THOMSON GEER
LAWYERS

Superannuation Case Law Update

June 2016

Contents

THOMSON GEER
LAWYERS

This publication is not advice and is intended to provide general information only. While Thomson Geer endeavours to ensure the quality of this publication, Thomson Geer does not accept any responsibility for the accuracy, completeness or currency of the material included in this publication, and will not be liable for any loss or damage arising out of any use of, or reliance on, it.

Thomson Geer thanks:
Scott Charaneka (Head of Superannuation and Wealth Management), Stanley Drummond (Adjunct Head of Superannuation and Wealth Management), Tina McDill (Lawyer), Emma Brooker (Lawyer) and Sammia Rebecca Jensen (Lawyer) for their assistance in preparing this publication.

1. TPD claims – the meaning of "unlikely ever" – *TAL Life Ltd v Shuetrim* [2016] NSWCA 68

In allowing appeals by 2 group life insurers from declarations and orders in favour of a member of a superannuation fund claiming total and permanent disablement (TPD) benefits, the NSW Court of Appeal (Beazley P, Leeming JA and Emmett AJA) has made a major clarification of the meaning of "unlikely ever" in the concept of unlikely ever to engage in any occupation, in the definitions of TPD in the policies. The court rejected the proposition that "unlikely ever" in this context means "a probability of less than 50%". Rather, those words mean that there is no real chance of the claimant returning to relevant work. The case is *TAL Life Ltd v Shuetrim; MetLife Insurance Ltd v Shuetrim* [2016] NSWCA 68.

Background

The trustee of a superannuation fund held group life insurance policies with TAL Life Limited and MetLife Insurance Ltd. The TAL policy was available to all members of the fund. The MetLife policy provided additional cover for police officers.

The TAL policy relevantly defined TPD as follows (at [10]):

> … The Insured Person having been absent from their Occupation through Illness or Injury for 3 consecutive months (where the Insured Person's condition is unclear it is reasonable to defer assessment) and having provided proof to the satisfaction of us that the Insured Person has become incapacitated to such an extent as to render them unlikely ever to engage in or work for reward in any occupation or work for which he or she is reasonably qualified by reason of education, training or experience.

The MetLife policy relevantly defined TPD as follows (at [11]):

> … 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 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 2007 Mr Shuetrim (the member) joined the New South Wales Police Force and became a member of the fund. Prior to that he had trained and worked as a mechanic.

In September 2011 he suffered a significant injury to his left elbow while undergoing training. He could not extend his arm properly and it was very painful. He attended his General Practitioner and was certified unfit for work for the next 2 weeks. He lodged a workers compensation claim and started receiving weekly payments.

From October 2011 he was certified for suitable duties only. From then until November 2011 he was office bound and did not attend to any police work on the road such as investigations or search warrants.

His last day at work was in November 2011. A year later, in November 2012, he was medically discharged from the Police Force.

In February 2013 he lodged a claim for TPD benefits with the trustee, claiming to suffer from an anxiety disorder and lateral epicondylitis, or "tennis elbow", of the left elbow. In March 2013 the trustee referred the member's claim to MetLife and TAL.

In September 2013 the member commenced proceedings in the Supreme Court of NSW against the trustee and MetLife, with TAL later added to the proceedings.

The TAL policy had a 3 month qualifying period, but TAL deferred assessment of the claim from the end of that 3 month period (in February 2012) until July 2012, following the completion of an arthroscopy on the member. By letter dated 17 December 2014 TAL denied the claim. The letter summarised the medical and psychological opinions available to TAL in the period in or around July 2012.

In 2014 and 2015 the member and his wife posted a number of photographs and comments on their respective Facebook pages. These posts included:

- a photograph showing the member and his wife and their 3 children in the family car with the member in the driver's seat (on the NSW South Coast during the school holidays);
- a photograph showing the member sitting in the driver's seat of his car wearing a pair of new sunglasses;
- photographs showing the member and his wife and their children over a period of several hours at King Street Wharf in Sydney, including at a restaurant;
- another photograph showing the member and his wife and their children at another restaurant at King Street Wharf;
- a photograph showing the member's son with the Emir of Uzbekistan at a soccer match at ANZ Stadium; and
- a post being a review by the member of Wet'n'Wild Sydney.

The member settled his claim against the trustee, and the trustee filed a submitting appearance.

The judgment at first instance

In March 2015 the matter was heard before Stevenson J. In April 2015 the court delivered judgment, holding that the member was TPD under both policies: *Shuetrim v FSS Trustee Corporation* [2015] NSWSC 464 at [307]. There was a subsequent judgment dealing with interest under section 57 of the *Insurance Contracts Act 1984* (Cth), and costs: *Shuetrim v FSS Trustee Corporation* [2015] NSWSC 795.

TAL and MetLife appealed to the NSW Court of Appeal.

The judgment of the Court of Appeal

The NSW Court of Appeal (Beazley P, Leeming JA and Emmett AJA) allowed TAL and MetLife's appeals.

"Unlikely ever"

The most important aspect of the judgment is what the court said about the meaning of "unlikely ever" in the concept of unlikely ever to engage in any occupation, in the definitions of TPD in the policies.

The court rejected the proposition that "unlikely ever" in this context means "a probability of less than 50%". Rather, those words mean that there is no real chance of the claimant returning to relevant work. "Unlikely ever" to return to work is a much harder test for a claimant to satisfy than "less than 50%" (at [68]-[91] and [190], particularly at [71], [88]-[89], [91] and [190]).

Precisely what the court said was this (the cases referred to in this passage are discussed below):

> [88] It seems clear to me that the headnote of *White* [*v The Board of Trustees* [1997] 2 Qd R 659] has caused some subsequent decisions to depart from what was applied in *Beverley* [*v Tyndall Life Insurance Co Ltd* [1999] WASCA 198; 21 WAR 327] (as well as by White J herself in *Wiley* [*v The Board of Trustees*, Supreme Court (Qld), White J, 3 April 1997, unrep]). Further, I accept TAL's submission that in most cases any attempt to express a likelihood in percentage terms will have merely the illusion of mathematical precision. I also agree with TAL's submission that the bracketed words in the TAL policy [ie, "(where the Insured Person's condition is unclear it is reasonable to defer assessment)"] tell against the construction in the headnote [of *White*]. Those words confirm what flows from the ordinary meaning of the language of "unlikely ever", namely, that where there is a real chance that a person may return to relevant work, even though it could not be said that a return to relevant work was more probable than not, the insurer would not be satisfied that the definition applies. "Unlikely ever" is, in this context, much stronger than "less than 50%".
>
> [89] What follows is this. To make an assessment of TPD, it is not sufficient for the insurer to be satisfied that it is more likely than not that the person will never return to relevant work. On the other hand, if there is merely a remote or speculative possibility that the person will at some time in the future return to relevant work, an insurer will not, acting reasonably and in compliance with its duties, be able to be satisfied that the person is not TPD. The critical distinction is between possibilities which are readily contemplatable even though they may not be more probable than not, and possibilities which are remote or speculative. A real chance that a person will return to relevant work, even if it is less than 50%, will preclude an Insured Person being unlikely ever to return to relevant work.

and:

> [190] … The question posed by the TAL policy … was not whether the court was satisfied that more probably than not Mr Shuetrim would ever return to relevant work. The question was whether the court was satisfied that there was not a real chance that he would ever return to relevant work.

In *White v The Board of Trustees*, in 1997 in the Supreme Court of Queensland White J had said ([1997] 2 Qd R 659 at 673):

> There is a body of opinion to which I have referred which would say that "unlikely" means "improbable" in the sense of a less than 50 per cent chance. In ordinary usage this may be much the same as saying that there is no real as opposed to a remote chance of the designated event occurring or to take up one of the dictionary meanings, the prospect of the event occurring is unpromising.

However, her Honour stated her conclusion in the following, rather different terms (at 674):

> I conclude that in approaching the task of informing its opinion the Board [of Trustees] did not have regard to the ordinary meaning of "unlikely" as meaning no real chance or even improbable and entertained something more remote as sufficient.

The headnote to *White* read in part:

> *Held*:
>
> (1) That in the definition "unlikely" meant "improbable" in the sense of a less than 50 per cent chance.

In *Shuetrim*, the Court of Appeal observed that White J had applied the test in the second passage reproduced above (ie, the "no real chance or even improbable" test) in reaching her Honour's decision. The Court of Appeal also observed that the first passage reproduced above appeared to have been the source of the holding in the headnote. Insofar as that first passage appeared to have equated the meaning of "a less

than 50 per cent chance" with "no real as opposed to a remote chance", the Court of Appeal did not agree (at [81]-[82]).

