Judicial Review of Personal Injury Commission Determinations:

Recent Decisions in NSW

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Thanks to Mark Robinson SC, Maurice Byers Chambers, for his contributions to this paper

MOTOR ACCIDENTS INJURIES ACT 2017 (NSW) CASES

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

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

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

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

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

Section 3.2(5) of the Act provides:

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

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

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

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

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

"no-fault" accident because there was fault on the part of someone, namely, the person who had negligently loaded the truck.

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

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

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

***AAI Ltd trading as GIO v Moon* [2020] NSWSC 714 (Wright J)**

The claimant made a claim for statutory benefits against GIO. Liability for the statutory benefits claim was denied on the basis that GIO alleged that the accident was caused mostly by Mr Moon's fault. Therefore, Mr Moon applied to DRS for a determination as to whether he was wholly or mostly at fault. This application was assessed under Pt 7, Div 7.6 of the MAI Act by the DRS as a "miscellaneous claims assessment matter" within Sch 2 cl 3(d) and (e) of that Act.

DRS determined that the accident was caused wholly by the fault of Mr Moon. He was awarded costs of the DRS dispute. The DRS Assessor said, in awarding costs:

> *"In accordance with s 8.3(4), s 8.10(3) and 8.10(4)(b) due to there being exceptional circumstances, I permit payment of the Claimant's reasonable and necessary legal costs incurred by the claimant in connection with the dispute outside the regulated amount prescribed by the Motor Accident Injuries Regulation."*

Section 8.10(3) provides that a claimant is only entitled to recover legal costs from an insurer under subs (1):

> *"if payment of those costs is permitted by the regulations or the Dispute Resolution Service".*

Under s 8.10(4), the DRS "can permit payment of legal costs incurred by a claimant but only if" the DRS is satisfied that:

> (1) the claimant is under a "legal disability" – s 8.10(4)(a); or
>
> (2) "exceptional circumstances exist that justify payment of legal costs incurred by the claimant" – s 8.10(4)(b).

The issue was whether it was lawful to award costs beyond the amount specified in the regulation. GIO contended that costs could not be awarded at an amount higher than allowed by the regulations, by virtue of sections 7.37, 7.42 and 8.3.

His Honour said, at [103] – [104]:

> *103. For all of these reasons, in summary, the legal costs that a claimant for statutory benefits is entitled to recover and be paid under s 8.10, are the "reasonable and necessary" legal costs "incurred by the claimant" in connection with the claim:*
>
> - *(1) where those legal costs do not exceed the relevant maximum legal costs fixed by the regulations made under s 8.10(2) and thus the payment of those legal costs is "permitted by the regulations"; and*
> - *(2) where those legal costs exceed the relevant maximum legal costs fixed by the regulations but the DRS:*
>   - *(a) is satisfied that the claimant is under a legal disability or that exceptional circumstances exist; and*
>   - *(b) has permitted the payment of those legal costs, in accordance with s 8.10(4).*
>
> *104. That conclusion does not, however, resolve all the relevant issues in this matter. The amount recoverable by a claimant from an insurer under s 8.10(1) for legal costs must also be "reasonable and necessary" and they must have been "incurred by the claimant in connection with the claim".*

In relation to the issue of when legal costs are "incurred" for the purposes of the legislation, his Honour said (at [144]):

> *144. For all of these reasons, on the proper construction of "incurred" in s 8.10(1) and of s 8.3, legal costs in connection with a statutory benefits claim are incurred:*
>
> - *(1) where the legal costs do not exceed the maximum costs fixed by the regulations under s 8.3(1), when the claimant becomes liable to pay and the lawyer becomes entitled to be paid and recover those legal costs in accordance with the Legal Profession Uniform Law and other relevant legal principles;[5] and*
> - *(2) where the legal costs exceed the maximum costs fixed by the regulations under s 8.3(1), when the DRS permits payments of those costs and the lawyer otherwise becomes entitled to be paid and recover those legal costs in accordance with the Legal Profession Uniform Law and other relevant legal principles.*

***Allianz Australia Insurance Ltd v Jenkins* [2020] NSWSC 412 (Adamson J)**

The claimant was a full-time cleaner in a nursing home, prior to being injured in a motor accident in 2018. Her pre-tax (gross) weekly earnings were $893. This amount increased as a result of indexation to a weekly amount, as at the date of the merit review conducted by the Panel, of $918 gross, or $764 after tax (net). It was agreed that the claimant's earnings were equivalent to her earning capacity and that the accident did render the claimant totally incapacitated for work.

