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SUPERANNUATION CASE LAW UPDATE
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1. Application to set aside consent orders – Matsen v Superannuation Complaints Tribunal [2017] FCA 765

The Federal Court (Perry J) has dismissed an application to set aside consent orders in an appeal to the Federal Court from a determination of the Superannuation Complaints Tribunal (SCT) concerning a superannuation death benefit distribution. The case is Matsen v Superannuation Complaints Tribunal [2017] FCA 765.

BACKGROUND

A member of a superannuation fund died without nominating a superannuation beneficiary and without leaving a will.

The trustee of the fund decided to pay 100% of the benefit to the deceased member's father.

On the application by the deceased member's former partner, the SCT substituted for the trustee's decision, its own decision to pay the death benefit to the deceased member's former partner, the deceased member's mother and the deceased member's father.

The father appealed to the Federal Court against the SCT, the trustee, the former partner and the mother.

The former partner later instituted her own appeal.

On 30 March 2016 the father and the former partner attended a court-ordered mediation. The father was self-represented. The former partner was represented by counsel and her solicitor. The other parties did not attend. The mediator was a Registrar of the Federal Court.

During the mediation there was no direct contact between the father on the one hand, and the former partner and her counsel and solicitor on the other hand. The mediator conveyed offers between the parties.

After some negotiation, the matter settled in principle between the father and the former partner on the following basis:

(a) The decision of the SCT was overturned. In lieu thereof, by consent, the death benefit was to paid as follows:

(i) $50,000 to the former partner;

(ii) The balance of the benefit to the father.

(b) The former partner agreed to withdraw her appeal with no order as to costs.

At the mediation the father and the former partner signed short minutes of order. The short minutes were not able to be filed in the Federal Court Registry at that time as they required the consent of the other respondents.

Following the mediation, the solicitor for the former partner contacted the other parties and obtained their consent.

On 22 June 2016 the matter came again before the court. At that hearing, the father told the court that he no longer agreed to the orders set out in the short minutes. As a result, the matter was stood over for further directions on 29 July 2016.

On 29 July 2016 the father consented to orders being made in terms of the draft consent orders signed by the parties, even though he indicated that he was unwell and that that played a part in his decision to do so.

On 5 October 2016 the father filed an application to set aside the consent orders made on 29 July 2016. The former spouse was the only party who opposed the application.

The court's decision

The court dismissed the application.

In so doing, the court began by noting the relevant principles.

The circumstances in which the court may vary or set aside a judgment or order after it has been entered are set out in rule 39.05 of the Federal Court Rules 2011 (Cth) which provides as follows:

The Court may vary or set aside a judgment or order after it has been entered if:

(a) it was made in the absence of a party; or

(b) it was obtained by fraud; or

(c) it is interlocutory; or

(d) it is an injunction or for the appointment of a receiver; or

(e) it does not reflect the intention of the Court; or

(f) the party in whose favour it was made consents; or

(g) there is a clerical mistake in a judgment or order; or

(h) there is an error arising in a judgment or order an accidental slip or omission.

Also, the High Court held in Harvey v Phillips (1956) 95 CLR 235 at 243-244 that:

> ... in the case of a compromise which is made within the actual as well as apparent authority of counsel a court does not appear to possess a discretion to rescind it or set it aside. The question whether the compromise is to be set aside depends upon the existence of a ground which would suffice to render a simple contract void or voidable or to entitle the party to equitable relief against it, grounds for example such as illegality, misrepresentation, non-disclosure of a material fact where disclosure is required, duress, mistake, undue influence, abuse of confidence or the like.

Absent a ground on which the consent order can be invalidated, "the consent order is good".

Here, the father's grounds for the application were summarised as follows:

(a) The applicant informed the mediator that it was "an unfair situation" as the applicant had no assistance and that he was not "up to the task".

(b) The applicant was "locked in a most unsuitable room".

(c) The applicant informed the mediator that at the time he was unable to negotiate as the travel had rendered him unable to protect is interests.

(d) The mediator refused to respond to that situation and "pressurised" the applicant to continue the process.

(e) The mediator advised the applicant that he was unable to leave until the applicant "wrote out the reasons" for leaving the negotiations, and that the applicant was in no condition to do so as he had been travelling "for a day".

(f) The applicant was in physical pain.

(g) The applicant had had eyesight problems.

(h) The applicant had most of his teeth removed.

(i) There was no "face to face with the other parties".

(j) The applicant only signed, presumably the Short Minutes, to enable him to leave the Federal Court building.

The court said:

> [23] A concern about the manner in which the mediation was held and the fact that it may not have accorded with the [father's] expectations in that regard, do not provide a basis on which to set aside the consent judgment in line with the principles to which I have earlier referred. Rather, as the [former spouse] submitted, the highest that the [father's] case can be put is that he entered into the agreement under duress from the Registrar.

However, none of the matters raised by the father could approach establishing duress (at [25]-[27]). The court said:

> [27] In short, in the circumstances, were it necessary to decide the point, I consider that the evidence falls well short of providing a basis upon which to infer that any pressure that the Registrar may appeared to have put on the [father] to continue the mediation was undue and that the consent orders should be set aside on the ground that the underlying agreement was entered into under duress.

