GD News

Gillis Delaney Lawyers

Welcome to our latest edition of **GD NEWS** that brings to you information on new trends and issues that impact on employment and the insurance market in Australia. We can be contacted at any time for more information on any of our articles.

NSW Workers Compensation- The Big Bang 1 October 2012

In June 2012 the NSW Government introduced radical changes to the NSW Workers Compensation Scheme. Whilst many of the changes that were introduced commenced from 19 June 2012, the following changes were deferred:

- the changes impacting on weekly benefit claims,
- the change of the system to a user pay system for costs where parties in a dispute are required to meet their own costs of a dispute in the Workers Compensation Commission; and
- the introduction of an enhanced role for Work Cover Inspectors to issue improvement notices requiring employers to provide suitable duties and the risk of fines for an employer for failure to comply with those notices were not proclaimed to commence.

However on 28 September 2012 the Government has proclaimed that all of the provisions not commenced will commence from 1 October 2012.

Seriously Injured Workers

From 17 September 2012 seriously injured workers (with greater than 30% whole person impairment) come under the new regime and receive the transitional rate of weekly compensation of $736.72 per week.

Single workers receiving weekly benefits who had their weekly payments capped at $432.50 per week will receive an increase in benefits, however those with a wife and a number of dependent children will find themselves worse off. Weekly compensation benefits for seriously injured workers will continue until they are 67 years of age.

Changes to Weekly Benefit Scheme

More significantly workers who are claiming weekly benefits on or after 1 October 2012 will find their claims managed under the new weekly benefits regime and from 1 January 2013, workers claiming weekly benefits prior to 1 October 2012 will be transitioned to the new legislative regime which will result in work capacity assessments being conducted for each of those workers and three months after the work capacity assessments take place those transitioning workers will have their benefits regulated by the new regime.

For weekly compensation claims made after 1 October 2012 benefits will be calculated based on average weekly earnings of the worker and no weekly compensation will be payable to a worker after five years (260 weeks) of weekly payments except where the worker has a whole person impairment greater than 30%.

There will be three entitlement periods (weeks 1 to 13, weeks 14 to 130 and after week 130), with weekly payments after week 130 weeks only available to totally incapacitated workers and partially incapacitated workers who have returned to work for at least 15 hours per week.

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For the first 13 weeks of incapacity injured workers will receive 95:% of their pre-injury average weekly earnings up to a maximum of $1,868.50, less any current earnings or amounts the worker is able to earn in suitable employment.

In weeks 14 to 130 totally incapacitated workers will receive 80% of their average weekly earnings and partially incapacitated workers will receive 80% of average weekly earnings, less an amount that reflects their capacity to earn. However, if a partially incapacitated worker has returned to work and is working 15 hours a week or more, they will receive 95% of their average weekly earnings less their actual earnings or amounts the worker is able to earn in suitable employment.

After week 130 weeks a worker must be totally incapacitated or partially incapacitated and have returned to work and be working more than 15 hours a week and earning more than $150.00 a week, to receive weekly compensation and be assessed by the Scheme Agent as being, unlikely to continue indefinitely to be, incapable of undertaking further additional employment or work that would increase the worker's current weekly earnings. The worker will then receive 80% of average weekly earnings, less their residual earning capacity.

Payment of weekly compensation will be dependent on a work capacity determination made by an insurer and the insurer must conduct work capacity assessments during the life of a claim. The assessments must be conducted in accordance with WorkCover Guidelines which were also published on 28 September 2012.

A new dispute resolution process for disputes about work capacity will feature an internal review by an insurer of its decision on a capacity with a merit review by WorkCover and a procedural review by a WorkCover independent review officer.

The following decisions of an insurer will be final and binding on the parties:

- a decision about a worker's current capacity;
- a decision about what constitutes suitable employment for a worker;
- a decision about the amount an injured worker is able to earn in suitable employment;
- a decision about the amount of an injured worker's pre-injury average weekly earnings or current weekly earnings;
- a decision about whether a worker is, as a result of injury, unable without substantial risk of further injury to engage in employment of a certain kind because of the nature of that employment;
- any other decision of an insurer that affects a worker's entitlement to weekly payments of compensation, including a decision to suspend, discontinue and reduce the amount of the weekly payments of compensation payable to a worker on the basis of any decision referred to above.

A decision to dispute liability for weekly payments of compensation is not binding.

These changes will remove the role of the Workers Compensation Commission in the determination of disputes about work capacity decisions and will provide an extremely restricted dispute model for workers.

Employer obligations to provide suitable duties

Chapter 3 of the Workplace Injury Management and Workers Compensation Act amongst other things imposes obligations on an employer to provide suitable duties to injured workers.

If a worker who has been totally or partially incapacitated for work as a result of an injury is able to return to work (whether on a full-time or part-time basis and whether or not to his or her previous employment), the employer liable to pay compensation to the worker under this Act in respect of the injury must at the request of the worker provide suitable employment for the worker.

The employment that the employer must provide is employment that is both suitable employment and (subject to that qualification) so far as reasonably practicable the same as, or equivalent to, the employment in which the worker was at the time of the injury.

The obligation does not apply if: it is not reasonably practicable to provide employment or the worker voluntarily left the employment of that employer after the injury happened (whether before or after the commencement of the incapacity for

work), or the employer terminated the worker's employment after the injury happened, other than for the reason that the worker was not fit for employment as a result of the injury.

The new legislation provides that WorkCover inspectors will be able to issue an Improvement Notice requiring an employer to remedy any contravention of its obligations under Chapter 3 of the Workers Compensation Act 1987. The inspector may issue an Improvement Notice to prevent a likely contravention from occurring or remedy the things or operations causing the contravention. The Notice must state the reasons below why the inspector believes the employer is contravening a provision or has contravened a provision and the action which must be taken. It is an offence not to comply with an Improvement Notice. No mechanism for appeal has been specified in the legislation.

Improvement Notices may be used by WorkCover to ensure employers provide suitable duties to injured workers.

Costs

The workers compensation commission becomes a no costs jurisdiction. Each party is to bear the party's own costs in or in

relation to a claim for compensation. The Commission has no power to order the payment of costs or to determine by whom, to whom or to what extent costs are to be paid.

The New Regulations

On 14 September 2012 the Workers Compensation Amendment (Miscellaneous) Regulation 2012 was published. The Regulations commenced on 17 September 2012 and dealt with the changes to weekly benefits of severely injured workers. The Regulation provides that the changes apply to a claim for compensation in respect to a worker's injury made before 17 September 2012 and determination of when the regime commences turns on the date the claim for compensation is made. There may be an issue in relation to injuries occurring prior to 17 September where no claim for compensation had been made prior to 17 September and in those cases claims do not appear to fall under the new regime and will be caught up in the transitional claims with the result that those claims for seriously injured workers will come into effect from 1 January 2013.

To facilitate the commencement of the new Weekly Benefits Regime from 1 October 2012, the Workers Compensation Amendment (Transitional) Regulation 2012 was published on 28 September 2012 and commences from 1 October 2012.

A number of important issues have been clarified. They are:

- Regulation 11 removes the application of the changes to lump sum benefits to any claim that specifically sought compensation for lump sum benefits prior to 19 June 2012. Arguably workers who made lump sum claims before 19 June 2012 are therefore not effected by the amendments to lump sum benefits and can continue to make claims for deterioration of their condition. Those who never made a lump sum claim before 189 June 2012 now only get one go at a lump sum claim.
- Lawyers will not be retained by insurers to assist with work capacity decisions as lawyers are not entitled to charge insurers for such services.
- Transitioning claims which are those made before 1 October 2012 will be subject to the new regime after 1 January 2013.
- There is an increase in the scale of costs payable to lawyers in disputes in the Commission however the new scale only applies to claims commenced in the Commission after 1 October 2012 subject to the rider that the old scale of costs will apply to claims made prior to 1 October 2012 provided proceedings are commenced in the Commission before 1 January 2012.

Importantly however the increased costs scale will act as a cap on what a worker can be charged by his lawyer and what insurers can pay their lawyers as the jurisdiction is effectively a no cost jurisdiction for proceedings commenced in the jurisdiction after 1 October 2012 unless there was a claim for compensation made before 1 October 2012 and proceedings commenced before 1 January 2013.

The changes will have a profound effect on the Workers Compensation Scheme in New South Wales.

New Dispute Process

The Government has also announced the establishment of a new legal assistance and review service offering a free, independent and quick process to resolve disputes between injured workers and insurers

According to the Minister:
"Features of the new system include:

- A free legal review service within the WorkCover Independent Review Office (WIRO) – no legal expenses need be covered by the worker;
- Reviews will be conducted by independent legal experts in the area of workers compensation;
- Where the insurer does not agree with the opinion of that independent legal advice, workers may be provided with independent legal representation to pursue matters in the Workers Compensation Commission following a merit review.

The fine print on the system was not available at the time of publication of this newsletter.

New Guidelines

But that is not all.