Very shortly after *White*, in *Wiley v The Board of Trustees* White J said ([2016] NSWCA 68 at [71]):

> … the ordinary meaning of "unlikely" means no real chance. Other cases use the test "improbable".

In Shuetrim, the Court of Appeal noted that in *Beverley v Tyndall*, in the Full Court of Western Australia Ipp J had followed the approach applied by White J in *White*, but without in terms identifying error in the headnote in *White* (at [83]-[86]). Ipp J had said:

> Her Honour applied the ordinary meaning of the term which she considered to be "no real chance or even improbable".

Malcolm CJ and Anderson J had agreed with this aspect of Ipp J's reasons.

Finally, in *Shuetrim* the Court of Appeal noted that in *Halloran v Harwood Nominees Pty Ltd* [2007] NSWSC 913 at [76] and *Ziogos v FSS Trustee Corporation as Trustee of the First State Superannuation Scheme* [2015] NSWSC 1385 at [82] it had been said that *White* is authority for the proposition that "unlikely" means a less than 50% chance.

Summing up, in *Shuetrim* the Court of Appeal disapproved that part of the headnote in *White* that is reproduced above.

In applying the words, "unlikely ever", the length of time to the claimant's expected retirement is also a relevant consideration. The court referred to *Cullinane v Mercer Benefit Nominees Ltd* [2006] FCAFC 82; 152 FCR 1 at [88] where the joint judgment had said:

> Given the uncertain nature of the appellant's condition, and the even greater uncertainty as to her long term prognosis, the experts, quite sensibly, appeared to follow the adage "never say never".

The Court of Appeal in *Shuetrim* then said:

> Relatively young people whose medical or psychological condition is uncertain will find it harder to prove to an insurer's or a court's satisfaction that they are unlikely ever to return to work for which they are reasonably fitted by education, training or experience (at [208]).

Here, the relative youth of the member was a relevant consideration.

(In a similar vein, in *Birdsall v Motor Trades Association of Australia Superannuation Fund Pty Ltd* [2014] NSWSC 632 at [152] Hallen J said:

> The use of the word "ever" in the definition should also not be forgotten. That word allows the insurer to look well into the future. The language ("unlikely ever") focuses on the duration of the occupational incapacity or inability to engage in or work for reward. In this respect, the age of the [claimant] is a relevant consideration.

An appeal by the claimant to the NSW Court of Appeal was dismissed: *Birdsall v Motor Trades Association of Australia Superannuation Fund Pty Ltd* [2015] NSWCA 104.)

Uncontroversial propositions

The court listed 7 propositions that it did not regard as controversial.

First, the TAL TPD definition does not turn upon the fact that the claimant is unlikely ever to undertake employment, but instead is expressed to turn upon the state of mind of the insurer.

Second, in considering the matter and reaching a state of satisfaction, the insurer is required to act reasonably.

Third, there are limits to what flows from the obligation to act reasonably. Reasonable persons may reasonably take different views. Unless the view taken by the insurer can be shown to have been unreasonable on the material then before the insurer, the decision of the insurer cannot be successfully attacked on this ground.

Fourth, the words "proof to the satisfaction of us" reflect an obligation on the part of the claimant to provide evidence in support of their claim.

Fifth, the TPD definition does not turn on the insurer being satisfied that the claimant will never be able to resume employment, but the lesser threshold that they are "unlikely ever" to do so. (The court's discussion of the meaning of "unlikely ever" has been summarised above.)

Sixth, all of the foregoing is subject to the obligations of good faith on the part of the insurer, as well as the (overlapping) implied obligations to act reasonably and to do all that is necessary to enable the other party to have the benefit of the agreement.

Seventh, the closing words of the TPD definition ("any occupation or work for which he or she is reasonably qualified by reason of education, training or experience") materially narrow the scope of the coverage given by the definition, from the perspective of the claimant.

Citing *Manglicmot v Commonwealth Bank Officers Superannuation Corporation Pty Ltd* [2011] NSWCA 204; (2011) 282 ALR 167 and *Hannover Life Re of Australasia Ltd v Dargan* [2013] NSWCA 57; (2013) 83 NSWLR 246, the court further noted that it is "settled law" that a

person who can undertake part-time work is not totally and permanently disabled.

The two-stage approach – Edwards should not be overturned

In *Edwards v The Hunter Valley Co-op Dairy Co Ltd* (1992) 7 ANZ Ins Cas 61-113 at 77,537, in 1992 in the Supreme Court of NSW McLelland J, having found that the insurer in that case had, by its own default, failed to form an opinion that the claimant in that case was TPD, held that the court could determine for itself whether the claimant was TPD. His Honour said:

> The formation by Zurich of the relevant opinion is of the nature of a condition of Zurich's liability under the policy. Zurich cannot rely on non-fulfilment of such a condition if fulfilment was prevented by its own default, and in such an event the issue upon which Zurich's opinion was required to be formed would become one for determination by the Court …

In Shuetrim TAL submitted that this aspect of Edwards should be overturned (meaning that if an insurer fails to duly form the relevant opinion, the court should remit the matter to the insurer so that it can duly form the relevant opinion). After reviewing the cases where this approach had been discussed and "misgivings" about it expressed, the court declined to overturn this aspect of Edwards. The court said (at [188]):

> … there seems to me to be no sound reason to depart from the approach which has been worked out in the body of law which TAL seeks to challenge. Although the doubts expressed … are not without force, I am not persuaded that compelling reasons have been shown to alter the existing state of the law.

In reaching this conclusion, the court noted that unlike a trustee, an insurer is not a fiduciary. The court said (at [187]):

> … different considerations apply to the formation of an opinion by an insurer as opposed to a trustee. A trustee is a fiduciary, and is required to make decisions leading to payments of money none of which is owned beneficially by the trustee. An insurer is not a fiduciary, but may (as in the present case) be operating a business with a view to making a profit, and every decision it makes to grant or refuse a claim will go directly to its profitability. As [counsel for the member] emphasised, by reference to what Malcolm CJ had said in Beverley [v Tyndall] at 331, "in the assessment of the claim under a policy, the insurer is [in] a very real sense acting as a judge in the insurer's own cause".

No breach of duty by MetLife

The trial judge had found that MetLife had breached its duty to the member by failing to give a vocational assessment report, which was highly equivocal, "any, or any proper, weight". The Court of Appeal overturned that finding.

Exclusion of later relevant evidence – breach of duty by TAL

As mentioned above, the TAL policy had a 3 month qualifying period, but TAL deferred assessment of the claim from the end of that 3 month period (in February 2012) until July 2012, following the completion of an arthroscopy on the member. TAL's letter of 17 December 2014 denying the claim summarised the medical and psychological opinions available to TAL in the period in or around July 2012, which effectively excluded later medical and psychiatric opinions expressed in 2013 and 2014 that were relevant to TAL's determination of the claim. The Court of Appeal held that by knowingly excluding relevant information from consideration, TAL had breached its duty to the member. As Muir J had said in *McArthur v Mercantile Mutual Life Insurance Co Ltd* ([2002] 2 Qd R 197 at [74]):

> Medical reports coming into existence after the relevant time will be admissible provided that they are pertinent to the determination of the [claimant's] condition at the relevant time.

McMurdo P had agreed with Muir J. McPherson JA also agreed with this aspect of Muir J's reasons, adding that it accorded with "the principle that the court does not speculate when it may know" ([2002] 2 Qd R 197 at [23]).

More recently, in *Finch v Telstra Super Pty Ltd* [2010] HCA 36; 242 CLR 254 at [66] the High Court had said that for a trustee to knowingly exclude relevant information from consideration would be a breach of duty.

The member was not TPD

The trial judge had said that the member's evidence on the critical question of his capacity to work was "unchallenged", and concluded that the member had sustained his onus of showing that he satisfied the definitions of TPD in each of the TAL and MetLife policies.

The Court of Appeal rejected this. The court noted the "disparity" between the member's claims and his posts on social media, and said that the appropriate finding "should have turned upon an evaluation of all of the evidence, not merely what was said, inevitably self-servingly, by [the member]" (at [198]-[199]).

The thrust of the medical evidence was that the member's elbow was "almost certain to improve with time". The member's evidence that it would never improve was of "scant probative value". He

did not produce evidence to explain why he was in the small minority of people who did not improve over time (at [200] and [206]).

The court accepted that the member was unlikely ever to return to the Police Force, but whether he could ever do other work, perhaps part-time work, was a different question. The court said (at [207]):

> … whether there is a real and not remote chance that he could at some stage resume work (perhaps part-time) as, for example, a mechanic or in an allied area is a very different question. The evidence of Mr Shuetrim's Facebook posts and his cross-examination confirms that at least in some respects (ability to deal with people, to drive a vehicle, to attend crowded venues), he has exaggerated his claims. To the extent that the history provided by Mr Shuetrim is exaggerated, the psychiatrists' opinions proceed on an incorrect premise ... Ultimately the onus is upon him to provide evidence sufficient to support the opinion required by the TPD definition, which is an opinion concerned with the remainder of his working life.