THE RESULT

In the result, the father's application to have the consent orders set aside was dismissed. The consent orders therefore stood.

The father was ordered to pay the former spouse's costs. There were no orders as to costs with respect to the trustee.

2. TPD claim – procedural fairness – Shepherd v ANZ Staff Superannuation (Australia) Pty Ltd [2017] VCC 566

In remitting a claim by a member of a superannuation fund for a total and permanent disablement (TPD) benefit to the trustee of the fund, the Victorian County Court (Her Honour Judge Tsalamandris) has held that the trustee had not afforded the member procedural fairness. The trustee should also have further investigated the member's claim, to attempt to reconcile the conflicting medical evidence. The case is Shepherd v ANZ Staff Superannuation (Australia) Pty Ltd [2017] VCC 566.

BACKGROUND

The member worked as a senior relationship manager for a bank.

The trust deed of the superannuation fund provided for payment of a TPD benefit where a member left "Service" on the grounds of TPD.

On 23 May 2013 the member was subject to a disciplinary meeting at the bank, following which he was suspended from work on full pay while an investigation took place. As a result, he suffered anxiety and depression, for which he sought medical treatment. His general practitioner certified him as being unfit for work. The member did not go back to work after 23 May 2013.

On 12 June 2013 the member lodged a claim for WorkCover benefits in relation to his anxiety and depression. The bank was a WorkCover self insurer and arranged for the member to be examined by Dr Triggs, psychiatrist. Dr Triggs diagnosed him as suffering an Adjustment Disorder, in partial remission. She considered the member's counselling and medication to be appropriate. Dr Triggs was of the opinion that the member had the capacity to perform his pre-injury duties both in the short and long-term, and the capacity to attend the proposed disciplinary meeting .

On 4 and 8 July 2013 the member attended two meetings with the bank's management.

On 9 July 2013 the bank terminated the member's employment, with effect from 8 July 2013, on the grounds that he had:

> [acted] dishonestly and without integrity in knowingly failing to declare [his] true financial position when applying for personal loans with [the bank in 2013] in order to gain a financial advantage for [himself];

and:

> [used his] external email account, namely Bigpond, to access internal, confidential and restricted information.

On 9 July 2013 the member was also advised that his WorkCover claim had been rejected (WorkCover rejection letter), on the basis that his injury was caused wholly or predominantly by management action, taken on reasonable grounds and in a reasonable manner, and further, that the member was not incapacitated for work. In making this decision, the self insurer relied upon the report of Dr Triggs, who considered the member capable of returning to his pre-injury duties.

In March 2014 the member, through his lawyers, lodged a claim for a TPD benefit with the trustee.

Both the member and the trustee (through a service provider) obtained various medical reports. These reports included a further report of Dr Triggs, obtained by the trustee.

On 12 December 2014, the trustee's claims committee met and considered, among other matters, the member's TPD claim. The claims committee ultimately accepted a recommendation that the claim be denied, but thought the member should be provided with the opportunity to respond to any material adverse to his claim.

On 19 December 2014 the trustee wrote to the member's lawyers, providing copies of the documents it relied upon in its assessment of the member's TPD claim (the procedural fairness letter). The documents provided included the WorkCover rejection letter, along with medical reports.

On 2 March 2015 the member's lawyers wrote to the trustee in response to the procedural fairness letter. This letter made submissions in relation to Dr Triggs, noting in particular that "she has consistently contradicted the opinions of other doctors who have examined our client". Additional medical reports were also provided in support of the member's claim.

On 22 March 2015 Dr Triggs provided a further supplementary report in which she commented on the medical material that had been provided by the member's lawyer's in support of the member's claim. Dr Triggs quoted extracts of the various medical records, and provided a commentary as to the differing medical opinions in relation to the member's work capacity. She ultimately remained of the opinion, however, that the member had the capacity to return to his pre-injury duties and hours with an alternative employer, and that his psychiatric impairment was not permanent.

On 26 June 2015 the claims committee met and accepted a recommendation that the member's claim for a TPD benefit be declined.

On 2 July 2015 the trustee wrote to the member's lawyers informing them of the trustee's decision that the member did not satisfy the definition of TPD, and further informing them that no reasons were given.

On 6 July 2015 the member's lawyers wrote to the trustee expressing concern as to the absence of reasons in the rejection letter and requesting a detailed explanation.

On 4 August 2015 the trustee wrote to the member's lawyers stating that, on the medical evidence available, the trustee had formed the opinion that the member's:

> ... mental incapacity does not render him unlikely ever to be able to work again in a job for which he is reasonably qualified by education, training or experience.

It was further stated that:

> The medical evidence demonstrates that [the member's] employment was terminated following certain workplace-related incidents and, had those incidents not occurred, he would not have ceased employment.

The member commenced proceedings against the trustee in the Victorian County Court, seeking a declaration that the trustee's decision to refuse his TPD claim be set aside on the basis that the trustee's decision to refuse the claim was void and of no effect.