Guidelines have been issued to address the process of dealing with disputes . The guidelines are comprised of some 116 pages published in the Government Gazette and are known as the WorkCover Guidelines for Claiming Compensation Benefits, Guidelines For Work Capacity decision Internal Reviews, Guidelines on Injury Management Consultants and WorkCover Work Capacity Guidelines . The guidelines note the following

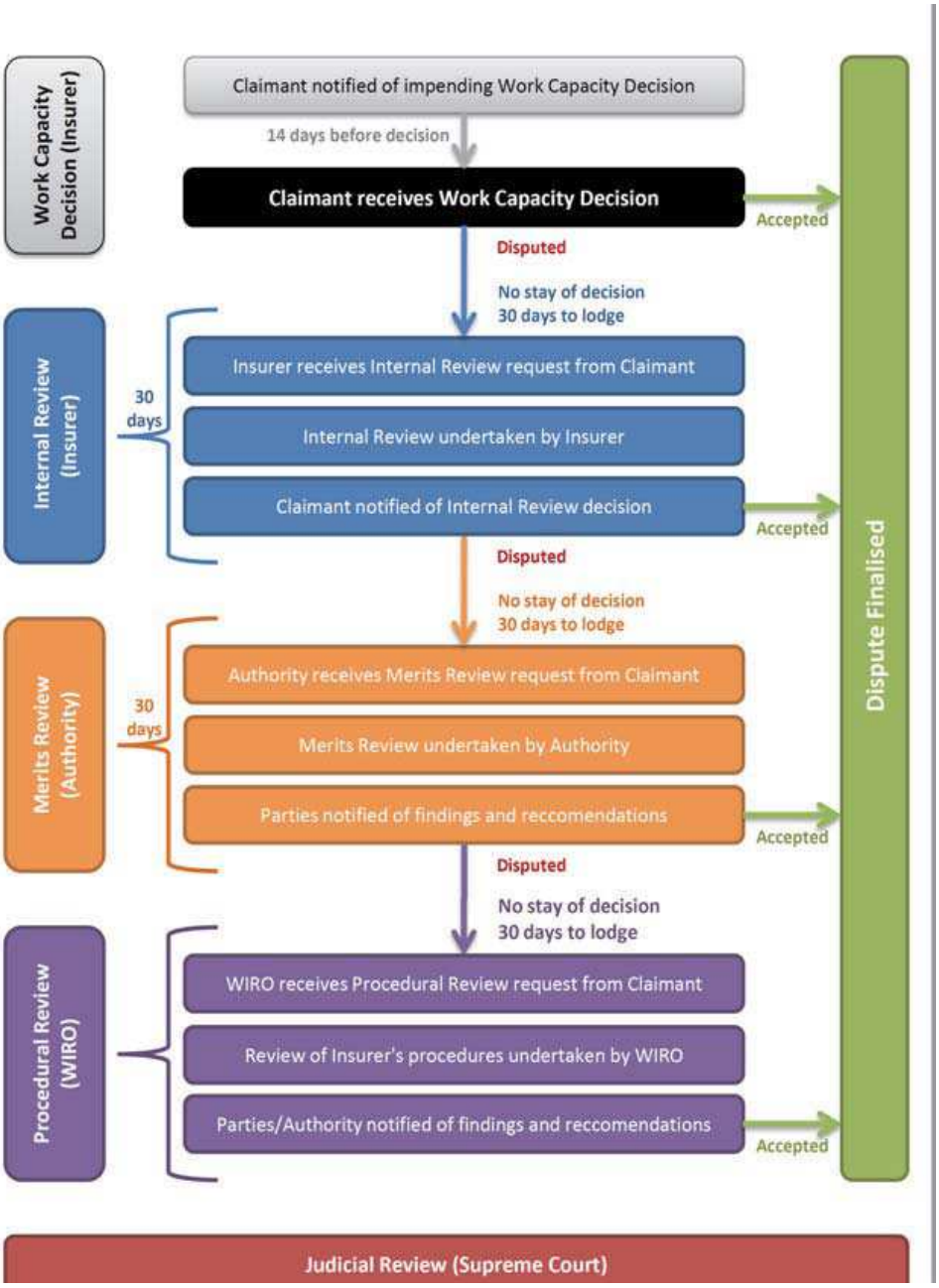
- " an insurer must arrange for all decisions to dispute all or part of a claim, to terminate or reduce weekly payments or to decline provisional payments on the basis of a peer review. At a minimum, the review is to be conducted by someone other than the person recommending the proposed decision and, by someone with requisite expertise,eg Technical Advisor or Senior Claims Supervisor.
- If the insurer continues to dispute the claim following a request for internal review they must issue a further dispute notice. The content of this dispute notice must comply with the requirements of section 74. Any further reports that have come into the possession of the insurer and that are relevant to the review decision are to be attached. The notice can refer to and rely on the content of the original section 74 notice and attachments, provided they remain applicable.
- a section 74 notice (setting out grounds of dispute) is not required to advise a worker of an insurer's work capacity decision.
- there are new forms to be used including a WorkCover Certificate Of Capacity. The nominated treating doctor or treating specialist is responsible for completing the form.
- legal practitioners acting for a worker are not entitled to be paid or recover any amount for costs incurred in connection with a review under this section of a work capacity decision of an insurer.
- the Authority will provide and maintain an advisory service to assist workers in connection with the procedures for Reviews of work capacity decisions.
- an application for Internal Review must be lodged by the worker with the insurer within 30 days of receiving the work capacity decision from the insurer.
- a worker may refer a work capacity decision to the Authority for Merit Review, but only after the dispute has been the subject of an Internal Review by the insurer. The worker does not need to attach to their application all of the existing documents and information relating to the claim or the work capacity decision, as the insurer will be required to provide all relevant information to the Authority as part of their reply to the application.
- the Merit Review by the Authority is to be undertaken by a person who was not involved in the making of the original work capacity decision or the internal review by the insurer; and has the appropriate level of knowledge, expertise and skill relevant to the particular work capacity decision referred. The Merit Reviewer may determine their own procedure

and is not bound by the rules of evidence and may inquire into any matter relating to the Review of the work capacity decision in such manner as they think fit.

- the Merit Reviewer is to act with as little formality as the circumstances of the matter permit and according to equity, good conscience and the substantial merits of the matter without regard to technicalities and legal forms.
- the Merit Reviewer may also make recommendations to the insurer based on their findings, which are binding on the insurer and must be given effect to by the insurer.
- a work capacity assessment undertaken by the insurer is a review of the worker's functional, vocational and medical status and helps to inform decisions by the insurer about the worker's ability to return to work in his or her pre-injury employment or suitable employment with the pre-injury employer, or at another place of employment.
- the insurer may conduct a work capacity assessment at any stage throughout the life of a claim. It is an ongoing process of assessment and reassessment that commences on notification of a workplace injury and continues as needed during the life of the claim.
- a work capacity assessment considers all available information which may include, but is not limited to:
    - reports from the treating doctor, treating specialist or other allied health professionals;
    - WorkCover Certificates of Capacity;
    - independent medical reports;
    - injury management consultant reports;
    - the worker's self report of their abilities and any other information from the worker;
    - the injury management plan;
    - reports from a workplace rehabilitation provider such as workplace assessment reports, return to work plans, functional capacity evaluation reports, vocational assessment report, work trial documents, job seeking logs, activities of daily living assessments, etc;
    - information from the employer such as documents relating to return to work planning; and
    - information obtained and documented on the insurer's claim file.
- the worker must attend and participate in any evaluation required by an insurer as part of the work capacity assessment.
- at a minimum, the insurer must commence a review of the worker's capacity for work once the worker has received a cumulative total of 78 weeks of weekly payments
- if a worker has an ongoing entitlement to weekly payments beyond 130 weeks, the insurer must conduct a work capacity assessment at least once every two years after this point.
- a work capacity decision is a discrete decision that may be made at any point in time and can be about any one of the factors described in section 43(1), such as the worker's capacity to earn in suitable employment. This is different to a work capacity assessment which is a review process that may or may not lead to the making of a work capacity decision or another type of decision regarding a claim.
- when making a work capacity decision the insurer should:
- ensure that all reasonable opportunities to establish capacity for work have been provided to the worker
    - ensure that the insurer meets their responsibility of establishing and supporting an injury management plan tailored to the worker's injury
    - evaluate all available and relevant evidence
    - follow a robust and transparent decision-making process with clear, concise and understandable information provided to the worker giving reasons for decisions
    - seek any additional information that is required to ensure the worker's current capacity for work is fully understood
    - providing opportunity for the worker to contribute additional information, especially if the decision may result in reduction or discontinuation of the worker's weekly payments

