed an application seeking leave to appeal from Parker J's decision to the NSW Court of Appeal. It also filed an application for an extension of the time for compliance with the statutory demand until after the appeal had been heard and decided.

In deciding Grandview's application for an extension of time, Beazley P noted that in *Creata (Aust) Pty Limited v. Gary Adrian Faull* [2017] NSWCA 230 White JA had set out the well-established principles to be applied by the court when determining such an application. These principles are:

- First, the general question of the prospects of success in the appeal and whether an arguable case has been shown;
- Second, whether the appeal will be rendered nugatory unless the extension is granted; and
- Third, as to the prejudice the respective parties will suffer in the alternative eventualities.

Grandview argued that Parker J had erred in deciding that a claim that had arisen after the application to set aside the statutory demand had been filed was not to be considered by the court. Grandview submitted that its offsetting claim for additional milestone damages had been foreshadowed in the evidence supporting Grandview's application, even if it had not been fully quantified at that time.

Grandview stated that numerous authorities (including *re Douglas Aerospace Pty Limited* (2015) 294 FLR 186 and *Diploma Construction (WA) Pty Limited v. KPA Architects Pty Limited* [2014] WASCA 91) supported its argument that it is sufficient for an offsetting claim to be in existence as at the date of the hearing to set aside the statutory demand, rather than the date when the statutory demand is served or when the application to set it aside is filed.

Beazley P agreed with Grandview on this point. Her Honour held that based on these numerous authorities, it was sufficient that an offsetting claim be in existence as at the date of the hearing to set aside the statutory demand.

Her Honour also agreed with Grandview that there was no doubt that if an extension of time to comply with the demand was not granted, the application seeking leave to appeal and any substantive appeal would be rendered nugatory.

However, Beazley P expressed concern at the delay by Grandview in instituting substantive proceedings to recover the amount of its offsetting claims, noting that those proceedings had only now been commenced. Her Honour stated that if Grandview had not commenced those proceedings, she would have dismissed the application for an extension of time. Whist that would have resulted in some prejudice to Grandview, there would have been significant prejudice to Budget who would have been kept out of its admitted entitlement to the two progress claims for over 12 months.

Also, Beazley P took into account the fact that the Court of Appeal had been able to allocate an early hearing date for the hearing of Grandview's application for leave to appeal, as well as the substantive appeal (which would be heard concurrently).

Accordingly, Beazley P ordered that the time for compliance with the statutory demand was extended to seven days after the Court of Appeal has delivered its decision on the appeal.

As discussed in our last newsletter, it is worth noting that Budget's strategy of serving a statutory demand to recover the amount of its payment claims served under the SOP Act was unusual – particularly given that the SOP Act entitles the claimant to recover the unpaid amount of its progress claims in court and the respondent to those claims is not permitted to raise any defence or to claim any right of set off.

By instead relying on the insolvency regime in the Corporations Act, Budget has (probably unwittingly) handed Grandview the opportunity to ventilate its own claims and (at least in the meantime) to avoid paying the amount of Budget's payment claims – which is utterly inconsistent with the policy behind the SOP Act and the processes of that Act.

Grandview's application for leave to appeal and the substantive appeal are listed to be heard concurrently on 4 March 2019. We will report on the outcome of that appeal.

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Report on recommended reforms to Western Australia's security of payment legislation

The Western Australian Government has released the report of Mr John Fiocco recommending several reforms to legislation in that State relating to the conduct of the construction industry and its security of payment regime.

The report was commissioned following issues arising on various public works projects, including the Perth Children's Hospital, Elizabeth Quay and the Optus Stadium projects, and the collapse of builders Diploma Group, Builton Corp Pty Limited and the CPD Group.

The poor outcomes from these and other construction projects has led to an examination by all Australian State governments of how insolvencies in the construction industry impact on the general economy of the country and of each State. Last year in Western Australia alone, the construction industry accounted for $20.3 billion in activity and the direct employment of around 140,000 people.

Mr Fiocco was thus appointed to inquire into and report on whether the *Building Services (Registration) Act 2011* (WA) (BSR Act) and/or the *Construction Contracts Act 2004* (WA) (CC Act) should be amended or replaced in order to enhance the disciplinary measures to be applied to builders and developers and to provide fairer contracting practices in the construction industry.

