

MOTOR ACCIDENT INJURIES ACT, 2017 (MAI)

“AN ACCIDENT WAITING TO HAPPEN”

16th July, 2017.

PART 1: Simon Harben SC

A. Introduction:

1. All of us here are familiar with the so called reform of Compulsory Third Party Insurance over the years and in particular, since the mid 1980s.
2. On 9th March, 2017 Victor Dominello, the then Minister for Finance, Services and Property, introduced the *Motor Accidents Injuries Bill 2017* into the NSW Parliament. The Bill was read for a second time and has now been enacted (the MAI) and, as Hunt points out in his paper, is due to commence on 1st December, 2017.
3. Anyone who is honest would concede that the impetus for this piece of legislation was political. It has been dressed up as being advantageous to the residents of this State. However, as has been analysed by Hunt in his look at the structure of the Act, that is clearly not the case.

B. The Second Reading Speech

4. There were several red flags evident in the Second Reading Speech. The Minister said:

*“I now turn to the details of the Bill. The Bill establishes a hybrid scheme. It delivers statutory benefits for injured road users with injuries **other than soft tissue or minor psychological injuries**, regardless of fault, while retaining the right to claim **modified common law damages** for those able to establish fault. The Lifetime Care and Support Scheme for severely injured people is not affected by the reforms. ... NCTP (New South Wales Compulsory Third Party Insurance Scheme) will extend coverage by providing a 6 month safety net for all at fault drivers.”*

*“When the **only injury is soft tissue or minor psychological injury**, statutory benefits for loss of income and treatment and care will be available for up to 6 months. All other injured people who are not mostly at fault will be entitled to additional income support and*

treatment and care. Under Division 3.3 people with moderate level injuries, up to and including 10% whole person impairment, (WPI) will receive regular income benefits of up to 95% of pre-injury weekly earnings for the first 3 months after an accident and up to 80% or 85% of pre-injury weekly earnings after that.”

“The Bill will **reduce costs** in a number of ways. The introduction of statutory and no fault benefits under Part 3 will **reduce legal costs** and the adversarial nature of the scheme because injured people will **no longer have to lodge a common law damages claim to get compensation for their injuries**. Costs will be further reduced by the **removal under Part 4 of access to common law damages for soft tissue and minor psychological and psychiatric injuries**, which have contributed to a large spike in scheme costs and reduced the proportion of benefits going to those with more serious injuries.”

“The Bill also tackles cost by allowing the **regulation of legal fees** that injured people can be charged. It allows for both the fixing of maximum legal costs by reference to the amount recovered by the claimant and a fee for service model. I have seen too many cases of injured people being left with a small fraction of their original payout after legal, insurance and other costs have been taken out. In one case an injured person received a payout of \$150,000.00 but was left with only \$60,000.00 after insurance and legal costs were deducted. In another instance, an injured person received a payout of \$40,000.00 but ended up with just \$479.00 in their pocket.”

“Importantly, the Bill is also designed to reduce fraudulent and exaggerated claims. **Fraud** and exaggeration currently cost New South Wales motorists as much as \$400 million per year and adds about \$75.00 to the cost of each Green Slip. **Parts 3 and 4 of the Bill will substantially reduce opportunities for fraudulent and exaggerated claims by providing statutory benefits for soft tissue and minor psychological injuries for up to 6 months and removing access to the common law system. Part 10 of the Bill will give the regulator stronger powers to investigate fraud as well as for prosecution and enforcement, and penalties will be increased for people abusing the system.**”

“Part 7 of the Bill establishes a new and enhanced dispute resolution model. If disputes do arise in a claim, this new model requires much more **robust decision making by insurers**, and provides an **independent dispute resolution service for disputes to be resolved independently**, flexibly, fairly, cost effectively and quickly. The State Insurance Regulatory Authority will also establish a claimant support service to provide injured people with assistance with completing and lodging forms as well as advice on claims and dispute processes. Part 10 of the Bill will introduce enhanced data collection and reporting, and real time performance monitoring of insurer behaviour and claim experience, to enable SIRA to better regulate the scheme.”

5. We all remember the *Pearce Bill* that the Government was intent on legislating prior to the current Act. That Bill was, for all intents and purposes, a Workers Compensation model. This Act is not as harsh but still contains many Workers Compensation features. Hunt explains some of these aspects of the legislation.
6. The real sting in the tail however is the utilisation of Guidelines and Regulations. It is guesswork at the moment as to how they will eventually pan out, but I will attempt to examine at least in a little detail, how those matters are being looked at for some things and how this might play out.
7. In that regard, Annexure A to this paper is a document headed “CTP Reform Program Update – 6th June, 2017”. That is a State Insurance Regulatory Authority (SIRA) document. If you look at it you will see on page 2 the reference to Guidelines and Regulations. The various dates on that page give you some idea about the speed with which this process has been moved along. We can expect soon the revised version of the Guidelines. As can be seen from Annexure A the process of fixing the Guidelines is also well underway and in fact a further meeting was convened Tuesday of this week.

C. Fraud

8. I make specific reference to this part of the Act because of a recent experience in a case that I have had. It is common knowledge that fraudulent claims have exploded in recent years. This is probably better known to defendant’s solicitors than plaintiff’s solicitors (at least those plaintiff’s solicitors who are not actively encouraging fraudulent claims and by that I mean all the plaintiff’s solicitors in this room).
9. The Minister referred to Part 10 giving the Regulator stronger powers to investigate fraud and the like. The relevant sections are 10.26-10.32.

10. However, the sections dealing with the deterrence and prevention of fraud are s.6.39-6.43. In the *Motor Accidents Compensation Act (MACA)* the comparable sections are s.116-s.119.
11. The table below shows the relative comparability of the 2 Acts in relation to those specific sections. The one real difference is the new s.6.41.