THE COURT'S DECISION

The court held that:

- the trustee had misconstrued the trust deed;
- the trustee had not afforded the member procedural fairness; and
- by failing to undertake further investigation to attempt to resolve the conflicting medical evidence, the trustee had failed to give genuine consideration to the member's TPD claim.

The trust deed

As mentioned above, the trustee denied the claim on 2 grounds. First, the member did not satisfy the TPD definition, ie being unlikely to be able to ever work again in a job for which he was reasonably qualified by reason of his education, training and experience.

Second, that he did not cease his Service with the bank as a consequence of mental incapacity Rather, left Service with the bank on the basis that he was terminated for misconduct, thereby rendering his medical incapacity effectively irrelevant (at [4] and [97]).

The court held that in interpreting the trust deed, the concepts "Service" and "employment" were not coextensive. "Service" was a broader concept. The court said:

> [110] Leaving "Service" will usually occur when a person resigns from, or is terminated from employment. However, I am satisfied that leaving "Service" can also logically encompass a situation in which an employee is absent from work for an indefinite period, whilst the employee still remains employed. Further, it is not uncommon for a person suffering mental incapacity, to leave service, but to remain formally employed for an extensive period of time thereafter.

Further, they may be concurrent reasons for a person to leave Service ([at [116]):

> Concurrent reasons may exist for the ceasing of Service. That is, both the termination of his employment and his mental incapacity could have, on their own, caused the [member] to cease Service.

The trustee had erred in not considering that the member may have left Service for a reason other than formal termination of his employment. The trustee had assessed the member's TPD claim on an incorrect construction of the trust deed (at [118]).

Procedural fairness

On the topic of procedural fairness, the court said:

> [121] A trustee is obliged to afford a claimant natural justice and to give a claimant a chance to address adverse information.

Here, procedural fairness required the trustee to make it clear to the member that "his termination from employment was likely to be determinative of his TPD claim" (at [134]). The court said:

> [130] … The requirement to afford procedural fairness extended so far as to ensure the [member] was aware of the extent of the material being considered by the [trustee's] claims committee, such that the [member] understood the adverse material the trustee was considering.
>
> [131] However, I am critical of the [trustee] in failing to afford the [member] procedural fairness in respect of the focus of its assessment; being the [member's] termination from employment. Whilst the WorkCover rejection letter was included in the procedural fairness letter, it was not listed separately, but was listed amongst the numerous medical reports.

and:

> [134] In these circumstances, I consider the obligation on the [trustee], was such that it was required to make clear to the [member], that his termination from employment was likely to be determinative of his TPD claim. Had this been conveyed, it would have afforded the [member] an opportunity to respond with material that may further have explained the circumstances of his termination. It would also have provided his solicitors with the opportunity to make submissions to the [trustee], in relation to what it considered the correct interpretation … of the Trust Deed.
>
> [135] In this instance, the WorkCover rejection letter was listed amongst numerous medical reports. Given the WorkCover rejection letter summarised medical reports obtained as at that date, the [member] and his solicitors may have considered it was included in the procedural fairness letter for its summary of those reports, rather than for its summary of the grounds of the [member's] termination.
>
> [136] I am of the opinion that, to adequately afford the [member] procedural fairness, the [trustee] ought to have listed the WorkCover rejection letter as a stand-alone document. It would then have been abundantly clear to the [member], that the termination of his employment was determinative in the committee's decision to reject his claim, and would have afforded him the opportunity to respond. The medical reports should then have been listed separately, as documents of relevance to the [trustee's] decision.
>
> [137] As part of its duty to act in good faith, I consider the [trustee] was obliged to do more than, what appears to me, effectively slip the WorkCover rejection letter amongst a bundle of medical reports. I consider this was unreasonable and sufficiently misleading as to have denied the [member] the opportunity to understand and respond to the material to be used against him. That is the purpose of the procedural fairness obligation, and I am not satisfied the [member] was afforded procedural fairness in this instance.

Failure to undertake further investigation

The court noted the "clear conflict" between the opinion of Dr Triggs, psychiatrist, whose reports were relied upon by the trustee, and the medical material relied upon by the member. When asked to reconcile the differing medical opinions, Dr Triggs had reaffirmed her previous opinion over that of the other medical practitioners (at [147]).

The court said that the trustee should have arranged an examination by an additional medical expert:

> [148] In such circumstances, in an attempt to reconcile the prevailing conflict, I consider the [trustee] ought to have arranged for the [member] to be examined by an additional independent medical expert. Such an approach would have been reasonable in the circumstances to allow the [trustee] to more fairly evaluate the differing medical opinions. Given the size of the TPD

claim, the cost of obtaining a fresh opinion, when compared with the cost of obtaining a supplementary report from Dr Triggs, would not have been a particularly onerous one.

The trustee's failure to undertake any further investigation demonstrated a failure to engage in a genuine consideration of the member's claim:

> [149] Accepting that there is a high duty on the [trustee] to make proper inquiries and considering the High Court's statement in Finch [v Telstra Super Pty Ltd [2010] HCA 36; (2010) 242 CLR 254] that a trustee has a duty to seek relevant information in order to resolve conflicting bodies of material, I consider the [trustee's] failure to undertake any further investigation, demonstrated a failure to engage in a genuine consideration of the [member's] TPD claim.