The court was not satisfied that the evidence supplied by the member sustained the opinion that, as at July 2012, he was unlikely ever to return to relevant work – which is to say in an occupation for which he was qualified by education, training or experience, even if only on a part-time basis (at [209] and [208]).

The result

In the result, the appeals by TAL and MetLife were allowed, and the member's proceedings against TAL and MetLife were dismissed. The member was ordered to pay MetLife's costs at first instance and on appeal. The court proposed that there be no order as to TAL's costs, either at first instance or on appeal.

Take away points

Shuetrim provides 3 key take away points.

First, the proposition that "unlikely ever" in TPD definitions means a less than 50% chance is dead and buried. Rather, those words mean that there is no real chance of the claimant returning to relevant work.

Second, the trial judge had said that the date for assessment of the member's condition was at the end of the qualifying period (ie, 3 months in the TAL policy and 6 months in the MetLife policy), subject in the case of the TAL policy to a deferral of the date for assessment "where the Insured Person's condition is unclear" and "it is reasonable to defer assessment". The Court of Appeal broadly agreed with this approach (at [110]-[111]).

Third, the trustee is required to consider medical and other relevant information coming into existence after the date for assessment of the member's condition. As the High Court said in *Finch v Telstra Super*, for a trustee to knowingly exclude relevant information from consideration is a breach of duty.

2. TPD claims - progressive reporting – *Wheeler v FSS Trustee Corporation* [2016] NSWSC 534

In allowing a claim by a member of a superannuation fund for a total and permanent disablement (TPD) benefit, the Supreme Court of New South Wales (Robb J) has held that the insurer had not given the member "any real or practicable opportunity to provide responsive proof" to the materials gathered by the insurer that were adverse to the member's claim. The insurer should have provided at least the primary doctors' reports, vocational assessment reports, the transcripts of interview and the investigation reports to the member at a much earlier time than when it sent its procedural fairness letter. The case is *Wheeler v FSS Trustee Corporation as trustee for the First State Superannuation Scheme* [2016] NSWSC 534.

Background

The trustee of a superannuation fund held 2 group life insurance policies with MetLife Insurance Ltd (the insurer).

The first policy relevantly defined TPD in the following terms (at [26]):

> the Covered Person having been absent from their Occupation through Injury or Illness for 6 consecutive months and having provided proof to the satisfaction of us that the Covered Person has become incapacitated to such an extent as to render the Covered Person unlikely ever to engage in or work for reward in any occupation or work for which he or she is reasonably qualified by reason of education, training or experience.

The first policy dealt with the making of claims in the following terms (at [28]):

13. CLAIMS

13.1. The Policyowner must notify us in writing as soon as is reasonably practicable of an event entitling the Policyowner to a Benefit.

13.2. It is a condition of payment of any Benefit that the Covered Person provide us with such evidence to substantiate the claim as we may reasonably require.

13.3. The Covered Person must submit at our expense to a medical examination conducted by a Medical Practitioner or other health professional appointed by us as we deem necessary …

The second policy contained broadly similar provisions (at [29] and [31]).

Ms Wheeler (the member) joined the NSW Police Force and became a member of the fund. She was covered by both insurance policies.

While serving in the Police Force, the member was subject to a series of frightening and horrifying events that rendered her unable to work. Her last day at work was 21 September 2010. In February 2012 she was medically discharged from the Police Force as hurt on duty. At the hearing it was common ground that at the time she ceased to carry out her duties she was suffering from post-traumatic stress disorder and major depressive disorder, as a result of her experiences while a member of the Police Force.

In May 2012 the member lodged a claim for TPD benefits with the trustee of the fund. Shortly thereafter, the trustee made a claim against the insurer under the 2 insurance policies.

By letters dated 4 and 26 November 2013 and 11 December 2013, in response to enquiries from the member's solicitor about the status of the member's claim, the trustee asked the insurer to release the medical reports in the insurer's possession in connection with the claim. The insurer did not respond to any of these letters.

In June 2014, the insurer not having made a determination on the member's claim, the member commenced proceedings in the Supreme Court of New South Wales against the trustee and the insurer.

On 13 August 2015 the insurer sent the member a procedural fairness letter, in which it outlined the effect of the material it had, both for and against the member's claims. With the letter the insurer provided the material upon which it proposed to make its determination. The insurer gave the member 14 days to make any submissions in response.

On 4 September 2015, a few days before the commencement of the hearing on 7 September 2015, the insurer sent the trustee a letter saying that it had rejected the member's TPD claims, and setting out its reasons for the rejection. At that time the member was 36 years of age. She had a remaining work life of 29 years, based upon a retirement age of 65 years.

The insurer took 21 March 2011 (ie 6 months after the member's last day at work, 21 September 2010) as the date for assessment of the member's condition (in the judgment also referred to as the "assessment date").

On the first day of the hearing the trustee filed a notice of submitting appearance in which it submitted to the making of all orders sought by the member and the giving of entry of judgment in respect of all claims made, save as to costs.

The judgment

The court delivered a lengthy judgment in favour of the member.

Was the insurer's rejection of the member's claim unreasonable?

The court held, for a number of reasons, that the insurer had failed to act reasonably in deciding that the member had not provided proof to the insurer's satisfaction, that she had become incapacitated, as at the date for assessment, through her illness, to such an extent as to render her unlikely ever to engage in any gainful profession, trade or occupation for which she was reasonably qualified by reason of education, trading or experience. The insurer's determination that the member had not satisfied the TPD definitions was therefore invalid.

Foremost among the court's reasons for this conclusion was the preferential weight given by the insurer to medical reports brought into existence relatively contemporaneously with the date for assessment (ie 21 March 2011), and the corresponding discounting of medical reports brought into existence closer to the date of the insurer's determination. In particular, in his final report of 28 August 2014, Dr Selwyn Smith, the member's treating psychiatrist, had changed his opinion from his earlier reports, and had explained why he had formed the opinion that the member would not be able to perform the occupations identified in the vocational assessment reports, either then or in the future, up to the expected date of her retirement.

This was the same kind of erroneous approach that the NSW Court of Appeal had identified in *TAL Life Ltd v Shuetrim; MetLife Insurance Ltd v Shuetrim* [2016] NSWCA 68. In *Wheeler*, the court said:

> [251] In my view, it was unreasonable for the Insurer to discount, on principle, the final report of Dr Selwyn Smith, and also the last report of Dr Wotton [a consultant psychiatrist who provided medico-legal reports to Employers Mutual NSW Ltd], because of the relative remoteness in time of those reports from the date of assessment, in comparison to other reports. The Insurer's determination must be found to be invalid for essentially the same reason as was given by Leeming JA in *Shuetrim* at [153].

Did the insurer breach its duty of good faith and fair dealing?

The court turned to the question of whether the insurer breached its duty of good faith and fair dealing to the member by reason of the *manner* in which it had investigated and determined the member's claim, as opposed to its *reasoning* in deciding that it was not satisfied that the TPD definitions had been satisfied.

As mentioned above, in May 2012 the member had lodged her claim for TPD benefits with the trustee, and shortly thereafter, the trustee had made a claim against the insurer under the policies. By letters dated 4 and 26 November 2013 and 11 December 2013 the trustee asked the insurer to release the medical reports in the insurer's possession in connection with the claim. The insurer did not respond to these letters.

The insurer first provided material that it had collected with its procedural fairness letter of 13 August 2015. This letter gave the member 14 days to respond.

The insurer submitted that it had no obligation to provide the material to the trustee or the member earlier than it did. The court rejected this submission, saying (at [281]):

> … in the circumstances of the present case, the Insurer's duty of fair dealing obliged it to provide at least the primary doctors' reports, vocational reports, the transcripts of interview, and investigation reports to [the member] at a much earlier time than it did.

