THE LAW SOCIETY
OF NEW SOUTH WALES

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9 November 2020

The Hon Wes Fang MLC
Committee Chair
Standing Committee on Law and Justice
Legislative Council
Parliament House, Macquarie Street
Sydney NSW 2000

By email: law@parliament.nsw.gov.au

Dear Mr Fang,

2020 Review of the Compulsory Third Party insurance scheme

The Law Society of New South Wales welcomes the opportunity to provide a submission to the Standing Committee on Law and Justice's (Standing Committee) review of the NSW Compulsory Third Party (CTP) scheme, the second since the creation of the 2017 CTP scheme through introduction of the *Motor Accident Injuries Act 2017* (the MAI Act).

The Law Society is the state's peak legal representative body and our members represent plaintiffs and insurers, all of whom are key stakeholders in the scheme.

In this submission, we discuss the following matters:

1. Access to legal representation under the CTP scheme;
2. Issues with the minor injury definition;
3. The 20-month waiting period for making a damages claim;
4. Issues in the Dispute Resolution Service;
5. Legal costs under the scheme; and
6. Legislative drafting issues.

1. Access to legal representation under the scheme

As raised in our previous submission to the Standing Committee as part of the 2018 Review into the CTP scheme, the Law Society continues to hold strong concerns about access to justice issues under the current CTP scheme. We note that under the current scheme, various claims continue to be dealt with in circumstances where claimants may not have access to appropriate and independent legal advice, which, given the complexities of the scheme, we consider a real barrier to just and equitable outcomes.

We note that, according to the most recent publicly available data provided by the State Insurance Regulatory Authority (SIRA), over the past 12 months, only 22% of claimants have

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had legal representation.[1] While the Law Society supports the development of a non-adversarial CTP insurance scheme, in practice, the current systems and structures do not support this objective. The complexity of the scheme and the power imbalances between parties necessitates the availability of legal assistance. Indeed, we consider that many of the fundamental problems with the current CTP scheme have occurred as a direct result of the decision to remove or significantly reduce the role of lawyers in the scheme without similar attempts to build processes to ensure that injured people are given access to the benefits they are entitled to or the treatment they need to recover. We continue to hold the strong view that reasonable funding for legal representation is crucial to the operation of the CTP scheme.

We note that on 1 March 2021, the Personal Injury Commission (PIC) will be established, with jurisdiction over CTP disputes. In our various submissions to the Government in relation to the establishment of the PIC, the Law Society has continued to advocate that the primary consideration in establishing a joint Commission must necessarily be whether such a Commission would result in better outcomes for parties involved in the process.

We note that the Standing Committee's 2018 Review of the Workers Compensation Scheme report recommended (recommendation 3):

> *'That the NSW Government preserve the Workers Compensation Independent Review Office and Independent Legal Assistance and Review Service in the workers compensation scheme, and expand its services to claimants in CTP insurance scheme disputes.'*

The Law Society considers that the approach to funding for legal representation is crucial to the development of the PIC. The Law Society continues to hold strong concerns that without appropriate consideration being given to developing a model for legal representation in the Motor Accidents Division of the PIC, accessibility issues will continue to manifest.

As we have advocated for previously, the Law Society supports the role of the Independent Legal Assistance and Review Service (ILARS), managed by an independent Workers Compensation Independent Review Office (WIRO). We support the availability of an ILARS-type model to legal funding being extended to statutory benefits disputes in the 2017 CTP scheme. In line with the Standing Committee's Recommendation 3, we recommend the expansion of the WIRO's jurisdiction to provide services to claimants in CTP statutory benefits disputes.

We note that SIRA is currently conducting a review into the provision of legal services under the CTP scheme, which includes considering the feasibility of expanding the ILARS scheme to cover CTP disputes. The Law Society welcomes this review and urges the Government to ensure that claimants under the CTP scheme are given the same access to legal representation as injured workers are under the workers compensation scheme.

2. The minor injury definition

Throughout the 15-month reform process leading up to the introduction of the 2017 CTP insurance scheme, the Law Society engaged in comprehensive discussions with the NSW Government, providing in-depth policy advice and recommendations to help shape a new CTP insurance scheme. While recognising the issues with the former scheme under the *Motor Accident Compensation Act 1999* (MAC Act), and that there would inevitably be some 'losers' in the new scheme, our recommendations focused on ensuring the 'losers' were not, in fact, the vast number of injured people the scheme was specifically designed to protect and

[1] State Insurance Regulatory Authority, "CTP Open Data" portal, accessed 20 October 2020 <https://www.sira.nsw.gov.au/CTP-open-data>.

compensate. We advocated in favour of upholding fairness for injured motorists as the primary objective for a new CTP scheme.