Clause 7 of Schedule 1 of the Act defines pre-accident earning capacity as follows:

> ***7 Meaning of 'pre-accident earning capacity'***
>
> *(1)* ***Pre-accident earning capacity*** *of an injured person means the weekly amount a person had the capacity to earn before the motor accident concerned in employment reasonably available to the person in view of the person's training, skills and experience.*
>
> *(2) If the amount of an injured person's pre-accident earning capacity cannot be determined, the amount is deemed to be the amount that is equal to 80% of the average weekly total earnings of adults in full-time employment in New South Wales last published by the Australian Statistician."*

Section 3.6 relevantly provides:

> ***3.6 Weekly payments during first entitlement period (first 13 weeks after motor accident)***
>
> *(1) An earner who is injured as a result of a motor accident and suffers a total ...* ***loss of earnings*** *as a result of the injury is entitled to weekly payments of statutory benefits under this section during the first entitlement period.*
>
> *(2) A weekly payment of statutory benefits under this section is to be at the rate of 95% of the difference between the person's pre-accident weekly earnings and the person's post-accident earning capacity (if any) for the first entitlement period.*

Section 3.7 relevantly provides:

> ***3.7 Weekly payments during second entitlement period (weeks 14–78 after motor accident)***
>
> *(1) An earner who is injured as a result of a motor accident and suffers a total ...* ***loss of earnings*** *as a result of the injury is entitled to weekly payments of statutory benefits under this section during the second entitlement period.*
>
> *(2) A weekly payment of statutory benefits under this section is to be at the rate of—*
>
> *(a) in the case of total loss of earning capacity—80% ...*

*of the difference between the person's pre-accident **weekly earnings** and the person's post-accident **earning capacity** (if any) after the first entitlement period.*

Section 3.8 relevantly provides:

3.8 Weekly payments after second entitlement period (after week 78)

*(1) A person who is injured as a result of a motor accident and suffers a total ... loss of **earning capacity** as a result of the injury is entitled to weekly payments of statutory benefits under this section after the end of the second entitlement period…*

(2) A weekly payment of statutory benefits under this section is to be at the rate of—

(a) in the case of total loss of earning capacity—80%...

*of the difference between the person's pre-accident **earning capacity** and the person's post-accident **earning capacity** (if any) after the second entitlement period.*

Section 3.9 relevantly provides:

3.9 Maximum weekly statutory benefits amount

*(1) For the purposes of this Division, the **maximum weekly statutory benefits amount** is $3,853.*

(2) If that amount is adjusted by the operation of this section, the applicable maximum amount is the amount as at the date the statutory benefit is payable.

(3) The Authority is, on or before 1 October 2017 and on or before 1 October in each succeeding year, to declare, by order published on the NSW legislation website, the amount that is to apply, as from the date specified in the order, for the purposes of subsection (1).

(4) The amount declared is to be the amount applicable under subsection (1) (or that amount as last adjusted under this section) adjusted by the percentage change in the amounts estimated by the Australian Statistician of the average weekly total earnings of adults in full-time employment in New South Wales over the 4 quarters preceding the date of the declaration for which those estimates are, at that date, available.

For the first two statutory periods, the insurer paid the claimant her net weekly earnings, and withheld the amounts of PAYG tax and paid that amount to the ATO.

For the third period, the issue was whether the claimant was entitled to be paid 80% of her gross earnings, or her net earnings. The ATO had issued an advice to the effect that the payments for the first two periods were taxable but the payments for the third period were not taxable. This is because the first two periods were for loss of earnings, and the third period was for loss of "earning capacity". Therefore, for the third period, the insurer was not required to withhold or send money to the ATO.

The merit review panel determined that the claimant was entitled to be paid 80% of her gross earnings. Her Honour quashed this decision, finding that the correct construction of the Act was that the claimant was entitled to be paid 80% of her net earnings for the third period. Otherwise, she would be in receipt of a windfall, receiving a tax component of her weekly earnings that she was not actually required to pay to the ATO.