<i>Motor Accidents Compensation Act</i>	<i>Motor Accident Injuries Act</i>
s.116	s.6.39
s.117	s.6.40
	s.6.41
s.118	s.6.42
s.119	s.6.43

12. It can be seen from the above table that in the new Act s.6.41 is additional to what we presently have in *MACA*. Obviously, the import of that section is to target those people who bring claims seeking damages by fraudulent means. However, they can be read much more widely than that. S.6.41 reads:

” 6.41 Fraud on motor accidents injuries scheme

- (1) *A person who by deception obtains, or attempts to obtain, for himself or herself any financial advantage in connection with the motor accidents injuries scheme under this Act is guilty of an offence if the person knows or has reason to believe that the person is not eligible to receive that financial advantage.*
- (2) *A person who by deception obtains, or attempts to obtain, for another person any financial advantage in connection with the Motor Accidents Injuries Scheme under this Act is guilty of an offence if the person knows or has reason to believe that the other person is not eligible to receive that financial advantage.*
- (3) *A person is not liable to be convicted of an offence against this section and any other provision of this Act as a result of the same conduct.*
- (4) *In this section:*

***"deception"** means any deception, by words or other conduct, as to fact or as to law, including the making of a statement or the production of a document that is false or misleading.*

***"financial advantage"** includes a financial advantage for an injured*

person (or a person who claims to be an injured person), an insurer or a medical or other service provider.”

13. Practitioners should in particular note from the above section the reference to and definition of “financial advantage” and who it refers to.
14. It is tolerably clear that these provisions were inserted to deter what has been called “claims harvesting” and the like. Taken at their literal face value however, I suppose they could capture an exaggerated claim or a claim lacking sufficient evidence as well. That is food for thought for lawyers and the medical profession alike.
15. The above comments are relevant in the context of a case that I recently had. The circumstances were these:
 - i. In 2012 a Mercedes passenger vehicle was travelling side by side with a large truck that had a dog trailer. They were travelling in Bankstown and were going under a rail overpass. The Plaintiff was in the Mercedes.
 - ii. The road under the rail overpass veered slightly to the left. Under the rail overpass the vehicles came into collision. The vehicles were insured by different CTP insurers.
 - iii. Eight months or so after that collision the Plaintiff reported the accident to the Police asserting that she was a passenger in the vehicle and that it was being driven by its owner (who subsequently became the First Defendant) , who was therefore classified as the insured driver. I was instructed to appear for the insurer of that vehicle.
 - iv. Following the report to the Police by the Plaintiff and about 4 weeks later a claim was served on my insurer alleging that the insured owner was the driver and was negligent and the Plaintiff, as passenger, was entitled to damages. It looked on its face a perfectly ordinary claim.
 - v. For reasons which are unclear, the Plaintiff’s solicitor thought it prudent to serve a claim form on the insurer of the truck. This prompted an investigation by that insurer of the circumstances with a view to defending the claim made against it. In the course of that investigation

the driver of the truck told an investigator that there was one adult in the car, that it was the Plaintiff and she was the driver.

- vi. The Plaintiff's solicitors abandoned the claim against the truck. In hindsight it is probable that this decision was taken in an attempt to remove the truck driver from the equation. In further investigations by my insurer contact was made with the other CTP insurer, and communication was had with the driver of the truck. The truck driver was very adamant about who was and was not the driver of the vehicle. Investigations were put in train and the driver of the truck was interviewed and a number of other people were also interviewed.
- vii. Proceedings were commenced against the First Defendant and immediately my solicitors wrote to the Plaintiff's solicitors offering a compromise and enclosing Terms of Settlement providing for a verdict for the Defendant with each party paying its own costs and asserting that the Plaintiff was not a passenger, that she was the driver and there could be no liability. That offer was rejected. From that point on the Plaintiff's solicitor was on notice.
- viii. A statement was taken by our investigator from the "insured driver", who was apparently related by marriage to the Plaintiff. That statement gave a clear and detailed version of the accident saying that he was in fact the driver and that the Plaintiff was a passenger. The legitimacy of that statement is still very much in question.
- ix. In light of the conflict in the evidence and what appeared to be a clear case of fraud, we sought an Order pursuant to s.119 of *MACA* (now 6.43) joining our CTP insurer to the proceedings as a separate party. We subsequently ceased to act for the First Defendant because we formed the view that he was part of the fraud. This may not have been correct as it may not have in fact been the First Defendant who provided the statement to the investigator. The Plaintiff consented to the order being made under s.119.
- x. For the purpose of the application pursuant to s.119 we had put on evidence from the driver of the truck as to his observations on the day of the accident. We also attached the Police report form which showed

his report on the day after the accident naming the Plaintiff as the driver of the vehicle.

- x. Following the s.119 order the Plaintiff then amended the Statement of Claim joining my insurer. For that purpose the Plaintiff's solicitor certified the amended Statement of Claim as to reasonable prospects. The Plaintiff had, of course, also certified the original Statement of Claim.
 - xii. The matter was listed for hearing and the Plaintiff tried to abandon the case. It asked us to consent to a discontinuance. We refused. They put on a Motion seeking leave to discontinue and that was opposed. A hearing took place in the District Court and I cross examined the Plaintiff's solicitor at length about the history of the matter and in particular the certification of the amended Statement of Claim. To say the least, the Judge was not happy. The Application was rejected and the matter went for trial the following week before a different Judge.
 - xiii. The Plaintiff sacked her legal representatives and did not turn up for the hearing. We argued for several days in front of the former Attorney General indicating that, pursuant to the Rules, we wished to proceed into evidence and to invite his Honour to make findings of the false claims made by the Plaintiff. The Judge eventually took the path of least resistance, preventing us from doing that, but giving us a verdict with indemnity costs.
 - xiv. The point was to send a message to those people carrying out fraud that enough was enough.
16. The purpose of relaying this is to remind everybody that in *MACA* and in the *MAI* there are specific provisions that obligate an insurer to deter and prevent fraud and in the current climate, fraud is very much at the forefront of thinking so care needs to be taken to assess cases constantly.
17. On cross-examining the Plaintiff's solicitor I specifically addressed s.62 of the *Legal Professional Uniform Law Application Act, 2014* (LPU) which says:
- "62. Costs in Civil Claims – No reasonable prospects of success*

Schedule 2 contains provisions relating to costs in civil claims where there are no reasonable prospects of success”.