When the Government's proposal for a minor injury test was first proposed in 2017, the legal profession raised strong concerns. We feared the overly restrictive definition, which fails to account for appropriate nuances or the real-life consequences of a person's injury, would have adverse outcomes for many moderately to seriously injured people in NSW.

In the three years since the minor injury definition's introduction, anecdotal evidence available to the Law Society, including from our members, doctors and claimants, suggests the minor injury definition has resulted in a significantly harsher treatment of claimants than under the previous scheme. We are seriously concerned that this definition is operating to deprive many genuinely injured people of appropriate benefits and compensation, despite the legitimacy and accepted reality of their injuries.

The definition of minor physical and psychological injuries

The definition of 'minor injury' goes to the very essence of the CTP scheme. It is central to the functioning of both the statutory and common law branches of the scheme. It is the mechanism by which statutory benefits may be cut off six months after the accident, and the means by which a person's ability to claim common law damages is determined.

'Minor injury' is defined in section 1.6 of the MAI Act, which empowers the *Motor Accident Injuries Regulation 2017* (the Regulation) to specify injuries that are, or are not, minor injuries.

The legislation defines minor physical injuries as soft tissue injuries. It covers an injury 'to tissue that connects, supports or surrounds other structures or organs of the body' but not an injury 'to nerves or a complete or partial rupture of the tendons, ligaments, menisci or cartilage'.[2]

The Regulation specifies that injury to a spinal nerve root manifesting in neurological signs, but not radiculopathy, is a minor injury.

The *Motor Accident Guidelines* (the Guidelines) list the five signs of radiculopathy, of which two must be present for there to be a non-minor injury (loss of asymmetry of reflexes, positive sciatic nerve root tension signs, muscle atrophy, muscle weakness referable to an appropriate spinal nerve root distribution and reproducible sensory loss referable to an appropriate spinal nerve root distribution).

The MAI Act defines a minor psychological or psychiatric injury as an injury that is not a recognised psychiatric illness. The Regulation includes an acute stress disorder or adjustment disorder, within the meaning of DSM-5[3], as a minor injury for the purposes of the Act.

Issues with the minor injury definition

The focus of the minor injury definition is on the categorisation of the objectively proven pathology related to the injury, not on the disabilities or impact flowing from that injury. By attempting to focus on how an injury can be diagnosed objectively, without any contemplation of the real-life consequences of a person's injury, we consider this definition leads to arbitrary, counterintuitive and unfair outcomes for claimants.

[2] *Motor Accident Injuries Act 2017* (NSW), section 1.6.
[3] *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition, published by the American Psychiatric Association 2013.

The Law Society reiterates the position we have put forward previously that many of the injuries categorised as 'minor' or 'soft tissue' injuries within the meaning of section 1.6 of the MAI Act are in no way minor with regard to the impact of the injuries on the day-to-day life and / or employment of a claimant.

We are particularly concerned the definition results in unfair outcomes for injured people with persistent physical and psychological symptoms who, despite having diminished work capacity after an accident, are nevertheless cut off from access to statutory benefits at 26 weeks and have no recourse to common law claims for damages, because under the legislation, their injuries are considered 'minor'.

Spinal injuries

Under the Guidelines, the line between minor and more serious nerve root injuries is the presence of verifiable radiculopathy. Under the AMA4 Guides, verifiable radiculopathy is sufficient to meet an assessment rating of DRE III, which provides for a 10% whole personal impairment (WPI) evaluation in relation to the lumbosacral spine and 15% WPI evaluation in relation to the cervicothoracic spine and thoracolumbar spine.

We note the group of spinal injury victims who have long-term consequences are mostly those who have suffered some insult to intervertebral discs and have pain which radiates into a limb, but whose injury falls short of the 'verifiable radiculopathy' a DRE III assessment requires. We understand the minor injury test is also being applied to capture, as minor injuries, disc injuries that do not result in an external rupture of the outer ligamentous structure (for example, an annular tear). Law Society members have noted numerous instances where disc bulges in the cervical or lumbar spine (without an external rupture of the outer ligamentous structure) have been classified as a 'minor injury' despite these injuries preventing a claimant from returning to employment at, or at periods approaching, the 26-week mark. Even those suffering from annular tears are not assured of avoiding categorisation as a minor injury (see, for example the Review Panel Certificate which is referenced in the judicial review decision of Harrison As J in *Briggs v IAG t/as NRMA Insurance* [2020] NSWSC 1318).