Briggs v IAG Limited t/as NRMA Insurance **[2020] NSWSC 1318 (Harrison AsJ)**

The claimant was assessed by a review panel with respect to a minor injury dispute. The review panel determined that his injury (significantly – an annular tear of the L4/5 disc) was not causally related to the subject motor accident and that therefore the injuries that were related to the accident were minor injuries for the purposes of the Act.
The claimant sought judicial review on a number of grounds. The primary point was that the review panel, in making its decision, had relied on an article from the "Spine Journal" in a significant way, without giving notice to the parties of its intention to do so. In fact, two pages of the review panel decision were directly taken from that article. The claimant relied on *Pascoe v Mechita Pty Ltd* [2019] NSWSC 454, where Button J had held (in relation to a similar situation where a medical panel had relied on a set of tables developed by the International Standards Organisation, without notice:

> *[70] In my opinion, the plaintiff is correct: it was a denial of procedural fairness for the Panel to take into account the ISO adversely to the plaintiff without giving him notice that it proposed to do so..*
>
> *...*
>
> *[79] In summary then: by taking into account the ISO adversely to the plaintiff without providing him with notice that it would do so, the Panel denied him procedural fairness; the ISO cannot be characterised as common sense or common knowledge, but rather is something quite specific and detailed; the important adverse consequence to the plaintiff of the determination by the Panel about the level of hearing loss and therefore WPI itself argue for the provision of procedural fairness of a level that encompasses notice with regard to the ISO; and it cannot be said that the plaintiff waived his right to be provided with such notice."*

Her Honour held, at [60]:

> *"As in Pascoe, it is my view that the Review Panel in these proceedings used the article to draw an important adverse conclusion about the plaintiff's case. The Review Panel had an obligation to provide the plaintiff with notice, and an opportunity to respond, before taking into account concepts drawn from an unknown source. To fail to do so was to deny the plaintiff procedural fairness. As such, the decision of the Review Panel should be set aside."*

QBE v Abberton **[2021] NSWSC 588 (Cavanagh J)**

The claimant was injured in a single vehicle accident. He alleged that the accident occurred because a kangaroo appeared suddenly in front of him, causing him to veer off the road in

order to avoid colliding with the kangaroo. He made a claim for statutory benefits against his insurer, QBE.

The insurer disputed that there was a kangaroo at all, and alleged that the accident occurred wholly as a result of the fault of the claimant. The insurer also alleged that the claimant was precluded from being entitled to statutory benefits by reason of having been charged with a serious driving offence related to the accident. He was charged with driving a motor vehicle with a low range prescribed concentration of alcohol (0.064). Section 7.37 of the Act relevantly provides:

> *(1) Statutory benefits under this Part are not payable to an injured person after the person has been charged with or convicted of a serious driving offence that was related to the motor accident…*
>
> *(3) A serious driving offence with which an injured person is charged or convicted is considered to be related to a motor accident only if--*
>
> *(a) the offence relates to the driving of a motor vehicle by the injured person, and*
>
> *(b) the motor vehicle was involved in the motor accident that caused the person's injury.*

The offence of driving with low range PCA is a serious driving offence by definition, under the Act.

The claimant made an application to the SIRA Dispute Resolution Service ("DRS") for determination of miscellaneous claims assessment matters. The matter was allocated to a Claims Assessor of the DRS (now a "Member' of the Personal Injury Commission of New South Wales which was established on 1 March 2021). Although the claims assessment matters that required determination were initially not well defined, by the time of the decision, there were three issues being determined:

(a) Whether, for the purposes of s3.28 of the Act, the insurer was entitled to cease paying statutory benefits to the claimant, on the basis that the accident was caused wholly or mostly by the fault of the claimant.

(b) Whether, for the purposes of Part 5 of the Act, the accident was a no-fault motor accident.

(c) Whether the insurer was entitled to refuse payment of statutory benefits under s3.37 of the Act, on the basis that the claimant had been charged with, or convicted of, a serious driving offence that was related to the motor accident.

Each of the abovementioned matters are "miscellaneous claims assessment matters" pursuant to schedule 2 of the Act (at 3(e), 3(g1), and 3(f) respectively).