18. I also specifically addressed Schedule 2 (LPU) which deals with costs in civil claims where no reasonable prospects of success and which at clause 2(3) says:
 - “(3) *This schedule applies despite any obligation that a law practice or a legal practitioner associate of the practice may have to act in accordance with the instructions or wishes of the client.*”
19. The Plaintiff’s solicitor should have been very mindful of these provisions. As has been pointed out in paragraph 14 above the situation would be very much more dire now bearing in mind s.6.41.
20. The lesson from this was that solicitors have an obligation, not only at the time they certify, but at all times to ensure that there are reasonable prospects of success. The LPU schedule reference means that one must carefully assess the client’s instructions as against that objective evidence which is available. The solicitor conceded that he had simply accepted his client’s instructions and didn’t really look at the question of the validity of the recertification. In my view, that case will go further.
21. It is clear from all that we now know, that fraud has escalated in these type of claims in recent times. That is not to say that I agree that fraud claims are something that could legitimise the change in legislation effected by the *MAI*.
22. As I earlier said, Defendant’s solicitors are probably more attuned to this, but it is a timely reminder for solicitors who act for Plaintiffs to be acutely aware of the issue and to understand that, in particular, s6.41 provides greater powers for the investigation of fraud and brings it more to the forefront of the thinking in relation to these cases and is something to be very wary of. Those acting for Plaintiffs would be unwise to simply accept at face value what they are told by their clients.

D The Sting in the Tail.

23. As I indicated before, the Regulations and the Guidelines related to various matters in the Act will be the real sting in the tail to be dealt with by practitioners on behalf of those litigants covered by the new legislative scheme. As you can see from Annexure A and as you probably know from your own knowledge, there have been ongoing consultations although within a very strict timeframe. My own view is that they are mostly window dressing and the Government will mostly do what it has already decided to do regardless of that input. Further submissions have gone in today from the Bar Association dealing with minor injury and the like.
24. Hunt has set out for you the references to minor injury by way of example. It is pertinent however to repeat the definition found in s.1.6.

"1.6 Meaning of "minor injury"

- (1) *For the purposes of this Act, a "minor injury" is any one or more of the following:*
- (a) a soft tissue injury,*
 - (b) a minor psychological or psychiatric injury.*
- (2) *A "soft tissue injury" is (subject to this section) an injury to tissue that connects, supports or surrounds other structures or organs of the body (such as muscles, tendons, ligaments, menisci, cartilage, fascia, fibrous tissues, fat, blood vessels and synovial membranes), but not an injury to nerves or a complete or partial rupture of tendons, ligaments, menisci or cartilage.*
- (3) *A "minor psychological or psychiatric injury" is (subject to this section) a psychological or psychiatric injury that is not a recognised psychiatric illness.*
- (4) *The regulations may:*
- (a) exclude a specified injury from being a soft tissue injury or from being a minor psychological or psychiatric injury for the purposes of this Act, or*
 - (b) include a specified injury as a soft tissue injury or as a minor psychological or psychiatric injury for the purposes of this Act.*
- (5) *The Motor Accident Guidelines may make provision for or with respect to the assessment of whether an injury is a minor injury for the purposes of this Act (including provision for or with*

respect to the resolution of disputes about the matter by the Dispute Resolution Service)."

25. It does not take a genius to work out that s. 1.6(4) and (5) are apt to cause problems. There is not a doubt in the world that the Government will make those powers work in a way that ensures as much restriction as possible.
26. By way of example, in relation to spinal injury SIRA has, in discussion, proposed that the line between minor and more serious soft tissue injury should be the presence of verifiable radiculopathy sufficient to meet a spinal assessment rating of DREIII which provides for a 10% whole person impairment if related to the lumbosacral spine and 15% whole person impairment in relation to the cervicothoracic spine and thoracolumbar spine. Those figures make the problem self evident.
27. There are very few injured Plaintiffs with soft tissue injuries assessed at DREIII or above. If that is the determining factor, this really means that no soft tissue injuries would receive damages unless the Plaintiff achieves the threshold for an award of non-economic loss damages. In effect, therefore, and in that respect, the new Act is no better than the *Pearce Bill* for those suffering from soft tissue neck or back injuries.
28. It is clear that SIRA wishes to develop guidelines to exclude the maximum number of "whiplash" claims on the basis that they are minor injuries within 6 months of the date of the accident. S.4.4 of the Act provides that no damages may be awarded if the person's only injury resulting from the accident was a "minor injury". Again, the problem is self-evident.
29. SIRA proposes that the following is a minor soft tissue injury:
 - i. An injury to tissue that connects, supports or surrounds other structures or organs of the body (such as muscles, tendons, ligaments, menisci, cartilage, fascia, fibrous tissues, fat, blood vessels or synovial membranes).

- ii. When there are symptoms of nerve injury (but not radiculopathy) for example Whiplash Associated Disorders guidelines (WAD) WADI, WADII and WADIII with no radiculopathy.

- 30. SIRA has proposed exclusion from a finding of minor soft tissue injury when:
 - i. There is radiculopathy (dysfunction of a spinal nerve root or nerve roots) and complete or partial rupture of tendons, ligaments, menisci or cartilage;
 - ii. E.G. WADIII with radiculopathy.

- 31. Further SIRA proposes that the assessment guidelines are to be the WAD 2014 Guidelines and the permanent impairment indicators for radiculopathy (2 or more of the 5 clinical signs) which are found in the current Permanent Impairment Guidelines.

- 32. The legal profession has argued that the WAD guidelines are a treatment tool but not appropriate as an assessment tool for the determination of something like minor injury. So much is clear from their stated purpose and objects of those guidelines.

- 33. Guidelines are apparently being developed for the management of acute whiplash associated disorders based on a Canadian model called the Canadian C-Spine Rule which apparently classifies whiplash associated disorders using the Quebec Taskforce classification. They are designed to cover the first 12 weeks following an accident but also form the basis of treatment decisions beyond that period. The guides provide that at a 12 week reassessment, that in at least 40% of cases, there should be complete resolution of symptoms. Cases are reviewed over the next 6 to 12 months until resolution is recommended. Who knows where this will all go.