COSTS

In a subsequent judgment on costs, the court (Her Honour Judge Tsalamandris) ordered the trustee to pay the member's costs of the proceedings on the standard basis, but with a set-off of the costs of an earlier costs order made on 8 February 2017: Shepherd v ANZ Staff Superannuation (Australia) Pty Ltd (No 2) [2017] VCC 696 at [36].

THE RESULT

In the result, the claim was remitted to the trustee for further investigation and reconsideration, with the trustee to pay the member's costs.

3. TPD Claim – failure by SCT to consider critical medical evidence – Carrette v Superannuation Complaints Tribunal [2017] FCA 640

In remitting a claim by a member of a superannuation fund for a total and permanent disablement (TPD) benefit to the Superannuation Complaints Tribunal, the Federal Court (his Honour Chief Justice Allsop) has held that the Tribunal failed to engage with critical parts of the medical evidence before it. The case is Carrette v Superannuation Complaints Tribunal [2017] FCA 640.

BACKGROUND

The member was employed as a police officer in the New South Wales Police Force between 1985 and 1996. During the course of his employment as a police officer, the member suffered post-traumatic disorder (PTSD) and major depressive disorder (MDD). The member was discharged from the police force on medical grounds in 1996.

From 1996 to 1997, the member was unemployed. From 1997 to 2006 the member had various jobs including both at the New South Wales Department of Transport and the Roads and Traffic Authority of New South Wales.

In March 2006, the member joined the QSuper Fund as an employee of the Department of Main Roads of Queensland.

From 2006 to 2007, during his employment at the Department of Main Roads of Queensland, he suffered significant stressors which led to psychiatric ill health. Those stressors included physical and verbal abuse and bullying from a group of men at the Department of Main Roads. During this time, the member exhibited symptoms of a psychiatric disorder referred to variously as PTSD, MDD or complex PTSD.

On 15 June 2006 the member lodged a workers' compensation claim for PTSD.

In August 2007 the member's employment with the Department of Main Roads was terminated due to ill health.

In 2008, the member worked as an inspection officer with the NSW Office of Liquor, Racing and Gaming. On 14 April 2009 he ceased working as a traffic controller with Road and Traffic Management Technologies.

THE TRIBUNAL'S DECISION

In affirming the decision of the Trustee that the Tribunal was provided with opinions of ten psychiatrists, three psychologists, an occupational therapist and a facility medical officer. These medical reports dealt with the member's symptoms from 1995 to 2000 and 2006 onwards.

The Tribunal was satisfied on the evidence before it that it was open to the Trustee to determine that the Complainant's TPD related to a medical condition, the signs and symptoms of which existed prior to him joining the Fund.

THE COURT'S DECISION

The court held that the Tribunal had failed to engage with the central material necessary for it to form its view that the member's current condition was not unrelated to his earlier condition. The Court set aside the decision of the SCT and remitted the matter back to the Tribunal for re-hearing.

The insurance policy

Before the Court it was somewhat common ground between the parties that the member suffered from PTSD and MDD after he ceased work with the NSW Police Force and that the symptoms were exhibited during the 1990's.

Central to the court's consideration was the application of clause 6.2(b)(ii) of the relevant insurance policy provided through the member's superannuation.

Clause 6.2(b) stated:

> 6 Pre-existing Medical Conditions
>
> ...
>
> 6.2 No insurance benefit will be paid for a claim unless:
>
> ...
>
> (b)
>
> (i) the member has been an insured member for fewer than 10 continuous years; and
>
> (ii) in the board's opinion, the member's total and permanent disablement or death or temporary disablement was not related to a medical condition the signs or symptoms of which existed before the start of the member's contributory membership.

The Court considered that both the evidence and the findings of the Tribunal were not precise as to at what point the member could have been seen to have reached a point of recovery from his PTSD condition brought on by work with the NSW Police Force. Such a finding would have an effect on the operation of clause 6.2(b).

The Court, at [13] and [15] stated:

> The question was whether cl 6.2 applied, such that no insurance benefit would be paid unless in the Board's opinion, that is, the Trustee's opinion, Mr Carrette's accepted total and permanent disablement was not related to a medical condition, that is, the PTSD or MDD of the 1990s, the signs or symptoms of which existed before the start of the contributory membership.
>
> The question to be focused upon, either in the positive or negative, assuming for present purposes there is no difference, is whether or not there was a relationship between [the member's] condition after 2007 and his condition in the 1990's, or whether they were unrelated.

The Court considered the 2013 report of Professor McFarlane which concluded that:

> Critical to understanding the cause of his total and permanent disablement is the course of Mr Carrette's symptoms. In the absence of the stresses of his employment with the Queensland Main Roads, it is my opinion that he would have remained much as he was in the period between 2000 and the commencement of his employment. He was functioning at a reasonable level and actively engaged in his family and work life.
>
> The stresses that he experienced with the Queensland Department of Main Roads and his continued intrusive preoccupation with what transpired are the cause of his subsequent symptoms and led to his total and permanent disablement. His background minor symptoms and subsequent stresses to leaving that employment only have made a minor contribution to his current state.