The court expanded on this, saying (emphasis added):

> [283] The policies required [the member] to provide proof to the satisfaction of the Insurer that the requirements of the TPD benefits were satisfied as at the assessment date. The Insurer in fact took control of the investigation, as was contemplated by the terms of the Policies dealing with claims. Notwithstanding that the Insurer procured almost all of the evidence upon which it acted, it rejected [the member's] claim on the basis that she had not supplied the Insurer with the necessary proof. If [the member] had had the carriage of the investigation, the Insurer would have been required to give her the time reasonably necessary to provide adequate proof. If in fact the Insurer took carriage of the investigation, it could not deny the claim on the basis that [the member] had not provided adequate proof, in circumstances where it had not given [the member] adequate time to supply that proof. The Insurer took three years to complete the investigation. It then gave [the member] only 14 days to respond to the procedural fairness letter. Fourteen days was self-evidently insufficient. However, [the member's] entitlement to have adequate time to provide the necessary proof to the Insurer would not have been afforded to her by simply giving a much longer time for her to respond to the procedural fairness letter. That would have unfairly prolonged even further, the time taken for the Insurer to determine [the member's] claim. *The only way that the Insurer could take carriage of the investigation itself, in a way that accommodated the Insurer's obligation to process the claim with reasonable expedition, and [the member's] entitlement to have adequate time to provide the necessary proof, was for the Insurer to provide the material that it had obtained earlier, and progressively, during the course of the investigation.*

This did not mean that the insurer had to conduct its investigations on an "open book" basis, but the insurer at least had to provide enough information to the trustee and the member to enable them to satisfy themselves that the investigation was proceeding on a "sound and fair" footing, and to give them sufficient time to obtain evidence in response to any adverse material. The court said (at [292], emphasis added):

> It might be wrong for the court to suggest that the Insurer's duty of good faith and fair dealing required it to conduct its investigations on an open book basis, so to speak, with the Trustee and [the member]. As the Insurer provided no information, it is not necessary to explore finally what the ambit of the information that should be provided would be. In my view, the terms of the TPD definitions required the Insurer to approach the issue on the basis that, even though efficiency and its own self-interest justified it conducting the investigation itself, it could not determine the application, unless the material upon which it was going to act reasonably satisfied the description of proof provided by the applicant. The Insurer might be entitled to proceed in a commercially sensible and practical way. *It would at least have to provide enough information to the Trustee and [the member] to enable them to satisfy themselves that the investigation was proceeding on a sound and fair, footing, and to give them sufficient time to obtain evidence in response to any material that was damaging to the application.* As I have said above, it would have been reasonable for the Insurer to provide the primary medical reports and the instructions given to the doctors; to provide transcripts of interviews given by [the member]; to provide vocational assessment reports; and a synopsis of any surveillance activities, at least after those activities had been completed.

The insurer had collected the material over

3 years. The response time allowed of 14 days was "derisory" (at [293]).

The court implied that the manner in which the insurer had investigated and determined the member's claim constituted a breach of the insurer's duty of good faith and fair dealing.

The court found that, taking the various factors together, the breach by the insurer of this duty of good faith and fair dealing was sufficiently serious that the consequence should be that the insurer had constructively denied the member's claim, before it actually rejected the claim on 4 September 2015. For both this reason, as well as the reason that the insurer had failed to act reasonably in determining that the member was not TPD, it was necessary for the court to form its own view as to whether the member was TPD (at [300]).

The court's determination

The court concluded that the evidence justified a finding that, as at the date for assessment, the member was TPD (at [366]).

Established legal principles

In the course of the judgment, the court identified a number of established legal principles relevant to TPD claims.

First, the requirement in the TPD definition that the member provide proof to the satisfaction of the insurer has the effect of "placing an evidential burden on the [member]". This is not the same thing as to say that the member has a burden of proof, as the process of determining claims is not the same as a judicial process (at [55]).

Second, having regard to the terms of the policies, the insurer's duty of good faith and fair dealing does not require the insurer to undertake its own investigations (at [56]).

Third, as the onus is on the member to bring forward adequate material, an obligation arises from the duty of good faith and fair dealing for the insurer to give the insured person a reasonable opportunity to bring forward that material (at [57]).

Fourth, if (for example, in the case of an unrepresented person) the member does not put forward sufficient material to enable the insurer to address the substantive issues that it is required to address, then the duty of good faith and fair dealing would require the insurer to say so, and to give the member an opportunity to put forward additional material (at [58]).

Fifth, the insurer's "statement of reasons for declining a claim should be understood as a practical document intended to inform the [member] of the basis of the decision rather than detailed reasons with reference to the evidence relied upon comparable to a judgment of a court or tribunal". The court added that while that is true, it is directed to the nature and complexity required of the letter informing the member of the reasons for the insurer's rejection of the claim. It does not obviate in any way the need for the insurer to comply with its duty of good faith and fairness, and to process and determine the claim in a way that is reasonable in the circumstances (at [59]).

Modified or extended legal principles

In *Wheeler* the court also appeared to modify or extend several other legal principles, as explained below.

The meaning of "unlikely ever"

In *Wheeler* the court said, in relation to the word "unlikely" in the context of the TPD definitions in the policies, that there were 2 propositions from earlier cases that survived the NSW Court of Appeal decision in *TAL v Shuetrim* in 2016. The court said (underlining added):

> [75] The first [of the 2 propositions that survived *Shuetrim*] is that the word "unlikely" sets a <u>much lower test</u> than would be posed if an insured had to establish absolute incapacity ... Leeming JA repeated this proposition in *Shuetrim* at [64].

In fact, what Leeming JA had said in *Shuetrim* at [64] was as follows:

> [64] Fifthly, the clause does not turn on the insurer being satisfied that the Insured Person will *never* be able to resume employment, but the lesser threshold that he or she is "unlikely ever" to do so. The clause is thus <u>more readily satisfied</u> than the language in *Manglicmot v Commonwealth Bank Officers Superannuation Corporation Pty Ltd* [[2011] NSWCA 204; 282 ALR 167] regarded by Giles JA as "quite emphatic": at [88].

In *Manglicmot*, Giles JA had said:

> [88] The Hannover TPD clause defines *total and permanent disablement*. It is quite emphatic: the member must be *unable ever to engage in or work for reward* in *any* occupation or work.

Putting this together, what Leeming JA was saying in *Shuetrim* at [64] was that the TPD definition in the TAL policy considered in that case – which used the words "unlikely ever" – was "more readily satisfied" than the TPD definition in the Hannover policy considered in *Manglicmot* – which used the words "unable ever". In the our view, this is *not* the same as saying that "the word 'unlikely' sets a much lower test than would be posed if an insured had to establish absolute incapacity".

The critical passages in *Shuetrim* about the

meaning of "unlikely ever" were ([2011] NSWCA 204 at [88], [89] and [190], emphasis added):

> … where there is *a real chance* that a person may return to relevant work, even though it could not be said that a return to relevant work was more probable than not, the insurer would not be satisfied that the definition applies.

and:

> … if there is *merely a remote or speculative possibility* that the person will at some time in the future return to relevant work, an insurer will not, acting reasonably and in compliance with its duties, be able to be satisfied that the person is not TPD.

and:

> The question posed by the TAL policy … was whether the court was satisfied that there was *not a real chance* that he would ever return to relevant work.

In our view, these passages can be summed up by saying that "unlikely ever" means that there is *no real chance* of the person returning to relevant work.

Prior to *Shuetrim*, it had been said that "unlikely" sets a "much lower test" than "unable" or "incapable": *Davis v Rio Tinto Staff Superannuation Fund Pty Ltd* [2002] FCA 376; (2002) 118 FCR 170 at [18]-[19], citing *Ivkovic v Australian Casualty & Life Ltd* (1994) 10 SR (WA) 325; and *Constantinides v Du Pont Superannuation Fund Pty Ltd* [2002] FCA 534 at [28]. Following *Shuetrim*, it may be correct to say that "unlikely" sets a "lower test" (rather than a "*much* lower test") than "unable" or "incapable".

"Unable" (without the word "ever") is not to be equated with "permanently unable". In *Cullinane v Mercer Benefit Nominees Ltd* [2006] FCAFC 82; (2006) 152 FCR 1 (at [10]) the Full Federal Court considered the following definition of "disablement" in rule 1.1 of the trust deed of a superannuation fund (emphasis added):

> "disablement" means any medical state of physical or mental incapacity which, in the opinion of the Trustee, after having considered independent medical evidence, renders the Member *unable* to engage in any gainful occupation or business or to perform any work for which, in either case, the Member is reasonably fitted by education, training or experience.

The Full Federal Court said ([2006] FCAFC 82 at [84]):

> There is a fundamental difference, in our view, between an incapacity that is permanent (even allowing for some latitude in the scientific certainty required for that assessment), and an incapacity that exists now, and will continue to exist in the foreseeable future. The latter test represents a significantly less stringent hurdle for an appellant to overcome, and is the correct test to apply in relation to the definition of “disablement” in r 1.1.

In other words, in this context "unable" referred to an incapacity that exists now, and will continue to exist in the foreseeable future.

Summing all this up, following *Shuetrim* and consistently with *Cullinane*, the correct position appears to be that:

- "unlikely" means "no real chance" (*Shuetrim*);
- "unlikely" sets a lower test (rather than a *much* lower test) than "unable" or "incapable"; and
- "unable" (without "ever") sets a lower test than "permanently unable" (*Cullinane*).

Deferring the date for assessment

In *Wheeler*, the insurer took the end of the 6 month qualifying period as the date for assessment. The court did not disturb this.

