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SUPERANNUATION CASE LAW UPDATE
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1. POLICE SUPERANNUATION ALLOWANCE - *SAS TRUSTEE CORPORATION V MILES* [2018] HCA 55

The High Court of Australia (Kiefel CJ, Bell, Gageler, Nettle and Edelman J) has dismissed a claim by an ex-police force member for an increased additional annual superannuation allowance under the *Police Regulation (Superannuation) Act 2006* (NSW). In doing so, the High Court held that disabled members of the police force cannot receive an additional superannuation allowance for incapacity for work outside the police force from an infirmity not caused by being hurt on duty. The case is *SAS Trustee Corporation v Miles* [2018] HCA 55.

POLICE SUPERANNUATION CLAIMS SCHEME

The *Police Regulation (Superannuation) Act* provides a scheme for police officers to receive an "annual superannuation allowance". Two sections were relevant to this case.

If a discharged officer is incapable of exercising the functions of a police officer (except where hurt on duty) and has served for 20 years or until the age of 60, they can receive an annual allowance of up to 72.75% of their salary (section 7(1)).

Where an officer was hurt on duty, they receive a minimum allowance of 72.75% of their salary (section 10(1A)(a))). They can also receive an additional amount up to 12.25% of their salary that is commensurate with their incapacity to work outside the police force (section 10(1A)(b)).

Section 10 is more generous than section 7, since the allowance is payable regardless of years of service (at [8]).

BACKGROUND

The member was an officer of the NSW Police Force. In 2003, the member was certified incapable from four orthopaedic infirmities of discharging his duties (at [12]).

Later in 2003, a delegate of the Commissioner of Police certified that those infirmities were caused by the member being hurt on duty. From late 2003, the member received 72.75% of his attributed salary (at [12]).

The member made several applications to increase his annual superannuation allowance. The NSW District Court increased his annual superannuation allowance to 82.55% of his attributed salary (at [13]).

In 2008, the member applied to amend the original certificate issued by the Commissioner of Police to include an additional infirmity of post-traumatic stress disorder. The member contended that when the original certificate was issued he was unaware that he had a psychiatric condition. The member's application was rejected by the trustee, the Industrial Court, and the Full Bench of the Industrial Court (at [15]).

In 2013, the member applied pursuant to section 10(1A)(b) to increase his superannuation allowance to 85%. The trustee rejected that application. Upon application to the NSW District Court Nielson J confirmed the trustee's decision. Nielson J held that the member's post-traumatic stress disorder could not be taken into account. It was a supervening incapacity and did not arise from the four specified infirmities (at [16]). The NSW Court of Appeal allowed the member's appeal, remitting matters of compensation to the NSW District Court. The trustee appealed this decision to the High Court.

THE HIGH COURT'S DECISION

The High Court allowed the trustee's appeal and held that incapacity for work outside the police force must result from an infirmity caused by the member having been on duty.

The court noted that section 10(1A)(b)(ii) permitted two constructions. One was that the section provides an additional allowance for a member incapacitated for work outside the police force regardless of the cause of the member's incapacity. On the alternate construction, the incapacity for work must result from an infirmity caused by the member having been hurt on duty (at [17]).

However, there were a number of textual and contextual indications that the operation of section 10(1A)(b)(ii) was limited to the latter interpretation (at [20] and [65]). This conclusion largely rested on five key points.

First, under section 7(1), a member of the police force rendered incapable from an infirmity caused otherwise than by being hurt on duty is only entitled to an allowance proportionate to their years of service. They are not entitled to any additional amount in respect of the member's incapacity for work outside the police force. This was consistent with a legislative intent that there should be no annual superannuation allowance paid in respect of incapacity not caused by being hurt on duty (at [21] and [44]).

Second, "disabled member of the police force" is defined in section 10(1) as a member certified *incapable* of personally exercising the functions of a police officer from an infirmity caused by being hurt on duty. The use in section 10(1A)(b) of the cognate expression "*incapacity* for work outside the police force" imported the same idea of incapacity from an infirmity caused by being hurt on duty (at [22]).

Third, in section 10(1A)(c) the additional allowance payable if the member is totally incapacitated is commensurate with the abnormality of risks the member was exposed to. The risks are those that cause the member to be hurt on duty. Consequently, "incapacitated" in section 10(1A)(c) meant incapacitated from the specified infirmity which was caused by being hurt on duty (at [24]).

"Incapacitated" in section 10(1A)(c) also appeared to have the same meaning as "incapacity" in section 10(1A)(b(ii). This supported the conclusion that "incapacity" in section 10(1A)(b)(ii) means incapacity for work outside the police force from the infirmity caused being hurt on duty (at [26]).

Fourth, it is unlikely that that the purpose of section 10(1A)(c) is to provide additional amounts by reference to risks that played no role in rendering the member incapable of work outside the police force (at [25]).

Finally, no allowance is payable unless the member notifies the Police Commissioner. The purpose of this notification is to allow the Commissioner to investigate the injury for the purpose of making a "hurt on duty" determination (at [27]).

RESULT

In the result, the High Court allowed the trustee's appeal. As the member's post-traumatic stress disorder was not determined to have been caused by the member being hurt on duty, it could not be considered. The member's allowance remained at 82.55% of his salary.

2. DEATH BENEFIT - PROCEDURAL FAIRNESS - *BULLIVANT V AUSTRALIAN MEAT INDUSTRY SUPERANNUATION PTY LTD* [2018] FCA 1588

In remitting a complaint about the manner of distribution of a death benefit to the Superannuation Complaints Tribunal (SCT), the Federal Court (Robertson J) has held that a lack of procedural fairness by the trustee of a superannuation fund did not of itself mean that the trustee's decision was not fair and reasonable. Rather, the SCT must look to see whether that lack of procedural unfairness meant that the trustee's decision was not fair and reasonable. The case is *Bullivant v Australian Meat Industry Superannuation Pty Ltd* [2018] FCA 1588.

BACKGROUND

A member of a superannuation fund died, leaving a de facto spouse (although a spousal relationship was disputed), two adult sons and one adult daughter.

When he joined the fund in 2005, the member nominated his three children as his preferred beneficiaries, with his sons to each receive 33% and his daughter 34% of his death benefit (at [13]).

The member's relationship with the spouse commenced in 2007 (at [14]).

In January 2015 the member had made a will naming another person as executor and providing for his estate to be distributed between his spouse and his three children, after certain lump sum bequests were made (at [15]).

In April 2015 the member died (at [16]).

In 2009 and 2010 the member had made 2 loans to the spouse totalling $200,000. The spouse claimed that she had repaid these loans. The children disputed that the loans had been repaid and claimed that the member had forgiven the loans shortly before his death. Apparently, the trustee did not give the spouse an opportunity to counter these statements of the children (at [21]-[22]).

THE TRUSTEE'S ALLOCATION

The trustee initially proposed the following allocation:

(a) to the spouse - 100%

The children and the LPR objected on the basis that she was not in a spousal relationship with the member and he had provided her with substantial loans prior to his death which had not been repaid.

The trustee then proposed the following allocation:

(a) to the LPR – 100%

This was on the basis that the member had made his will a few months prior to his death in which he had nominated that his estate be distributed between his three children and his spouse after certain lump sum bequests were made. The trustee noted the member had made loans to the spouse which he had apparently forgiven and which had not been repaid. As a result, the trustee determined that paying the benefit to the LPR was fair and equitable to all parties in the circumstances.