    - ensuring decision makers have the appropriate expertise, ability, and support to make the decision they are making.
- any work capacity decision should be logical, rational and reasonable. It should be a decision that is more likely than not to be correct.
- before making a work capacity decision that may result in a reduction or discontinuation of the worker's weekly payments the insurer must, at least two weeks prior to the work capacity decision, communicate this to the worker in a way that is appropriate in the circumstances of the case, and preferably by telephone or in person.
- determining the worker's current work capacity and the amount they are able to earn in suitable employment are work capacity decisions
- the insurer must provide 3 months notice before reducing or discontinuing the worker's weekly payments
- the Work Capacity Decision Notice must:
    - reference the relevant legislation
    - explain the relevant entitlement periods
    - state the decision and give brief reasons for making the decision
    - outline the evidence considered in making the decision, noting the author, the date and any key information. All evidence considered should be referred to, regardless of whether or not it supports the decision.
    - clearly explain the line of reasoning for the decision
    - state the impact of the decision on the worker in terms of their entitlement to weekly payments, entitlement to medical and related treatment expenses and return to work obligations
    - advise when the decision will take effect
    - detail any support, such as job seeking support, which will continue to be provided during the notice period
    - advise that any documents or information that have not already been provided to the worker can be provided to the worker on request to the insurer
    - advise of the process available for requesting review of the decision and how to access the required form, Application for review of a work capacity decision by insurer.
- If a worker wishes to refer a work capacity decision for an internal review, they should lodge a completed Application for Review of a Work Capacity Decision form with the insurer within 30 days of receiving the work capacity decision from the insurer
- the insurer must write to the worker within 30 days of receiving the application advising of the outcome of the internal review and if the insurer fails to do so the worker may then make an application for Merit Review by the Authority
- The Authority must write to the worker and insurer within 30 days of receiving the application advising of the outcome of the Merit Review and must include the decision, its impacts, any recommendations and reasons. The notification must also advise the worker about the availability of further review options.
- The Merit Review of the Authority will be subject to judicial review in the Supreme Court where a party will be able to challenge the decision.
- The challenge to the Merit Review will be on the same terms as challenges to administrative decisions currently conducted in the Supreme Court of NSW.

The following diagram published in the WorkCover Guidelines highlights the process that applies to a review of a work capacity decision



So there we have it. Take a deep breath and off we go with a new workers compensation scheme in full swing from 1 October 2012.

Fire Service Levies in Victoria- Insurance Industry Not Involved

From 1 July 2013 the insurance industry's role in the collection of a fire services levy will come to an end as the Victorian Government moves to a regime where Local Councils take on the responsibility for collection of the levy.

Victoria's fire services are currently funded by financial contributions from insurance companies who pass on the costs of the contributions by imposing a fire services levy on insurance premiums.

In a move that will ensure that all property owners, not only those who insure their property fund Victoria's fire services, the

Government has introduced a system where a levy will be collected through Councils. The levy will be included in rate notices and based on the capital improved value of the property.

There will be a fixed fee or $100.00 for residential properties and $200.00 for non residential properties, together with a variable rate determined on the nature of the property (eg residential, industrial, commercial or primary production). There will also be a separate levy charged in the Metropolitan Fire Brigade and Country Fire Authority areas in recognition of the different costs of funding each service.

The Victorian Government expects that with the removal of the fire service levy and associated GST and stamp duty costs from insurance policies there will be a 20% reduction in the total amounts paid by Victorians through the current fire services levy.

Property owners will receive notices of the fire services property levy on their Council rate notices commencing from 1 July 2013. The fire services levy moves from an insurance based system to a property based system at this time.

Insurance for property will be more affordable as a consequence of the changes and the red tape for the insurance industry that flowed from the need to collect and account for a fire services levy will become a burden of the past.

In July 2012 NSW released a Discussion Paper on the Fire Service Levy and in the not too distant future is likely to adopt a similar approach as in Victoria with a $300 charge collected with council rates. An insures role in the collection of the fire service levy is likely to come to an end in Australia very shortly.

New Meaning of the Term Flood in Insurance Contracts

The Insurance Contracts Regulation 1985 has been amended to provide that for prescribed insurance contracts the term "flood" will have a prescribed meaning irrespective of any other definition found in that insurance contract.

The prescribed contracts of insurance to which the definition applies are home building insurance contracts, home contents insurance contracts, insurance contracts that combine home building insurance and home contents insurance, contracts that provide insurance cover in respect of destruction of or damage to a strata title residence and contracts that provide insurance cover in respect of the loss of the equipment, stock, inventory or premises of a small business.

A small business is one which has operated in the last completed financial year and its turnover was less than $1 million and the total number of hours worked each week by the employees of the business is no more than 190 hours (whether on a full time, part time or casual basis). It is noted that 190 hours is equivalent to five employees each working a 38 hour week.

The Regulations also provide that an insurer must take reasonable steps to ensure that a contract of insurance containing a different definition is not a prescribed contract in respect of loss caused to a business that would, at that time, be a small business.

The new definition is in the following terms:

"Flood" means the covering of normally dry land by water that has escaped or been released from the normal confines of any of the following:

(a) a lake (whether or not it has been altered or modified);

(b) a river (whether or not it has been altered or modified);

(c) a creek (whether or not it has been altered or modified);

(d) another natural water course (whether or not it has been altered or modified);

(e) a reservoir;

(f) a canal;

(g) a dam."

This definition will apply even where the term flood is defined in those prescribed contracts of insurance.

These amendments do not come into force until 19 June 2014 which will provide insurers with time to redraft policies and implement procedures to address the changes.

New Privacy Legislation in Australia

The Privacy Amendment (Enhancing Privacy Protection) Bill 2002(the "Bill") which was introduced into the Federal Parliament in May 2012 was passed by the Lower House on 17 September and has had its second reading in the Senate and it appears that the much awaited reforms to privacy will soon be upon us.

The Bill is designed to bring Australia's privacy protection framework into the modern era. The new Australian Privacy Principles will apply to both the private and public sectors and will continue to deal with the collection, storage, security, use, disclosure, and the right of access and correction of personal information.

There are specific privacy principles for direct marketing and stronger protection for consumers when companies disclose personal information overseas.

Companies will be required to develop detailed privacy policies and make them clear and easily accessible to their consumers.

Credit providers will have positive obligations to help consumers correct their credit information and it will be easier to make complaints about incorrect credit reporting information.

The Australian Privacy Commission will also play a substantial role in the protection of privacy, dealing with complaints and conducting investigations.

The Privacy Commission will be able to direct an organisation to take steps to stop certain conduct or take action to address any loss or damage caused and will be able to apply to the Court for a Civil Penalty Order against organisations and penalties range from $22,000 for an individual to $110,000 for a company for an offence and increase to maximum penalties of $220,000 for an individual and $1.1 million for a company for serious and repeated breaches of privacy.

There will be a nine month deferral on the commencement of the new provisions once the legislation is passed which will allow businesses to update their privacy policies and practices.

For a more detailed analysis of the Bill you should refer to our June Newsletter which is available on our website.

Privacy and protection of personal information is about to become a hot topic for Australians as businesses grapple with the changing face of privacy legislation in Australia.

Legal Privilege For Assessor's, Investigator's & Adjustor's Reports

When an insurer receives a claim it may need to investigate the circumstances relating to the claim for the purposes of determining indemnity and/or assessing the insured's ultimate liability for the claim. Consideration of potential recovery actions may also be necessary and investigators and experts may be appointed to conduct factual investigations and assessments. In some circumstances an investigator or an adjustor will be commissioned by an insurer and when lawyers are retained, the lawyers will generally request that any future reports be addressed to those lawyers.

If a claim proceeds to litigation it is usual for an insurer to receive a Subpoena to Produce Documents and the claimant will attempt to obtain copies of investigator's reports and/or expert reports obtained by the insurer before the commencement of the proceedings. Access to documents obtained by the insurer may well help the claimant. Legal privilege protects documents from production.

If a document is obtained for the dominant purpose of obtaining legal advice it is protected from production pursuant to legal privilege.

However, it is not enough that a report is addressed to a lawyer for privilege to attach. The report must have been brought into existence for the dominant purpose of using it or its contents to conduct or aid in the conduct of litigation or for advice in respect to legal proceedings that were in contemplation.

Recent decisions of the NSW Supreme Court and Federal Court provide guidance on the Court's approach to legal privilege.

In *Melrose Cranes & Rigging Pty Limited v Manitowoc Crane Group Australia Pty Limited*, Justice Campbell of the Supreme

Court of NSW was called on to determine a claim for legal privilege over documents obtained by an insurer in relation to damage to a crane following a fire.

Melrose Cranes claimed damages from Manitowoc in negligence and for breach of contract in respect of severe fire damage to its mobile crane. The crane was purchased by Melrose Cranes from Manitowoc and from time to time Manitowoc had serviced the crane under warranty, with the last service occurring some five to six days before the fire.

Manitowoc served Subpoenas to Produce Documents upon three companies who were not parties to the proceedings. Subpoenas were issued to Thomas King & Associates Pty Limited, Greg Kelly & Associates Pty Limited and Australian Forensic Pty Limited. Each of these companies had carried out factual or technical investigations into the matters in dispute between Melrose Cranes and Manitowoc. Manitowoc sought access to the documents produced by these companies and a claim for privilege was made by Melrose Cranes.

UAA, the insurer of Melrose Cranes, argued the documents were brought into existence for the dominant purpose of using it or its contents to conduct or aid in the conduct of litigation at the time of its production. UAA argued that if that was not accepted, advice privilege was attracted which still provided an entitlement to legal privilege.

On the day after the fire the claims manager at UAA had been advised by Melrose Cranes that they had experienced problems with the crane since day one and that the crane had been serviced a few days before the accident. The insurer appointed an adjustor to assist in recovering the crane and assessing the damage. That assessor inspected the crane and advised the claims manager that the crane had been recently serviced and he was concerned and there seemed to be something wrong with the servicing. At this stage the claims manager telephone Bob King of Thomas King & Associates to investigate the circumstances of the incident. Greg Kelly was also engaged to investigate the cause of the fire.