The certificate issued by the Assessor contained the following findings:

1. For the purposes of section 3.28 the motor accident was not caused wholly or mostly by the fault of the injured person

2. For the purposes of Part 5 the motor accident is a no-fault motor accident.

3. For the purposes of section 3.37 the insurer is not entitled to refuse payment of statutory benefits

The Assessor found:

(a) The insurer has not established that the claimant was at fault for the purposes of s3.28 of the Act.

(b) The claimant was involved in a single vehicle no-fault motor accident within the meaning of s. 5.1 of the Act.

The Assessor found that he was required to proceed on the basis that the claimant had committed a serious driving offence within the meaning of s3.37(5) of the Act. The s3.37 issue therefore turned on the third defendant's findings as to whether the serious driving offence was related to the motor accident (as set out in s3.37(3)).

The Court has not yet determined the proper statutory construction of the words "relates to" and "related to" in s3.37. It is not settled whether those words require a causal relationship or merely an association. In this case, the Assessor didn't really deal with that issue, simply finding that the serious driving offence was related to the driving of the motor vehicle, and effectively side-stepping the question of whether a causal relationship is required. The Assessor noted:

> *"Subsection 3.37 (3) provides that a serious driving offence is considered to be related to the accident only if:*
>
> *(a) The offence relates to the driving of a motor vehicle by the injured person, and*
>
> *(b) The motor vehicle that was involved in the motor accident that caused the person's injury."*

He found:

> *"In the present case, the offence relates to the driving of a motor vehicle by the claimant.*
>
> *He is the injured person. It follows that ss 3.37 (3)(a) is satisfied."*

In this case, the ultimate decision as to s3.37 did not turn on the question of whether the serious driving offence "related to" the driving of the motor vehicle (ie, the s3.37(3)(a) issue). Rather, it turned on the construction of s3.37(3)(b), being whether "*the motor vehicle was involved in the motor accident that caused the person's injury*". In relation to this issue, the Assessor found that the claimant's use of his vehicle did not cause his injury (because he had found that it was a no-fault accident), that the claimant's motor vehicle was not involved in the accident that caused the claimant's injury, and that therefore section 3.37(3)(b) is not satisfied.

The insurer challenged the finding under s3.37(3)(b), on the basis that it was an error of law to find that the claimant's motor vehicle was not involved in the motor accident, given that it

was a single vehicle accident and there was no other vehicle that could satisfy the definitional requirements of the Act.

Cavanagh J found (at [67] – [69]:

> 67. *The motor vehicle, being the motor vehicle referred to in s 3.37(3)(a) which the claimant was driving, must be the motor vehicle which was involved in the motor accident that caused the person's injury.*
>
> 68. *"Motor accident" is defined to mean an incident or accident involving the use or operation of a motor vehicle that caused the death or injury to a person in the circumstances as set out in the definition in s1.4 of the MAI Act. The definition of motor accident thus necessarily requires that there be the use or operation of a motor vehicle that causes the injury. If there is no accident involving the use or operation of a motor vehicle that causes the injury, then there is no motor accident as that term is defined.*
>
> 69. *In this matter there was only one motor vehicle. It was the motor vehicle being driven by the claimant. Irrespective of whether the claimant veered off the side of the road because of the presence of a kangaroo or for some other reason, the motor accident was a single vehicle motor accident. The only motor vehicle which was involved which could satisfy the definition of motor vehicle was the claimant's motor vehicle. It was that motor vehicle which the claimant was driving to which the offence relates. It was that motor vehicle which was involved in the motor accident that caused the claimant's injury.*

The decision was quashed for error of law on the face of the record, and remitted to a different PIC Member to be determined according to law.

WORKERS COMPENSATION SCHEME CASES

Kitanoski v JB Metropolitan Distributors Pty Limited [2019] NSWSC 1802 (Adamson J)

The plaintiff was injured at work when a box fell from a shelf. He was initially assessed as having 0% WPI and this was confirmed by an appeal panel. The plaintiff made a further application for medical assessment and on this further assessment he was assessed as having 7% WPI.