The spouse complained to the SCT, saying that the trustee had made its decision on incorrect information as she had repaid all her debts to the member.

THE SCT DETERMINATION

The SCT set aside the trustee's decision and determined that the benefit should be allocated between the spouse and the children in equal shares, as follows:

(a) to the spouse – 25%;

(b) to the elder adult son – 25%;

(c) to the younger adult son – 25%; and

(d) to the adult daughter – 25% (at [2]).

In the SCT's view, the fact that the trustee had not given the spouse an opportunity to counter the statements made by the children about the loans amounted to a "lack of procedural fairness" which made the trustee's decision unfair and unreasonable:

> 51. The Tribunal considered that whether or not the Spouse had repaid the loans, the Trustee did not appear to have offered her the opportunity to counter the statements of the other Parties that the loans had not been repaid prior to it reversing its decision to pay her the Benefit. In the opinion of the Tribunal, this lack of procedural fairness makes the Trustee's decision to pay the Benefit to the LPR unfair and unreasonable.

As no-one was financially dependant on the member, the SCT attached importance to the member's wishes as recorded in his will which had been made several months before his death:

> 53. In the Tribunal's view the purpose of superannuation is to provide income in retirement to a member and his or her dependants. In the event of a death before retirement, the Tribunal's approach is to consider what might have occurred had the member not died, and whether there is anyone who had an expectation of ongoing financial support or a right to look to the Deceased Member for ongoing financial support had the Deceased Member not died.
>
> 54. The Tribunal considered that none of potential beneficiaries to the Benefit were financially dependent on the Deceased Member and there was no evidence that any of them had an expectation of future financial support.
>
> 55. Under superannuation law a death benefit does not form part of a deceased member's estate and whilst a Trustee may have regard to the provisions in a will when distributing a death benefit it is not bound by it.
>
> 56. However, given the terminal nature of the Deceased Member's illness, the Tribunal considered that his Will was executed in anticipation of his death and a strong indication of his wishes.

Allocating the benefit between the spouse and the children in equal shares was consistent with the member's wishes as recorded in the will.

The spouse appealed to the Federal Court.

THE FEDERAL COURT DECISION

The Federal Court (Robertson J) upheld the appeal and remitted to matter to the SCT. A lack of procedural fairness by the trustee did not of itself mean that the trustee's decision was not fair and reasonable. Rather, the SCT must look to see whether that lack of procedural unfairness meant that the trustee's decision was not fair and reasonable.

The court said:

> [44] ... In my opinion it is clear that the Tribunal, at [51], misconstrued its jurisdiction by proceeding on the basis that a lack of procedural fairness of itself made the trustee's decision to pay the benefit to the deceased's legal personal representative unfair and unreasonable. As the Full Court made clear in *[Board of Trustees of the State Public Sector Superannuation Scheme v Edington* [2011] FCAFC 8] at [46] and [50], the Tribunal's consideration of whether a trustee's decision was "fair and reasonable" in the circumstances is to be based on the actual decision, not the process which led to the decision.

and:

> [55] In summary, the Tribunal misunderstood the statutory concept of "air and reasonable in the circumstances" by looking only at the procedural unfairness it found rather than looking to see whether that procedural unfairness meant that the decision itself was not fair and reasonable.

The SCT had failed to complete its task. Whether or not the trustee's decision was fair and reasonable required making a finding on the issue of whether the spouse had repaid the loans to the member (at [52]). The court said:

[56] ... in my opinion the Tribunal could not have decided that the [trustee's] decision was or was not unfair or unreasonable without deciding the question of the repayment or otherwise of the [spouse's] debt to the deceased. The Tribunal needed to look at the practical operation of the trustee's decision. The Tribunal made this error of law by way of a related error of law by which it gave a dispositive or absolute value to the deceased's will in support of its reasoning that it did not have to decide the question of the repayment or otherwise of the applicant's debt to the deceased.

[57] For these reasons I would allow the appeal, set aside the determination of the Tribunal and remit the matter to be determined again by the Tribunal in accordance with law.

RESULT

In the result, the matter was remitted to the SCT to be determined again by the SCT in accordance with law. The court made no order for costs (at [57]-[59]).

3. TPD CLAIM - THE BEST EVIDENCE OF INABILITY TO OBTAIN WORK - *NEWLING V FSS TRUSTEE CORPORATION (NO 2)* [2018] NSWSC 1405

The New South Wales Supreme Court (Parker J) has dismissed a claim by a member of a superannuation fund for a total and permanent disablement (TPD) benefit. In so doing, the court said that in a case like this, the best evidence of inability to obtain work is evidence of actual unsuccessful attempts to obtain, or to hold down, relevant employment; while the second best evidence is some form of expert assessment. The case is *Newling v FSS Trustee Corporation (No 2)* [2018] NSWSC 1405.

BACKGROUND

The trustee of the superannuation fund held a group life insurance policy which provided death and TPD benefits in respect of fund members (at [3]).

Relevantly to the subsequent litigated TPD claim, the definition of TPD in the policy read in part (at [3]):

> While covered under this policy, Total and Permanent Disablement shall have the following meaning: ...
>
> (b) ... the Insured Member having been absent from their Occupation with the Employer through injury or illness for six consecutive months and having provided proof to our [ie the insurer's] satisfaction that the Insured Member has become incapacitated to such an extent as to render the Insured Member unlikely ever to engage in any gainful profession, trade or occupation for which the Insured Member is reasonably qualified by reason of education, training or experience;

In 1991 the claimant joined the NSW Police Force (at [18]).

In 1997 she was promoted to Senior Constable. Later in 1997 she fell down a flight of stairs at work, injuring her back. She returned to work, but her work was restricted to light duties. She worked in intelligence at a desk job. She returned to her full pre-injury hours of about 30 hours per week (at [18]).

She made a workers' compensation claim for disability arising out of her fall in 1997. The claim was settled, apparently in 2001. The terms of settlement provided for her to receive compensation for a 15% impairment of her back and a 5% impairment of her right leg, but for an award in favour of the Police Force with respect to her left leg (at [20]).

In 2004 the claimant was transferred to the Marine Area Command at Balmain in Sydney. She continued to work at a desk job in the intelligence area. She was promoted to Sergeant in May 2005. She worked on a flexible roster, reportedly working on average 74 hours per fortnight (at [21]).

Between December 2008 and May 2009 she took three periods of leave totalling approximately eleven weeks. This was a combination of sick leave, annual leave and "extended" leave. In May 2009 she was certified by her general practitioner, Dr Bong, as being fit only for restricted duties at reduced hours of two six-hour shifts per week (at [22]).

The claimant returned to work in May 2009 but then took a further four weeks of leave in June 2009. The beginning of this period of leave coincided with the hospitalisation of her son. When she returned to work in July 2009, she submitted a police incident notification form stating that she had sustained back spasms while sleeping over at the hospital. She made a workers' compensation claim as a result, based on aggravation of her earlier back injury (at [23]).

When the claimant returned to work in May 2009, Inspector Thommeny had been appointed as her supervisor. The claimant came into conflict with Ms Thommeny concerning her requests for leave and her restricted working hours. The claimant claimed that this amounted to workplace bullying and harassment. Ms Thommeny's superior, Superintendent Hutchings, was drawn into the dispute and seemed eventually to have supported Ms Thommeny (at [24]).