Some injured people under the MAC Act have been assessed as having soft tissue injuries to the cervical, thoracic and lumbar spine, attracting a DRE II rating of 5% to all three levels of the spine and an overall assessment of 15% WPI. Despite such injuries involving ongoing pain, often radiating from the spine into a limb, stiffness and muscle spasms, and although entitled to non-economic loss, claimants under the current scheme cannot recover damages for that non-economic loss because they will be assessed as having a minor injury, which prevents them recovering any damages at all. Conversely, a person may sustain a chipped tooth in a motor vehicle accident which is highly likely to attract a 0% WPI, but which is considered a non-minor injury, despite that injury having no impairment on any part of their work or domestic life.

If the Government's intention is to protect people with genuine injuries who suffer economic loss, we submit that the current application of the 'minor injury' test is not achieving this outcome. We restate our position that the DRE III classification is much too high with respect to excluding minor neck and back injuries from ongoing statutory benefits and the damages regime. We also note the lack of nuance in minor injury determinations and the arbitrary line drawn between minor and non-minor injuries, with no regard to the real-life consequences of an injury.

To ensure claimants with legitimate and incapacitating symptoms are afforded the protection and compensation they require, we strongly urge the Standing Committee to consider this definition as part of the review. We suggest consideration be given to amending either the 'minor injury' definition in the MAI Act or clarifying in the Regulation that:

1. injuries assessed as DRE II are excluded from the definition of 'minor injury', and
2. any person assessed with a combined whole person permanent impairment of greater than 10% is taken as having non-minor injuries.

Psychological injuries

Psychological injuries are rarely evident immediately after an accident. The true extent of the injury may not surface until after the insurer has made its minor injury decision or even after the first 26 weeks following the accident. For the surviving spouse, post-traumatic stress disorder (PTSD), for example, may not present until the acute stage of grieving has passed, and a claimant with a minor physical injury causing unremitting pain may not develop a substance abuse disorder for a year after an accident.

There is also an inherent inconsistency with the minor injury threshold requirements and a medical practitioner's ability to diagnose a DSM-5 psychological condition. For example, if a claimant does not experience psychological symptoms immediately after the accident, the DSM-5 requires that a period of six months pass before a diagnosis of PTSD can be made. In such circumstances, the diagnosis would occur after the insurer has made its minor injury determination, depriving the claimant of their ongoing statutory entitlements.

We consider it manifestly unfair to deny a claimant benefits due to a delayed onset of symptoms. We therefore recommend that:

1. statutory benefits be required to continue beyond six months if a claimant is unable to be diagnosed for minor injury purposes, and
2. the insurer's minor injury determination be reviewable upon receipt of further evidence which demonstrates a non-minor injury exists.

The Law Society is also concerned with the categorisation of all adjustment disorders as being 'minor'. The problem is that DSM-5 relevantly divides adjustment orders into two separate categories: acute and persistent on the one hand, and chronic disorders on the other. By definition, an acute adjustment disorder cannot last more than six months, so there is no difficulty with classifying such an injury as being minor. However, we are concerned about a chronic adjustment disorder being categorised as minor when significant symptoms are still experienced a number of years post-accident. It is quite conceivable that a condition diagnosed as a chronic adjustment disorder can be assessed above 10% whole person impairment yet it is still categorised as a minor injury because of the blanket categorisation of all adjustment disorders as being minor injuries pursuant to section 4 of the Regulation.

We therefore suggest that only acute adjustment disorders should be classified as 'minor'.

SIRA's review of the minor injury definition

In 2019, SIRA conducted a review of the minor injury definition. SIRA published its report, 'Review of Minor Injury Definition in the New South Wales CTP Scheme'[4] in February 2020, ultimately concluding that the minor injury definition and its application is consistent with the intended outcomes of the MAI Act.

The Law Society brings to the Standing Committee's attention, the following information outlined in SIRA's report:

- Out of the 4,768 not at fault minor injury claims, 2,878 were classified as neck and back

[4] SIRA, "Review of the Minor Injury Definition in the NSW CTP Scheme", February 2020 <https://www.sira.nsw.gov.au/__data/assets/pdf_file/0005/600737/Review-of-Minor-Injury-Definition-in-the-NSW-CTP-Scheme-report.pdf>.

injuries. In other words, soft tissue spinal injuries constitute around 60% of minor injury claims.