However, the court said, *obiter*, that if by the date for assessment specified in the policy the member's condition has not sufficiently stabilised, the insurer can defer the date for assessment – even where (as in this case) the policy does not expressly provide for deferral of the date for assessment. The court said (at [96]):

> Many illnesses and injuries will lead to substantial long-term uncertainty of outcome. The question will be whether the Insurer’s duty of good faith and fairness to the fund member will require, in an appropriate case, that the Insurer defer the assessment of the fund member’s complaint until there has been at least a reasonable opportunity for the condition of the fund member caused by the illness or injury to stabilise, at least to the greatest extent reasonably possible, to give a sound basis for the application of the TPD definition. That would involve an attempt to remove, as far as reasonably possible, the degree of uncertainty of outcome caused by uncertainty about the level of incapacity suffered by the fund member. It would lead to a conscious attempt to minimise the possibility that claims by fund members with genuine TPD are wrongly rejected, because of an irrelevant uncertainty as to the true level of incapacity as at the assessment date.

In our view, this proposition extends the law and introduces new complexities and uncertainties. Does this allow the insurer to defer the date for assessment indefinitely, provided that the member's condition has not sufficiently stabilised? And what happens if the doctors do not agree on to extent to which the member's condition has stabilised? The proposition opens up a further field of potential disagreement.

Progressive reporting

As mentioned above, in response to enquiries from the member's solicitor about the status of the member's claim, the trustee wrote to the insurer 3 times asking the insurer to release the medical reports in the insurer's possession in connection with the claim. The insurer did not respond to any of these letters. The insurer first provided material that it had collected with its procedural fairness letter, some 3 years after the claim had been lodged. This letter gave the member 14 days to respond.

The court held that the insurer's duty of good faith and fair dealing obliged it to provide at least the primary doctors' reports, vocational reports, the transcripts of interview, and investigation reports to the member at a much earlier time than it did. Even though it might be wrong to suggest that the insurer's duty required it to conduct its investigations on an "open book" basis, the insurer should have provided enough information to the trustee and the member to enable them to satisfy themselves that the investigation was proceeding on a sound and fair footing, and to give them sufficient time to obtain evidence in response to any adverse material. The insurer should have provided material progressively during the course of the investigation.

Perhaps this could be described as conducting an investigation on a "half-open book" basis.

In our view, this idea of progressive reporting also extends the law and introduces new complexities and uncertainties. Is the principle meant to apply only where the member or the trustee asks about the status of the claim, or in all circumstances? Does it only apply to adverse material, or does it apply more broadly? Is the insurer required to identify the adverse material within the documents provided with some degree of specificity and, where appropriate, provide some explanation of why the material is considered adverse?

Trustees would have to allocate additional resources to monitoring insurers' investigations of TPD claims, and to reviewing the material received from insurers.

It would appear that progressive reporting on TPD claims could significantly increase the cost to insurers and trustees (and indirectly to fund memberships generally) of handling these claims. The introduction of progressive reporting on TPD claims generally across the industry would be a major new development.

The result

In the result, the court concluded that the member was entitled to the TPD benefits under the policies plus interest, and that the insurer should pay the member's costs (at [367]).

Take away points

Wheeler provides 3 key take away points.

First, an insurer must give a person claiming a TPD benefit a real and timely opportunity to provide responsive proof to the materials gathered by the insurer that are adverse to the claim.

Second, depending on the time needed by the insurer to conduct its investigation, this may mean providing materials progressively during the course of the investigation. In other words, the investigation may have to be conducted on a "half-open book" basis.

Third, if by the date for assessment specified in the policy the person's condition has not sufficiently stabilised, the insurer may be required to defer the date for assessment – even where the policy does not expressly provide for deferral of the date for assessment.

The first of these points cannot be controversial. However, the second and third points would seem to extend the law, and in relation to these points we may not have heard the last word.

3. TPD claim – inconsistent medical evidence – *Miljevic v Holden Employee Superannuation fund Pty Ltd* [2016] FCA 718

In dismissing an appeal from a determination of the Superannuation Complaints Tribunal (SCT) by a member of a superannuation fund claiming a total and permanent disablement (TPD) benefit, the Federal Court (Besanko J) has held that in the circumstance of that case, the trustee of the fund was not required to make further inquiries to resolve inconsistencies in the medical evidence. The case is *Miljevic v Holden Employee Superannuation fund Pty Ltd* [2016] FCA 718.

Background

The member claimed a TPD benefit. The trustee rejected the claim.

After complaining to the trustee, the member complained to the SCT.

The SCT determination

The SCT affirmed the trustee's decision to reject the claim.

After summarising the medical evidence, the SCT said (at [17]):

> 59. The Tribunal considered the medical evidence. The majority of specialist opinions, while accepting there was some organic basis to the Complainant's symptoms, were perturbed by non-organic factors, over-reaction on examination and a failure to respond to usual treatment modalities.
>
> 60. The Tribunal noted that appropriate investigations did not reveal underlying pathological change consistent with the Complainant's symptoms. For example, the CT of his lumbar spine did not show any disc abnormality and only minor facet joint arthritis. An MRI of his spine revealed only some bulging of the L5-SI disc, upper limb nerve conduction studies were normal and ultrasound examination of his right shoulder revealed a small supraspinatus muscle tear and acromioclavicular bursitis. The Tribunal was of the opinion that none of these radiological findings accounted for the claimed severity of the Complainant's symptoms.
>
> 61. The Tribunal was not provided with any surveillance video evidence of the Complainant. However, the Tribunal noted that Drs JM, AT and MG, having viewed the surveillance video, taken for Workers' Compensation purposes concluded that the Complainant had misrepresented his symptomatology. Dr VJ, the treating GP, has certified the Complainant as being TPD but every other reporting medical practitioner has declared his fit for more sedentary duties.
>
> 62. The Tribunal noted that the Complainant terminated employment after the release of the surveillance video, and at that time, there was no support from the medical practitioners for his TPD claim except for Dr VJ.
>
> 63. The Tribunal was of the opinion that the majority of the medical evidence indicated that the Complainant did not meet the Trust Deed definition of TPD at the relevant date.

The SCT concluded that, having regard to the evidence submitted, the decision of the trustee to reject the member's claim for a TPD benefit was fair and reasonable in its operation in relation to the member in the circumstances.

The appeal to the Federal Court

The member appealed to the Federal Court, naming the trustee as sole respondent. The trustee filed a submitting notice save as to costs, and did not appear at the hearing.

The member claimed that the SCT had made the following 2 errors of law (at [19]):

> 1. The Tribunal (standing in the shoes of the [trustee]) has erred in law in not making further enquiries to resolve inconsistencies in the expert evidence available.
>
> 2. The Tribunal (standing in the shoes of the [trustee]) has erred in law in not having formed a fair and reasonable opinion as to entitlement to a TPD benefit.

The member contended that the trustee should have made further inquiries to resolve the inconsistent medical evidence.

The Federal Court decision

The Federal Court dismissed the appeal.

The court referred to the decisions of the High Court in *Finch v Telstra Super Pty Ltd* [2010] HCA 36; (2010) 242 CLR 254 and the Victorian Court of Appeal in *Alcoa of Australia Retirement Plan Pty Ltd v Frost* [2012] VSCA 238; (2012) 36 VR 618, and noted that in *Frost* Nettle JA had made the point that the trustee's duty to inquire does not require the trustee to do the impossible. Nettle JA had said (at [28]):

> So to say does not mean that a trustee is required to do the impossible. Nor is it to suggest that a trustee is expected to go on endlessly in pursuit of perfect information in order to make a perfect decision. The reality of finite resources and the trustee's responsibility to preserve the fund for the benefit of all beneficiaries according to the terms of the deed means that there must be a limit. Like the judge below, I accept that a trustee is not under an obligation to go on endlessly seeking more and more information.

After characterising the medical evidence which the SCT had summarised, the court said:

> [35] If it be assumed that the Tribunal considered the most relevant evidence to be that of Dr VJ, Dr SS and Dr PK and weighed that evidence, then I do not think it can be said that its decision was unfair or unreasonable. I have read the relevant reports of Drs VJ, SS and PK. Each of the reports addresses the correct question in terms of the definition of the TPD benefit in the trust deed. Each of the reports addresses the relevant medical issues and there is nothing obvious which has been overlooked. The reports of Dr SS and Dr PK were obtained by the trustee through an independent consulting firm, Mercer Outsourcing Australia Pty Ltd, and that was done to assist the trustee in determining the very issue the trustee was required to decide. I do not think the trustee was required to seek another medical report simply because there was a conflict between the opinions of Dr SS and Dr PK respectively on the one hand, and the opinion of Dr VJ on the other. In submissions, the applicant was not able to identify a particular matter or particular inquiry which was such that it might reasonably lead to a resolution of the conflict.