In August 2009 the claimant consulted her general practitioner Dr Bong and was diagnosed with "anxiety/depression" as a result of alleged workplace harassment. Dr Bong certified her as unfit for work and she went off work. She was referred to Dr Smith as her treating psychiatrist. He first saw her in September 2009 and diagnosed her as having "Adjustment Disorder with Depressed and Anxious Mood" (at [25]).

Dr Bong also referred the claimant to Dr Kwok, a neurosurgeon, concerning her back complaints. Dr Kwok saw her in September 2009. He concluded that further conservative treatment of her back would not help and

surgery was suggested. He advised the claimant on the likelihood of success and possible complications but she did not take up this suggestion (at [26]).

The claimant made a further workers' compensation claim as a result of her psychiatric diagnosis. She remained off work until December 2009 when her leave entitlements ran out (at [27]-[28]).

In February 2010 the claimant saw Dr Scougall, an orthopaedic surgeon, at the request of her workers' compensation lawyers. He diagnosed her as having chronic back pain with "non verifiable radiculopathy symptoms in her left leg" (and not her right leg which had been the subject of the earlier award). At the time the claimant was reportedly continuing to work on restricted hours of two seven hour days per week (at [29]).

In May 2010 her claim for aggravation of her back injury was declined on the ground that any such aggravation did not arise out of, or in the course of, her employment. She challenged this decision. In September 2010 she again saw Dr Scougall at the request of her workers' compensation lawyers. He repeated his diagnosis and opinion on causation (at [29]).

In October 2010 the claimant saw Dr Crowle, an occupational physician, at the request of the Police Force, for the assessment of a proposed return-to-work plan. Dr Crowle diagnosed her as having a "history of chronic back pain and left S1 radiculopathy". At the time, she was still attached to the Marine Area Command but her hours were still seven hours per day, two days per week, with a travel restriction of no more than twenty minutes. As a result of this travel restriction, she was working from an office at Prospect in Sydney where she was provided with a workstation allowing for remote communication with the Marine Area Command (at [30]-[31]).

The claimant later increased her work hours to three seven-hour days per week, but subsequently reduced them to two five hour days per week, complaining of increasing pain, before she went off work for the final time on 2 September 2011 (at [32]).

The group life policy expired on 30 September 2012, before the 6-month "qualifying period" applicable to the claimant had been completed on 2 March 2012. The insurer took no issue with this, as the claimant had gone off work and the qualifying period had commenced before the policy expired (at [10]-[11]).

In April 2012 the claimant lodged a TPD claim. In May 2012 she was discharged from the Police Force on medical grounds (at [31] and [1]).

The medical evidence lodged with the claim comprised a "medical statement" by the claimant's general practitioner Dr Bong; and medical certificates by Dr Bong and her treating psychiatrist Dr Smith which had originally been prepared for workers' compensation purposes. Dr Bong's medical certificate recorded a diagnosis of "severe chronic low back; severe anxiety depression diagnosed [illegible symbol] adjustment disorder". Dr Bong certified that the claimant was unfit to return to the Police Force and should be medically discharged. Dr Bong also certified that the claimant had reached "maximum medical improvement". Dr Smith's medical certificate recorded a diagnosis of "Adjustment Disorder with Depression and Anxious Mood". Dr Smith certified that the claimant's employment was in his opinion a substantial contributing factor to this injury. He also certified that the claimant had reached "maximum medical improvement" and that in his opinion she was not fit to return to the Police Force and should be medically discharged. The opinions recorded in these certificates were not supported with any reasoning. They simply involved the doctor ticking a box or writing a few words on the form (at [34]-[38]).

The insurer investigated the claim and obtained medical reports which provided support for the proposition that the claimant may have the capacity to return to employment outside the Police Force. These reports were from the claimant's treating psychiatrist Dr Smith, from Dr Robinson, an orthopaedic surgeon, and from Dr Ng, a psychiatrist. The insurer also obtained a vocational assessment report and arranged surveillance (at [45]-[71]).

In March 2015 the insurer sent a procedural fairness letter. In March 2015 the claimant's lawyers sent a submission in response. In July 2015 the insurer responded by letter with a 38 page long Information Summary, and invited a further response. The letter concluded that the balance of the medical evidence was to the effect that the claimant was not TPD (at [84]-[122]).

There was further correspondence between the insurer and the trustee (at [123]-[134]).

THE PROCEEDINGS

In June 2016 the claimant commenced proceedings in the NSW Supreme Court against the trustee and the insurer (at [136]).

The trustee played no active part in the proceedings (at [13]).

In 2017 the insurer applied for the question of whether it had breached its obligations as insurer to be dealt with separately and first. The claimant consented to this, and orders for a separate determination of the "first stage" were made: *Newling v FSS Trustee Corporation* [2017] NSWSC 1839.

THE COURT'S DECISION

The court noted that the claimant (as a member of a superannuation fund covered by a group life insurance policy) had standing to enforce the trustee's rights against the insurer under the policy, and that if the claimant succeeded the insurer would pay the benefit to the trustee who would then account for it to the claimant (at [13]).

The court dismissed the claimant's claim.

The court said that the allegations of breach put forward on behalf of the claimant could be grouped under five headings (at [145]):

(1) failure to make a decision at all;

(2) alternatively, failure to give reasons for the decision;

(3) unfairness to the claimant in assessing her claim;

(4) unreasonableness in assessing the claimant's medical condition;

(5) unreasonableness in assessing the claimant's likelihood of obtaining work.

The court rejected all of these allegations.

Failure to decide

In relation to this point, the court said that the policy required that proof be provided to the insurer's satisfaction of the relevant incapacity. The insurer had no obligation to assemble such proof for itself; and so, for practical purposes, it was up to the claimant to do so. In this sense, the onus lay on her (at [148]).

Failing to give reasons for decision

In relation to this point, the court rejected a submission made on behalf of the claimant that the insurer's duty of good faith necessarily carried with it an obligation to give reasons for its decision. In this respect the court departed from previous statements in *Ziogos v FSS Trustee Corporation* [2015] NSWSC 1385 [75] (Ball J) and *Carroll v United Super Pty Ltd* [2018] NSWSC 403 [102] (Slattery J) that an insurer's duty of utmost good faith requires it to give reasons for its decision (at [149]-[166]).

In *Newling*, the court said (at [144]):

> The [New South Wales] Court of Appeal [in *Hannover Life Re of Australasia Ltd v Jones* [2017] NSWCA 233] has explicitly adopted a test of unreasonableness which requires a plaintiff to demonstrate that the decision in question was not open to "an insurer" acting reasonably. That test is not specific to the particular insurer in question, … If the decision is one which could have been made by an insurer acting reasonably, then it must be sustained.

and:

> If it is sufficient for the decision in question to be open to "an insurer" acting reasonably and fairly, then an inability to understand what the insurer's particular process of reasoning was, does not necessarily mean that breach is established. The Court can decide whether the decision falls within the permissible range without knowing the specific reasoning process followed by the insurer.

Here, even if the insurer were required to give reasons for its decision, there was no breach (at [166]).