- While the data indicates that 76% of persons with minor injuries have returned to work after 26 weeks, there is no information provided about what happened to the remaining 24%. We also query whether this failure to return to work is a long-term issue. It is noteworthy that for labourers, the return to work rate after 26 weeks is 70%. There is no analysis in relation to what happened to the 30% of labourers who have not returned to work after 26 weeks.
- The latest figures the Law Society has access to, published by SIRA in June 2020, indicate that only 9% of insurer internal reviews for minor injury decisions resulted in a decision in favour of the claimant. In these circumstances, we query the utility of the internal review process, at least in relation to minor injury decisions by insurers.[5]
- The data discloses that 59% of minor injury claims that involve a spinal injury were active for the purposes of treatment and care beyond 26 weeks. We consider that this indicates that typical whiplash injuries are likely to have longer term treatment and care needs and it is unclear whether these needs are being met.

Based on these findings, we are concerned that significant adverse outcomes are being experienced by labourers with soft tissue spinal injuries. Further, based on the openly available data SIRA produces under its Open Data Analysis tool, at October 2020, 8,094 people had been assessed as having suffered a minor injury, while 6,187 injured persons have been assessed as having sustained a non-minor injury. This means that nearly 57% of persons who have thus far been assessed under the minor injury test have been assessed as minor.

Proposed way forward

The Law Society suggests that the minor injury definition the Government has developed has resulted in genuinely incapacitated people being denied proper compensation because their disability does not meet the demanding test imposed by the legislation. We submit the current definition is not operating as intended and we urge the Standing Committee to consider alternatives to it as part of this review.

The recommendations we have made throughout this section assume the maintenance of the existing 'minor injury' definition, notwithstanding the various issues associated with it. In our view, however, a better approach would be for the Government to reconsider and reformulate the minor injury definition.

We therefore reiterate the position we put forward in 2016 and 2019 directly to SIRA, that instead of the current 'minor injury' definition, a 'narrative test' should be developed, which includes objective evidence of physical or psychological injury, but that does not rely solely on a number (for example, a WPI percentage). Instead, such a test should also consider the consequences of the injury on a person, and contain elements along the lines of:

- A permanent reduction in physical, psychosensory or intellectual potential that is the result of an anatomo-physiological injury:
  - that can be detected medically and can therefore be assessed on the basis of appropriate clinical testing, supplemented by a study of additional tests furnished (eg MRI, x-ray, CT scan, etc), and
  - that is compounded by pain phenomena and psychological impacts or ordinarily associated with the sequelae described, as well as consequences in everyday life that are customarily and objectively associated with such injury.

[5] SIRA, "CTP Insurer Claims Experience and Customer Feedback Comparison", 30 June 2020 <https://www.sira.nsw.gov.au/__data/assets/pdf_file/0004/909256/CTP-insurer-claims-and-experience-and-customer-feedback-comparison-June-2020.pdf>.

3. 20-month waiting period for making a claim for damages

The Law Society notes that an injured person may, in defined circumstances, claim damages for economic loss (Div 4.2 of the MAI Act), and damages for non-economic loss (Div 4.3 of the MAI Act).

However, an injured person may only ordinarily claim common law damages where they can prove the accident was the fault of another person. While statutory benefit claims are made in the immediate aftermath of the accident, common law claims with no pain and suffering entitlement cannot ordinarily be made until 20 months have passed.

We note that the 1999 MAC Act scheme was plagued by small claims, and that the increased frequency of these claims resulted in the introduction of a $50,000 legal fee contracting-out cap. When the 2017 CTP scheme was introduced, various mechanisms were included in the scheme to remove the frequency of these claims, including:

i. a $75,000 legal fee cap,
ii. a minor injury threshold, and
iii. a 20-month prohibition on common law damages settlements.

Noting our comments above, we consider that the minor injury definition is arguably working better than intended to remove small claims from the system. Noting the current restrictions in place, and in the absence of substantive amendments to the minor injury definition, the Law Society queries whether the 20-month waiting period before making a common law damages claims is still required.

In our view, injured people who have 'non-minor' injuries should not have to wait 20 months to receive compensation for their injuries if small claims have already been removed from the scheme at the 26-weeks post-accident mark. The Law Society considers that the 20-month application rule is an unnecessary friction point in the scheme which directly contradicts subsection 1.3(2)(g) of the MAI Act, which is 'to encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes'.