- 34. The Canadian Rule regards high risk factors such as the nature of the impact or age (65 or older) as warranting further investigation, but there has been no acknowledgment thus far by SIRA that these factors warrant further

investigation. In other words, in this whole process there seems to be picking and choosing. To say the least we are all, at this stage, in the dark.

35. The response of the legal profession to SIRA's proposals were to provide a list of inclusions or exclusions. They include:
 - i. Inclusions – being an injury to the spine where there are no objective signs of injury.
 - ii. Exclusions – being a spinal injury assessed at or above DRE-II under AMA-IV and under the existing Permanent Impairment Guidelines. In other words non-verifiable radiculopathy would be sufficient to exclude an injury from being treated as a minor injury.
36. In relation to psychological injury SIRA proposed that the following are minor injuries:
 - i. Acute stress disorder.
 - ii. Adjustment disorder.
 - iii. Symptoms of psychiatric illness such as symptoms of depression, anxiety or PTS.
37. SIRA proposed that psychological injuries would not be minor when the symptoms meet the diagnostic criteria for recognised psychiatric illness according to DSM-V that is not:
 - i. Acute stress disorder (see above).
 - ii. Adjustment disorder (see above).
38. Further, SIRA proposed that the assessment guidelines be the Diagnostic and Statistical Manual of Mental Disorder 5th edition (DSM-V).
39. As you can imagine, the approach of the legal profession was to submit that to categorise a psychological condition as a “minor injury” based purely on diagnosis was wholly unsatisfactory. Things such as an Adjustment Disorder could range from acute resolving in a fairly limited timeframe to chronic which could be, and often is, grossly debilitating.

40. The legal profession suggested, inter alia, that the severity of the psychological condition should be measured by the functional impairment or the extent to which the person's quality of life was affected on a day to day basis. The argument went that one would need to analyse each person's injury on a case by case basis taking into account the number of symptoms, their severity and duration and, of course, the impact of those symptoms on everyday functioning.
41. The problem gets worse when we look at s.3.44 which provides that the Regulations can prescribe certain statutory benefits determinations will not be binding in relation to claims for damages. It says:

“3.44 Statutory benefits determinations relating to fault etc not binding in relation to common law claims

(1) This section applies to a determination made by an insurer or the Dispute Resolution Service in connection with a claim for statutory benefits as to:

(a) any fault of the owner or driver in the use or operation of the motor vehicle, or

(b) contributory negligence in relation to the motor accident, or

*(c) **any other matter prescribed by the regulations.***

(2) Any such determination is not binding in connection with a claim for damages in relation to the same motor accident.”

42. From the perspective of an injured Plaintiff, the most general reading of the above section would cause concern when we consider the question of, for example, determinations made by an insurer or the Dispute Resolution Services as to causation or whether an injury was a minor injury. The question is posed as to what if causation and the determination of minor injury are not prescribed so as to have the protection of s.3.44. Depending on the timing Plaintiffs under this Act could be deprived of any common law rights at a very early stage.
43. Submissions have been made that the regulations should prescribe the following decisions (in the context as set out above) as non-binding:

- i. Whether an injury is a minor injury.
 - ii. Whether an injury is causally related to the accident.
44. There is a simple rationale for the above:
- i. The question is what the possibility is of ascertaining the degree of WPI or to fully investigate causation issues within 26 weeks, which is the timeframe for a determination about a minor injury under the statutory benefits scheme.
 - ii. The situation must be prevented where plaintiffs are deprived of their now limited common law rights as a result of decisions for policy reasons. Injured persons should not be deprived of their limited common law rights as a result of an early decision by an insurer within 6 months of the accident. They may not have received legal advice. They may not have fully appreciated the significance of the determination. They may not understand the relevant dispute pathways.
 - iii. Apparently SIRA is considering the question of minor injury from the perspective of injury management (see Annexure B) and is, in our view, placing far too much emphasis on WAD guidelines for minor whiplash as applicable to all soft tissue injuries. Those treatment guidelines are apparently at an early stage of development. SIRA does not seem to acknowledge that spinal injuries cover a range of severity. The assumption seems to be made that all spinal injuries are minor.
45. Submissions have been put forward by the Bar and others opposing the use of DREIII as a classification by arguing that it is much too high for the purpose of excluding soft tissue neck and back injuries from the damages regime. The singular use of the DRE assessment on its own is probably dangerous, but the process goes on and we wait to see where that decision will lie. There is reference above to verifiable radiculopathy but as we all know there are a group of whiplash victims who have had some insult to intervertebral discs

and have pain radiating into a limb but they do not achieve the verifiable radiculopathy that a DREIII assessment requires.

46. In submissions that have been finalised overnight, two recent examples are given:

- i. A diesel mechanic who was 58 suffered a neck injury in a rear end collision and was initially assessed as suffering from pain and tenderness at C7 and diagnosed with whiplash. The accident was in early 2012. A CT scan shortly afterwards disclosed spondylitis at C5/6 and he was experiencing pain in his neck and right shoulder. He was referred to a neurosurgeon in May, 2012 (4 months after the accident), who diagnosed him as having problems involving his neck, shoulder and upper extremities related to C5/6 and C6/7 spondylosis.

He was advised that surgery would be necessary should his symptoms escalate but he kept working and continued to do so. He rejected surgery but agrees that it might become necessary eventually. He was awarded \$200,000.00 for future economic loss. Even though he undoubtedly had a neck injury which was causing nerve pain he was assessed at MAS as DREI leading to a Whole Person Impairment of 0%.

- ii. A 23 year old forklift driver was T-Boned at a roundabout suffering left sided disc protrusions at C5/6 and C6/7. Prior to the accident he was a keen rugby league player and he was extremely fit. He was unable to resume his sport and about 8 months after the accident stopped work because he had developed severe pain in his neck associated with looking up. That led to a period off work and sporadic light employment following.