Approximately a month after the fire lawyers were appointed and UAA instructed the lawyers to recover from Manitowoc and take over instructions to Kelly and King and to advise on whether there was a recovery claim and what further information would be needed. At this stage the lawyers were also requested to obtain a second opinion from Geoff Gudmann of Australian Forensic.

The lawyers contacted King and Kelly and the reports were thereafter addressed to the lawyers.

Campbell J noted that when determining privilege it was necessary to examine the dominant purpose for which the documents came into existence.

Campbell J noted that to qualify as the dominant purpose, the relevant purpose must be the ruling, prevailing or most influential purpose. It is not sufficient that the purpose is a primary purpose or even a substantial purpose, as the test is one of clear paramountcy. It was noted there must be a real prospect of litigation as distinct from a mere possibility for litigation to be reasonably apprehended.

The Court noted that the question of dominance is determined on an objective basis looking at the facts and when it comes to insurance matters, it is the intention of the insurer who commissioned the report that is relevant, rather than the intention of its author.

Campbell J was satisfied that the insurer was aware from the outset that Melrose Cranes attributed responsibility for the damage to Manitowoc. The Court accepted that different experts had been retained and had differing roles. Information was required to assist with the decision whether or not to admit the claim and secondly, documents were required to be obtained for submission to solicitors for advice about recovery.

From the start the insurer had the prospect of a recovery action in its mind, however Campbell J was not satisfied that the purpose of bringing a recovery action enjoyed clear paramountcy over the need to know essential facts to enable the insurer to decide whether to admit the claim. However, by the time lawyers had been engaged recovery proceedings had become the paramount purpose. In fact, the lawyers had reinstructed the persons from whom reports had been commissioned.

When the lawyers were retained there was a real prospect of recovery proceedings being instituted. Accordingly, it followed that documents which post dated the lawyer's involvement were protected from disclosure by litigation privilege.

However, Campbell J did sound a warning to insurers that the retention of a loss adjustor, investigator or expert to prepare a

report about the cause and origin of the fire which damaged the crane, which it is contemplated will be submitted to lawyers for advice, is not the retaining of a third party to act as an agent to communicate with the lawyer on behalf of the client and advice privilege does not attach to communications between the lawyer and those experts retained by the insurer. To secure protection it is still necessary to demonstrate that the documents were secured for the dominant purpose of using it or its contents to conduct or aid in the conduct of litigation.

The Federal Court was also recently called on to determine a claim for privilege in relation to a loss adjustor's report provided to a lawyer in the matter of *Ensham Resources Pty Limited v Aioi Insurance Company Limited*. In that case Ensham suffered property damage and consequential loss as a result of the overflow of a river and creek which inundated a mine. Ensham made a claim and the insurer engaged lawyers and a loss adjustor to advise in relation to the claim.

In discussions between the lawyers and the loss adjustor it was agreed that the reports should be addressed to the lawyers so that the reports would be privileged from production.

The loss adjustor prepared numerous reports and Ensham's claim was ultimately declined by the insurer. Ensham sought orders from the Court that the loss adjustor's reports be produced to the Court to determine the claim for legal privilege made over the documents.

In this case it was clear that there was a deliberate attempt by the lawyers for the insurer to secure legal professional privilege over the loss adjustor's report. The loss adjustor has originally been commissioned by the insurer and the loss adjustor's retainer was terminated, with the loss adjustor being re-engaged by the lawyers.

The Court confirmed that where documents are created for two or more purposes of equal significance they will not be created for the dominant purpose of providing advice in respect of legal proceedings. Cowdrey J confirmed that:
"Legal professional privilege protects the confidentiality of communications made in connection with giving or obtaining legal advice or for the provision of legal services including representation in proceedings in a Court".

A person claiming privilege bears the onus of establishing at the time the document was produced, litigation was reasonably contemplated. That test is an objective one. It is not necessary that litigation is absolutely certain, however there must be a reasonable probability or likelihood that such proceedings will be commenced. Cowdrey J confirmed that to attract litigation privilege the documents must be prepared for the dominant purpose of providing advice or assistance in relation to anticipated proceedings and:

> *"If on inspection of the disputed material, the Court is not satisfied that the dominant purpose for its creation was submission to solicitors for the purposes of legal advice, the material will not be privileged if the contents of the material and surrounding circumstances indicate other purposes. The purpose of an insurer conducting its insurance business, which may include placing an amount in money terms on its contingent liability, formulating its attitude to future business relationships with the insured, informing head office to obtain necessary instructions or decisions in complying with reporting requirements, is not sufficient to attract the privilege".*

Cowdrey J noted:

> *"Where an insured has made a claim on its liability insurer, and solicitors are acting for the insured and the solicitors state that the insurer had instructed them to advise on the question of liability, indemnity and quantum upon receipt of a report from a particular third party, it would be open to conclude that the dominant purpose, if not the sole purpose, of the report commissioned by the solicitors acting on behalf of the insurer was for the use in the preparation of confidential legal advice."*

Cowdrey J determined in this case there existed a real prospect of litigation and that such litigation was foreseen by the insurer's solicitors. A mine had been catastrophically damaged and very costly remedial measures were known to be required to de-water the mine and there was a very real possibility that those measures would exceed an applicable policy sub-limit. There was also the question of insurability of some of the property. Here the reports were obtained for the dominant purpose of providing advice in relation to litigation.

Insurers are entitled to claim legal privilege over reports prepared by loss adjustors and experts even where the experts were initially engaged by the insurer, however privilege will only attach once it becomes clear that the reports will be produced for the dominant purpose of use in legal advice to insurers on litigation which is reasonably contemplated. Addressing a report to a lawyer is not enough. Legal proceedings must be reasonably contemplated. When indemnity issues arise or recovery

actions are contemplated and lawyers are retained, reports provided to the lawyers subsequent to their engagement, will benefit from protection against production on the grounds of legal privilege.

Should You Call Your Expert to Give Evidence

In personal injury claims the onus is on the plaintiff to establish the facts which make up the cause of action.

Sometimes there are disputes as to what caused an injury.

In the recent decision of *Taupau v HVAC Constructions (QLD) Pty Limited & Ors*, the NSW Court of Appeal was called on to determine whether or not Taupau suffered an injury from electric shock where there was competing expert evidence and none of the expert engineers were called to give evidence. In this case it was necessary for the Court of Appeal to determine the basis on which the Court of Appeal can review the findings of a trial judge particularly where there is unchallenged expert evidence.

Taupau was employed by Forstaff Australia Pty Limited, a labour hire firm. For several months his services had been hired to HVAC Constructions (QLD) Pty Limited ("HVAC"). HVAC Constructions Pty Limited was also joined as a party but the claim against them was dismissed as that entity played no role in the incident.

Taupau alleged that he suffered electric shock.

The trial judge found that the system of work was unsafe but Taupau had not established that he had suffered electric shock as he claimed although he had suffered a burn to his thumb and atrial fibrillation.

The claims against Forstaff and HVAC were dismissed. An appeal followed.

The principal challenge to the appeal was that the findings that Taupau had not experienced an electric shock, was wrong.

Whilst the trial judge had accepted expert evidence from Associate Professor Blackburn, it was alleged there was unchallenged aspects of the evidence of another engineering expert, Dr Graham that explained how Taupau could have and did experience an electric shock. It was said there was also engineering evidence form Mr Seeger-Snowden which supported Mr Taupau's claim of electric shock.

Taupau complained that the trial judge had overlooked the medical and lay evidence supporting a finding of electric shock and had erred in preferring one expert over another noting that the experts were not cross examined.

Taupau's evidence was that he was engaged in the process of bolting new fans in a ventilation room, lying on the floor in a confined space, using a socket, a screwdriver and a shifter with his gloves off to allow him to feel the bolts. Whilst he was there another worker commenced welding and Taupau saw what he described as lightning, coming towards him from the welder, causing him to be thrown backwards and he felt a burning sensation in his head and pins and needles in his fingers. After the incident he was taken to Mt Druitt Hospital, where a diagnosis of atrial fibrillation was made.

There were three expert engineering reports and none of the experts were cross examined.

The experts were in conflict as to whether or not an electric shock occurred.

Beazley JA, in a unanimous judgment concluded the trial judge was wrong in her approach to the expert evidence.

Beazley JA noted that:

> *"A trial judge is not required to accept evidence merely because it is unchallenged. However, the fact that evidence is unchallenged may provide occasion to reason for its acceptance. ….. In this case there was no cross examination and the unchallenged evidence to which Taupau referred was evidence that was not met or commented upon by the opposing expert."*

Beazley JA noted that a trial judge was placed in a difficult position where she was required to make a determination on expert evidence of a technical kind without the benefit of cross examination. However, Beazley JA noted:

"A trial judge placed in that position by the parties, is required to analyse evidence in order to make findings on the issue to which the expert's evidence is directed. This may and usually does involve the acceptance of one expert or group of experts over another, not on the basis of a demeanour findings, which is unavailable when none of the experts is cross examined, but on the cogency of the evidence, given the issues addressed."