The 20-month delay before an insurer is formally notified of a damages claim also has a delaying factor on the readiness of the matter to proceed to a damages settlement or assessment. This is because an insurer typically does not commence investigations of the claim (including medical assessments) until they have received formal notification of a damages claim. Given the limited timeframe of three months within which the insurer is required to respond to service of a damages claim, it should be unsurprising that our members are aware of incidents where there has been some delay occasioned by insurers ensuring all medico-legal and other evidence is collated before the claim is assessed. The experience of many of our members is that there appears to be a reluctance among some insurers to make a decision about whether the claimant does or does not pass the threshold to recover damages for non-economic loss. This creates further issues in resolving the dispute because the DRS has been unwilling to refer a non-economic loss determination to a medical assessor unless a dispute arises.

Finally, we consider that section 6.23 of the MAI Act, which prevents any settlements within two years of the motor accident unless the claimant's whole person impairment is greater than 10%, creates additional unnecessary delays. This provision prevents parties from settling a claim, or even meaningfully discussing settlement of a claim, until a further four months have passed after the damages claim has formally been made. Noting that section 6.22 of the MAI Act only requires an insurer to make a reasonable offer of settlement 'as soon as practicable', we consider section 6.23 discourages prompt settlement discussions.

4. Issues in the Dispute Resolution Service (DRS)

The COVID-19 pandemic has had a significant impact on a range of services, both at the state and national level. While the Law Society is conscious that in these unprecedented times, it may be difficult for governments to adapt and respond, we are becoming increasingly concerned that the already significant delays in the DRS have been further exacerbated by the pandemic.

We understand there is now backlog of over six months for DRS medical and other assessments. We are becoming increasingly concerned that this is causing significant problems for many claimants who are unable to have their matters considered, and may, in the interim, suffer significant financial disadvantage, particularly if their statutory benefits are cut off and they do not have access to Centrelink payments.

Despite the schemes being similar in nature, the Law Society is not aware of similar delays having occurred in the Workers Compensation Commission. The Law Society suggests that the NSW Government needs to urgently consider mechanisms to reduce this backlog.

One solution to address these issues now and into the future would be for an amendment to the MAI Act to enable a stay of an insurer's earning capacity or minor injury decision, pending a DRS assessment. We note this is available in the workers compensation scheme, under section 289B of the *Workplace Injury Management and Workers Compensation Act 1998,* and consider a provision along those lines may enhance access to justice for claimants under the CTP scheme.

5. Legal costs

As outlined above, given the complexity of the issues and processes involved, the Law Society considers that the availability of expert legal advice to help all stakeholders under the CTP insurance scheme is essential to creating a fair compensation scheme. It also ensures an outcome which achieves justice for all parties. The Law Society continues to hold strong concerns that the costs available to legal practitioners for services under the scheme are inadequate, and represent a significant underfunding of the work required of lawyers working in the system, particularly in the context of statutory benefit disputes.

We consider it is fundamental that the Regulation reflects the reality of costs incurred. We understand that some legal practitioners are, on occasion, having to personally bear costs incurred outside of those provided for in the Regulation. This is not a sustainable model for practice. We are particularly concerned that without resolution of this issue, the availability of competent legal practitioners to assist stakeholders under the scheme may diminish as the administrative and other costs associated with professional legal services continue to make the provision of those services under this scheme untenable for many practitioners. This will inevitably have an adverse impact on the capacity of decision-makers to resolve disputes in a timely, just and cost-effective manner, and on the ability of injured people to access justice.

The Law Society suggests that this Committee consider, as part of this Review, the growing issues arising from a prohibitive regulated costs framework contained in the Regulation. The Law Society suggests that Schedule 1 to the Regulation be reviewed in its entirety. We note that SIRA has commissioned its own independent review of legal support available under the scheme and we welcome this development.

<u>Costs model</u>

The Law Society has identified various unintended consequences associated with the regulated costs provisions under the MAI Act and Regulation. We are particularly concerned that the relevant provisions do little, in practice, to incentivise the early resolution of disputes.

We note this is contrary to the objects of the Act, which include to 'encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes'.[6]

Insurer representatives

We note that under clause 3 of Schedule 1 to the Regulation, where an insurer's solicitor can demonstrate to a Dispute Resolution Officer that a review is not merited, insurer representatives are entitled to recover payment of up to 8 monetary units. Where the dispute proceeds to a review panel assessment, both parties can recover 16 units.

In our view, the reduced fee for bringing the dispute to an end at an early stage fails to account for the fact that a reply involves a two-step process:

1. the respondent must address whether there is cause to suspect error; and then
2. if such cause exists, the merits of the application regarding the subject matter must be dealt with.

In practice, this is dealt with in a single reply, which means the same amount of work goes into a reply regardless of what stage the dispute is determined. This is a cost-effective way to manage the dispute, but it may involve a detailed set of submissions addressing the relevant authorities around the alleged legal error.