At [26] the Court found that:

> For present purposes, the importance of this is that Professor McFarlane was saying that this was a different condition effectively unrelated to the earlier condition and one that was best understood as complex PTSD and not PTSD or MDD. Also importantly, in the report of 30 January he makes clear his view that complex PTSD is not included in the DSM handbook and thus it is not a diagnosis or identification of a condition directly referable to the DSM as a medical construct. The importance of this last point will become evident when one looks at the reasons of the Tribunal.

After considering the reasons of the Tribunal the Court held that:

- the Tribunal had not appreciated the importance of the separate condition of complex PTSD (in 2006) to the conditions of PTSD and MDD (in 1995);
- accordingly, the Tribunal had failed to engage with the central material necessary for it to form the view that the current condition of the member was not unrelated to the earlier condition;
- the subject matter was not one which permitted other than a remittal of the matter to the Tribunal to deal with all questions before it including the status of Professor McFarlane's views.

THE RESULT

The Court set aside the decision of the SCT and remitted the matter back to the Tribunal for re-hearing. Costs were awarded in favour of the member to be paid by the Trustee.

4. TPD Claim – opinion of insurer not unreasonable; no obligation on insurer to obtain labour market analysis – Dotlic v Hannover Life Re of Australasia Limited [2017] NSWSC 986

The NSW Supreme Court has dismissed a claim by a member to set aside decisions of the Trustee and Insurer that the member was not totally and permanently disabled within the meaning of the group life insurance policy. The case is Dotlic v Hannover Life Re of Australasia Limited [2017] NSWSC 986.

BACKGROUND

The member is a 35 year old Bosnian immigrant who had been in Australia since the age of 19.

In 2009, the member was in a minor motor vehicle accident which gave rise to some injuries which were the subject of workers compensation and statutory benefits.

In 2012, the member made an application as a member of the Construction and Building Unions Superannuation Fund that he was totally and permanently disabled under the group life insurance policy issued by Hannover Life Re Australasia Limited.

A significant number of medical reports were obtained and before the Trustee and Insurer when making their determination as to the member's claim. The medical reports (summarised at paragraphs [17 – 28] of the Court's reasons) were generally of the view that the member was capable of employment in the future, albeit with some limitations.

In particular:

- Dr Habib (orthopaedic surgeon) said in 2011 that the plaintiff was 'considered fit for restricted suitable and light duties on a part-time basis' subject to certain restrictions; and in 2012, that 'efforts should be made for rehabilitation based functional/vocational assessment to return him to suitable duties'.
- Ms Kondakoff (exercise physiologist) concluded in May 2012 that the member had
  - demonstrated that he has improved his functional and postural tolerances to be able to meet the physical requirements of his rehabilitation goal;
  - had more functional capacity than currently reflected on his medical certificate;
  - had the capability to work for 5 hours per day 5 days per week;
- Dr Stephenson (orthopaedic surgeon) said in 2011 that the member was " fit for a variety of other jobs now that do not involve heavy manual labouring work"
- Ms Leaver (physiotherapist/vocational assessor) determined that the member was "capable of full-time employment" and "is suitable for a range of other occupations";
- Mr Raue (psychologist/vocational assessor) concluded that the member was "an intelligent man who is likely to have a lot to offer employers over and above simple labouring or hands-on work";
- Dr Gibson (occupational physician) endorsed the recommendations made that the member was fit for a range of occupations;
- Dr Anderson (occupational and environmental medicine physician) concluded that the member was "certainly not totally and permanently disabled";
- Dr Kafataris (injury management consultant with WorkCover) had a favourable view in 2010 of the member's prospects to return to work;
- Dr Guirgis (consultant orthopaedic surgeon) determined that the member should avoid some activities that required heavy or repetitive lifting;
- Drs Nguyen, Smith and Newlyn (consultant psychiatrists) concluded that the member was not incapacitated for employment from a psychiatric point of view.

THE COURT'S DECISION

Threshold question

The Court formed the conclusion that there was more than enough material available to the insurer from which it was able reasonably to form the opinion that the plaintiff was not 'unlikely ever' to be able to engage in regular employment (part-time or full-time) for which he was reasonably fitted by education, training or experience.

In arriving at its finding the Court had regard to the now well-established principle in Edwards v The Hunter Valley Co-Op Dairy Co Ltd (1992) 7 ANZ Ins Cas 61-113 at 77,536 as approved in TAL Life Ltd v Shuetrim [2016] NSWCA 68 at [61]-]62].

> Where under a contract, rights or liabilities depend upon the subjective state of mind of a party, eg the party's approval, opinion or satisfaction, of or about something, it can be a difficult question whether the party is subject to an implied obligation in reaching that state of mind, or failing to reach it, as the case may be, to be bound by objective standards of reasonableness ... However in the field of insurance, it is well established that where under a contract of insurance an element of the insurer's liability is expressed in terms of the satisfaction or opinion of the insurer, the insurer is obliged to act reasonably in considering and determining that matter.

He added:

> To say that an insurer must act reasonably in forming or declining to form an opinion is not to say that a Court can substitute its own view for that of the insurer. As North J pointed out in Doyle at 529, '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.