He was advised that he was a candidate for spinal surgery. He wanted to become a Police Officer but that was now out of the question. His work history would suggest only physical activities but for the accident. He was assessed at DREI on behalf of the Defendant and DREII by the Plaintiff's doctors.

47. Both of the plaintiffs referred to above, in circumstances where the DREIII classification is used, would be confined to some very limited statutory benefits if DRE is the threshold for minor injury. They would have no entitlement to seek damages. Their statutory benefits claim would have been worthless because they both continued to work through the first 26 weeks apart from a short period of time off work after the accident.
48. The above examples demonstrate both the danger and the importance of the Regulations and Guidelines whatever they ultimately will be.
49. There is no time today but at a future time a further paper will be presented that will deal with other aspects of the Regulations and Guidelines and in particular the question of costs and the review process which has been touched on by Hunt. Annexure C deals with regulated costs and their application to the MAI. Other costs and the proposed Regulations are the subject of current “negotiations”. In fact, a further workshop was held this week and we await the outcome of that process.
50. Hunt’s paper gives a good snapshot of the workings of the MAI. At this point in time, however, the full effect of the new legislation cannot be properly gauged until the Guidelines and Regulations are finalised and some opportunity to look at them in practice has been provided. A further updating paper is proposed in the not too distant future in that regard.

Dated: 16th June, 2017.

Simon J Harben SC

Hunter Street Chambers

MOTOR ACCIDENT INJURIES ACT 2017

“AN ACCIDENT WAITING TO HAPPEN”

PART 2

Simon Hunt

1. APPLICATION OF THE ACT.

The Motor Accident Injuries Act 2017 (“MAIA”), received assent on the 4 April 2017, and is due to commence on the 1 December 2017.

It is anticipated that the Act will apply to motor accidents occurring on or after the 1 December 2017.

2. IMPORTANT DEFINITIONS.

Minor injury:

Sections 1.6(2) and (3) of the Act define “minor injury” as including the following:

- **Soft tissue injury.**
A soft tissue injury is “an injury to tissue that connects, supports or surrounds other structures or organs of the body (such as muscles, tendons, ligaments, menisci, cartilage, fascia, fibrous tissues, fat, blood vessels and synovial membranes), but not an injury to nerves or a complete or partial rupture of tendons, ligaments, many sky or cartilage.”
- **Minor psychological or psychiatric injury.**
A psychological or psychiatric injury is “a psychological or psychiatric injury that is not a recognised psychiatric illness.”

Part 3 of the CLA applies to claims for statutory benefits under the MAIA, by virtue of the provisions of s.3.39. As such, the inclusion of a psychological or psychiatric injury that is not a recognised psychiatric injury does not sit with the provisions of s.31 of

the Civil Liability Act, given that section excludes liability for damages for mental harm in the absence of diagnosis of a recognised psychiatric injury.

In addition to those definitions of minor injury, ss.1.6(4) and (5) provide that the regulations may include or exclude specified injuries in and from the definition, and the Motor Accident Guidelines may make provision for respect to the assessment of whether an injury is a minor injury.

Negotiations are continuing between the government and stakeholders (including the NSW Law Society and the NSW Bar Association) as to the content of the regulations and the Motor Accident Guidelines.

Person Most at Fault.

The MAIA establishes a no fault scheme of statutory benefits.

There is however, some restriction in relation to the benefits recoverable by a claimant who is "*most at fault*".

A claimant is most at fault where their contributory negligence in relation to the accident is greater than 61%. (s.3.28(2))

In as far as contributory negligence is concerned, it is also important to note the provisions of s.3.38, which provide specified circumstances in which a finding of contributory negligence must be made, and that the regulations may fix the percentage by which weekly payments are to be reduced for contributory negligence, in respect of specified conduct which constitutes contributory negligence of an injured person. The reduction for contributory negligence applies to weekly payments after six months from the accident.

3. CLAIM PROCEDURES.

Part 6 of the MAIA sets out the procedure for making a claim under the Act.

The MAIA establishes two types of claims, Statutory Benefits and Damages.

The starting point for each is however, the making of a claim.

Reporting to police.

The procedures for making a claim under the MAIA include “*motor accident verification requirements.*” (s.6.8)

The MAIA, does not itself make provision for the reporting of an accident to police. However, s.6.8 provides that the Motor Accident Guidelines may set out a claimant’s obligations in that regard.

Failure to comply with the motor accident verification requirements may be excused however, a full and satisfactory explanation must be provided. (s.6.9(b))

As with the procedural aspects of making a claim under MACA, the insurer will lose the right to dispute compliance with the motor accident verification requirements, where it does not reject the claim on the ground of non-compliance within two months of receiving the claim, or within 2 months of receiving the explanation for delay.

There is no obligation on an insurer to determine a claim for statutory benefits, until the motor accident verification requirements have been complied with. (s.6.9(a))

Similarly, the motor accident verification requirements must be complied with before a claim is referred to the Dispute Resolution Service. (s.6.10(1))

Notification of the Claim.

The method by which a claim under the MAIA must be made is set out in s.6(15).

The provisions mirror the provisions for making a claim under the MACA.

Notice of the claim will need to be given in accordance with the Motor Accident Guidelines, supported by medical evidence and with authority given to the insurer to obtain documents relevant to the claim.

Time for Making a Claim.

The time for making a claim for statutory benefits under the MAIA, is set out in ss.6.12 and 6.13.

- A claim for statutory benefits must be made within 3 months after the date of accident to which the claim relates. (s.6.13(1))
- Where the claim is not made within 28 days of the accident, weekly payments of statutory benefits are not payable in respect of any period before the claim is made. (s.6.13(2))
- A claim for statutory benefits may be made more than 3 months after the accident, if a full and satisfactory explanation for delay is provided and either the claim is made within 3 years of the date of accident, or is made in respect of the death of a person or injury which results in degree of permanent impairment that is greater than 10%. (s.6.13(3))

Determination of the Claim by the Insurer.