Beazley JA went on to state the approach that should be adopted by the trial judge and commented as follows:

- "*The trial judge is required to engage with the issues canvassed and to explain why one expert is accepted over the other.*
- *There has to be a reasonable basis as to why some evidence is accepted and other evidence is not.*
- *Evidence cannot be considered in isolation from other evidence.*
- *The cogency of the expert's evidence is dependent upon there being a basis established in the evidence for the views expressed.*
- *In the present case, this required the Court to consider the evidence of Taupau, the contemporaneous documentary evidence as to how the incident occurred, the engineering evidence and the medical evidence and determine how the evidence of each related, if at all, to the other evidence in the case."*
- *The trial judge had found that two expert's reports were diametrically opposed. Beazley JA did not agree. Rather, there was evidence in one expert's report that had not been dealt with by the other expert. That evidence presented a factual matrix to establish the basis of an electric shock which was not addressed by Associate Professor Blackburn."*

Beazley JA concluded that the trial judge did not fully appreciate the importance of the evidence of Dr Graham and the fact that it went unchallenged.

Whilst the case required an examination of the cause of the burns on the thumb, expert engineering evidence and the cause of atrial fibrillation, the trial judge did not:

"advert to the absence of the necessary factual underpinnings to Associate Professor Blackburn's evidence. Her Honour accepted one, essentially irrelevant, aspect of his evidence relating to the burns, which was not a sufficiently cogent aspect of his evidence as to warrant its acceptance. In my opinion, this challenge to Her Honour's judgment has been made good.

The medical evidence also supported the likelihood of electric shock. Mr Taupau suffered an immediate and serious onset of atrial fibrillation. Unless that could be explained on the basis that he had not previously noticed he had such symptoms and the stress of the burn made him aware of it, it is difficult to see that the atrial fibrillation was otherwise explicable. For the reasons I give below, I do not consider that the evidence supported a finding that Mr Taupau already had the condition but was merely unaware of it."

After careful consideration of the medical and expert evidence, Beazley JA concluded the evidence pointed overwhelmingly to Taupau having suffered atrial fibrillation because he experienced an electric shock and given that the appeal was by way of a re-hearing, it was appropriate for the Court of Appeal to find that liability had been established as against HVAC.

The case demonstrates the difficulties that are encountered by trial judges who do not have the benefit of oral evidence from an expert and cross examination of expert witnesses particularly where there is complex technical expert evidence.

Whether or not the cross examination of the experts in this case would have led to clarification of the issues is a matter of conjecture, however if the experts were called, in all likelihood the differences in the expert reports would have been highlighted and perhaps resolved. It is unlikely that evidence of one witness would have been left unchallenged.

The moral of the case is a simple one, where there is complex technical expert evidence, the experts should be called to give evidence and inconsistencies in opinions should be challenged.

However, it must be remembered the Courts are adopting a proactive approach to case management and where there are various experts it is common, particularly in the Supreme Court, joint expert reports are required which identify issues which are in agreement and those which are disagreed.

After a joint expert report is provided during the trial those experts are often "hot tubbed" and give joint evidence on the issues remaining in dispute. In this way the Court is best placed to watch the experts argue their positions and this aids a trial judge to determine the cogency of the expert evidence.

One can only speculate a joint expert report and hot tubbing of the expert witnesses would have ensured the correct resolution of Taupau's claim at the trial.

Competing expert opinions are not uncommon. Cases which involve technical expert evidence will present challenges for judges who need to consider that evidence, particularly where experts are not called to give oral evidence in the trial. So the answer is simple. Ensure that expert evidence does not go unchallenged if that evidence is in dispute and call your expert to give evidence.

Reinstatement of Injured Workers

In NSW a worker that has been injured during the course of his employment who has been terminated because of his injury can seek reinstatement when the worker becomes fit for employment within 2 years of the termination.

The recent decision of the Industrial Relations Commission in Chau v Visyboard Pty Limited provides a cogent warning to employers that there can be serious consequences for the employer where they terminate an injured worker whose injuries have rendered them unsuitable for the inherent physical requirements of their former role. The worker can bring a reinstatement application against the employer within 2 years of the termination if the worker becomes medically fit for their former duties or any similar duties and compensation orders can also be made.

With the new Workers Compensation Regime in NSW where most workers will see their entitlement to weekly compensation benefits end after two years of compensation payments, reinstatement applications are likely to become the vogue in the future. It must be remembered that an application for reinstatement must be brought within two years of dismissal however the Workers Compensation Act 1987 provides that an employer commits an offence if the worker is dismissed because the worker is not fit for employment as a result of the injury in the first 6 months after he became unfit.

So what happened in Chau's case?

Chau was a machine operator employed by Visy. He suffered a back injury during the course of his employment in 2005 and was absent for various periods in each of the years until his termination on 8 July 2011. The reason given for termination was that Mr Chau was incapable of performing his pre-injury duties now or in the foreseeable future.

Three months after his termination Chau produced to Visy a medical certificate certifying that he was fit to resume work and he forwarded a letter requesting a return to work immediately in a full time capacity in his pre-injury position as a machine operator. Visy did not reinstate Chau.

Chau then sought reinstatement under Section 242 of the Workers Compensation Act 1987.

Prior to Chau's termination Visy procured an independent medical assessment which noted Chau was fit for his pre-injury duties status but was at risk of aggravating his underlying degenerative condition and he should avoid heavy manual handling and repetitive awkward lifting. It was noted unrestricted pre-injury duties did have a risk of aggravation and Chau's spinal condition would worsen over the years.

Visy determined to terminate Chau's employment on the basis that he was unsuitable for the inherent physical requirements of his former role.

Section 241 of the Workers Compensation Act 1987 provides that a worker may apply for reinstatement of employment of a kind specified in the application if they produce to the employer a certificate to the effect that the worker is fit for employment of that kind.

Reinstatement order cannot be made more than two years after the injured worker was dismissed.

The reinstatement must be to employment of a kind that is available and that the employer can reasonably make available for the worker.

In this case the worker produced a medical certificate demonstrating he was fit for work and the Commission determined it was appropriate for Visy to reinstate the worker subject to the proviso that the employer provide a direction that Chau avoid repetitive and awkward lifting and he not lift more than 20kg in a static lift or 16kg in a dynamic lift. The Court directed that

Chau shall at all times comply with the direction.

Effectively, the Commission required the employer to reinstate the worker to a position other than his pre-injury employment. Effectively the employer was required to provide modified duties.

In addition, Visy were ordered to pay compensation to Chau, being his ordinary weekly rate of pay, less any workers compensation payments received from the date of his termination until the date of his reinstatement.

The Commission noted that the power to order reinstatement is a discretionary decision and it is necessary to determine the fitness for employment based on the medical evidence. In this case the medical evidence stacked up and Chau was fit for pre-injury duties although there was a need to restrict those duties as a consequence of the potential risk of re-injury.

The Commission considered it was practical for Visy to make the modified position available as the machine required three persons to attend the machine and other employees could assist Chau to lift weights above the restriction the Court imposed.

The Commission noted the onus on the employer was simply to issue a direction to Chau and to ensure that he understands the direction and to monitor compliance. The Court noted this did not impose an unfair burden on Visy.

The Commission noted that to resist a Reinstatement Application the onus was on the employer to satisfy the Commission that the roles of machine operator and assistant machine operator were either not available or that it was not reasonable for the employer to make them available. It was noted that "available" does not mean "a pre-existing specified position designated by the employer which is vacant". The term "available" is taken to mean "another position was of avail, to, capable of being used by, or at the disposal or within reach of, the employer – whether or not it was vacant at the time."

The Commission noted there was no evidence that Visy was unable to reasonably make available to Chau the work of the machine operator or an assistant machine operator and accordingly, the reinstatement Order was made.

Reinstatement applications will be available to workers after their entitlement to weekly benefits end provided they are fit for work and they bring their application within 2 years of their termination.

So will reinstatement applications become the new source of work for lawyers acting for injured workers?

Investigating Workers Compensation Claims-Consequences for Employers

From time to time employers are faced with workers compensation claims which are considered spurious and in some causes, fraudulent. If it appears a claim is fraudulent, an employer may need to take disciplinary action against the employee. However, an employer needs to proceed cautiously in its investigations in relation to the worker's conduct as the employer may find itself before the Federal Magistrate's Court in an adverse action claim as a consequence of the action that it takes. The recent decision of the Federal Magistrate's Court in CFMEU v Leighton Contractors Pty Limited, highlights the difficulties which can confront an employer in these circumstances.

Section 340 of the Fair Work Act provides that a person must not take adverse action against another person because the other person has a workplace right, or has not exercised a workplace right.

A workplace right means a person is entitled to the benefit of or has a role or responsibility under a workplace law, workplace instrument or order made by an industrial body.

Adverse action is taken by an employer against an employee if the employer dismisses the employee or injures the employee in his or her employment or alters the position of the employee to the employee's prejudice. Threatening to take action also constitutes an adverse action.