Mr Fiocco's appointment followed the McGowan Government's announcement that project bank accounts for government projects would be expanded starting in July 2019, and that a Subcontractor Support Unit led by the Small Business Commissioner would be established.

Mr Fiocco is a senior member of the Western Australian bar, and during his 40 years in practice as a barrister he has spent many years practising and teaching in the areas of bankruptcy, insolvency, commercial law and contract law.

In his report, Mr Fiocco recommends several measures designed to better protect and support small businesses in the construction industry.

These recommendations include the following:

- The amendment of the BSR Act to provide that any builder that fails to pay an undisputed judgment debt (or an amount determined by an adjudicator under the security of payment legislation to be due to a claimant) may be subject to demerit points. If the builder accumulates 3 demerit points within a 3 year period, then the builder's registration may be suspended or cancelled, and/or a fine may be imposed. It is also recommended that builders be obliged to self-report their failures in this regard, at the risk of attracting a fine of $5,000.
- The implementation of stronger protection of the security provided by contractors and subcontractors. The report recommends that it should be mandatory that all security be returned no later than 12 months after practical completion of the work under the contract, and such provision would override any term in the contract.
- The introduction of new legislation to require 10 business days' notice to be provided before a principal of a construction contract is entitled to have recourse to security.
- The amendment of the BSR Act to implement various requirements with respect to the form of construction contracts and in order to make the contracts used for the same project as consistent as possible.
- The introduction of new security of payment legislation to replace the CC Act, largely adopting the east coast model of security of payment legislation and implementing many of the recommendations of Mr John Murray in his recent report to the Federal Government on reform to security of payment laws throughout the country.
- The introduction of a retention trust scheme whereby any party that holds retention moneys pursuant to the terms of a construction contract is deemed to hold the money on trust for itself and for the person from whom the retention moneys are withheld, irrespective of the contract value.
- The introduction of a deemed trust scheme, whereby any payment received by a party under a construction contract is deemed to be held on trust for the benefit of any party who performed

the work. This scheme would apply to contracts entered into with respect to projects with a value of over $1 million.

The recommendations in Mr Fiocco's report are being considered by the Western Australian Government and it is anticipated that they will announce in 2019 the extent to which they propose to implement those recommendations.

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EMPLOYMENT ROUNDUP

Employer's Right to Direct Employee to Attend a Medical Examination

The Fair Work Commission recently confirmed where there was a general duty of care owed by an employer to its employees and/or the public - it grounded the right of an employer to require an employee to undertake an independent medical examination to determine an employee's fitness for duty. The employer must hold a reasonable belief there may be some risk to the employee, other employees or the public if the employee should undertake his or her duties at work without such an examination.

In *Fitzsimmons v Alice Springs Town Council*, Commissioner Bissett of the Fair Work Commission in October 2018 considered a dispute notified to the FWC by the employee regarding the non payment of wages to the employee for a five day period during which an employee failed to attend a medical examination as directed by the employer.

Section 739 of the *Fair Work Act 2009* provides the Fair Work Commission can deal with a dispute where a modern award, enterprise agreement or contract for employment provides for the Fair Work Commission to deal with the dispute.

The employee applied for annual leave over the 2017/2018 Christmas/New Year period. The employer rejected the application for leave on operational grounds as other staff had approved leave before the employee's application. After his request for annual leave was rejected, the employee went on a period of paid and unpaid sick leave from mid November 2018 until mid January 2018.

In early January, whilst on sick leave, the employer required the employee to attend their nominated doctor to certify the employee was fit to return to work.

The employee advised the employer he had a medical certificate form his own doctor certifying him fit to return to work on 12 January. The employee initially refused to attend the employer's nominated doctor – on the basis he believed he could not be forced to see the employer's nominated doctor and the fact he also had a medical certificate certifying him fit for work from his own doctor.

The employee eventually attended the employer's nominated doctor on 18 January. The employer's nominated doctor certified the employee was fit to return to work on 18 January 2018. As such, the employee sought payment for the period 12 to 18 January 2018.

The requirement for the employee to be examined by the employer's nominated doctor was so the employer could determine whether the employee was fit to return to his duties.

Commissioner Bissett was satisfied there was a general duty of care owed by an employer to all its employees and as such that grounded a right to request an employee to undertake an independent medical examination to determine fitness for duty if the employer held a reasonable belief there may be some risk to the employee, other employees or the public if the employee should return to work without such an examination.