The Court had regard to the medical reports referred to above as well as the brief medical report of the member's treating practitioner. Whilst the Court noted that the one line assessment (the doctor had completed a proforma medical report on which he ticked a box stating that he did not expect that the member would ever be able to do a job for which he is reasonable fitted by education, training or experience) his Honour referred to the problem that sometimes arises where general practitioners simply accept the member's account without questioning its truthfulness or completeness (at [13]).

Ultimately, the Court was satisfied that proper account had been taken by the insurer of the member's physical capacity, psychological makeup, availability of employment and likelihood of obtaining it (see Dargan at [43]; Jones v United Super Pty Ltd [2016] NSWSC 1551 at [62])).

Vocational assessment

An adjunct to the member's first claim in respect of the insurer's assessment was a contention that there was no evidence of any actual labour market analysis to assess the likelihood of the plaintiff obtaining any such employment.

The Court held that:

- it did not accept any failure on the part of the insurer and the trustee to have regard to the "real world" in considering whether the member met the definition of total and permanent disablement under the insurance policy;
- it did not accept that it was necessary for the insurer to undertake a detailed labour market analysis that resulted in finding the member a particular job with a particular employer willing to employ the member.

His Honour stated (at [33]) that:

> The insurer's responsibility was to form an opinion about the probabilities, having regard to the terms of the policy. In doing so, it was reasonable and appropriate to base its opinion on the considered professional advice of experienced vocational assessors. It appears to have been careful in doing so – referring in its letter of declinature dated 1 July 2014 to its review of 'all available evidence' and the 'weight of evidence' on multiple occasions. And it summarised the information on which it based its opinion and the terms of the policy that it was addressing. My impression is that the conduct of the insurer was cautious and comprehensive. It was certainly fair.

THE RESULT

The Court answered the separate question in favour of the insurer and trustee and dismissed the proceedings. The member was ordered to pay the defendants' costs.

COSTS - OBSERVATIONS

Whilst the member was ordered to pay costs in this matter the Court made a number of observations about the conduct of the matter.

The Court noted that, given the member's financial circumstances it seemed likely that his solicitors were running the matter on a speculative basis. Given the size of the claim the matter ought to have been commenced in the District Court rather than the Supreme Court and therefore his Honour would not have ordered costs in favour of the member even if he had been successful. Moreover, the costs of the litigation bore no relation to the size of the claim – little attempt had been made to ensure proportionality, economy and restraint.

5. Superannuation benefits – matters affecting entitlement to and payment of benefits – Treasurer, Minister for Aboriginal and Torres Strait Islander Partnerships and Minister for Sport v Nuttall [2017] QSC 137 [written by CG]

The Queensland Supreme Court has ordered a former member of the Queensland Legislative Assembly to pay 25% of the publicly funded component of the commutation value of his primary pension. The case is Treasurer, Minister for Aboriginal and Torres Strait Islander Partnerships and Minister for Sport v Nuttall [2017] QSC 137.

BACKGROUND

The defendant, Mr Nuttall, is a former minister of the Queensland State Government (between 22 February 2001 and 7 December 2005) and a member of the Legislative Assembly from September 1992 to 8 September 2006.

Pursuant to section 15 of the Parliamentary Contributory Superannuation Act 1970 (PCS Act) Mr Nuttal paid contributions to the fund at the rate of 11.5% of each instalment of his salary paid to him as a member of the Legislative Assembly. Contributions were also paid into the fund out of a consolidated fund under section16 of the PCS Act.

From 9 September 2006 Mr Nuttal received a pension out of the fund pursuant to section 17 of the PCS Act.

In 2007, the PCS Act was repealed and the amount held in the fund was transferred to the State Public Sector Superannuation Fund. Members of the fund became members of the State Public Sector Superannuation Scheme (the Scheme).

Section 340 of the Superannuation (State Public Sector) Deed 1990 which established the Scheme mirrored the terms of section 17 of the PCS in defining the amount of pension payable to a person who ceases to be a member of the Legislative Assembly.

On 16 December 2010 Mr Nuttal was convicted of five offences of official corruption committed between 10 December 2011 and 29 July 2005.

The offences were prescribed offences for the purposes of the Public Officers Superannuation Benefits Recovery Act 1988 (the Act). Section 7(2) of that Act says that:

> 7 Assessment of liability
>
> ...
>
> (2) If the judge hearing the application is satisfied that—
>
> a) the person convicted of the offence or offences to which the application relates is a publicly funded superannuant; and
>
> b). the application relates to 1 or more prescribed offences; and
>
> c) the liability incurred under section 6(1) by the person upon conviction of that prescribed offence or those prescribed offences subsists;
>
> the judge shall order the person to pay to the Treasurer on behalf of the Crown a sum, considered by the judge to be just and equitable, assessed by the judge in accordance with section 8.

At trial, Mr Nuttal conceded that he was liable under section 7(2) of the Act to pay a sum to the Treasurer by reason of his convictions. The substance of Mr Nuttal's contentions before the Court related to the period of time relevant for repayment and the factors the Court should take into account in assessing the quantum payable under the Act.