We query the rationale behind lowering the recoverable fee for the quick resolution of the dispute if an insurer representative has been wholly successful in preventing an unmerited claim proceeding to the DRS and ultimately, saving the scheme costs. We understand the cost of convening three assessors for a review panel would be greater than 8 units.

The Law Society is concerned these provisions, which result in legal representatives recovering lower fees for better outcomes, act as impediments to proper legal representation in the motor accidents scheme.

We recommend subparagraph 1(3)(b)(ii) of Schedule 1 to the Regulation be amended to remove the 8 unit restriction and enable legal representatives to recover costs in line with the recoverable amount for disputes that progress to the DRS for review.

Claimant representatives

Similar issues with the regulated costs regime exist for claimants and their legal representatives. For example, we note there is no provision for recovery of costs for initial advice or ad-hoc telephone advice. We consider an increased focus on initial advice would help with claimant expectations in relation to the 26-week cut-off period for statutory benefits, and would reduce unnecessary disputation by unrepresented claimants.

We also note claimant lawyers do not receive a fee if a dispute does not proceed past the internal review point, even where they have done a significant amount of work which has resulted in an insurer overturning the original decision.

We are concerned that, as a result, more disputes proceed to the DRS for review when, if appropriately resourced, claimant lawyers may be more successful in helping to resolve the matter during the initial stages of the process.

We recommend provision be made for recovery of costs by claimants' lawyers for advice or services provided at any stage of the review process.

[6] *Motor Accident Injuries Act 2017,* subsection 1.3(2)(g).

PAWE and other weekly payment disputes

The Law Society understands that the initial reasoning behind not allowing legal fees for pre-accident weekly earnings (PAWE) and other weekly payment disputes, was the assumption that injured people would be able to work out the payments with the insurer's assistance.

In practice, however, PAWE has become one of the most complex issues in the CTP scheme. In our view, legal representatives should be able to assist claimants with PAWE and weekly payment disputes, and should be entitled to legal fees for those services.

Further, we note instances of at least one insurer that has had significant issues relating to PAWE in their systems. However, SIRA's compliance reviews, and/or the penalties they have imposed, are not publicly available. We consider SIRA should be required to publish all regulatory determinations and penalties in a central, easily accessible place. This would enhance scheme transparency.

Recovery of costs and expenses

We note that some insurers refuse to pay legal representatives for medical disputes without a cost order. This is because clause 2 of Schedule 1 to the Regulation provides that costs for medical disputes can only be allowed by a claims assessor or a court. This is problematic because medical disputes are routinely referred by DRS directly to a medical assessor (not a claims assessor) who has no power to award costs. In our view, this is an unnecessary scheme friction which should be addressed. We suggest that the legislation be amended to empower insurers to pay legal fees and disbursements in all applicable statutory benefit disputes without the need for an order from the DRS.

6. Legislative drafting issues

The Law Society has raised concerns previously over some legislative drafting issues in the CTP scheme. Many of these issues have not been addressed, and we therefore request the Standing Committee's consideration and review of these ongoing issues during the current inquiry.

Section 7.23: The binding nature of medical assessment decisions

The use of the word 'conclusive evidence' in paragraph 7.23(2)(b) of the MAI Act operates to make a DRS medical decision, including those that relate to earning capacity, binding on a court or the DRS (in relation to both a claims assessment and merits review). The only exception to the binding nature of these decisions is where the court, under subsection 7.23(3), considers that there has been a denial of procedural fairness.

In practice, this means that a medical assessor could find a claimant:

- fit to return to full time pre-injury duties – meaning no earning loss and therefore no loss of capacity, or
- fit to return to suitable duties with no earning loss – meaning no loss of capacity.

In both cases, paragraph 7.23(2)(b) of the MAI Act would preclude the claims assessor, merit reviewer or court from making any findings contrary to the that of the medical assessor, absent a successful application for review or further medical assessment under section 7.24 or 7.26 of the MAI Act. The operation of subsection 7.23(2) of the MAI Act therefore effectively turns economic loss claims into a medical assessment issue. We consider this may have significant consequences in a claim for damages if the claimant receives an unfavourable result during a

DRS medical assessment (see clause 8(3) of Schedule 1 to the MAI Act and clause 4.58 of the Guidelines).

Schedule 2 of the MAI Act makes earning capacity decision disputes the exclusive jurisdiction of a medical assessor. We note that in the workers compensation scheme, however, the earning capacity decision's equivalent is called a Work Capacity Decision, and such disputes are determined by arbitrators.