The court noted that in *Board of Trustees of the State Public Sector Superannuation Scheme v Edington and Another* [2011] FCAFC 8; (at [61] per Kenny and Lander JJ) the Full Federal Court had said:

> Generally speaking, issues of the weight to be given to evidence do not give rise to a question of law.

The result

In the result, the member's appeal to the Federal Court was dismissed. The member's claim to a TPD benefit was rejected.

Take away point

This case confirms that where, in the context of a TPD claim, there is inconsistent medical evidence, the trustee can give more weight to some evidence and less weight to other evidence, without the trustee necessarily being required to make further inquiries in an attempt to try to resolve the inconsistency.

4. TPD claim – complaint to SCT treated as withdrawn – *Burtaleea v AustralianSuper Pty Ltd* [2016] FCA 521

The Federal Court (Buchanan J) has held that a decision of the Superannuation Complaints Tribunal (SCT) to treat a complaint about claim for a total and permanent disablement (TPD) benefit as withdrawn, on the basis that the complaint was "misconceived" and "lacking in substance", was not open to appeal under section 46(1) of the *Superannuation (Resolution of Complaints) Act 1993* (Cth) (Complaints Act). The case is *Burtaleea v AustralianSuper Pty Ltd* [2016] FCA 521.

Complaints Act

Section 22(3)(b) of the Complaints Act provides that the SCT may decide to treat a complaint to the SCT as having been withdrawn where "the Tribunal thinks that the complaint is trivial, vexatious, misconceived or lacking in substance".

Section 37(5) prevents the SCT doing anything that is contrary to the governing rules of the fund or any contract of insurance held by the trustee of the fund.

Section 46(1) provides that a party to a determination by the SCT may appeal, on a question of law only, to the Federal Court.

Background

A member of a superannuation fund had death and TPD cover under a group life insurance policy held by the trustee of the fund. The member's employer paid the premiums on his behalf as an incident of his employment from October 2005 to October 2006, when he left that employment.

The policy provided that cover in respect of a member would end 13 months after the last employer contribution in respect of the member was received by fund.

In October 2007 the trustee sent the member a system-generated letter, which was not returned as undeliverable, saying that his cover would cease the following month, in November 2007. Member statements sent to the member's recorded address from 2008 onwards showed that death and TPD cover was "0". Again, these member statements were not returned as undeliverable.

The member alleged that he became TPD in 2009 and lodged a claim, which the trustee rejected.

In 2014 the member complained to the SCT.

The SCT's decision

In January 2015 the SCT wrote to the member pointing out that his cover under the policy had ended in November 2007, and saying that it had no power to reinstate cover because it was prevented by section 37(5) of the Complaints Act from acting contrary to the governing rules of the fund or the contract of insurance. The letter said that the complaint was "misconceived" and was "lacking in substance", and that it should be withdrawn under section 22(3)(b) of the Act.

In March 2015 the SCT informed the trustee that, for the reasons explained in its letter to the member of January 2015 it had decided that his complaint was "misconceived" and "lacking in substance" under section 22(3)(b), and that it had decided to treat the complaint as withdrawn. On the same day, the SCT wrote to the member saying that, for the reasons in its letter of January 2015, it was treating his complaint as withdrawn.

The appeal to the Federal Court

The member appealed to the Federal Court against the trustee and the SCT.

The SCT filed a submitting appearance and took no active part in the proceedings.

The trustee objected to the competency of the appeal on a number of grounds.

At the hearing, the trustee relied on an amended notice of objection to competency whereby, to the matters originally raised, it added the contention that a decision by the SCT under s 22(3)(b) of the Complaints Act was not a "determination" against which a right of appeal was given by section 46(1) of the Act.

The Federal Court's decision

The court agreed with this new contention. The SCT's decision to treat the member's complaint as withdrawn under s 22(3)(b) was not open to appeal under section 46(1).

The court said:

> [53] The scheme of the Act permits complaints under Part 4. A complaint may, but need not, lead to a review under Part 6. It will not do so if it is withdrawn under s 21. Nor will it, in my view, if it is treated as withdrawn under s 22(3) (or s 22(1), s 22A(2)).
>
> [54] Part 5 of the Act deals with conciliation of complaints. Section 27 provides (emphasis added):
>
> **27 Inquiries by Tribunal**
>
> If:
>
> (a) a complaint has been made to the Tribunal; and
>
> (b) *the complaint has not been withdrawn*; and
>
> (c) the Tribunal is satisfied that the Tribunal can deal with the complaint under this Act;
>
> the Tribunal must inquire into the complaint and try to settle it by conciliation.
>
> [55] Part 6 commences with s 32:
>
> **32 Arrangements for review meetings**
>
> (1) If the Tribunal has tried to settle a complaint by conciliation under Part 5 but has not been successful, the Tribunal must fix the date, time and place for a review meeting.
>
> (2) The Tribunal must write to the parties inviting written submissions by the date specified in the notice.
>
> (3) The date specified for the meeting must be such as to allow a reasonable period for the parties to make written submissions.
>
> [56] Part 6 goes on to specify procedures for considering a review and then making a determination. It is a determination under s 37 (and succeeding sections) which may be the subject of an appeal under s 46.
>
> [57] *In my view, Parts 5 and 6 do not concern, or operate upon, a complaint which is withdrawn or taken to be withdrawn. In particular, s 46 does not contemplate, or provide, an appeal against a decision under s 22(3) of the Act*.

The result

In the result, the court held that the member's purported appeal was not competent, and must be dismissed.

The court also said that there should be the usual order for costs in favour of the trustee. The SCT was given 7 days in which to make any application for costs.

5. The meaning of "interdependency relationship" – *Williams v IS Industry Fund Pty Ltd* [2016] FCA 524

The Federal Court (Reeves J) has held that the Superannuation Complaints Tribunal (SCT) had failed to consider the approximate 6 month period before a son's death in determining whether the son and his father were in an interdependency relationship "immediately before the death of" the son. The court also held that the SCT had failed to consider whether the reason why the father and son were not living together immediately before the death of the son was because the son suffered from a physical, intellectual or psychiatric disability. The case is *Williams v IS Industry Fund Pty Ltd* [2016] FCA 524.

Background

The son lived in Ohio, in the United States of America, with his parents, until their divorce in about 1999/ 2000. Following his parents' divorce, the son lived in Ohio with his mother. From 2000 to 2005, the son attended college in Pittsburgh and during most of this period he lived on campus. He would, however, return to his mother's home in Ohio during college breaks.

From September 2005 until November 2010, the son lived variously in Pittsburgh, New York and Philadelphia in the United States of America. In November 2010, he commenced working for the Club Med organisation in the Whitsunday Islands, in Queensland, Australia. Upon commencing that employment, he joined a superannuation fund.

In May 2011, the son took 2 weeks' planned leave and returned to Ohio, where he stayed with his father. At the conclusion of his leave, he was scheduled to commence work at the Club Med resort at Turkoise in the British West Indies. However, at about that time he was diagnosed with cancer and, as a consequence, he never resumed his employment.

In late June 2011, the son was admitted to hospital in Cincinnati, Ohio for palliative care treatment. He remained in hospital until late September 2011, at which time he was transferred to a hospice in Michigan.

The son passed away in November 2011.

The trustee of the fund decided to pay the son's death benefit to the legal personal representative of the son's estate. Critical to that decision was the question of whether the son had an "interdependency relationship" with his father.

After unsuccessfully objecting to the trustee's decision, the father lodged a complaint with the SCT.

The issue

The issue in the case was whether the son was in an interdependency relationship with his father.

The SCT's decision

In the SCT's view, the issue before it was whether the father and son were living together prior to the son's death. The SCT said:

> Under sl0A of the SIS Act, two two persons are in an interdependency relationship if they live together or, if they do not live together, the reason they don't is that one of them suffers from a physical, intellectual or psychiatric disability. There is no evidence that, whilst the Deceased Member was working in Australia shortly before his death, he was suffering from any physical, intellectual or psychiatric disability.
>
> The issue for the Tribunal, therefore, in determining whether the Trustee's decision was

> fair and reasonable, is whether the Complainant and the Deceased Member were living together prior to the latter's death.

Based on that evidence, the SCT found that the father and son were not living together prior to the son's death. The SCT said:

> The Tribunal, therefore, finds that the Deceased Member was not living with the Complainant prior to his death and the two weeks that he stayed with the Complainant in May 2011 were whilst he was on vacation from his job and that he was due to live overseas after the two week vacation.

The SCT therefore held that the father was not in an interdependency relationship with the son.

The SCT affirmed the decision of the trustee of the fund to pay the son's death benefit to the son's legal personal representative.