The Commissioner accepted the employer held a reasonable belief there may be some risk to the employee, other employees or the public if the employee returned to work without a clearance from the employee's appointed doctor.

Consequently the request from the employer for the employee to attend the independent medical examination was lawful and reasonable.

Whilst the Commissioner noted it would not have been unreasonable for the employer to accept the medical certificate of the employee's own doctor dated 12 January, it did not absolve the employee of his conduct of refusing to attend a medical appointment arranged for the employee on 15 January.

Consequently the employee's failure to comply with a lawful and reasonable direction resulted in the employee not attending work from 12 to 18 January 2018.

The Commission determined there was no basis the employee should have been paid for the five days from 12 to 18 January 2018.

The Commissioner noted in deciding whether a direction is reasonable and lawful will depend on the particular circumstances of the matter.

However where an employee ignores a direction that is reasonable and lawful it may have dire consequences for the employee including termination for misconduct.

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Terminated because of a disability – Pecuniary penalty and backpay?

Employees who, for one reason or another, are absent from work for extended periods can generate difficult decisions for employers. Where the absence is a result of ill-health, moving to terminate the employment can lead to costly traps.

In a recent case in the Federal Court of Australia - *Robinson v Western Union Business Solutions (Australia) Pty Ltd [2018] FCA 1913* - the issue was whether the termination of an employee after 7 months' absence due to a medical condition constituted the taking of "adverse action". The Court found that it did, and awarded the employee compensation and imposed a significant penalty on the employer.

How did this come about?

The employee commenced employment in February 2013 as a "Client Executive".

In 2015, he made a complaint about his manager and a mediation took place, resulting in "good progress". Later in 2015, a separate dispute arose concerning entitlement to a commission payment.

In September 2016, the employee went on sick leave alleging a mental disability. A series of medical certificates was submitted to the employer – citing reasons for unfitness up until February 2017 such as:

"suffering from a medical condition"

"very significant work related stress and depression"

"significant work related stress"

"a major deressive [sic] disorder associated with significant anxiety"

At the same time, the worker commenced a claim for workers compensation, which was ultimately declined. In the course of that claim, separate certificates were provided attesting to "no current capacity for any employment" up until May 2017.

Understandably, the employer wanted to gain some idea of whether – and when – the worker was likely to return to work. It asked for more information from the employee a number of times, and attempted to schedule appointments with independent medical experts. These requests proved fruitless – the employer was not able to obtain independent medical assessment.

In May 2017, the employee was dismissed. His termination letter stated:

I refer to your last email from 18 April 2017, with attached medical and Workcover certificates indicating that you are not fit to return to work.

You have not attended work for a period of 7 months, with 3 of these months constituting unpaid leave. In that time, you have refused multiple, reasonable attempts by Western Union Business Solutions (Australia) (the Company) to attend an independent assessment by Dr Istvan Schreiner, the company's nominated practitioner.

Given that you cannot give any indication as to when you will return to work, your unreasonable failure to cooperate with the Company's attempts to obtain up-to-date, specialist medical advice and in light of the Company's serious concerns about your capacity to return to work, the company has decided to terminate your employment. This termination will take effect on 8 May, and you will be paid two months' pay in lieu of notice plus accrued but untaken leave entitlements.

The employee then filed an application under the *Fair Work Act 2009* (Cth) (***the Act***) claiming, amongst other things, that his employer had contravened s 351 of the Act in taking adverse action against him <u>because of his physical or mental disability</u>.

Section 351 of the Act provides as follows:

Discrimination

(1) An employer must not take adverse action against a person who is an employee … of the employer because of the person's … physical or mental disability …

(2) However, subsection (1) does not apply to action that is:

…

(b) taken because of the inherent requirements of the particular position concerned; or …

Action "because of"

The requirement that action be taken "because" of a person's disability directs attention to the subjective reason or reasons as to why the action was taken.

Often this will involve direct evidence of the relevant decision maker.

The impact of section 361 of the Act is to deem that action has been taken because of a prohibited reason, unless proven otherwise. So, the onus is always on the action taker to disprove that assumption.

Also, a reason can still be a prohibited reason even if it was not the sole reason for the action. In other words, if the action was taken partly because of a disability it will fall foul of the section.