The Court in CFMEU v Leighton Contractors Pty Limited considered the action taken by Leightons in respect to its employee Hayward who had made a workers compensation claim in connection with a work injury.

Hayward made an application for compensation pursuant to the Workers Compensation and Rehabilitation Act 2003 (QLD) ("WCR Act") in respect of an injury which occurred on 31 August 2011.

Haywood was employed by Leighton as an operator in the pit at the Moorvale Coal Mine. He claimed to have suffered a neck/back injury whilst driving a truck. Hayward presented to his doctor, alleging he had suffered a neck and back injury and a severe whiplash injury was diagnosed, which was said to be caused by a load being dumped into the tray and jostled about. It was not in doubt that Hayward suffered an injury on 31 August and made a bona fide claim for WorkCover entitlements at that time.

However, in late September Leighton's health and safety superintendent received a call from an employee which caused suspicions to be aroused as to the veracity of the nature and extent of the alleged injuries. The concerns were based upon rumours.

Leighton ultimately arranged surveillance of Hayward and provided a copy of the surveillance report to WorkCover. Medical reports obtained by WorkCover were also obtained by Leightons which revealed the medical evidence was inconsistent with a significant injury where Hayward alleged that he was totally incapacitated.

Hayward was ultimately stood down while Leighton conducted its investigation into the circumstances of the workers compensation claim.

The CFMEU complained that Leighton's conduct in employing surveillance, calling meetings and corresponding with Hayward to make allegations about dishonesty and threatening disciplinary action in respect of those matters and his ultimate suspension, constituted adverse action in respect of his workplace rights.

Burnett FM confirmed that the WCR Act is a workplace law and Hayward had a workplace right arising from a claim made for applicable WorkCover entitlements.

It was also noted that Hayward had a workplace right arising from Leighton's use of the workers compensation documents in contravention of Section 572A of the WCR Act which provides that a person must not for a purpose relating to the employment of a worker obtain or attempt to obtain a workers compensation documents about the worker, or use or attempt to use a workers compensation document about the worker. Leighton did obtain documents raised for the workers compensation application and the compensation documents included the surveillance report and an independent report of a medical practitioner.

The Federal Magistrate accepted that Leighton's conduct in calling upon Hayward to show cause before standing Hayward down and threatening dismissal, together with the subsequent related correspondence constituted adverse action for the purposes of the Fair Work Act by altering his position to his prejudice but the action taken was not in relation to a workplace right.

The Court held that Hayward sought to exercise his workplace rights, they being his right to make a WorkCover claim or his right not to have his workers compensation documents used by Leighton against him, but Leightons took actions appropriate to investigating and processing a claim of fraud made against an employee in respect of the employee's conduct relevant to the employer/employee relationship.

In this case, whilst Hayward had a workplace right and Leighton had taken adverse action against him, Leighton established that its actions were motivated by a concern that there had been fraud on the part of Hayward in bringing the claim. The Magistrate concluded that Leighton had acted in a bona fide manner and reasonably at all times and if its conduct was adverse action, Hayward's rights were not operative in the decision to undertake that action. The operative reason for the use of documents was to enquire into the integrity of Hayward's dealings with Leighton and those associated with it and not because of Hayward's workplace right.

The case serves to highlight the fine line that an employer must tread when investigating a suspicious workers compensation claim.

A workers compensation claim gives rise to a workplace rights and the general protection provisions in the Fair Work Act prohibit employers from taking adverse action in respect of workplace rights however they do not prevent an employer taking appropriate action to investigate a suspicious claim.

The general protection provisions in the Fair Work Act do not prevent an employer from conducting investigations into fraudulent workers compensation claims and taking appropriate action were the employer is investigating conduct that impacts

on the employee/employer relationship. However an employer's use of documents created for a workers' compensation claim needs to be carefully considered when employers intend to take disciplinary action and or terminate an employees engagement when a workers' compensation claim is involved.

In this case Leighton's actions were not taken consequent to the employee's workplace rights, rather the investigations concerned the employee's conduct relevant to the employee/employer relationship.

Workers Compensation Roundup –Does Inappropriate Touching By A Carer Constitute A Fresh Psychological Injury?

Recently, Deputy President Roche in Sydney South West Area Health Service v Dyer was required to determine whether a psychological condition which resulted from treatment for a physical injury was a primary psychological injury or a secondary psychological injury.

The worker suffered a serious injury to her left elbow when she fell in her employer's car park when leaving work. Liability was accepted and she had extensive treatment to the elbow, including surgery to replace a tendon. Following that operation her left arm was immobilised in a brace. As she was so restricted after the surgery the insurer approved the provision of domestic assistance, including personal care assistance with bathing. Whilst at the worker's home a nurse/carer inappropriately touched the worker. The nurse was charged with offences under the Crimes Act but was ultimately acquitted.

It was not disputed that as a result of the elbow injury the worker suffered a secondary psychological injury in the nature of an aggravation of a pre-existing depressive disorder and as a result of the inappropriate touching incident by the carer, the worker developed a post traumatic stress disorder. This was medically evidenced as a further aggravation of her depressive condition (the "psychological condition").

The worker claimed compensation for whole person impairment of 22% due to the psychological condition that allegedly resulted from the incident when she was inappropriately touched, together with compensation for pain and suffering resulting from that impairment.

The issues in dispute were whether the worker suffered a primary psychological injury arising out of the inappropriate touching incident in the course of or arising out of her employment and if so, whether her employment was a substantial contributing factor. It should be noted if an injury is considered to be a "secondary psychological" injury rather than a primary injury, a worker is precluded from an award of lump sum compensation for permanent impairment by virtue of Section 65A of the Workers Compensation Act 1987 ("WCA").

The Arbitrator initially determined that the worker suffered an injury in the nature of a psychological injury arising out of her employment, employment was a substantial contributing factor to that injury and the injury was a primary psychological injury.

The employer appealed on the basis that the inappropriate touching event broke the chain of causation between the physical injury and the psychological condition or in the alternative the injury was a secondary psychological injury.

The appeal was determined by Deputy President Bill Roche in the employer's favour. It was noted the test of causation in a claim for lump sum compensation is the same as the test in a claim for weekly compensation, namely has the impairment "resulted from" the relevant work injury. Based on the authorities the Deputy President indicated that what is required is a common sense evaluation of the causal chain. Whilst it was important to consider the nurse's intention when he touched the worker as she stepped out of the bath, in the absence of evidence from the nurse, his acquittal of any criminal wrongdoing provided little insight into his intentions or motivation. On the undisputed evidence available to the Deputy President, he was comfortably satisfied that on the balance of probabilities the nurse's actions constituted an assault. The nurse did something that he had been told not to do and something that on the evidence was not a part of the assistance he had been engaged to provide. The medical evidence was unanimous that it was that conduct that caused the worker's psychological condition. Nevertheless, the Deputy President did not accept that the worker's psychological condition resulted from the physical injury. The physical injury merely created a need for care. When the nurse touched the worker in a manner contrary to her express instructions he was not providing care required because of the physical injury. He was committing an assault. That did not result from the physical injury but from the nurse's deliberate and unauthorised act.

The Deputy President was satisfied that the chain of causation was broken by the nurse's assault and thus the worker's psychological condition did not result from the injury to the elbow. Accordingly the injury was not a primary psychological injury.

By way of further comment, the Deputy President stated that just because a later psychological condition did not result from the pain and discomfort of the earlier physical injury, it does not follow as an alternative it must be a primary psychological injury. In the case in question the physical injury required the worker to have surgery and receive personal care. If as a consequence of receiving that care, as opposed to being assaulted, the worker developed a psychological condition, that condition would clearly be a secondary psychological injury under Section 65A. The injury would have arisen as a "consequence of" a physical injury.

It is pleasing to note the Commission will use a common sense approach when examining the question of causation. We have noted a trend in the increase of claims for primary psychological injuries both in terms of workers seeking to secure additional lump sum compensation or achieve the 15% WPI threshold in order to lodge a claim for work injury damages. These claims must be carefully to determine whether the event which caused the development of the subsequent psychological condition was "extraneous or extrinsic" to the original physical injury. If so the claim can be declined.

CTP Roundup

Future Economic Loss Buffers – It's Not That Simple For Assessors

When determining a claim for economic loss in a civil liability claim or a motor accident compensation claim, the Court is called on to compensate a plaintiff for loss of earning capacity. Generally that loss of earning capacity is a measure of the difference between the earning capacity after the accident and an assessment of what the capacity would have been in the absence of injury.

The calculation can be difficult in circumstances where significant speculation is necessary. In those circumstances the Court will often award a "buffer" to compensate a claimant.

The Courts have noted where the selection of a figure for economic loss is fraught with uncertainty the preferred course is to award a lump sum as a buffer without engaging in an artificial exercise of commencing with a precise figure and reducing it by a precise percentage.

However, the NSW Court of Appeal in *Allianz Australia Insurance Limited v Sprod*, confirms that where an arithmetic approach is used to calculate a buffer it is incumbent on a CARS assessor to calculate the loss on the basis of the arithmetic calculation and state the reasons why assumptions have been made in the calculation of economic loss.