The time in which the insurer must determine liability for a claim for statutory benefits, is as follows:

- Within 4 weeks of the claim for statutory benefits being made, the insurer is required to determine liability for the payment of statutory benefits during the first 26 weeks after the injury occurred. (s.6.19(1))
- Within 3 months of the claim for statutory benefits being made, the insurer is required to determine liability for the payment of statutory benefits after the first 26 weeks. (s.6.19(2))
- There is a deemed acceptance of liability for statutory benefits where the insurer fails to determine liability within the time prescribed. (s.6.19(4))

Making a Claim for Damages.

The provisions for making a claim for damages are set out in ss.6.13 – 6.15 of the MAIA.

The Act provides that the way this is to occur is governed by the Motor Accident Guidelines. (s.6.15)

- A claim for damages cannot be made before the expiration of 20 months after the accident to which the claim relates, unless the claim is pursued in respect

of the death of a person, or injury has resulted in a degree of permanent impairment that is greater than 10%. (s.6.14(1))

- A claim for damages must be made within 3 years of the date of the motor accident to which the claim relates. (s.6.14(2))

There is provision for late claims which require the claimant to provide a full and satisfactory explanation for delay (s.6.14(3)), and the circumstances in which the insurer loses the right to dispute the late claim.

If the insurer validly rejects the explanation, the claim is to be referred to the Dispute Resolution Service, for determination of whether the claimant has a full and satisfactory explanation.

The time in which the insurer must determine liability in a claim for damages, is as follows:

- Within 3 months of the claim being made, the insurer must either admit or deny liability for the claim. (s.6.20(1))
- Failure to determine a claim in accordance with the MAIA, results in a deemed denial of liability. (s.6.20(4))

4. BENEFITS PAYABLE UNDER THE ACT.

STATUTORY BENEFITS.

The statutory benefits available under the MAIA, are similar to the entitlements of injured workers under the Workers Compensation Act, and are set out in Part 3 of the MAIA.

The key features of the statutory benefits scheme are as follows:

- It is a no fault scheme and benefits are available, even if the claimant was at fault. (s.3.1)

- Benefits are paid by the relevant insurer however, in cases where there is an entitlement to treatment and care beyond 5 years after the accident, those benefits are payable by the Lifetime Care and Support Authority.

Weekly Payments.

Weekly payments of statutory benefits are payable as follows:

- During the first 13 weeks after the accident (first entitlement period), payments are made at 95% of the difference between the claimant's "pre-accident weekly earnings" and the claimant's "post-accident earning capacity (if any)". (s.3.6)

Pre-accident weekly earnings are defined in Clauses 4 – 6 of Schedule 1 of the Act.

Where the claimant has been in employment for a continuous period of 12 months prior to the accident, that figure will be their average gross earnings during that period.

During the first entitlement period, a claimant's post-accident earning capacity is assessed by reference to the claimant's fitness for work in their pre-injury employment.

- During weeks 14-78 after the accident (second entitlement period), payments are made as follows:
 - Where the claimant has a total loss of earning capacity, at the rate of 80% of the claimant's pre-accident weekly earnings.
 - Where the claimant has a partial loss of earning capacity, at the rate of the difference between 85% of the claimant's pre-accident weekly earnings and their post-accident earning capacity.
- After week 78 the first arm of the equation in the assessment of entitlements is the same as that during the second entitlement period however, the assessment of post-accident earning capacity during this period is in accordance with Clause 8(3) of Schedule 1 of the Act.

- “Post-accident earning capacity” is defined in Clause 8(2) of Schedule 1 of the Act.
 - During the first and second entitlement periods (up to and including week 78), it is based on the claimant’s earning capacity in their pre-injury employment. (Clause 8(1)(a) of Schedule 1)

The claimant’s fitness for work is assessed by reference to the criteria in Clause 8(2) of Schedule 1.

- After week 78, it is based on the claimant’s earning capacity in any employment reasonably available to them. (Clause 8(1)(b) of Schedule 1)

The claimant’s fitness for work is assessed by reference to the criteria in Clause 8(3) of Schedule 1.

The length of time for which a claimant is entitled to weekly payments of statutory benefits depends upon classification of the injury and the assessment of their impairment.

- Where the claimant is “**most at fault**”, or has suffered “**minor injuries**”, weekly payments of statutory benefits for a period of no longer than 26 weeks after the accident occurred. (s.3.11)

No matter what incapacity for work might flow from the injury, it is the definition of minor injury which controls the length of time for which there is an entitlement to weekly payments of statutory benefits.

- Where the injury is not a minor injury and the claimant has suffered **permanent impairment not greater than 10%**, weekly payments of statutory benefits are capped at 104 weeks, unless there is a pending claim for damages, in which case they are capped at 156 weeks. (s.3.12(2))

- Where the claimant has suffered **permanent impairment greater than 10%**, weekly payments of statutory benefits are capped at 260 weeks, provided there is a pending claim for damages. (s.3.12(3))
- Weekly payments of statutory benefits may only be paid up to retirement age as determined in accordance with the Social Security Act 1991, save where the claimant had reached retirement age at the time of the accident, in which case payments are available for a period of 12 months after the accident occurs. (s.3.13)
- In the event of contributory negligence, a reduction in weekly payments of statutory benefits applies after 26 weeks, to the extent of the claimant's contributory negligence. (s.3.38(1))

The division goes on to set out circumstances in which a finding of contributory negligence is mandatory.

Section 3.38(4) provides that the regulations may fix the percentage by which weekly payments of statutory benefits are to be reduced because contributory negligence in respect of specified conduct that constitutes contributory negligence of the injured person.

- The MAIA provides procedures for the claimant's obligations including authorising the insurer's access to medical records; providing certificates certifying incapacity; and informing the insurer where there is a change in circumstances.
- Except for circumstances in which the claimant has returned to work, or there is a change in the claimant's earnings from any employment, where weekly payments of statutory benefits have been paid for a continuous period of at least 4 weeks, the insurer is required to give a period of notice before discontinuing or reducing weekly payments. (s.3.19)

Treatment and Care.

Statutory benefits are payable for treatment and care however, benefits are no longer available for gratuitous attendant care services.