The plaintiff applied to the Registrar for leave to appeal against the medical assessment on the grounds in s 327(3)(a) (deterioration of the plaintiff's condition), (c) (incorrect criteria) and (d) (demonstrable error). He did not rely on s 327(3)(b) (the availability of additional relevant information). The Registrar was satisfied that demonstrable error had been made out, and referred the matter to an Appeal Panel.

The appeal panel dismissed the appeal. It was noted that although the worker had requested a re-examination by the panel, they did not consider it was necessary, and determined that they had sufficient evidence before them to determine the appeal. The plaintiff had made an application to put on fresh evidence before the panel. The panel found that the additional evidence (medical reports commenting on the AMS decisions, and a statutory declaration from the plaintiff) simply sought to cavil with the AMS decisions and did not add anything.

The plaintiff alleged in judicial review proceedings that the panel had denied him procedural fairness in failing to re-examine him, especially in circumstances where credit was in issue. It was also contended that the panel denied him procedural fairness in failing to consider the further medical reports.

As to the first ground, Her Honour said, at [54] – [55]:

> *54. It is plain from the provisions referred to above, that the Panel is to undertake a review of the medical assessment conducted by the AMS. Its role is not to undertake a fresh medical assessment unless it has decided to revoke the MAC and considers that it is obliged to do so to enable it to issue a new certificate. Therefore, there is no entitlement on the part of the plaintiff to be re-examined by the Panel.*
>
> *55. Mr Emmett, who appeared on behalf of the Employer, referred me to decisions of this Court to the effect that the Panel has no power to re-examine a plaintiff unless and until the Panel is satisfied that there is an error in a MAC.*

This explains how this case can be distinguished from *Boyce v Allianz Australia Insurance Ltd* [2018] NSWCA 22, which is a case that arose under MACA where the review panel is required to conduct its assessment afresh.

Adamson J held that the issue that arose here was whether it was (as the plaintiff contended) not *open* to the appeal panel to refuse to re-examine the plaintiff. As to the question of whether the panel was required to re-examine the plaintiff because it was going to make adverse findings of credit, Her Honour found that there was no denial of procedural fairness in this regard, as the plaintiff was able to make submissions to the panel about any errors in the AMS decisions, and (at [64]):

> *[64] In so far as the AMS assessed the plaintiff's credit, its assessment was based on two matters: first, a disparity between the history the plaintiff gave and the objective facts as established by the documents which had been placed before the AMS; and second, a disparity between the symptoms described by the plaintiff and any known organic cause. The first matter was a matter of record. The second matter was one which called for medical expertise. Each of these matters was germane to the assessment of impairment since it was important to determine whether the plaintiff was a reliable historian and whether the findings on examination reflected an organic cause. This task was pre-eminently one for the AMS, as a medical expert. The Panel did not need to examine the plaintiff to review the AMS's comparison between his stated symptoms and any known organic cause since this was a matter within its medical expertise. Nor did it need to have regard to the plaintiff's statement since the fact of the disparity between findings on examination and known organic cause was not something that could be explained by the plaintiff himself.*

As to the argument that there was a denial of procedural fairness in failing to admit the "fresh" evidence in the form of further medical reports, Her Honour said (at [73]):

> *[73] As its reasons reveal, the Panel's view was that the authors of the Additional Reports were merely providing commentary on the findings and reasons of the AMS. The Panel is an expert body which is well-placed to review the AMS, another expert or group of experts. A new report from a doctor which post-dates the assessment conducted by the AMS does not thereby constitute fresh evidence. Its contents must be examined to ascertain whether it is actually fresh or whether it merely rehashes old arguments or cloaks submissions in a new form. It was open to the Panel to consider that the Additional Reports fell into the latter category.*

Accordingly, it was found that there was no error in the appeal panel decision, and the plaintiff's Summons was dismissed.

Ballas v Department of Education (State of NSW) **[2020] NSWCA 86**

The plaintiff sustained psychological injury in the course of her employment as a teacher. She was assessed by an AMS as having 8% WPI. This included a class 2 assessment for "social and recreational activities" on the basis that she gambled on poker machines and spent about 1 hour at the club. The plaintiff lodged an application to appeal that decision, on the basis that the AMS had made a demonstrable error and applied incorrect criteria. She submitted that the category of social and recreational activities was not directed to solitary activities that do not involve interactions with other people, and therefore her gambling was not relevant to the assessment for that category. She contended that a proper assessment of that category would have been a class 3 rating which would have increased her total WPI to 17%.