Unfairness in assessment process

In relation to this point, the court accepted that, as the process of assessing the claim was under the insurer's control, the insurer was obliged to adopt an assessment procedure which gave the claimant a full and fair opportunity to prove her claim to the insurer's satisfaction. This included both defining the issues under consideration and presenting the evidence which bore on those issues (at [168]).

Here, the insurer had given the claimant a full and fair opportunity to present her case. The court was not satisfied that the insurer had unfairly or unreasonably disregarded her interests (at [174]).

Unreasonableness in assessing the claimant's medical condition

In relation to this point, the court said that what was in issue was the extent of the claimant's disabilities, both physical and psychiatric, and in particular their effect on whether she was, in March 2002, disabled from working again. These questions were critically dependent upon self-reporting by the claimant, as well as being matters of judgment and opinion. The insurer was not obliged to accept everything that was said by the claimant or on her behalf. The insurer was entitled to be doubtful or even sceptical if doubt or scepticism was reasonably open (at [185]).

It was wrong to suggest that the only question before the insurer was whether its doctors' opinions were preferable to those of the claimant's doctors. To frame the question in that way presupposed that the case presented by the claimant's doctors was complete and compelling. It was also wrong to suggest that the insurer needed to have "sound reasons" for reaching conclusions other than those reached by the claimant's doctors. The insurer was not obliged to approach the assessment on the footing that the material put forward by the claimant prima facie established her claim and the onus lay on the insurer's doctors to rebut it (at [186]).

Unreasonableness in assessing likelihood of obtaining work

In relation to this point, the court said that the onus was on the claimant to provide proof of her inability to work. The insurer had taken it upon itself to obtain a vocational assessment report. But it was not enough for her to adopt the defensive posture of seeking to "pick holes" in the suggestions which were put forward in that report. Rather, it was for the claimant to prove affirmatively to the insurer's satisfaction that there was no real chance that she would work again (at [222]).

There was no evidence that the claimant looked for alternative work after she left the Police Force. Indeed the evidence showed that she made a positive decision in November 2012 to take herself out of the labour market. That did not, of course, mean that she could not establish that she was and would remain unable to find suitable alternative work. The court said (at [223]):

> But in a case such as this, the best evidence of inability to obtain work would have been evidence of actual unsuccessful attempts to obtain, or to hold down, relevant employment. The second best evidence would have been some form of expert assessment. The claimant presented neither of these. In relying solely on opinions from her doctors, which relied critically on what she had told them, she was taking on a difficult task.

By late 2008 the claimant had been working at a desk job in the Police Force for more than a decade. On her own account, and also that of Dr Smith, she worked dynamically and effectively in overcoming any residual effect of her back injury. The vocational assessment obtained by the insurer which identified a wide range of potentially suitable office jobs as available to the claimant accorded with what one would think based on common experience (at [224]).

Having regard to the deficiencies in the claimant's case on this point, and the uncertainties about her claimed disabilities, it was reasonably open to the insurer not to be satisfied that she was unlikely ever to engage in suitable alternative employment in the future (at [225]).

Should a second stage enquiry be a paper exercise?

This was enough to dispose of the proceedings. The insurer had not breached its obligations and a "second stage" enquiry was not required.

Nevertheless, the court queried the jurisprudential basis on which the court acts in these kinds of cases. On one approach, if the insurer fails to act fairly and reasonably, the ensuing decision is of no contractual effect. There is no decision at law (and so a fresh decision has to be made) (at [226]-[227] and [229]).

However, on another approach, a breach by the insurer sounds in damages (if a statutory or common law duty) or equitable compensation (if an equitable duty). On this approach, the second stage would be an enquiry into the loss or damage flowing from that breach. The court would determine what the decision would have been had the insurer acted fairly and reasonably. If the court finds that in that event the claim would have been allowed, then damages can be recovered for the value of the claim. If the court is not satisfied that the breach made any difference,

then the claim will fail. This approach would result in a second stage enquiry with a different focus. If the flaw identified in the first stage were confined to the reasoning process, then the second stage enquiry should arguably be limited to the material before the insurer. The second stage, like the first stage, would be a purely "paper" exercise and there would be no room for evidence to be given on the actual state of disability and employability of the plaintiff. If the breach involved the fairness and reasonableness of the process itself, the factual enquiry would be wider. The court would have to decide what evidentiary material and what submissions would have been put before the insurer had the process been carried out fairly and reasonably. The court would then have to decide what decision the insurer, acting fairly and reasonably would have made on that material (at [226]-[235]).

The court mentioned these matters as being relevant to the formulation of questions for separate and preliminary determination in these kinds of cases (at [236]-[237]).

RESULT

In the result, the member's claim for a TPD benefit was dismissed with costs.

4. TPD CLAIM - THE EFFECT OF MEDICATION - *FOLMER V VICSUPER PTY LTD* [2018] NSWSC 1508

The New South Wales Supreme Court (Hallen J) has allowed a claim by a member of a superannuation fund for a total and permanent disablement (TPD) benefit. In so doing, the court said that the insurer had failed to consider whether, in the real world, "full-time business, occupation or regular duties" for a person suffering from the psychological condition from which the member was suffering, and who was taking both anti-depressant, and anxiolytic, medication, was reasonably available. The opinion formed by the Insurer was not open to it acting reasonably and fairly in the consideration of the claim. The case is *Folmer v VicSuper Pty Ltd* [2018] NSWSC 1508.

BACKGROUND

The trustee of the superannuation fund held a life insurance policy which provided TPD and other benefits in respect of fund members (at [6]).

Relevantly to the subsequent litigated TPD claim, the definition of TPD in the policy read in part:

> ... in relation to an Insured Member who has been in gainful work at any time during the two years immediately preceding the Date of Disablement:
>
> (a) (i) the Insured Member has been continuously unable to work because of injury or illness for the TPD Waiting Period; and
>
> (ii) in the Insurer's opinion (after considering medical and other evidence satisfactory to the Insurer) the Insured Member is unable ever again to work for reward in any business, occupation or regular duties for which he or she is reasonably qualified by education, training or experience;
>
> ...
>
> For the purposes of this definition business, occupation or regular duties means:
>
> - full-time business, occupation or regular duties where the Insured Member was working at least 15 hours per week at the Date of Disablement ... (at [102])

In September 2007 a person (the member) commenced employment as a community development officer and counsellor with a mental health service, and became a member of the fund (at [2] and [8]).

In the period from 1994 to 2005, at different times, the member had held various positions, in different organisations, in different states of Australia, as a counsellor, youth support worker, disability support worker, case worker, social worker, and a researcher. She had been involved in areas of personal development, counselling, community development projects, women's health, the provision of assessment and intervention to Centrelink customers, case work and regular case conferencing. She was a "Published writer on Community Development & Health Promotional Models" (at [53]-[54]).

In March 2006 the member was involved in what her counsel described as a "very unfortunate incident". She was involved in a single vehicle motor vehicle accident in Warrugul, Victoria. It was alleged that she was alcohol affected at the time of the accident. She asserted that, following her arrest, she had been taken into police custody, searched whilst in custody, and assaulted by the police (including sexually). She described this incident as "having ruined my life" (at [56]).

The member gave evidence about the sequelae of these events. In summary, she said that:

(1) when having to deal with the police, her stress would increase;

(2) at any time that she needed to go to court, it had caused her great stress;

(3) her anxiety and depression would gradually improve and then she would have something to do with a court event and her condition would worsen again;

(4) the great stress she felt in attending at court would affect her depression and anxiety;

(5) the outcome of the proceedings had been "quite unpleasant"; and

(6) following the conclusion of the initial court proceedings, she started to feel better (at [58]).