Statutory benefits remain available for the loss of capacity to provide gratuitous domestic services to a claimant's dependents, but not in circumstances where those services are replaced with gratuitous assistance.

Where the claimant is "**most at fault**" and was over 16 years of age at the time of the accident, or has suffered "**minor injuries**", statutory benefits for treatment and care are not payable beyond 26 weeks after the accident occurred. (s.3.28)

Despite that restriction, the Motor Accident Guidelines may authorise payment of treatment and care expenses for a longer period, where that would improve the recovery of the claimant, where the insurer delayed approval for the treatment and care expenses, or in other appropriate circumstances. (s.3.28(3))

Statutory benefits for treatment and care are not payable where the claimant is a participant of the Lifetime Care and Support Scheme. (s.3.32)

Statutory benefits for treatment and care expenses continue after a claim for damages has been finalised (s.3.40), and even if the claimant's entitlement to statutory benefits by way of weekly payments has ceased.

Restrictions on Statutory Benefits.

Statutory benefits are not payable in the following circumstances:

- Weekly payments of statutory benefits cease to be payable where the claimant pursues a claim for damages in respect of the accident. (s.3.40)
- Weekly payments following the injured person's death. (3.34(a))
- Where the injured person is compensation under the Workers Compensation Act 1987 is payable to the claimant in respect of the injury concerned, or such payments would be payable if liability for workers compensation payments had not been commuted. (s.3.35(1))

The injured person must however, have made a successful claim for workers compensation, or failed to comply with a request by the CTP insurer under the Act

for them to make a claim for workers compensation payments in respect of the injury.

Statutory benefits for funeral expenses are not payable, if they are paid or payable under the Workers Compensation Act 1987.

Where a claim is made for statutory benefits in circumstances where a claim has also been made for workers compensation benefits, there is an obligation on the person making those claims to inform both insurers, and an entitlement for the insurers to exchange information. (s.3.35(7))

- Where the claim arises in respect of the death of or injury to a person resulting wholly or mostly from the fault of the person as the owner or driver of a motor vehicle in the use or operation of the vehicle, if the vehicle was uninsured at the time of the accident. (s.3.36(1))

Section 3.36(5) provides that a person driving an uninsured vehicle with the owner's authority is entitled to statutory benefits, if they did not have any reasonable grounds for believing that the motor vehicle was an uninsured vehicle.

- Where the injured person was charged with or convicted of a serious driving offence that was related to the accident, excepting where the person is acquitted of the offence charged, or where the proceedings are discontinued. (s.3.37)
- The provisions of Part 3 of the Civil Liability Act apply to the payment of statutory benefits under the MAIA, as they apply to an award of damages under the CLA. (s.3.39)

DAMAGES.

A claim for damages may not be pursued where the claimant has suffered a "minor injury".

The heads of damage which may be recovered in a claim for damages, are set out in Part 4 of the MAIA.

A claim for damages is limited to a claim for non-economic loss as permitted by Division 4.3 of the Act, and a claim for economic loss as permitted by Division 4.2.

Damages for non-economic loss are only payable where the claimant has suffered a degree of impairment greater than 10%. (s.4.11)

Other than the provision that the injury be more than a minor injury, the threshold applicable to claims for damages for non-economic loss, does not apply to the recovery of damages for economic loss.

The MAIA provides limits on the amount which may be awarded by way of damages for non-economic loss and economic loss

The MAIA does not prescribe a limit on the age to which damages for economic loss may be awarded.

The MAIA continues the obligation which exists in ss.85A and 65B of the MACA, for a claimant to provide relevant particulars of the claim for damages as soon as possible (s.6.25) and for the insurer to direct a claimant to particularise the claim, if particularisation of the claim has not occurred within 2 years and 6 months of the accident (s.6.26).

Failure to particularise the claim within 3 months of the insurer making a request pursuant to s.6.26, results in the damages claim being deemed to have been withdrawn.

A claim for damages cannot be settled within 2 years of the accident unless the degree of impairment is greater than 10% (s.6.23(1)),

A claim for damages cannot be settled unless the claimant is legally represented (s.6.23(2)), or the settlement is approved by the Dispute Resolution Service (s.6.23(3)).

Resolution of claim for damages does not finalise the claimant's entitlement to continue to recover statutory benefits in respect of treatment and care expenses, but does finalise the entitlement to weekly payments and a deduction must be made from the damages, in respect of weekly benefits paid at the time of resolution. (s.3.40)

DISPUTE RESOLUTION.

STATUTORY BENEFITS.

Internal Review.

Where there is a dispute about the insurer's decision, a claimant must first seek an Internal Review of the decision by the insurer. (s.7.41(1))

There is provision in s.7.41(2), for the Motor Accident Guidelines to exclude as yet unidentified disputes, from the need for an internal review.

There is no need for an internal review where an insurer declines to conduct a review, or has failed to complete an internal review and notify the decision, as and when required to do so.

Merit Review.

If dissatisfied with an internal review, application may be made by a claimant for Merit Review.

The decisions which constitute a Merit Review matter, are set out in Clause 1 of Schedule 2 of the MAIA, and comprise the following:

- Whether statutory benefits are payable to a claimant.
- Decisions relating to the amount of weekly payments payable; suspension of weekly payments for failure to comply with the provisions of the Act; and whether an insurer has given the required period of notice before discontinuing or reducing weekly payments.
- The amount of statutory benefits payable for funeral expenses.
- Whether treatment expenses are reasonably necessary.
- Whether treatment expenses are properly payable.
- Whether the vehicle was uninsured at the time of the accident.

- Whether the insurer is entitled to refuse payment of statutory benefits in relation to certain mental harm.
- Whether statutory benefits are payable for treatment and care, including the loss of capacity to provide gratuitous domestic services to others.
- Whether expenses have been properly verified.
- Whether the duty of a claimant or insurer to act with good faith, to resolve the claim, and of a claimant to minimise loss, has been complied with.
- Whether the insurer is entitled to delay conveying an offer of settlement on a claim for damages.
- Whether all relevant particulars of a claim for damages have been provided to the insurer.
- Whether the insurer is entitled to give the claimant a direction to provide further particulars.