Disability

The Court confirmed that the term "disability" employed in s 351(1) includes the "manifestations" of that disability. One must look to the ordinary meaning of the word. In its ordinary meaning "disability" denotes both the condition and its manifestations - that is, the label of the condition, and how the condition affects the person.

Inherent Requirements of the position

The burden is on the employer to prove that adverse

action was taken because of the inherent requirements of "the particular position concerned".

It is first necessary to identify "the particular position concerned", and then to determine whether the decision was made because of the inherent requirements of that position.

The High Court has held that whether something is an "inherent requirement" of a particular employment depends on whether it was an "essential element" of the particular employment. However, the inherent requirements of employment embrace much more than the physical ability to carry out the physical tasks encompassed by the particular employment. Thus, implied in every contract of employment are obligations of fidelity and good faith on the part of the employee with the result that an employee breaches those requirements or obligations when he or she discloses confidential information or reveals secret processes. Furthermore, it is an implied warranty of every contract of employment that the employee possesses and will exercise reasonable care and skill in carrying out the employment. These obligations and warranties are inherent requirements of every employment. If for any reason – mental, physical or emotional – the employee is unable to carry them out, an otherwise unlawful adverse action may be protected by the provisions of the Act.

Similarly, carrying out the employment without endangering the safety of other employees is an inherent requirement of any employment.

It would be artificial to draw a distinction between a physical capability to perform a task and the safety factors relevant to that task in determining the inherent requirements of any particular employment. That is because employment is not a mere physical activity in which the employee participates as an automaton. It takes place in a social, legal and economic context. It is therefore always permissible to have regard to this context when determining the inherent requirements of a particular employment.

Was section s351 breached?

There was no issue that the employer had taken action adverse to the employee. Termination of employment will always be adverse action.

As to the reason(s) for dismissal, the Court held that the termination letter, and the employer's evidence, established there were 2 operative reasons:

- the "unreasonable failure to cooperate with the Company's attempts to obtain up-to-date, specialist medical advice"; and
- "concerns" as to the employee's "capacity to return to work".

The Court was of the view that the taking of the adverse action was "*because of*" his mental disability. That conclusion as to the reason for his dismissal was reached because no distinction could be drawn between the employees "*capacity*" to return to work and his mental disability.

On the particular facts of this case, the Court was of the opinion that any lack of "*capacity*" of to return to work was but a "*manifestation*" of the claimed mental disability and a "*manifestation*" that could not be "*severed*" from that disability.

Also, the Court held that the decision to terminate was not taken because of the inherent requirements of the position of the employee. This was not on the basis that the disability did not mean that the position could not be performed, but rather because the employer had only expressed "concerns" as to whether the employee could carry out his role. It had not obtained definitive evidence nor reached a conclusion as to the ability to perform the essential tasks and duties of the role.

The employer therefore had taken the adverse action for a prohibited reason – because of disability – and not because of the inherent requirements of the position. Its 'suspicions' as to capacity were not enough to get the benefit of the inherent requirements exemption.

The Court accordingly awarded the employee compensation assessed in an amount of $140,000. It also penalized the employer for its breach of the Act in the amount of $20,000.

A very costly exercise for the employer and alarming for those involved in making such decisions. The take away is that termination of a worker with some 'disability' is fraught with traps, and will always require reasoned, dispassionate thinking and the benefit of sound advice.

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WORKERS COMPENSATION ROUNDUP

NSW Workers Compensation Changes Update

In our November edition of GD News we discussed the Workers Compensation Legislation Amendment Act 2018 which was passed by Parliament on 26 October 2018 with some changes coming into effect on the passing of the legislation and other provisions being deferred until the promulgation of Regulations. The 2018 Act introduces amendments to dispute resolution processes and assessments for permanent impairment and pre-injury average weekly earnings.

On 1 January 2019 the Workers Compensation Amendment Regulation 2018 commenced and the amendments to dispute resolution processes and assessments for permanent impairment have now

commenced.

The Workers Compensation Commission will now determine disputes about Work Capacity Decisions if the decision as to work capacity was made on or after 1 January 2019. Such disputes can also be referred for expedited assessment. An injured worker has the option to ask for a review of the Work Capacity Decision by the insurer (by a different person to the person who made the original decision) or to commence proceedings in the Workers Compensation Commission.