At about the time the member commenced work with, and while employed by, the mental health service, the member became aware that her mother had health issues. Her mother suffered a severe cerebral stroke which caused bleeding on the brain and which required her mother to be rushed to Hobart for emergency surgery. While her mother was so unwell, it fell to the member, at least partly, to look after other members of the family (at [69]).

In January 2008, while still employed by the mental health service, the member commenced a full-time course to obtain a PhD in Philosophy of Modern Social Work at the University of Tasmania. When she commenced the course, she felt it was the right choice for her "to think about other options for my future in terms of employability", including, perhaps, going into academia. She studied off campus via online, telephone and correspondence. She continued as a research candidate until she totally withdrew from the course in April 2011 (at [68]).

Later in January 2008 the member ceased working with the mental health service. The precise circumstances of her ceasing working were not set out, in any detail, in the evidence. There did not appear to have been a specific incident that prompted the cessation of her employment. Nor did she assert that she had been injured at work or that she was discharged by the mental health service on medical grounds (at [70]).

In an Application for "Early access to reserved superannuation benefits on medical grounds" dated 7 August 2014 the member stated, as the reason for her retirement from the workforce, "Nervous breakdown. Mutual agreement to cease work". The date of the "nervous breakdown" was not given in that document (at [71]).

Following her ceasing employment, the member looked after her mother and continued with her PhD studies (at [76]).

In September 2009 the member was assaulted by a former boyfriend as a result of which assault she sustained several physical injuries, including several rib fractures, she had difficulty breathing and suffered ongoing pain in her back. The assault also had an aggravating effect on any anxiety, or depression, from which she was suffering and made her more agoraphobic (at [80]).

In February 2012 the member commenced a Post Graduate Criminology Degree at Monash University. She studied off campus via online, telephone and correspondence until she withdrew from the course on in July 2012 (at [86]).

In March 2014 the member claimed a TPD benefit of $90,000. In cross examination she agreed that she made the claim by reason of both the initial event in March 2006 and all of the consequences of the event in September 2009, and that it was the whole problem, globally, that had prevented her from ever working again (at [89]).

In May 2016 the insurer sent a procedural fairness letter (at [134]).

In November 2016 the insurer denied the claim by sending a document headed "TPD Final Claim Summary Dated 23/11/2016" to the trustee (at [145]).

In March 2017 the trustee also declined the claim (at [152]).

THE PROCEEDINGS

In April 2017 the member commenced proceedings in the New South Wales Supreme Court against the trustee and the insurer (at [13]).

Counsel for the trustee and the insurer told the court that if the trustee received the TPD benefit from the insurer, it would forward the money to the member. The member's claim against the trustee was accordingly not pressed (at [42] and [23]).

THE COURT'S DECISION

The court allowed the member's claim.

The insurer did not form an opinion that was reasonably open to it (at [355]).

The insurer's approach to the assessment of the member's claim was deficient in two main respects. First, "work" in the definition of TPD in the policy meant full-time work ("full-time business, occupation or regular duties"), but the insurer apparently not given detailed consideration to this. The court said:

> 327 However, the Insurer did not seem to give detailed consideration to the definition of business, occupation or regular duties where the Insured Member was working at least 15 hours per week at the Date of Disablement as "full-time business, occupation or regular duties" (my emphasis). In this regard, the concept of business, occupation or regular duties for which the Insured Person is reasonably fitted by education, training or experience directs attention to the insured's vocational history to date, and to occupations for which that vocational history fits the insured.

and:

> 335 The TPD Final Claim Summary did not identify any categories of full-time work in the business, occupation or regular duties, for which the [member] was reasonably qualified by education, training or experience, which she would be able to perform. That she was able to maintain her academic studies in Social Work throughout 2008 would not, necessarily, go to whether she was continuously unable to work because of injury or illness for 6 months after the Date of Disablement, or for that matter, thereafter. After all, her studies were conducted off campus via online, telephone and correspondence attendance, which was not what was required for being, again, able to "work for reward in any business, occupation or regular duties for which ... she is reasonably qualified by education, training or experience".

Second, the insurer had failed to consider the effect of the member's medication for her psychological condition. The court said:

> 342 In my view, the Insurer took too narrow a view of the concept of being unable ever again to work for reward, carrying out full-time business, occupation or regular duties for which [the member] was reasonably qualified by education, training or experience, by failing to have due regard to the psychological obstacles, and difficulties with memory, and competitive disadvantages that would be likely to adversely impact upon her ability to do so.
>
> 343 The Insurer also failed to consider, in any meaningful way, the effect of the medication which the [member] was being prescribed for her psychological condition. Thus, the Insurer failed to take into account a significant component of the [member's] incapacity.

and:

> 352 … how the requirement to continue to take the medication in order to remain "better" would affect her ability to work "full-time" was not identified.

Both criticisms are discernible in the following passage:

> 341 Taken overall, the decision in the TPD Final Claim Summary reflected a failure by the Insurer to consider whether, in the real world, "full-time business, occupation or regular duties" for a person suffering from the psychological condition from which the [member] was suffering, and who was taking both anti-depressant, and anxiolytic, medication, was reasonably available. In this regard, the opinion formed by the Insurer was not open to it acting reasonably and fairly in the consideration of the claim.

The geographical location of relevant work did not play any substantial role, as the requirement relating to the member's inability to work "full-time" in any business, occupation or regular duties for which she was reasonably qualified by education, training or experience, was satisfied (at [370]).

It was likely that the member could have undergone some retraining. Yet, the psychological condition from which the member suffered at the time she ceased work in January 2008, and which continued throughout the 6 month period thereafter, would have prevented her from working work "fulltime" in any business, occupation or regular duties for which she was reasonably qualified by education, training or experience (at [371]).

RESULT

In the result, the member's claim for a TPD benefit of $90,000 was allowed with interest (at [374]).

5. TPD AND INCOME PROTECTION CLAIMS - INSURER'S RIGHT TO ASK FOR FURTHER PROOF OR MORE INFORMATION - *MACRAS V NULIS NOMINEES (AUSTRALIA) LTD* [2018] FCA 1867

The Federal Court (Davies J) has dismissed an appeal by a member of a superannuation fund from a determination of the Superannuation Complaints Tribunal (SCT) affirming decisions by the insurer and trustee of the fund. The member was claiming a total and permanent disablement (TPD) benefit and an income protection benefit. The insurer decided that it was unable to determine the member's claims until the member cooperated in providing further proof or information. The trustee agreed with the insurer. The case is *Macras v Nulis Nominees (Australia) Ltd* [2018] FCA 1867.

THE INSURANCE POLICY

The trustee of the superannuation fund took out an insurance policy. As for when benefits would be paid, the policy said:

> We will pay a Benefit when we have proof satisfactory to us:
>
> - that all the events entitling the Trustee to payment of the Benefit have happened; and
> - of the Member's age.
>
> We may ask for further proof or information to be satisfied that the Trustee is entitled to the Benefit.

The policy also said:

> We will not pay a Benefit for any disability, condition or loss arising from or contributed to by:
>
> …
>
> Sickness or Injury that first appeared, happened or was diagnosed before this insurance started or was last reinstated (unless disclosed to, and accepted by, [the Insurer] as a part of the application or reinstatement process).