Importantly, the decisions which constitute a Merit Review matter do not specify decisions going to liability or the assessment of contributory negligence. They are Miscellaneous Disputes and are determined by the Dispute Resolution Service.

Section 7.14(3) provides that a decision determining a Merit Review is binding on the parties, subject to review by a review panel in accordance with the provisions of s.7.15(1).

An application for review of a Merit Review decision may only be made on the grounds that the decision was incorrect in a material respect and that the Proper Officer is satisfied that there is reasonable cause to suspect the decision determining the review was incorrect in a material respect having regard to the particulars set out in the application.

Medical Assessment.

As with the MACA, the MAIA provides for Medical Assessment matters to be determined by a medical assessor.

What constitutes a Medical Assessment matter is set out in Clause 2 of Schedule 2 of the Act, and comprises the following:

- Disputes about the degree of impairment caused by a motor accident.
- Whether treatment and care to an injured person's reasonable and necessary in the circumstances, or relates to an injury caused by a motor accident.
- Whether for the purpose of continuation statutory benefits after 26 weeks, the treatment or care provided to an injured person will improve the recovery of the injured person.
- The degree of impairment of the earning capacity on an injured person.
- Whether an injury is a minor injury for the purpose of the Act.

An application may not be made for referral of a dispute for Medical Assessment until the decision has been the subject of an Internal Review; unless the insurer has failed to complete an Internal Review and notify the claimant of the decision as required to do so; or has declined to conduct an Internal Review. (s.7.19)

The provisions set out in s.7.23 as to the status of a Medical Assessment are the same as those contained within the MACA.

Similarly, application may be made for Review of a Medical Assessment by a review panel (s.7.26) and/or Further Medical Assessment (s.7.24) as is the case under MACA.

Miscellaneous Disputes.

Miscellaneous Disputes in connection to a claim to do with statutory benefits, are to be referred to the Dispute Resolution Service. Its decision is binding. (s.7.42).

What constitutes a Miscellaneous Dispute, is set out in Clause 3 of Schedule 2 of the Act, and comprises the following:

- Whether there has been due enquiry in search to establish the identity of an unidentified vehicle.
- Whether the death of or injury to a person has resulted from a motor accident in this state.
- The identity of the relevant insurer.
- Whether, for the purpose of cessation of weekly payments of statutory benefits to a person most at fault or with minor injuries, was caused by the fault of another person.
- Whether an insurer is entitled to refuse to pay statutory benefits, based on the injured person having committed a serious driving offence.
- The reduction of statutory benefits after 6 months, for contributory negligence.
- Whether, for the purpose of Part 6 of the Act, a full and satisfactory explanation has been given for delay or non-compliance.
- Whether the motor accident verification requirements of the Act have been complied with.
- Whether the insurer is entitled to refuse to pay weekly payments of statutory benefits due to delay in making the claim.
- Whether a late claim may be made for damages.
- Whether a claim may be rejected for non-compliance with the manner in which notice of a claim is to be given.

As Mr Harben SC has touched on, s.3.44 of the MAIA currently provides that a decision made by the Dispute Resolution Service in relation to statutory benefits, is not binding in relation to the determination of the fault of the owner or driver in the use or operation of a motor vehicle, or in the assessment of contributory negligence in relation to a motor accident.

The section also allows for the regulations to prescribe other matters as not binding.

Unless the section or the regulations are expanded to include other matters, decisions as to issues including causation; injury; the extent of incapacity; and whether treatment is reasonable and necessary may be binding.

This means that Dispute Resolution Decisions potentially have a far reaching affect, given the effect of the decisions in matters such as Tuifino v Warland [2000] NSWCA 110; CSR Timber Products Pty Ltd v Weathertex Pty Ltd [2013] NSWCA 49; Charafeddine v Morgan [2014] NSWCA 74; which confirm that an estoppel may arise where there has previously been a determination of an issue between the parties, albeit that the rules of evidence and other procedures do not apply to the proceedings said to give rise to the estoppel.

DAMAGES CLAIMS.

Claims for damages are determined through the Dispute Resolution Service.

The 3-year limitation period previously found in s.109 of the MACA is maintained by virtue of s.6.32(1) MAIA. The provisions for an extension of the limitation period are also maintained.

While s.109 MACA and s.6.32(1) MAIA are in identical terms, it might seem that the limitation period applies only in respect of court proceedings, and not an application for assessment by the Dispute Resolution Service.

However, s.7(33) changes the landscape and provides that a claim for damages cannot be referred for assessment under the Division more than 3 years after the date of accident, unless a full and satisfactory explanation for the delay is provided to the Dispute Resolution Service and the claims assessor grants leave.

This makes it clear that claims for damages in respect of motor accidents are subject to a limitation period of 3 years, irrespective of whether they are brought by way of court proceedings, or by way of an application for assessment through the Dispute Resolution Service.

Beyond that, the arrangements for assessment of claims, applications for exemption, and the commencement of court proceedings remain the same as contained within the MACA.

COSTS.

Part 8 of the MAIA deals with costs.

Section 8.3(1) provides that the regulations may make provision for the maximum amount of costs payable to an Australian legal practitioner acting for a claimant or an insurer, including declaring that no costs are payable for any such legal service or other matters of a kind specified in the regulations.

Section 8.3(3) provides that an Australian legal practitioner is not entitled to be paid or recover fees for providing a legal service or other matter, which exceeds the maximum costs fixed for the service or matter by the regulations under the section.

Section 8.3(5) provides that an Australian legal practitioner is it not entitled to recover costs for a legal service provided to a party to a claim for statutory benefits in connection with the claim unless payment of those legal costs is permitted by the regulations or the Dispute Resolution Service.

Section 8.10(4) provides that the Dispute Resolution Service can only permit payment of legal costs in relation to a claim for statutory benefits, if the claimant is under a legal disability, or exceptional circumstances exist.

The Regulations are currently the subject of negotiation between the government and stakeholders, including the NSW Law Society and the NSW Bar Association.

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16 June 2017.