We are concerned about the implications of this provision in circumstances such as in relation to the below case study:

- A process worker suffered a fractured wrist (non-minor injury) and loses his employment due to his inability to return to work after a motor vehicle accident.
- The claimant is unable to find another job due to his age (55), injuries and language difficulty (English is not his first language).
- At week 60, the claimant is subject to an earning capacity assessment. The insurer's earning capacity decision relies on a vocational assessment which deems him fit to work as a store man on the basis he does not do lifting above 15 kg; a console operator; or a process worker. (Insurers' earning capacity decisions will often rely on a vocational assessment of the claimant's ability to do some work. The work does not need to exist or be readily available.)
- The claimant lodges a DRS application and the DRS medical assessor finds that he has capacity to work in all proposed vocations, that he can earn a certain amount of money in excess of his pre-accident weekly earnings and that there is no entitlement to weekly statutory benefits.
- The claimant is not paid for 20 weeks. He still is not able to find a job.
- At week 80 (20 months), he makes a damages claim, and the same is accepted.
- Theoretically, under section 7.23, the DRS medical assessor's finding is binding on the claims assessor and the claimant is not able to claim any future economic loss.

To address these issues, the Law Society suggests that section 7.23 of the MAI Act:

- should be reworded to enable a DRS medical assessor's findings on earning capacity to be binding only in relation to the provision of statutory benefits, or
- as an alternative, should be made a merit review or miscellaneous claims assessment matter to be determined by a merit reviewer or a claims assessor.

<u>Section 7.52: the role of Authorised Health Practitioners</u>

Section 7.52 of the MAI Act operates to prevent parties relying on a report from a health practitioner in proceedings for damages or for a statutory benefits dispute, unless the practitioner is either a treating health practitioner or is a practitioner who is authorised under the Motor Accident Guidelines. In our members' experience, the issues with this provision include that the list of Authorised Health Practitioners appearing on the SIRA website is subject to regular change, such that it is not always easy to ascertain whether a particular specialist is currently authorised or not. Our members have also advised that a number of doctors have been removed from this list without their knowledge. The difficulty with a restricted list of Authorised Health Practitioners is that those practitioners are expected to accept fees for providing medico-legal reports which are significantly below market rates for such reports. Under clause 28 of the Regulation, the maximum fee payable for a medico-legal report is currently $1,660.00.

Given these difficulties, the Law Society submits that the restrictions imposed by section 7.52 should be removed. Alternatively, we consider that SIRA should not require the health practitioners on that list to take active steps to retain their authorisation, but that SIRA should

still be empowered to take disciplinary action against recalcitrant health practitioners in extreme circumstances where removal from the list may be justified.

Time limits in the scheme

Subsection 6.13(2) provides that if a statutory benefits claim is not made within 28 days after the motor accident, a claimant cannot recover statutory weekly income benefits for the first 28 days. There is no discretion provided in relation to this.

The Law Society notes instances where a claimant may not be in a position to make the claim – for example they may not be aware of the requirement (in instances where a person has been injured just outside the ACT and has been taken to a hospital in Canberra), or may not be in a fit state to make a claim (for example, if they are in a coma).

The Law Society suggests that SIRA conduct a review of all the time limits in the MAI Act, with a view to evaluating how they are working, whether they should remain as is or be tempered with a discretion. This would be particularly timely now that the DRS has moved online and the legal profession continues to work with SIRA on various issues associated with the online portal. We note, for example, that the DRS online portal was recently offline for several days. This is likely to prove problematic in circumstances where strict time limits are enforced and hand delivery or delivery by document exchange is no longer available to legally represented parties.

If this recommendation is adopted, the Law Society would welcome the opportunity to contribute to such a review.

Issues raised by judicial decisions

There have been a number of recent judicial decisions which have raised various issues with the drafting of the MAI Act.

AAI Limited v Singh [2019] NSWSC 1300

In the decision of *AAI Limited v Singh [*2019] NSWSC 1300 (the *Singh* decision), Justice Fagan of the Supreme Court considered the operation of sections 5.1 and 5.6 of the MAI Act. Section 5.1 of the Act defines a 'no-fault motor accident' as:

> a motor accident in the state not caused by the fault of the owner or driver of any motor vehicle involved in the accident in the use or operation of the vehicle and not caused by the fault of any other person.

Section 5.6 of the Act provides:

> A person whose liability for damages or statutory benefits in respect of the death of or injury to a person results from the person being deemed under this Part to be a person whose fault caused the death or injury is entitled to recover contribution in respect of that liability from a person (whether or not the driver of a motor vehicle) whose fault actually caused the death or injury.