FACTS

In 2012, the member applied for death, TPD and income protection cover. In his application the member disclosed that he had suffered from anxiety in 2009 and had been on medication.

In early 2016, the member was diagnosed with various conditions, including anxiety and Asperger's syndrome. From the medical reports supplied, some of these conditions could have been present for a long time but only diagnosed in 2016. Later in 2016, the member ceased work.

In early 2017, a psychologist considered it was likely that a further six months to two years would be required before the member could perform his normal duties again.

Later in 2017, the member lodged claims with the insurer for TPD and income protection benefits. On reviewing various medical records, the insurer formed the view that it could not make a decision (at [6]). It required more information to ascertain whether the member's conditions had existed before the cover had been taken out (at [6]). The trustee also had not made a formal review of the member's claim, as no decision had been made by the insurer (at [7]).

The member complained to the SCT about the trustee's and insurer's decisions.

The member also revoked his authorisation for the insurer to access his medical records (at [6]).

THE SCT'S DETERMINATION

The SCT affirmed the decisions of the insurer and the trustee. The SCT determined that the insurer's assessment that the member's claims could not progress until the member provided the insurer authority to obtain further medical evidence was "fair and reasonable" in the circumstances.

The SCT noted that under the insurance policy, the insurer would pay a benefit when it had satisfactory proof that all the events entitling payment had happened. Further, the policy said that the insurer may ask for further proof or information that the trustee is entitled to the benefit.

The SCT considered that this right extended to information to allow the insurer to ascertain whether a condition was pre-existing at the time of the application. The insurer had also provided reasons as to why it required further information, including concerns that the member had not disclosed his full medical history when applying for insurance cover.

The member appealed the SCT's determination to the Federal Court.

FEDERAL COURT'S DECISION

The court dismissed the member's appeal. The court held that it was open to the SCT to affirm the decisions of the trustee and insurer, having regard to the medical evidence before it and the policy's provisions (at [12]). With regard to the insurer's decision, the court relied on four key pieces of evidence.

First, a report of the member's general practitioner advised that the member had a long history of depression (at [12]).

Second, a psychologist's report expressed that the member may have suffered from Asperger's syndrome since childhood and had symptoms of depression and anxiety from 2006 for which he sought counselling (at [12]).

Third, the psychologist reported that the member was diagnosed with depression for which he sought treatment (at [12]).

Fourth, Medicare records indicated that the member had numerous consultations for psychological treatment and mental health reviews prior to the policy's commencement (at [12]).

The court also held that it was open to the SCT to find that it was fair and reasonable for the trustee not to make a decision on whether to make a payment until it received notification from the insurer about the member's entitlements (at [13]).

RESULT

In the result, the member's appeal was dismissed. It was fair and reasonable for the insurer not to determine the member's claims until the member provided the insurer with further proof or information. It was also fair and reasonable for the trustee to agree with the insurer.

6. INCOME PROTECTION CLAIM - BENEFITS NOT REDUCED BY OFFSET CLAUSE - *BUSWELL V TAL LIFE LTD* [2018] NSWSC 1507

The NSW Supreme Court (White J) has held that an offset clause in an income protection policy did not entitle the insurer to reduce the claimant's monthly income benefits by an amount which the claimant had received in settlement of a claim for work injury damages against her employer. The settlement amount was not any form of income. Nor was it "Other Disability Income" within the meaning of that term in the policy. The case is *Buswell v TAL Life Ltd* [2018] NSWSC 1507.

THE CLAIM FOR DAMAGES

The claimant was a member of the NSW Police Force from 1989 until 2014, when she was medically discharged. In 2013 she had ceased performing duties as a police officer (at [2]).

The claimant brought a claim for work injury damages for psychological damages against her employer, the State of NSW (NSW Police Force), under the Workplace Injury Management and Workers Compensation Act 1998 (NSW) (at [8]).

In 2017 the claim was settled. The claimant, her employer and its insurer entered into a settlement deed. The deed provided that without admission of liability, the claimant's claim would be settled on the basis that the insurer would pay $350,000 inclusive of costs and clear of workers' compensation payments in full and final satisfaction of her claim for work injury damages. The sum of $350,000 was in addition to all payments made to the claimant pursuant to the Workers Compensation Act 1987 (NSW). The claimant received $300,000 after deduction of her costs of $50,000 (at [8]).

THE CLAIM FOR INCOME PROTECTION BENEFITS

As a member of the NSW Police Force, the claimant was a member of a superannuation scheme.

In 2012 the trustee of the scheme had taken out an income protection policy (at [3]). The policy contained what is commonly called an offset clause. This clause provided for monthly benefits to be reduced, in the following terms:

> 1.9.1 The amount of any Benefit payable in respect of an Insured Person for a month will be reduced by any Other Disability Income which accrues to that person during that month (at [5]).

The definition of "Other Disability Income" in the policy read as follows:

> Other Disability Income means any income (other than Return To Employment Income) which an Insured Person may derive during a month for which the Benefit is payable and includes;
>
> (a) any benefit payable under other income protection insurance policies; and
>
> (b) any benefit under any workers compensation, statutory compensation, pension, social security or similar schemes or other similar State, Federal or Territory legislation; and
>
> (c) any benefit paid under state or federal legislation such as the Department of Veteran Affairs; and
>
> (d) any other income payments including Employer funded sick leave entitlements.
>
> Any Other Disability Income which is in the form of a lump sum or is commuted for a lump sum, has a monthly equivalent of one sixtieth (1/60) of the lump sum over a period of sixty (60) months.
>
> If it can be shown that a portion of the lump sum represents compensation for pain and suffering; or the loss of use of a part of the body, we will not take that portion into account as Other Disability Income (at [6]).

In 2014 the insurer accepted a claim by the claimant for income protection benefits under the policy (at [3] and [7]).

In 2017 the insurer became aware of the settlement of the claimant's claim for work injury damages earlier in 2017. The insurer asserted that the settlement amount was Other Disability Income, invoked the offset clause and reduced the monthly benefit by $5,000 (at [9]).

The claimant commenced proceedings against the insurer in the Supreme Court of NSW. The trustee was not a party.

In the Supreme Court proceedings, the agreed facts included the following characterisation of the claimant's claim against her employer:

3. The elements of the [claimant's] claim [against her employer] were as follows:

   (a) damages for past and future economic loss;

   (b) damages to account for past and future lost superannuation;

   (c) Fox v Wood damages; and

   (d) costs.

...

10. The settlement sum is divisible as follows:

   (a) costs:

   $50,000.00

   (b) damages for economic loss (including lost superannuation and tax):

   $300,000 (at [11])

THE COURT'S DECISION

The court held that in the circumstances, the offset clause did not operate to reduce the amount of the claimant's monthly income protection benefit.

The insurer's submissions

The insurer did not dispute that for the purposes of taxation, the settlement amount would be treated as capital and not income. Nor did it dispute that common law damages were not "benefits" as that word was used in the Workers Compensation Act. Rather, the insurer submitted that the definition used the word "income" in a wide sense and subparagraphs (a)-(d) of the definition informed the meaning to be given to the word "income" in the first part of the definition to indicate that it extended to any benefits received by the insured person, whether or not those benefits would be classified as income for the purposes of income tax law (at [19]-[24]).