Sprod was a forklift driver who was injured in a motor vehicle accident. A CARS assessor, when considering future economic loss noted:

> *"The claimant is concerned about the possibility of losing his job. He explained that he is the only light duties worker in the area of the factory where he works. He is concerned that a pallet system will be introduced at work. This will leave very little for him to do and I infer increase his chances of losing his job. .. I am satisfied that there is a chance of the claimant losing his present job, despite his benevolent employer and he will then be at a disadvantage on the open labour market. Bearing in mind the claimant's present high earnings I am satisfied that it is appropriate to allow $250.00 nett per week for future economic loss."*

The CARS assessor assessed future economic loss was then allowed at $250.00 per week for 18.3 years.

Allianz appealed to the Supreme Court on the basis that the assessor fell into jurisdictional error or error of law on the face of the record because of the failure to comply with section 126 of the Motor Accidents Compensation Act which provides that a Court cannot make an award for future economic loss unless the claimant first satisfies the Court that the assumptions about future earning capacity or other events on which the award is to be based accord with the claimant's most likely future circumstances but for the injury and determines the amount of any such award of damages by adjusting the amount of damages for future economic loss by reference to the percentage possibility that the events concerned might have occurred but for the injury.

Allianz argued that the approach of the assessor was not an approach by way of buffer but an arithmetic calculation and on that approach there was no basis for the figures adopted by the assessor in the evidence. Hoeben J concluded there was no reason why the amount allowed should not be treated as an award of a buffer. Hoeben J noted the only difference was that the assessor, instead of specifying a lump sum, specified a percentage of the claimant's earnings by reference to which he

calculated a lump sum. Hoeben J noted that Section 126 of the Act allows for a buffer to be awarded for future economic loss.

Hoeben J noted the decision of *Penrith City Council v Parks* confirms buffers can be awarded and:

> *"The occasion for a buffer is when the impact of the injury upon the economic benefit from exercising that incapacity after injury is difficult to determine. There is still a comparison between the economic benefits, although the difference cannot be determined otherwise than by the broad approach of a buffer."*

Parks' case concluded that Section 126 did not preclude the award of a buffer for future economic loss.

However, Allianz in an appeal to the Court of Appeal challenged the findings of Hoeben J and the Court of Appeal was called on to determine whether or not the assessor's award in this case was actually a buffer or an arithmetic calculation requiring a statement of the assumptions that were the basis for the award.

Barrett JA, in a unanimous judgment concluded this was not a buffer case.

Barrett JA noted:

> *"The underlying principle is that the plaintiff should have a sum by way of damages for the difference between earning capacity as it would have been in the absence of the injury and the earning capacity as it is following the injury. Both elements involve uncertainty and conjecture and, therefore, require that assumptions be made, albeit assumptions shaped by the available evidence. The assumptions cover, among other things, remaining expectancy of working life, the impact of the injury on that expectation, the extent to which the ability to function will be curtailed and the earnings that work according to the reduced ability will produce, together with assumptions regarding discounted present value and investment returns and as to vicissitudes or adverse contingencies. Because of s 126(1), an assessor has a duty to form an opinion that the assumptions to be applied in relation to such matters going to future earning capacity "accord with the claimant's most likely future circumstances but for the injury.*
>
> *The duty under s 126(1) to be satisfied that the adopted assumptions accord with the most likely future circumstances but for the injury is supplemented by the s 126(3) duty to articulate the assumption on which the award is based. This, as has been said in this Court more than once, is to ensure transparency and, at the same time, to inject an element of rigor or method that may be overlooked or simply abandoned if the statutory system did not insist on the identification and articulation of the assumptions employed.*
>
> *.....*
>
> *In a true "buffer" case, the obligations imposed by s 126 upon the assessor may be discharged by much more generalised statements: ... But there will still be, of necessity, some assumptions. Assumptions as to life expectancy and likely remainder of working life are examples, even if circumstances mean that the assumptions are necessarily somewhat impressionistic. But if that is the quality of the relevant assumption, it is still possible for it to be stated, if only in very general terms, for example, that remaining working life has been assumed to be a minimum of five years and a maximum of twenty years. That, while it would do little to elucidate any basis of calculation, would serve to accentuate one aspect of the uncertainty that formed the very basis for resort to the evaluative approach of "buffer".*

Barrett JA noted the assessor made an articulated calculation. There was no statement by the assessor of the assumption or assumptions underlying the figure of $250.00 nett per week and there was no expressed explanation of why a period of 18.3 years was chosen. Barrett JA was of the view that there was a failure of the assessor to engage with and perform the tasks prescribed by Section 126. Once the assessor embarked upon a process of calculation, the duties imposed by Section 126 were enlivened.

Accordingly, the Court of Appeal found this was not a buffer case. The Court of Appeal was also somewhat critical of the Hoeben J's comments about CTP insurer challenges to economic loss claims where he commented that the appeals appeared to be:"thinly veiled attempts at a merits appeal where no such appeal is provided for under the Act."

Barrett JA pointed out that:

> *"All that needs to be said about this aspect of the judge's reasons is that the comments did not appear to have been central to the decision and that, in any event, a Court obviously cannot approach any application before it otherwise than according to the merits of the particular case."*

Whilst Barrett JA noted his judgment was not intended to suggest that assessors must prepare elaborate statements of

reasons and explanations of assumptions, rather assessors must “of course” work on the basis of facts that an important element of the statutory scheme is employment of the expertise and experience of assessors as specialists.

Barrett JA concluded:

> *“it is important to emphasise that nothing I have said is intended to suggest that assessors must prepare elaborate statements of reasons and explanations of assumptions. They must, of course, work on the basis of facts but an important element of the statutory scheme is the deployment of the expertise and experience of assessors as specialists. They are not meant to act as if they were judges. Their task is only to assess the amount that "a court would be likely to award" as damages. The function is no more than to estimate and to predict likelihood. There is a clear place for informed intuition and speculation. The purpose of s 126, a provision directed at judges and applied in a derivative way to assessors, is to produce a reasonable degree of transparency as to assumptions and the reasons for them so that those interested in the assessment may have an insight into the way in which the task of assessment was performed. The section recognises that assumptions are necessary and appropriate. It does not seek to define aspects that may or may not properly be made the subject of assumptions about future earning capacity. Its aim is merely to ensure that an insight can be obtained into the content of the assumptions and the reasons for their adoption.”*

The judgment highlights the requirement that assessors must state the assumptions upon which economic loss claims are determined even where buffers are concerned. Where arithmetic calculation is relied on to determine a buffer, then a determination of those assumptions takes on even more significance.

One concern arising from *Sprod’s* case is that assessors may actively avoid commenting on figures where they determine buffers in an attempt to avoid a challenge to their findings.

Sprod’s case is instructive as it serves as a heads up on the assumptions that ought to be addressed by an assessor when awarding damages for future economic loss by way of a buffer.

Overturning A Finding Of Contributory Negligence Is A Hard Ask

The recent NSW Court of Appeal decision in *O’Neill v Little* demonstrates the difficulty which will confront an insurer when, on appeal, it seeks to challenge findings of contributory negligence.

Little was injured in a motor vehicle accident. She was driving along a street in a northerly direction and came to a stop at an intersection regulated by a Give Way sign.

O’Neill was travelling east along the 8ntersectring with the sun low in the western sky and travelling at 50 km/h. Little’s view to the west was obscured by the glare of the sun and after stopping at the Give Way sign she proceeded into the intersection and was struck by O’Neill’s vehicle behind the front passenger door near the rear wheel. O’Neill only saw Little’s vehicle in his peripheral vision shortly before the collision. The trial judge attended a view of the scene of the accident.

Whilst excessive speed was not seen to be a factor, the trial judge concluded it would have been prudent for O’Neill to have slowed her vehicle. The Judge noted that the fact that Little drove a vehicle through a Give Way sign prior to a collision did not necessarily determine whether the other driver involved in the collision had been negligent.

The trial judge ultimately found that O’Neill was negligent, however concluded that a fair apportionment of liability was achieved by a reduction in the damages by 55% for contributory negligence.

An appeal followed.

The Court of Appeal confirmed that the right hand rule is not the be all and end all in relation to questions of responsibility. Neither is a failure to take reasonable care in failing to give way at an intersection regulated by Give Way signs.

The Court of Appeal noted that the trial judge had found that O’Neill had failed to keep a proper look out and if she had done so she would have been able to avoid the collision by a minor adjustment to her speed.

A witness to the accident noted that Little had stopped briefly at the Give Way sign and then proceeded at “just a normal take off speed” into the intersection.
The Court of Appeal noted that this was not a case of a driver being confronted by unpredictable behaviour creating an unavoidable danger. Little saw O’Neill’s vehicle as it approached the intersection and wondered whether it was going to brake

or not. Little had a clear view of the intersection and O'Neill's vehicle traversing it relatively slowly and if she had slowed, the collision could have been avoided. The trial judge was not wrong to find O'Neill was negligent.

Then there was the challenge to the assessment of contributory negligence which was claimed to be manifestly inadequate.

Section 5R of the Civil Liability Act 2002 provides that when determining whether a person who suffered harm has been contributorily negligent in failing to take precautions against the risk of that harm, the standard of care required from the person who suffered harm is that of the reasonable person in the position of that person and is to be determined on the basis of what the person knew or ought to have known at the time.