His Honour reasoned that the clear meaning of the 'no-fault motor accident' definition under section 5.1 of the Act rendered section 5.6 'redundant' and of no effect.[7] His Honour found it was not possible to reconcile a provision limiting Part 5 to accidents where no one is at fault

[7] *AAI Limited v Singh* [2012] NSWSC 1300 at [18].

with a provision in that same Part allowing the recovery of damages from a person whose fault actually caused the accident.[8]

Justice Fagan concluded his judgement in the *Singh* decision with the recommendation that Parliament amend the MAI Act, either to:

1. reflect the intention provided under section 5.1 of the Act that Part 5 only applies to accidents where no one is at fault, by repealing section 5.6,[9] or
2. in the alternative, if the Parliament intended to give effect to section 5.6, then amending the definition of a 'no-fault accident' under section 5.1 to reflect that intention.[10]

The Law Society suggests that the MAI Act be amended to reconcile the contradictions between sections 5.1 and 5.6.

At paragraph 27 of his judgment, his Honour also recommended amending Chapter 5 of the MAI Act to remove any reference to statutory benefits. Section 3.1 entitles a person injured in a motor vehicle accident in NSW to recover statutory benefits in circumstances where the accident was caused by the fault of someone or where it was a no-fault accident, even if the person claiming the benefits was at fault and caused their own accident. We note that if Chapter 5 was so amended, it would continue to operate to extend common law lump sum damages to people injured in no-fault accidents.

Noting Justice Fagan's decision, the Law Society also suggests that SIRA urgently:

1. review information contained in relevant databases in relation to all blameless, no-fault or inevitable accident claims,
2. notify relevant insurers in those cases of the recent decision, and
3. require insurers to contact claimants who have had their benefits terminated in similar situations to Mr Singh and immediately take action to restore those benefits.

AAI Ltd trading as GIO v Moon [2020] NSWSC 714

In *AAI Ltd trading as GIO v Moon* [2020] NSWSC 714, Justice Wright of the Supreme Court of NSW considered the interaction between sections 8.3 and 8.10 of the MAI Act.

In his decision, Justice Wright determined that win, lose or draw, a claimant is entitled to costs as there is nothing in the MAI Act to prevent an award of costs to an unsuccessful party.[11]

Justice Wright noted there are two main provisions relating to costs: section 8.3, which deals with costs between a party (claimant or insurer) and their lawyer, and section 8.10, which deals with the costs between two parties (claimant and insurer) and prevents an insurer recovering costs from the claimant, but does allow a claimant to recover costs from the insurer.[12] His Honour found that under subsection 8.10(3) of the MAI Act, there are two means by which a claimant can be paid costs by an insurer; either because the Regulation provides for it, or because DRS permits it. His Honour found, therefore, that there are two corresponding categories of legal costs recoverable from an insurer:

a) all legal costs that do not exceed the maximum costs fixed in the Regulation; and
b) costs which exceed the maximum costs fixed by the Regulation if DRS permits this, in accordance with the circumstances set out in subsection 8.10(4).

[8] Ibid.
[9] *AAI Limited v Singh* [2012] NSWSC 1300 at [26].
[10] Ibid.
[11] *AAI Ltd trading as GIO v Moon* [2020] NSWSC 714 at [82].
[12] Ibid, see [70], [72] and [74].

Justice Wright determined that DRS can permit the payment of legal costs over and above the regulated amounts if the claimant is under a legal disability or because there are exceptional circumstances in the claim. This is because solicitors acting for infants or persons without legal capacity might be required to undertake more work than for a claimant without such legal disability.[13] Other cases may be exceptional because of an 'unusual degree of factual or legal complexity … requiring the incurring of more substantial legal costs by a claimant'.[14] His Honour acknowledged that costs still had to be reasonable and necessary, but he clearly recognised that for some claims, costs over and above the regulated amounts can be recovered from the insurer.

The Law Society notes that section 8.10 of the MAI Act only applies to claimants, and not insurers. To address the disparity between the costs available to claimant and insurer lawyers, the Law Society suggests that the MAI Act be amended to clarify that, in line with the Supreme Court's decision, costs over and above the regulated amounts be recoverable by both claimants and insurer lawyers.

Thank you again for an opportunity to comment on this consultation. Should you have any questions in relation to this submission, please contact Adi Prigan, Policy Lawyer, on (02) 9926 0285 or email Adi.Prigan@lawsociety.com.au.

Yours sincerely,

Richard Harvey
President

[13] Ibid, at [98].
[14] Ibid, at [99].