The insurer further submitted that the settlement amount could fairly be seen as income derived as a result of a benefit under the workers' compensation scheme because that scheme was the source of the right to sue for modified common law damages which was released under the settlement deed (at [25]-[26]).

Finally, the insurer submitted that the definition of "Other Disability Income" in the policy contemplated that Other Disability Income may be in the form of a lump sum whether or not it is the result of a commutation (at [43]).

The claimant's submissions

The court described the claimant's submissions as "straightforward". A damages award for personal injury is not income, but capital and therefore could not be said to be income for the purposes of the definition of Other Disability Income. Damages are awarded not for the loss of income as such, but for the loss of earning capacity in so far as that is productive of financial loss. Earning capacity is a capital asset. An award of damages is not taxable because it does not fall within the ordinary concept of income (at [13]).

The claimant also submitted that the payment in satisfaction of her claim for damages was not a benefit under a workers' compensation scheme or under workers' compensation legislation. Although the Workers Compensation Act modified the damages that can be awarded in respect of an injury caused by the negligence or other tort of a worker's employer and the Workplace Injury Management and Workers Compensation Act 1998 (NSW) regulated the steps to be taken in bringing a claim for work injury damages, neither Act provides the source of the right to bring the claim for damages. The claim is brought under the common law as is recognised by the heading to Div 3 of Pt 5 of the WC Act, namely "Modified common law damages" (at [14]).

The court's decision

The court rejected the insurer's submissions. In key passages, the court said:

> ... according to ordinary concepts the receipt of damages for personal injury, or a settlement sum in compromise of a claim for damages for personal injury, is capital and not income. The reason that income tax is not payable on the settlement sum is not because of any special provision peculiar to taxation law, but because it is not income according to ordinary concepts ... (at [21])

and:

> The better construction is that sub-paragraph (b) [of the definition of "The Disability Income"] refers to "any benefit under any workers compensation ... scheme". Workers' compensation schemes have a long history and are based in statute. They provide benefits, sourced in statute, for injured workers.
>
> When the clause is read as a whole the word "benefit" is not capable of bearing the construction contended for, but refers instead to statutory benefits provided by legislation identified in the paragraph (at [38]-[39]).

and:

> The definition of Other Disability Income only results in a reduction of the benefits payable under the policy if the insured receives or derives income (within the ordinary meaning of that term) or what is taken to be included as income if the amount falls within any of paras (a)-(d) of the definition. The settlement sum was not income within the ordinary meaning of that term. Unless if falls within any of paras (a)-(d) (and only (b) is relevant) then it is not Other Disability Income. The mere fact that the sum in settlement of the claim for damages was received in a lump sum does not mean that it is Other Disability Income (at [47]).

The court concluded that the amount received in settlement of the claimant's claim for work injury damages was not income. Nor was it a benefit under workers' compensation legislation. Nor was it any other income payment. It therefore did not fall within the definition of "Other Disability Income" and the offset clause did not operate to reduce the amount of the claimant's monthly income protection benefit. Accordingly, the declaration and orders sought by the claimant should be made (at [48]).

RESULT

In the result, the court held that the offset clause in the policy did not operate to reduce the amount of the claimant's monthly income protection benefit. The court:

- declared that the amount of $300,000 paid to the claimant by her employer or its insurer in settlement

of her damages claim did not fall within the definition of "Other Disability Income" in the policy;

- ordered the insurer to reinstate the claimant's monthly benefits under the policy;
- ordered the insurer to pay all arrears under the policy plus interest at the rates prescribed for the purposes of s 57(3) of the Insurance Contracts Act 1984 (Cth) from the dates instalments of arrears were payable; and
- ordered the insurer to pay the claimant's costs (at [50]).

COMMENTS

As the name suggests, income protection insurance (also called salary continuance insurance) provides protection against loss of income. The insured person's pre-disability income stream is replaced by a stream of payments under the policy, up to a percentage limit (typically 75%) of the insured person's pre-disability income which is set by the policy. The purpose of the percentage limit on benefits is to ensure that the insured person retains an incentive to return to work.

Income protection insurance has been described in the following terms:

> An income protection policy is designed to provide regular benefits, payable monthly or sometimes fortnightly, to replace earned (that is, earned by personal exertion as opposed to investment) income which has been lost by the insured because of disability.
>
> (I Enright, P Mann, R Merkin, G Pynt and S Traves, Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, Background Paper 29: Life Insurance, 28 August 2018, at [3.20])

An income protection benefit is "income according to ordinary concepts" and therefore "assessable income" for tax purposes (Income Tax Assessment Act 1997 (Cth) (ITAA 1997), s 6-5(1); and Australian Taxation Office (ATO), Product Ruling PR 2016/6, paras [50]-[53]), irrespective of whether the policy is held by a superannuation trustee or is held outside superannuation. (An income stream paid from a superannuation fund because of a person's temporary inability to engage in gainful employment is not a "superannuation benefit" for the purposes of ITAA 1997: s 307-10(a).)

Income protection insurance is to be contrasted with total and permanent disablement (TPD) insurance. In the usual case, ie where the insured person is working, TPD insurance provides protection against loss of earning capacity. The benefit is paid as a lump sum (although some policies provide for the benefit to be split into 2 or more instalments). A TPD benefit paid outside superannuation is not assessable income for tax purposes: ATO, Product Ruling PR 2007/20, para [35]. Whether, and if so to what extent, a TPD benefit paid through superannuation is assessable income depends on the particular circumstances: ITAA 1997, Div 301; and ATO, Product Ruling PR 2017/11, para [16(d)].

Although the cover provided by an insurance policy always depends on the particular words used and the potential application of certain sections of the Insurance Contracts Act, ordinarily one would not expect the benefits provided by an income protection policy to be reduced by reference to benefits received by the insured person on account of loss of earning capacity, as opposed to loss of income. To achieve this result (if this result is intended), clear words must be used.

7. NOTIONAL ESTATE CLAIM - *RE ESTATE GRANT, DECEASED* [2018] NSWSC 1031

The NSW Supreme Court (Lindsay J) has made orders affecting a superannuation death benefit, under the "notional estate" provisions of the *Succession Act 2006* (NSW). The court made a family provision order in favour of the member's stepson in the sum of $750,000, payable out of a superannuation death benefit designated as notional estate. The case is *Re Estate Grant, deceased* [2018] NSWSC 1031.

FAMILY PROVISION ORDERS

Briefly stated, Pt 3.2 ("Family provision orders") of the Succession Act confers on the court the power to make a family provision order in favour of an "eligible person". An "eligible person" is defined as including (among other categories of people) a person who was the spouse of the deceased person at the time of the deceased person's death, a child of the deceased person, or "a person … who was, at any particular time, wholly or partly dependent on the deceased person" (s 57(1)(a), (c) and (e)(i)). The court may make a family provision order where:

- the court is satisfied that "adequate provision for the proper maintenance, education or advancement in life of the person" has not been made by the will of the deceased person, or by the operation of the intestacy rules in relation to the estate of the deceased person, or both (Succession Act, s 59(1)); and
- the court thinks that provision "out of" the estate of the deceased person ought to be made for the maintenance, education or advancement in life of the eligible person (s 59(2)).