The Workers Compensation Commission now also has jurisdiction to determine claims for permanent impairment without those claims being referred to an Approved Medical Specialist. If it is appropriate a dispute as to permanent impairment will be referred to a teleconference before an Arbitrator without referral to an Approved Medical Specialist.

In addition, the Regulations set out detailed requirements for the content of dispute notices in statutory and work injury damages claims generally requiring more detail and identification of all evidence considered in the decision making process.

The amending provisions in relation to calculation of Pre Injury Average Weekly Earnings ("PIAWE") are yet to commence.

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Deemed Dates of Injury in Disease Claims

The determination of the deemed date of injury in disease injury claims has become exceedingly important in determining a worker's entitlement to lump sum compensation as a consequence of the various thresholds that have been included in the workers compensation legislation since the 2012 amendments.

This issue has been the subject of discussion in a number of Presidential determinations recently arising out of the interpretation and application of the deemed date for Section 4 (b) injuries under Sections 16 and 17 of the legislation.

In *Westpac Banking Corporation v Hungerford* [2018] NSWWCCPD 50, the worker was employed as a bank teller from March 1988. In February 2009 the worker notified her employer of an injury to her right thumb, hand and wrist which she attributed to the nature of her employment duties. Liability for the claim was accepted and the worker received payments of weekly compensation. After undergoing surgery to her right wrist in July 2010 the worker ultimately returned to suitable duties in September 2010 before ceasing employment entirely in November 2011 after she was certified totally unfit for work.

In July 2017 the worker's solicitors notified a claim pursuant to Section 66 for permanent impairment compensation of the right upper extremity (thumb, hand, wrist, elbow and shoulder) and the left upper extremity (thumb, hand, wrist, elbow and shoulder).

The insurer ultimately accepted liability for injury to the right thumb, hand and wrist and made an offer for 20% whole person impairment. Liability was disputed in relation to the right elbow, right shoulder, left hand, left wrist, left elbow and left shoulder.

In proceedings before the Workers Compensation Commission an arbitrator found the worker's injury to the right hand and wrist consisted in the aggravation of an arthritic disease condition falling within Section 4(b)(ii) of the 1987 Act. The arbitrator also found the worker suffered a consequential condition to her left hand and wrist as a result of overcompensation for her injured right hand and wrist. The arbitrator was not satisfied the worker suffered consequential conditions in any other disputed body parts.

The dispute in relation to the degree of whole person impairment of left and right upper extremities (hands and wrists) was remitted to the Registrar for referral to an approved medical specialist ("AMS") with a deemed date of injury of 4 July 2017. The arbitrator rejected the employer's submission there should be different dates of injury for the left and right limb injuries. He found that as the condition of the left limb was consequential upon injuries to the right limb only one date of injury applied and that was the date on which the claim was made.

The employer lodged an appeal on the basis there was an error on the arbitrator's part in concluding the deemed date of injury should be taken as the date of the claim for permanent impairment compensation rather than the date of incapacity.

On appeal the then President Judge Keating was of the view the appeal was misconceived, stating the authorities supported the finding the deemed date of injury was determined by reference to the type of compensation claimed. As the arbitrator found the injury to the right hand and wrist was an aggravation of a disease injury under Section 4(b)(ii), Section 16 applied to determine when the injury was deemed to have happened. The authorities establish that in claims for weekly compensation the injury shall be deemed to have happened at the time of the worker's death or incapacity (Section 16(1)(a)(ii)). The authorities have held Section 16(1) can fix different dates of injury for incapacity and impairment injuries and in the latter case the relevant date is the date of the claim.

In relation to the factual situation under determination Judge Keating commented the authorities establish if the claim is for lump sum compensation any earlier claim for weekly compensation is irrelevant. He further stated it was immaterial the symptoms and pathologies resulting in the claim for continuing incapacity were

indistinguishable from the symptoms and pathologies for which the claim for permanent impairment compensation was founded. Impairments resulting from the same injury are to be assessed together where the impairment is consistent and accepted as a consequential injury arising from that accepted injury.

The decision has confirmed that in disease injuries to which Sections 15 and 16 apply, the relevant date of injury in relation to claims for compensation for whole person impairment is deemed to be the date on which the claim for compensation is made, irrespective of any earlier dates that may have been deemed in respect of entitlement to weekly compensation arising from incapacity resulting from the injury.