The Delegate of the Registrar refused the application for appeal, finding that the PIRS categories are generic and general in description, and overlapping. Critically, the Delegate said:

[25] I do not accept that the activity of attending the an [sic] RSL club once a month to play poker machines is necessarily an activity that ought to fall within Class 3 (Moderate Impairment) of social or recreational functioning, and not class 2 (Mild Impairment) as the AMS found. Whilst the activity may be undertaken individually, it seems to me it is undertaken regularly (not rarely) and requires active involvement (playing machines). The activity does not appear to require prompting by family or friends or the attendance of a support person. In any event, the PIRS categories are not a rigid in formation and they are to be applied by an AMS based on the history taken by him and her during the clinical examination.

Further, at [29]:

[29] I am not satisfied that the AMS has made the assessment based on incorrect criteria or that there is a demonstrable error on the face of the MAC. The AMS has provided reasons in relation to his assessment for social functioning and he appropriately considered the material before him, including the report of Dr Rastogi, and the history provided by the worker in reaching his conclusion. The appeal is not to proceed.

The plaintiff sought judicial review of the Delegate's decision.

The Court of Appeal dealt with an allegation that the Registrar's delegate in the Workers Compensation Commission hade overreached in exercising the "gatekeeper" role in the provisions in the Workers Compensation legislation. At [70] to [72] Bell P and Payne JA observed:

[70] In both written and oral submissions, Senior Counsel for Ms Ballas contended that the Delegate misconstrued the "gatekeeper" nature of the task ascribed by s 327(4) to the Registrar. He submitted that the Delegate, rather than looking to whether the appeal grounds were capable of being made out, proceeded to determine the appeal. An analysis of the Delegate's language lends strong support to this submission. Thus phrases such as "I do not accept that ..." (see [25] of the Delegate's decision extracted at [37] above) and "I am not satisfied that the AMS has made the assessment based on incorrect criteria or that there is a demonstrable error on the face of the MAC" (see [29] of the Delegate's decision) both have the tone of final determination.

[71] Certainly, the Delegate did not express herself in terms of whether Ms Ballas' proposed grounds of appeal were capable of, in the sense of having the potential to be, made out. Dr Allars sought to counter this argument by stating that it followed from the conclusory language in which the Delegate expressed herself that she must have necessarily formed the opinion that the proposed grounds were not capable of being made out. In other words, a conclusion that something is not made out must carry with it an implicit conclusion that it is not capable of being made out.

[72] The fallacy with this submission is that it reasons backwards from the non-expert conclusion that the Delegate was not authorised (or qualified) to reach.

> *An assessment of arguability, to adopt and adapt the language of Gleeson JA in Vannini, is a very different exercise, as the Registrar or his or her Delegate is required to make that assessment "on the face of the application, and in any submissions made to the Registrar": at [19]. It involves an assessment and satisfaction that an argument to support the nominated grounds is manifest in those two documents. If it is, that argument passes the gatekeeper and goes to the expert Appeal Panel. This process does not involve the Delegate in assessing the correctness of the argument but simply that what has been put forward is arguable.*

The decision of the Delegate was quashed.

Peachey v Bildom Pty Ltd (Quality Siesta Resort Pty Limited and Quality Hotel) [2020] NSWSC 781 (Adamson J)

The plaintiff sustained psychiatric injuries as a result of a work accident. Her impairment was assessed by an AMS at 15%, with a one-tenth deduction for pre-existing condition.

Both the plaintiff and the employer appealed to an appeal panel. The plaintiff alleged that the AMS decision was based on incorrect criteria and contained a demonstrable error, because the AMS ought to have considered and applied clauses 1.31 – 1.32 of the guidelines and because the evidence showed that there had been improvement in her condition as a result of treatment and therefore there should have been an increase in her assessment of impairment for treatment effects. This would have resulted in a WPI score of an additional 2 or 3% and would have been sufficient to enable her to reach the threshold of 15% under s 65A of the 1987 Act.