The Court noted it was well settled law that a finding on a question of apportionment is a finding upon a "question, not of principle or of positive findings of fact or law, but of proportion, of balance and relative emphasis, and of weighing different considerations. It involves an individual choice or discretion as to which there may well be differences of opinion by differing minds."

As a trial judge is called on to balance the respective responsibilities of the parties at fault, the Court of Appeal will only overturn an assessment where the apportionment is outside an appropriate range for that assessment.

In this case Sackville AJA, in the unanimous judgment of the Court of Appeal, declined to overturn the assessment of contributory negligence as it was not manifestly inadequate and was in the permissible range. However Sackville AJA commented that had he been called on to carry out that assessment at trial he might well have been inclined to attribute some greater responsibility to Little than 55%.

In this case the trial judge had accepted that Little was more responsible for the accident and that was an appropriate finding and whilst different judges could come to different conclusions about an appropriate assessment, the assessment made by the trial judge was not outside the appropriate range.

Appellant Courts will not disturb findings of apportionment unless there is some error or principle or fact or where the apportionment is plainly wrong. That is because when making value judgments minds may differ as to the relative blame of a person's actions.

Once contributory negligence is found there must be an apportionment.

The apportionment must look at the respective shares in the responsibility for the damage and involves a comparison of both parties culpability, that is, the degree of departure from the standard of care of the reasonable man and the relevant importance of the acts of the parties in causing the damage.

The apportionment must take into account the whole conduct of each negligent party in relation to the circumstances. In this case the apportionment was not plainly wrong.

As can be seen a challenge to a finding of contributory negligence will be difficult to win.

Warning to financiers – register PPS security interests correctly or lose priority to collateral: Carson, in the matter of Hastie Group Limited (No 3) [2012] FCA 719

The Personal Property Securities Act 2009 (Cth) (PPSA) deems four common commercial arrangements to be security interests. These are PPS leases, retention of title arrangements, bailments and commercial consignments. Such interests must now be registered. As this case shows, if not registered correctly, financiers' rights may be lost.

In Carson, in the matter of Hastie Group Limited (No 3) [2012] FCA 719 (Carson No 3) the Court examined PPS leases registrations. The decision is the first of an Australian Court which underscores business risk for financiers under PPSA and sets a precedent for third parties to sell collateral where registrations of security interests are defective or ambiguous.

In Carson No 3, secured parties with registered interests in personal property lost rights against secured property and priority to third party lenders because of inadequate registrations in the Personal Property Securities Register (PPSR) and difficulties which Administrators appointed to the grantors encountered in identifying collateral and locating it.

Financiers generally, including lessors under PPS leases, should check their PPS agreements, review their security documents with customers/grantors and ensure they can identify their collateral and its whereabouts or risk the unfortunate consequences which occurred here.

Financiers should also carefully consider whether they should rely on transitional security interests if a grantor has also granted a security interest over all present and after acquired property. Carson No 3 shows that in some situations transitional interests may be defeated and priority may be given to later registered security interests in the same collateral.

This article considers the differences between the previous law and PPSA, what contributed to the problem for lease financiers of the Hastie Group and what financiers can do to protect themselves from similar problems.

Old law and new law

Under pre-PPSA law, in a borrower's insolvency, evidence of title to personal property usually insulated a lease financier from third party claims against the leased property. The use of a registered fixed charge over the leased property provided additional protection for the financier.

Previously, third parties and insolvency practitioners in formal appointments could easily and economically establish a financier's interest in personal property under the previous law by obtaining a copy of a fixed charge from ASIC's register. Such charges usually itemised the leased property in a schedule and were available on line.

By contrast, under PPSA, third parties and insolvency practitioners are not able to instantly obtain an electronic image of a security agreement. The agreement itself is not registered in the PPSR. Registration is now by description of the security interest and the collateral to which it attaches. However registration can include reference to a particular security agreement.

A secured party is to provide a copy of the security agreement to an interested person after receiving a written request to do so, but it is permitted up to 10 business days to comply. Also, anecdotally, it seems that security agreements frequently contain provisions requiring parties to them not to disclose them, except by compulsory process such as Court order.

Therefore under PPSA, a financier or insolvency practitioner can be delayed when seeking a copy of a third party's security agreement in the absence of cooperation from the grantor and/or because of non-disclosure obligations in security documents.

The fundamental problems for the equipment financiers and Administrators in Carson No.3 were firstly, the way in which registered security interests had been described in the PPS register and secondly, the way in which collateral had been described in the PPS register. The particular circumstances of the Hastie Group also contributed to the problems.

Circumstances of Hastie Group companies

On 28 May 2012 (date of appointment), the Administrators were appointed to 44 companies in the Hastie Group. Companies in the Hastie Group provided mechanical, electrical, plumbing, refrigeration and ventilation services. The Hastie Group had three operating divisions, one of which was known as the MEP division. The Court's decision related only to companies in the MEP division.

At the date of appointment, the Hastie Group had approximately 1,600 projects under way in Australia. It had premises at up to 40 different locations. Hastie Group companies each had an asset register, separate records and separate offices.

Despite the existence of asset registers, it was not clear to the Administrators which particular entity owned or possessed which collateral, or to what security interests each item of collateral may have been subject. This was so because:

- books and records of the companies were inadequate in as far as they did not describe the nature and location of all plant and equipment;
- when plant and equipment had been moved between sites or between companies in the group, records were not kept as to those movements;
- the business of the Hastie group companies was decentralised;
- the Administrators had no alternative but to terminate the employment of most of the 2,700 employees of Hastie Group companies. The Administrators were therefore unable to verify with staff critical information about the nature and extent of security interests over equipment identified in the PPSR;
- investigations of the Administrators up to 5 July 2012 revealed the existence of many unregistered transitional security interests; and
- at 5 July 2012 a lack of clarity remained as to precisely what personal property was in the possession of the Hastie Group.

As at 5 July 2012 the Administrators were continuing to exercise rights in relation to 19 sites because plant and equipment was located at those sites. The estimated cost of relocating the plant and equipment to a single site exceeded its commercial value. Furthermore, weekly rental was payable in relation to each of these 19 sites, exposing the Administrators to considerable ongoing personal liability for rental under s.443B(2) of the Corporations Act.

Before applying to the Court, the Administrators had written to all secured parties who had registered a security interest against the companies in the PPSR. Each such creditor was asked to supply to the Administrators information about each security interest that it held. Within about three weeks after sending those letters, the Administrators had received responses from only about 20% of secured parties. However, many of the responses did not adequately particularise the equipment or identify the security agreement under which the security interest arose. Compounding the difficulty, many registrations in the PPSR were vague in their descriptions of equipment and did not refer to underlying security agreements.

Using information obtained from the books and records of the companies, the Administrators then wrote to 12 secured parties who appeared to have an interest in some of the equipment. These letters enclosed a list of equipment and requested the consent of such creditors to the sale of equipment subject to their security interests, or responses indicating that the secured party did not so consent. Each letter stated that absent a response within a specified time, the Administrators would proceed as if that the secured party did not have a security interest in any item in the list.

The Administrators then advertised in newspapers in terms that were similar to the letters sent to the 12 secured creditors. Additionally, the Administrators distributed emails to 3,000 creditors whose current email addresses were known, seeking information as to any claims to equipment. The email contained a notification similar to the newspaper advertising.

Despite these activities, and reviewing company records including registers of leased assets, by 5 July 2012, the Administrators had identified about 3,700 items of unclaimed equipment. The Administrators submitted to the Court that it was in the interests of creditors that all unclaimed equipment be sold promptly by online auction.

The Court's orders – sale of collateral

The Court gave directions (that is, judicial advice) to the Administrators under section 447D of the Corporations Act by which they were justified in selling equipment but also requiring:

- further newspaper advertising in relation to auctions of unclaimed equipment;
- deposit of net proceeds of sale into a separate escrow account to be held for 3 months after the completion of sales;
- the Administrators to write to all known creditors informing them of asset realisations and the 3 month escrow period in which claims to sale proceeds could be made; and
- at expiry of the 3 month period, the Administrators were to apply unclaimed sale proceeds in the administrations of the companies.

How can secured parties mitigate risks from PPSA?

There are a number of serious, adverse implications of the decision in Carson No.3 for financiers. Firstly, the sale will result in the deduction of sale costs and the expenses and remuneration of the Administrators for their work in realising and preserving collateral, and hence an erosion of the security. Secondly, the application of unclaimed sale proceeds subordinates registered security interests to Hastie Group's banks, which have all assets security. Thirdly, transitional security interests intended to attach to and be enforceable against collateral which the Administrators have been unable to identify, are also subordinated to the banks' security.

Under the old law, a loss of priority to a competing secured creditor rarely occurred, and then, it did not usually happen because of the information in the register. PPSA presents a greater risk to secured parties because of problems that can occur in identifying the owner of collateral or a secured party having an interest in it. Secured parties should register their interests in the PPSR so as to identify the security agreement giving rise to the interest, the collateral (eg by serial or other number), provide in the register a contact name and email address for inquiries, register transitional security interests and ensure they are aware of the location of their collateral at all times.

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