THE COURT'S DECISION

The Court identified the factors relevant to its assessment of what sum should be commuted by Mr Nuttal as being:

- the long period he served in Parliament before he began offending;
- that his offending occurred during the time when he was a minister;
- that he took bribes of significant amounts thus creating great potential to erode public respect for and confidence in the institutions critical to the good order of government and society;
- the value of the gain to Mr Nuttal of $147,000 was substantial (and he had the use of the money for between five and six years) but that it had been repaid with interest;
- that he repaid other sums to the Crown as some measure of his willingness to make recompense.

In arriving at these factors the Court drew on the decisions in Re Lane (no 936 of 1991; Ryan J, 9 October 1992, (unreported)) and Re Lewis [1995] QSC 73.

In Re Lane an order was made for payment of $25,000 where the maximum amount under s 8(1) was $834,657.89. The gain from the offences was $5,030.92 which had been repaid. The offences involved misuse of a ministerial credit card.

By way of contrast, in Re Lewis, the former Commissioner of Police was ordered to pay the maximum amount calculated under s 8(1) being $1.43 million. In that case the offending occurred over a 10 year period and involved personal gain of about $580,000 which had not been repaid.

THE RESULT

Taking into account the factors identified above, the Court held that Mr Nuttall should pay the Treasurer on behalf of the Crown 25% of the publicly funded component of the commutation value of his primary pension being $1,577,682 (including interest).

6. TPD claim – standard of review adopted by Court (whether unreasonableness in the Wednesbury sense); whether Court undertakes "merits review" of insurer's opinion on entirely objective basis; whether ETE clause requires a connection between suggested future work and the claimant's education, training and experience – Hannover Life Re of Australasia Ltd v Jones [2017] NSWCA 233

The NSW Court of Appeal has dismissed an appeal brought by Hannover Life Re of Australasia Ltd from the decision in Jones v United Super Pty Ltd [2016] NSWSC 1551. The Full Court held that neither the relevant inquiry for the Court when reviewing an insurer's opinion in a "merits review" nor an in inquiry into whether the insurer's decision is unreasonable in the Wednesbury sense. The relevant inquiry is whether the opinion formed by the insurer was not open to the insurer acting reasonably and fairly in considering and determining the claim. The case is Hannover Life Re of Australasia Ltd v Jones [2017] NSWCA 233.

BACKGROUND

The claimant was born in 1982. He left school in NSW at age 16, having obtained his School Certificate.

He completed an apprenticeship with a roofing contractor and qualified as a tradesman roof plumber with a Certificate 3 in metal roof plumbing. He subsequently gained a number of additional tickets, including Professional Association of Climbing Instructors, asbestos removal class B, safe work at heights ticket, elevated work platform over 11 metres, 20 ton non-slew crane, occupational health and safety induction, and explosive power tools.

In 2002 he suffered an injury to his lower back while lifting metal roof and wall sheets over a parapet wall to a fellow worker. This caused pain to radiate down the back of his left leg. His condition worsened and in 2003 he underwent a hemi-laminectomy at S1 on the left side, which was successful. He returned to work three months later with a different employer, as a roofing supervisor.

From 2003 until 2011 he worked in a series of supervisory roles with different roofing companies. All these roles involved significant manual labour. In early 2007, he took up a supervisory position with CMC Metal Roofing in Townsville, Queensland. (Although not mentioned in the judgment, it appears that at about this time the claimant moved from Sydney, where his previous employers were based, to Townsville.)

Although the operation in 2003 had been successful, he continued to have pain in his lumbar spine which radiated down the back of his left leg, which was worse when bending or lifting or while standing or sitting for long periods.

In mid-2011 he was loading asbestos sheeting, which was quite heavy, into a bin when he noticed some soreness in his back, which increased significantly, and he developed right leg pain, which became more severe than the back pain. On 7 September 2011 he had a CT scan of the lumbar spine, which was reported as showing, at L5/S1, a prominent central disc protrusion with calcification, somewhat more pronounced towards the left side. The previous hemi-laminectomy at S1 on the left side was noted.

At about this time he stopped working, and on 10 October 2011 his employer closed down. Its jobs and its employees were transferred to other contractors. However, the claimant did not resume work.

In June-October 2012 the claimant lodged a claim with the trustee of his superannuation fund for a TPD benefit.

In October 2012 the claimant underwent a re-do laminectomy, which resulted in some improvement. However, he still had pain in the right calf and walked in a restricted fashion.

Shortly before this, he had been referred to Dr Marshman, neurosurgeon, for further investigation, particularly of discogenic pain. Dr Marshman first saw him in August 2012. In March 2013 Dr Marshman noted that there were "a lot of fear-avoidance mechanisms in operation that he freely admits to" (at [24]-[25]).

Dr Marshman provided a report dated 22 August 2013 to the superannuation trustee. This relevantly read (at [33]):

2. The clinical diagnosis is persistent right L5 sciatica. The cause is considered to be cytokine-mediated irritation of the exiting L5 nerve root as a result of the co-localisation of a residual protruded and degenerate L5/S1 disc after prior surgery. Fear-avoidance mechanisms (which Clinton freely acknowledges) also compound this case, and Clinton has become somewhat dependent upon opiate analgesia.