The appeal panel determined that it was not apparent that there had been a substantial or total elimination of permanent impairment as a result of long term treatment, and therefore no adjustment should be made for the effects of treatment. The appeal panel made the same assessment (15% less 10%, rounded to 14%).

The plaintiff sought judicial review on a number of grounds. In quashing the decision, Adamson J said (at [57]):

> *57. In order to address cl 1.32, the Appeal Panel was obliged to consider and record in its reasons whether there has been long-term treatment and if so, what the treatment comprised and whether it has been effective to result in either a substantial or total elimination of the original permanent impairment. If the answers to these questions are in the affirmative, the Appeal Panel is also obliged to consider and decide whether, if treatment is withdrawn, the worker is likely to revert to the original degree of impairment. This analysis does not amount to a gloss on cl 1.32; it is merely a summary of what is required by its wording. The approach taken by the Appeal Panel as disclosed by its reasons was insufficient to demonstrate that it had addressed that which was required to determine whether an adjustment under cl 1.32 was warranted. This constitutes an error of law on the face of the record: Wingfoot at [55]; Vegan at [130].*

***Specialist Diagnostic Services Pty Ltd t/as Laverty Pathology v Aisha Naqi* [2020] NSWSC 1791 (Schmidt AJ)**

The worker made a claim for psychological injuries arising from workplace bullying. She was initially assessed by an AMS as having 13% WPI. She appealed, and the appeal panel revoked that decision, and determined instead that her WPI was 17%. The employer sought judicial review of that decision, and the earlier decision of the Delegate that referred the matter to the appeal panel. Numerous errors were alleged.

The employer firstly argued that the Delegate had erred in the same was as the Delegate in *Ballas*, by overstepping the gatekeeper function. It was said that when the Delegate said "The AMS has made a demonstrable error when assessing the PIRS category of employability", this revealed the *Ballas* type error. Schmidt J held that, reading the decision beneficially, this statement simply identified the ground of appeal that the worker had made out. Her Honour also found that this did not constrain the exercise of jurisdiction by the appeal panel.

The employer also alleged that the Delegate had failed to respond to a substantial and clearly articulated argument made by the employer (a "*Dranichnikov"* error). Schmidt J held that there was no obligation on the Delegate to give reasons at all, and therefore there could be no constructive failure to exercise jurisdiction, and no denial of procedural fairness, by failing to refer to the employer's argument in the reasons that she did give.

As to the appeal panel decision, the employer said that the appeal panel had erred in that it failed to determine that there was an error in the AMS decision before deciding to re-examine the worker. Her Honour rejected this argument, finding that the appeal panel did find that there was error in the AMS decision in its preliminary review, and that there was no obligation on the panel to give notice to the parties of this view that was formed at the preliminary review. There was nothing wrong with the appeal panel giving reasons for this in its final statement of reasons.

The employer also alleged that the appeal panel had failed to respond to its substantial and clearly articulated argument (much in the same was as it was alleged the Delegate had). Although the appeal panel did have a duty to give reasons (unlike the Delegate), Her Honour found that there was no *Dranichnikov* type error. She stated:

> *[131] While the Appeal Panel did not outline all of the submissions which the parties had each advanced, it did not have to do so. It said in its reasons that it had taken them into account and explained why it had come to the conclusion that Dr Parmegiani had erred, as Vegan required. It did not have to consider whether his conclusions were open in the way which arose in Jenkins, as Specialist Diagnostic Services contended, but rather whether he had made any of the errors about which Ms Naqi complained in her grounds of appeal, and if he had, to come to its own conclusions on the materials it had to consider about those matters.*
>
> *[132] The reasons given establish that the Appeal Panel undertook the statutory task required of it by s 328, explaining why it finally concluded that Dr Parmegiani's certificate had to be revoked and issuing Ms Naqi a new one, that reflecting the conclusions it had arrived at in relation to the grounds of*

> *appeal advanced on the material it had to consider. On the explanation there given there is simply no reason to doubt that the Appeal Panel considered the case Specialist Diagnostic Services advanced, despite the failure to refer to Jenkins.*

In any event, Her Honour found that even if she was wrong about the fact that the appeal panel did take the employer's argument into account, she found that the employer's argument could not have actually led to the result that the employer was contending, and therefore issues of materiality arose.

The Summons was dismissed.