The appeal to the Federal Court

The father appealed to the Federal Court on the basis that the SCT had failed to take account of 2 matters as relevant considerations, namely:

- whether the father and son had an interdependency relationship immediately before his death on 7 November 2011; and
- if that were not so, whether that state of affairs was caused by the son having suffered from a physical disability.

In relation to the first matter, the father contended that the SCT erred by asking about his son's intentions in relation to his living arrangements when he arrived in Ohio on 1 May 2011 and confining its deliberation to the period immediately surrounding that date.

In relation to the second matter, the father accepted that, at the date of his son's death, they were not "living together" because at that time his son was living in a hospice. However, the father contended that, by the time his son first went to hospital, his son had been living with him between 18 May 2011 and 24 June 2011, and had apparently decided to do this "in the face of the terrible death sentence that he … received in this period".

The Federal Court's decision

The Federal Court held that the SCT had failed to take account of the above 2 matters as relevant considerations.

In relation to the first matter, the court relevantly said:

> … there is no evidence from the Tribunal's Reasons that it had any regard to the six months (approximately) period between May 2011 and the date of the deceased's death in November 2011, which period plainly falls within the temporal confines of the expression "immediately before the death of" the deceased.

and:

> All of these aspects of the Tribunal's reasons go to demonstrate that this is not a case where the Tribunal has made an erroneous factual finding as [the trustee] has contended. Rather they demonstrate that the Tribunal has made a finding about a matter, namely, whether [the father] and his son were living together, without having regard to the period it was bound to consider: that immediately before the death of the deceased. For these reasons, I therefore consider the Tribunal failed to take into account a relevant consideration which it was bound to. It necessarily follows that the Tribunal has made an error of law in this respect.

In relation to the second matter, the court relevantly said:

> The next question is whether the Tribunal failed to consider this matter. On that question, despite [the trustee's] contention that the Tribunal did not have to consider this matter, there is some indication from the Tribunal's Reasons that it may have, at least incidentally. … If, contrary to [the trustee's] submission, this statement can be taken as some indication that the Tribunal did consider the question posed by s 10A(2)(b) of the SIS Act, I consider it did so erroneously. That is so because, as with the first matter above, reg 1.04AAAA specifies that the relevant period for the purposes of determining this matter is the period "immediately before the death of" the deceased. Further, as with the first matter, it is apparent from this statement that the Tribunal confined its consideration to the period up to May 2011. For these reasons, I therefore consider the Tribunal failed to take into account a relevant consideration which it was bound to, namely, assuming [the father] and his son were not living together within the requirement in s 10A(1)(b) of the SIS Act, whether the reason why that was so was because his son suffered from a physical, intellectual or psychiatric disability.

The result

In the result, the court held that the appeal must be allowed and that the matter be remitted to the SCT to be heard and determined according to law and the reasons in the judgement.

6. The meaning of "interdependency relationship" – *TBCL and Commissioner of Taxation* [2016] AATA 264

The Administrative Appeals Tribunal (AAT) (Deputy President Dr P McDermott RFD) has agreed with the Commissioner of Taxation that, based on the information before the Commissioner, a member of a superannuation fund was not in an "interdependency relationship" (within the meaning of that term in section 302-200 of the *Income Tax Assessment Act 1997* (Cth) (ITAA97)) with his parents just before he died. The AAT remitted the matter to the Commissioner to request that the parents make another application for a private ruling based on additional information. The determination is *TBCL and Commissioner of Taxation* [2016] AATA 264.

Background

The son was a member of a superannuation scheme that included a life insurance policy. The son was killed in a motorcycle accident. At the time of his death, the son was 22 years old and was employed as a pilot.

The insurer paid the policy benefit of $500,000 to the son's parents in their capacity as administrators of the son's estate.

The parents applied to the Commissioner of Taxation for a private ruling that the sum was not assessable income because they were each a "death benefits dependent" of the son in that they had each been in an "interdependency relationship" with the son just before he died. (From the AAT determination it is apparent that the parents did not put forward an alternative argument that they were each a death benefits dependant in that they were each "any other person who was a dependant of the deceased person just before he or she died", under section 302-195(1)(d). See *Edwards v Postsuper Pty Ltd* [2007] FCAFC 83.)

The parents' position in the private ruling application was that the following facts indicated an interdependency relationship:

- the son, up to the time of his death, lived at home with his parents for most of his life;
- the only time the son did not live with his parents was during a two year period, when the son lived in Melbourne while he completed his pilot's course;
- the parents paid $40,000 towards the total cost of the son's course, accommodation of $250 per week and living expenses of $1,000 per month while he lived in Melbourne;
- over the years the parents bought the son various items and paid for expenses which included, amongst other items, a computer, TV, pilot's gear and a motor vehicle;
- the son also paid various expenses for his parents;
- at the time of the son's death, the parents and the son shared their living expenses (such as $350 per week for food, $850 for electricity per quarter, council rates of $3,000 per year and water charges of $1,600 per year) equally;
- the parents provided the son with domestic support in the form of preparing meals, doing laundry, cleaning, and a number of other tasks. In turn the son helped his parents by performing tasks around the house;
- in relation to personal care, the parents and the son provided each other with love, care affection and psychological assistance; and
- at the time of the son's death, his parents had just begun to convert their garage into a private living space for the son. Approximately $1,000 was spent on the conversion prior to the son's death and at least a further $7,000 was spent after the son's death as work had already commenced and needed to be completed.

The Commissioner issued a Notice of Private Ruling to each of the parents containing a ruling that each parent was not a death benefits dependent of the son.

Each parent lodged an objection to the Notice. The Commissioner disallowed the objections.

Each parent lodged an application to the AAT for review of the objection decision. The applications were heard together.

At the hearing, the parents tendered additional information in the form of a statutory declaration and a statement made by the proprietor of a restaurant. This additional information had not been provided to the Commissioner before the objections were made.

The additional information referred to matters such as:

- the assertion of a close personal relationship;
- the provision of physical and emotional care;
- the relationship being more than one of convenience; and
- public aspects of the relationships.

The determination did not explain the content of the additional information further.

The issue

The issue in the determination was whether the son was in an interdependency relationship with his parents just before he died.

Meaning of "interdependency relationship"

"Interdependency relationship" is defined in section 302-200 of ITAA97. Briefly stated, 2 persons (whether or not related by family) have an interdependency relationship if:

- they have a close personal relationship;
- they live together;
- one or each of them provides the other with financial support; and
- one or each of them provides the other with domestic support and personal care.

Matters that are to be taken into account in determining whether 2 persons have an interdependency relationship are set out in regulation 302-200.01 of the *Income Tax Assessment Regulations 1997* (Cth).

The AAT's decision

Private ruling

The AAT said that the Commissioner's private ruling was correct, as the facts (as before the Commissioner) did not satisfy the essential requirements of an interdependency relationship.

In coming to this conclusion, the AAT considered the matters set out in regulation 302-200.01, and commented as follows:

- *the duration of the relationship* – the duration of the relationship itself did not point to an interdependency relationship;
- *the ownership, use and acquisition of property* – the reference to "use" required consideration of the "actual use" of the property "just before the son died" and that the intended use of the garage was "not within the ambit" of this matter;
- *the degree of mutual commitment to a shared life* – there was no assertion of a mutual commitment to a shared life in the facts or that the son and applicants ever made such a mutual commitment;
- *the care and support of children* – the facts did not contain any assertion in this regard;
- *the reputation and public aspects of the relationship* – the facts did not refer to any reputation and public aspects of the relationship;
- *the degree of emotional support* – while there was an assertion of “emotional support”, the assertion did not outline the degree of emotional support nor did the assertion refer to any individual instances of emotional support;
- *the extent to which the relationship is one of mere convenience* – the facts did not contain any assertion as to the extent to which the relationship was one of mere convenience; and
- *any evidence suggesting that the parties intend the relationship to be permanent* –the facts comprising the scheme did not refer to any evidence suggesting that the parties intended the relationship to be permanent.

The AAT also considered the requirements of an interdependency relationship in section 302-200, and commented as follows:

- *close personal relationship* – the parents' reference to “love, care, affection and psychological assistance” did not refer to any facts which provided a basis for any indication that there was such a relationship;
- *shared residence* – this requirement was satisfied;
- *financial support* – this requirement was satisfied;
- *domestic support and personal care* – the conjunction "and" in this requirement indicated that both requirements of “domestic support” and “personal care” must be met. The AAT noted that the Commissioner had accepted that the facts satisfied the requirement that the parents and the son provided domestic support to one another. However, in the AAT's view, the facts comprising the scheme were insufficient to indicate that each of the parents and their son provided each other with “personal care”.

Treatment of the additional information

The AAT said that its role was confined to a consideration of the stated facts in the "scheme" identified in the private ruling.