The court may also make a family provision order "in relation to":

- property that is not part of the estate of the deceased person; or
- property that has been distributed,

if it is designated as "notional estate" of the deceased person by court order made under Pt 3.3 ("Notional estate orders") of the *Succession Act* (s 63(5)).

In *Re Estate Grant*, deceased, the court made notional estate orders in relation to the first kind of property (ie, property that was not part of the actual estate of the deceased person). The property was the deceased member's interest in a superannuation fund (ie, a superannuation death benefit).

BACKGROUND

Briefly, in 2015 a member of a self-managed superannuation fund died of brain cancer, aged 55 years. He was survived by his second wife, and his twin sons born by his first wife in 1990.

The first wife also had two other sons who became stepsons to the member. One of these, Maximillian (Max), had been born in 1988 in the presence of the member. The member treated Max as his own son and it was not until Max was 17 years old that he discovered that the member was not his real father (at [22]-[28], [39] and [60]).

There were no children of the second marriage (at [22]).

In 2014 the member made a will naming his brother as executor, and Max and the twin sons as sole beneficiaries in equal shares. The second wife received nothing under the will. The first wife, Max and the twin sons were informed of the contents of the will by email that same day (at [6] and [60]).

The court held that the member's subsequent marriage to his second wife in 2015 (less than 3 months before the member died) had revoked this will, and that the member had died intestate (at [37]-[38] and [159]).

Against this eventuality, Max had applied for a family provision order, as he had no entitlement upon an intestacy (at [16] and [63]). (Why Max had no entitlement upon an intestacy is not explained in the judgment. At common law, a child who was not the deceased's own child (either legitimate or illegitimate) or an adopted child, has no right to claim any share of the estate on intestacy: Re *Leach (deceased)* [1985] 2 All ER 754, 759. This is reflected in the use of the word "issue" rather than "child" in various sections of the Succession Act, for example, in sections 111-113.)

All parties accepted that Max had standing to apply for a family provision order as a person who, during his youth, had been a dependant member of the deceased member's household (at [59]).

The member left an actual estate with an estimated net value of about $4.4 million (excluding personal effects). The principal asset was a 94.8% beneficial interest in a residential property at McMahon's Point in Sydney where the member (until his death) and the second wife resided. All parties agreed that at the time of trial in 2018, the member's 94.8% beneficial interest in the property was worth about $5,332,500, subject to a bank mortgage liability of about $900,000 (at [2], [4], [33], [54]-[55], [73] and [225]).

The member also left a superannuation fund with an estimated value of about $858,000. The member had not made a binding or non-binding death benefit nomination. All parties agreed that the superannuation fund was available for designated as notional estate (at [2], [21] and [193]-[194]).

Under the NSW intestacy rules, the member's actual estate would be distributed as follows:

- to the member's second wife – the member's personal effects, a statutory legacy, and one-half of the remainder of the member's estate; and
- to the member's twins sons – the other half of the remainder of the estate (at [50]).

(As mentioned above, Max would receive nothing.)

Of a net estate with an estimated value of about $4.4 million (not including personal effects), the second wife's share was estimated to be worth about $2.4 million and the respective shares of the twin sons was estimated to be worth about $990,000 each (subject to orders for costs in the proceedings). The total costs incurred by all parties were about $500,000 (at [51]).

In 3 sets of proceedings, the essential contest was between Max and the twins, on the one hand, and the second wife, on the other hand. Max and the twins sought to uphold the validity of the will, by which they stood to receive one-third of the estate each. The second wife claimed that the will had been revoked by the member's marriage to her. If the will had been revoked, the member had died intestate, and the second wife would receive the bulk of the estate (at [15]-[16]).

Against the eventuality that the will was held to have been revoked, Max had brought a family provision claim. Against the eventuality that the will was held not to have been revoked, the second wife had brought her own family provision claim (at [15]-[16]).

THE COURT'S DECISION

The court held that the member's marriage to the second wife had revoked the will, and that the member had died intestate. This made it necessary consider Max's claim for a family provision order. On the other hand, the second wife's application for a family provision order had to be dismissed (as under the intestacy rules she would receive the bulk of the estate) (at [159]-[160]).

The second wife wanted an extension of time in which to exercise a right under the Succession Act as the member's spouse to acquire the member's beneficial interest in the McMahon's Point property. The court granted her this extension of time (at [184]).

The court noted that, if Max's family provision application was pressed, there were factors which warranted the making of his application. Not until he was 17 years old did he discover the truth about his paternity. He had been treated by the member as a son, on a par with the member's own twin sons. He had been, thus, a natural object of the member's bounty. Upon the member's intestacy, he was not a beneficiary even though under the member's will he stood to receive one-third of the estate, on a par with the twin sons. In common with the first wife and his step-brothers, he was informed by the member of the terms of the will via email on 3 January 2014, the day it was executed. Max's application satisfied the jurisdictional requirement that the court be satisfied that, having regard to all circumstances, there be factors which warrant the making of the application (at [62]).

The court designated all benefits to be paid out of the superannuation fund consequent upon the death of the deceased member as notional estate for the purpose of making a family provision order in favour of Max, and for the purpose of any order that costs of the family provision proceedings of Max and the second wife be paid out of the notional estate (at [212]).

The court made a family provision order in favour of Max, in the sum of $750,000, payable out of the notional estate, that is, out of the member's superannuation entitlement, designated as notional estate (at [228]).

RESULT

In the result, the court made a family provision order in favour of Max, the member's stepson, in the sum of $750,000, payable out of the member's superannuation death benefit designated as notional estate.

The member's actual and notional estate was to be distributed as follows:

- to the member's second wife – about $2.4 million (subject to costs);
- to the member's twin sons – about $990 each; and
- to Max, the member's stepson – $750,000, to be paid out of the member's superannuation death benefit (at [225] and [228]).

This case once again demonstrates the broad reach of the notional estate provisions of the NSW *Succession Act*. A family provision order can override the usual manner of distribution of a superannuation death benefit.

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Scott has comprehensive experience in the establishment, licensing, governance, administration, distribution, restructuring, investment and tax matters associated with superannuation, funds management and life insurance products. He is a regular speaker at conferences, has designed key training programs for boards and responsible managers and is a guest lecturer at UNSW law school. In 2012-2019 Scott was recognised by his peers in *Best Lawyers in Australia* in the Superannuation Law category, and in 2015-2019 in the Regulatory Practice category. In 2015-17 he was listed in *Who's Who Legal: Pensions & Benefits*.

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Stanley specialises in insurance, superannuation, funds management and financial services regulation. He is a prolific author who has written many articles for the Insurance Law Journal, the Insurance Law Bulletin and the Superannuation Law Bulletin. Until recently he was also a co-author of Wickens The Law of Life Insurance in Australia. His contributions included new chapters "Insurance in Superannuation" and "Privacy and Direct Marketing". In 2014-2019 Stanley was recognised by his peers in *Best Lawyers in Australia* in the Insurance Law category. In 2015-17 he was listed in *Who's Who Legal: Pensions & Benefits.*

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Loretta has been Chair of Thomson Geer since 2007. She has served as a director of an industry superannuation fund. Her main practice areas are funds management and private markets, and mergers & acquisitions. In *Chambers Asia Pacific* (2013 - 2016) Loretta was recognised in the Private Equity category for her "extensive experience in fund formation, handling of buyouts, and work for superannuation funds".