In relation to industrial deafness claims under Section 17 two arbitral decisions dealing with the deemed date of injury, *Hay v Commonwealth Steel Company Pty Limited* [2018] NSWWCCPD 30 and *Penrith Rugby League Club Limited v Van Poppel* [2018] NSWWCCPD 55, discussed the relevant deemed date of injury for the purposes of Section 17(1) of the 1987 Act.

In *Hay* the worker was employed from 1988 to March 1993 in noisy employment with Commonwealth Steel. He was also in deemed employment with the NSW Rural Fire Service as a volunteer firefighter from 1989 to late 1997. This deemed employment was noisy up to early 1992 but not thereafter. Both employments were noisy at times. The last employment was with NSW Rural Fire Service whereas the last exposure to "noisy" employment was with Commonwealth Steel in 1993. At issue was the last employment to the nature of which the injury was due for the purposes of Section 17(1) of the 1987 Act.

In *Hay* Deputy President Wood found the Rural Fire Service was clearly an employer who employed the worker "in an employment to the nature of which the injury was due" and he remained in the employ of the Rural Fire Service beyond his employment with Commonwealth Steel. As the authorities indicate that for the purposes of Section 17 it is not necessary or correct to identify a precise time when the injury occurred or to isolate certain duties performed during the whole period of employment with a noisy employer, the Deputy President concluded the arbitrator was correct to find the Rural Fire Service was the last "noisy" employer for the purposes of Section 17(1)(a)(ii).

In the subsequent decision of *Van Poppel*, the worker was employed by the Club from 1977 to 1982 as a bar attendant during which time she was exposed to loud disco music throughout three, nine hour shifts per week. Thereafter she continued her employment in a clerical capacity with no exposure to loud noise. The worker was assessed to have 7% whole person impairment due to industrial deafness. A dispute arose as to the appropriate deemed date of injury between the insurer on risk as at 1982 when the worker's employment was last noisy and the insurer as at the date of notice in 2016.

At first instance the arbitrator concluded the appropriate deemed date of injury was in 1982. The insurer on risk in 1982 challenged the finding asserting the deemed date of injury should be the date in 2016 when notice of the claim was given.

Acting President Michael Snell considered the "elements of artificiality" in Section 17(1) of the Act referred to in the decision of *Lobley* which make the task of the worker easier in ascertaining the employer to be sued and in proving the claim and the assignment of the responsible employer clearer. Following consideration of a number of authorities, including *Hay*, the Acting President noted it was common ground the Club employed the worker in "noisy" employment to the nature of which the injury was due. The Club to which she gave notice of injury in December 2016 whilst she remained in its employ was an employer who employed the worker in "noisy" employment. This was sufficient to engage the application of Section 17(1)(a)(i) and thus the deemed date of injury was the date when notice of injury was given in December 2016. Therefore the clear words of Section 17(1)(a)(i) were satisfied.

The Acting President observed the question posed by Section 17(1)(a)(i) is whether at the time notice was given the worker was "employed in an employment to the nature of which the injury was due". This focuses on both whether the employment was of the nature to which the injury was due, and whether the worker was employed in that employment at the time the notice was given.

Section 17 deems the injury suffered to have happened at a particular time for the purposes of the Act and the time the injury actually happened is irrelevant. There is no requirement the relevant employment need continue to be noisy as at the date when the notice of injury was given.

In the circumstances where the deemed date of injury was the date of notice in December 2016, the claim for lump sum compensation pursuant to Section 66 was not available as the assessment of impairment was not greater than 10% and thus the threshold in Section 66(1) was not met.

Thus in industrial deafness claims the date of claim for lump sum compensation is relevant for the purpose of determining the deemed date of injury. If at the time of making the claim the worker remains in the employ of an employer to the nature of which the injury is due, that employer will be found liable to compensate the worker irrespective of whether the noisy employment has continued at the date the claim is made. The threshold to be applied to the claim is that relevant as at the deemed date of injury, not when the noisy employment ceased.

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Section 323 - Deductions for Previous Injuries and Work Injury Damages

In our June 2018 Newsletter we looked at the rights of workers who suffer from a combination of injuries over time and the difficulty in determining the whole person impairment caused by a particular injury.

The recent decision of the Court of Appeal in *Vannini v Worldwide Demolitions Pty Limited*, demonstrates that when assessing impairments prior injuries must be taken into account and injuries caused by prior incidents may result in a reduced impairment assessment with the result that a worker will not be able to reach the impairment threshold to bring a work injury damages claim.