The AAT said that the additional information was “materially different” from the scheme to which the private ruling related, and to have regard to the additional information would mean that the AAT would "travel beyond those facts as identified in the ruling".

The result

In the result, the AAT remitted to the Commissioner to request that the parents make another application for a private ruling based on additional information.

7. Judicial advice – *Bideena Pty Ltd as trustee for the Bideena Pty Ltd Superannuation Fund* [2016] NSWSC 735

The New South Wales Supreme Court (Sackar J) has said that a trustee who embarks upon litigation without having obtained judicial advice does not, by that reason alone, lose any right of indemnity out of the trust assets. The case is *Bideena Pty Ltd as trustee for the Bideena Pty Ltd Superannuation Fund* [2016] NSWSC 735.

Background

The trustee of a self managed superannuation fund (SMSF) commenced proceedings in the Federal Court against 6 defendants. The trustee's claims largely related to allegations of oppressive conduct within the meaning of section 232 of the *Corporations Act 2001* (Cth) on the part of 2 companies.

The directors of the trustee and the members of the SMSF were a Mr and Mrs Bevan,

The defendants in the Federal Court proceedings applied for security for costs on the basis that the trustee was required to obtain judicial advice before commencing the proceedings in order for the trustee to indemnify itself out of the property of the SMSF.

The trustee agreed to obtain judicial advice, notwithstanding that its position was that it was not necessary for it to do so in order to have a right of indemnity.

The trustee applied to the New South Wales Supreme Court for advice, under section 63 of the *Trustee Act 1925* (NSW).

The court's decision

In *Macedonian Orthodox Community Church St Petka Inc v His Eminence Petar the Diocesan Bishop of Macedonian Orthodox Diocese of Australia and New Zealand* (2008) 237 CLR 66 the High court had said:

> [74] A necessary consequence of the provisions of s 63 of the Act is that a trustee who is sued should take no step in defence of the suit without first obtaining judicial advice about whether it is proper to defend the proceedings.

In *Bideena*, the court said that the High Court's remarks in *Macedonian Orthodox* had not been taken to imply that a trustee who embarks upon litigation having not obtained judicial advice loses any right of indemnity. Rather (at [33]):

> … the better view of the authorities importantly *Macedonian Orthodox* is that it is not obligatory on the part of a trustee to first seek judicial advice before bringing or defending a claim. The High Court in *Macedonian Orthodox* said no more than that it was desirable that trustees in doubt as to a cause of action seek advice under s 63 rather than rely on s 85 after the event.

The trustee submitted that this was an "exceptional" case, and that judicial advice as to whether the trustee was justified in pursing the proceedings was therefore unnecessary. The court summarised the trustee's reasons as to why this case was "exceptional" as follows (at [35]):

- the *Superannuation Industry (Supervision) Act 1993* (Cth) requires the beneficiaries (Mr Bevan and his wife) to be directors of the trustee company, and both of the director-beneficiaries support the Federal Court proceedings (Mr and Mrs Bevan have both sworn affidavits to the effect that they met as the board of Bideena on 19 February 2016 and resolved to bring the Federal Court proceedings)
- Counsel's advice has been obtained
- the trust deed (cl A6.1 and 5.2(b)) empowers the trustee to institute and conduct any legal proceedings concerning the Fund, and provides for indemnity of the trustee against any liability incurred in the exercise or performance of its powers and duties
- the *Superannuation Industry (Supervision) Act* provides that a provision that would purport to exclude or limit the trustee's indemnity would be void, and so the indemnity cannot be limited or excluded by failure to obtain judicial advice.

The court accepted this as a "correct analysis" (at [36]).

The result

In the result, the court advised the trustee that it could continue the Federal Court proceedings and be indemnified out of the assets of the fund.

Take away point

A trustee who embarks upon litigation without having obtained judicial advice does not, by that reason alone, lose any right of indemnity out of the trust assets

8. Membership of contributory scheme – *Wood v The Retirement Benefits Fund Board* [2016] TASSC 15

The Supreme Court of Tasmania (Heerey AJ) has held that a member of a public sector contributory superannuation scheme who resigned her appointment as a Magistrate to take up an appointment as a Judge the next day did not cease to be an "employee" of the State, and therefore did not cease to be a member of the scheme. The case is *Wood v The Retirement Benefits Fund Board* [2016] TASSC 15.

Background

A person (the member) was appointed as a Magistrate in 1994. She became a member of the contributory scheme under the *Retirement Benefits Act 1993* (Tas).

In 1999 there was a major change to the Tasmanian public sector superannuation system. Because very large unfunded liabilities were being incurred under the defined benefit contributory scheme, that scheme was replaced by an accumulation scheme. Under this new scheme, benefits would only be available insofar as they were funded by employer and employee contributions. The benefits under the accumulation scheme were less generous than the benefits under the contributory scheme.

As the member was already a member of the contributory scheme, she continued as a member of the contributory scheme.

On 8 November 2009 the plaintiff resigned her office as a magistrate. The resignation was in contemplation of her appointment as a judge of the Supreme Court of Tasmania, which in due course occurred on the following day, 9 November 2009.

The issue

The issue in the case was whether the member, by resigning her appointment as a Magistrate, had ceased to be an "employee" of the State, and had therefore ceased to be a member of the contributory scheme.

The court's decision

The court held that the member had not ceased to be an "employee" of the State, and had therefore not ceased to be a member of the contributory scheme.

The court said (footnotes omitted):

> [22] The common law takes no account of part of a day. So the plaintiff's appointment as a magistrate continued up until midnight on 8 November 2009 and her appointment as a judge commenced immediately on the commencement of 9 November.
>
> [23] As an analogy by way of illustration, if a sergeant was commissioned as a lieutenant, one would not say there was any cessation of service in the Army, even though there was appointment to a new office. One might say that the sergeant had been promoted, as indeed could be said about the plaintiff's elevation to the Supreme Court.
>
> [24] In a taxation context, Gibbs J said in *Reseck v Federal Commissioner of Taxation* (1975) 133 CLR 45 at 50:
>
> > "In most cases in which a workman ceased his employment on a Friday and commenced employment again with the same employer on the following Monday it would be impossible to say that his employment had ever been terminated."

and:

> [26] It is a familiar argument that, because Parliament says something about A, B and C, but nothing about D, one can infer an intention about D. No doubt this can often be a useful tool in the interpreter's workshop. But here there is the competing principle that "there is a presumption in all legislation that it is not intended to interfere with vested interests".

The result

In the result, the member's claim was upheld. She was still a member of the contributory scheme.

Our superannuation expertise

We act for a broad range of superannuation clients located around Australia. Our clients include some of the country's largest industry, corporate and public sector schemes, with most of our client relationships going back many years. Our Superannuation team operates as a "seamless team" across our Sydney, Melbourne, Brisbane and Adelaide offices.

Scott Charaneka, Head of Superannuation and Wealth Management

+61 3 8080 3637 | +61 477 700 380 | scharaneka@tglaw.com.au

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 has previously worked as an in-house counsel at Legal & General and ING. 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 2012-2017 Scott was recognised by his peers in *Best Lawyers in Australia* in the Superannuation Law category, and in 2015-2017 in the Regulatory Practice category. In 2016 he was listed in *Who's Who Legal: Pensions & Benefits*.

Stanley Drummond, Adjunct Head of Superannuation and Wealth Management

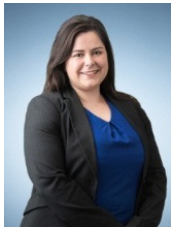
+61 2 8248 5854 | +61 400 676 386 | sdrummond@tglaw.com.au

Stanley specialises in insurance, superannuation, funds management, financial planning and FSR. He is a co-author of Wickens The Law of Life Insurance in Australia. His contributions have included new chapters "Insurance in Superannuation" and "Privacy and Direct Marketing". In 2015-2017 Stanley was recognised by his peers in *Best Lawyers in Australia* in the Insurance Law category. In 2016 he was listed in *Who's Who Legal: Pensions & Benefits*.

Loretta Reynolds, Partner, Markets

+61 3 8080 3705 | +61 8 8236 1406 | +61 403 069 819 | lreynolds@tglaw.com.au

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, 2014 & 2015) Loretta was recognised in the Private Equity category for her "extensive experience in fund formation, handling of buyouts, and work for superannuation funds".



Claire Gitsham, Partner

+61 3 8080 3554 | +61 407 146 339 | cgitsham@tglaw.com.au

Claire is an experienced commercial litigation specialist having practised in Victoria, New South Wales, Queensland, South Australia, Western Australia and federal jurisdictions. She has a particular expertise in SCT complaints, litigated TPD claims and general commercial matters, acting for superannuation trustees.