Vannini was employed in heavy labouring work in 2008, developing a gradual onset of back pain. His condition deteriorated to the point he underwent surgery on 4 August 2008 although no workers compensation claim was made in respect of that injury and operation.

The injured worker subsequently resumed work with Effective Demolitions and when they would not make allowances for his condition he ceased working with them. In early 2009 he commenced employment with Worldwide Demolitions Pty Limited and suffered a further injury to his lower back and leg on 6 March 2009, subsequently lodging a lump sum compensation claim in relation to that injury.

The injured worker pursued his rights under Section 66 of the 1987 Act for his 2009 injury and lodged proceedings in the Workers Compensation Commission for lump sum compensation. He was assessed by Dr Rosenthal, approved medical specialist, as having a 22% whole person impairment with no finding that any part of the impairment was due to a pre-existing condition, injury or abnormality.

The employer challenged Dr Rosenthal's findings on the basis the certificate contained a demonstrable error and was based on incorrect criteria. It was asserted Dr Rosenthal had not applied any deduction for a pre-existing condition.

The Medical Appeal Panel determined Dr Rosenthal had fallen into error in finding the injured worker's whole person impairment was not due to any pre-existing, injury or abnormality and assessed whole person impairment at 24% and concluded 50% was due to the previous injury to the lumbar spine in 2008. That gave rise to a nett impairment of 12% whole person impairment.

The Medical Appeal Panel concluded there was ample evidence the injury in March 2009 contributed to the current impairment, noting the March 2009 injury was only seven months after the original injury and surgery was performed at the same level of the spine.

The injured worker sought Judicial Review of that determination in the Supreme Court of NSW alleging jurisdictional error on the part of the Appeal Panel, error of law on the face of the record, unreasonableness of the decision, a failure to accord procedural fairness and failure to give adequate reasons. That challenge failed.

The injured worker dissatisfied with that result filed a further challenge but to no avail as in December 2018 the Court of Appeal found Justice Fagan did not err in rejecting the Application for Judicial Review.

The Court of Appeal when considering the evidence observed there were internal inconsistencies in the medical evidence.

Dr Bodel provided a report dated 5 July 2010 wherein the doctor assessed 5% whole person impairment as a result of the injury in 2009. The doctor apportioned two thirds of the total pathology to the original injury in 2008 and one third to the 2009 injury.

Dr Bodel then provided a further report dated 23 August 2016 in which he assessed 22% whole person impairment with no deduction.

The Court of Appeal noted, as did the Medical Appeal Panel and His Honour Justice Fagan, that there was no explanation as to why Dr Bodel changed his opinion in relation to apportionment.

The Court of Appeal observed that in order for the appeal to succeed there needed to be a demonstrable error and Section 327(3)(d) of the 1998 Act required such an error be contained in the certificate, that is, the error must be apparent in the certificate of the approved medical specialist.

A demonstrable error will not result merely because the Medical Appeal Panel disagrees with the opinion of the approved medical specialist. The Court of Appeal observed there is no express limitation on the material to which the Medical Appeal Panel may have regard when assessing whether the original medical certificate contains a demonstrable error. The concept of demonstrable error is not defined in the Act and is open to various interpretations ranging from the broad to the narrow.

A determination made without consideration of information or material to support the finding will result in a demonstrable error but a difference of opinion does not where material is available to support a finding.

The Court of Appeal determined the reasons of the Medical Appeal Panel under challenge must be read as a whole and considered fairly and the reasons for concluding a deduction should be made were set out in the decision and should be read in context. The Court analysed the evidence put forward by the injured worker including the reports of Dr Bodel and found the Medical Appeal Panel implicitly found error on the part of the approved medical specialist in concluding no deduction that should be applied for the previous

injury. There was no error by the Appeal Panel or by Fagen J.

In this case the Section 323 deduction reduced the whole person impairment assessment below the threshold for a work injury damages claim. The worker's impairment resulted from a combination of injuries not one injury and the impairment caused by each injury fell below the work injury damages threshold so work injury damages were not available.

Where an impairment results from a combination of injuries it is critical to review the medical evidence to determine whether a deduction to the impairment assessment should be made pursuant to Section 323 and where the deduction brings the impairment below the work injury damages threshold work injury damages will not be available.

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