...

5. The two operative medical conditions are: 1) cytokine-mediated right sciatica, and 2) psychological factors such as fear-avoidance and opiate dependence.

6. The two operative medical conditions outlined in Q5 above are both equally limiting upon a successful return to work.

...

8. The prognosis for a return to work (both medium and long-term) is currently poor without successfully addressing both conditions outlined in Q5 above.

9. Clinton has continued pain and operates fear-avoidance mechanisms: both render him unfit to return to his previous employment.

10. It is possible for Clinton to retrain for a desk job which can capitalise up-on his previous knowledge and experience.

11. Yes, I believe that Clinton could be re-employed as a Building Supervisor with no manual duties.

Later in August 2013 the trustee asked the fund's group life insurer to assess the claim.

THE CLAIM IS DECLINED

In January 2014 the insurer declined the claim. The trustee agreed with the insurer's decision. The claimant asked for the decisions to be reviewed, and provided a further medical report. In March 2014 the insurer confirmed its earlier decision. The trustee again agreed with the insurer's decision. This was communicated to the member in April 2014.

Briefly stated, the insurer's position, with which the trustee agreed, was that the following occupations were suitable for the claimant (at [47] and [53]):

Retail Sales (Hardware)

Courier/Delivery Driver

Console Operator

Customer Service Advisor/Telemarketer.

Later in 2014 the claimant commenced proceedings against the trustee and the insurer in the Supreme Court of NSW.

DECISION AT FIRST INSTANCE IN JONES V UNITED SUPER PTY LTD [2016] NSWSC 1551

The court held that the decisions of the insurer and the trustee were void, and that the claimant was TPD as he satisfied both limbs of the definition of TPD.

First Stage Inquiry

After setting out the relevant history of the claim, Mr Jones' injury, the medical and occupational evidence and the Insurer and Trustee's reasons for declining the claim, his Honour set out his reasons for determining that the Insurer's decision had miscarried.

At [55] his Honour set out what he identified as the circumstances in which the Court could review and avoid the Insurer's decision. His Honour said:

In the present context, where under a contract of insurance, an element of the insurer's liability is expressed in terms of the opinion of an insurer, the insurer has an implied obligation to consider and determine whether it should form the relevant opinion, which involves a consideration and determination of the correct question; and in the exercise of powers affecting the interests both of itself and of a claimant such as Mr Jones, the insurer is under a duty of good faith and fair dealing requiring it to have regard to the interests of the claimant, and an obligation to act reasonably in determining and considering the matter. (TAL Life Ltd v Shuetrim [2016] NSWCA 68 at [61]; Edwards v Hunter Valley Co-Op Dairy Co Limited (1992) 7 ANZ Ins Cas 61-113; Chammas v Harwood Nominees Pty Limited (1993) 7 ANZ Ins Cas 61-175; Hannover Life Re of Australia Limited v Sayseng [2005] NSWCA 214; (2005) 13 ANZ Ins Cas 90-123; Halloran v Harwood Nominees Pty Ltd [2007] NSWSC 913 at [31]). Thus the insurer's decision will be liable to be reviewed and avoided by the court where:

(1) The insurer misdirects itself in law, that is to say, it asks the wrong question;

(2) The insurer takes into account an irrelevant consideration or fails to take into account a relevant consideration; or

(3) The insurer otherwise does not act fairly, in good faith and reasonably in forming an opinion as to the plaintiff's disability. (TAL Life Ltd v Shuetrim [2016] NSWCA 68 at [61], [66]; Wyllie v National Mutual Life Association of Australasia Ltd (1997) 217 ALR 324 at 339-341).

The Insurer's reasons for rejecting Mr Jones' claim (which were unchallenged on appeal) were stated to be:

(1) Mr Jones' physical restrictions did not preclude him from engaging in Regular Remunerative Work as a hardware retail salesperson, as a courier/delivery driver, as a console operator, and as a customer service adviser/telemarketer ("the suggested occupations");

(2) these were entry level positions, so that no retraining was required;

(3) employment in those occupations was available in Townsville; and

(4) given that he was relatively young, it could not be said that he was unlikely ever to be able to engage in work in one or more of those occupations

In determining that the Insurer's decision had miscarried, the Court concluded that:

> ... the insurer's reasons reveal a failure to take into account the impact of the plaintiff's fear-avoidance syndrome, and his competitive disadvantages, and thus to take into account significant components of the plaintiff's incapacity and properly and fairly to assess whether he was likely to be able to engage in the suggested occupations (at [69]);

[and]

> ... the insurer erred in law in its application of the ETE clause, in treating jobs for which no further training was required, although unrelated to Mr Jones' education, training or experience as jobs for which he was fitted by education, training or experience. The insurer should first have identified the occupation(s) for which Mr Jones' education, training or experience fitted him, of which in reality there was but one – that of manual labour, in which the insurer accepted that he was never likely to engage (at [79]).

The above three findings were all challenged by the Insurer on appeal.

Second Stage Inquiry

Once his Honour was satisfied that the Court could substitute its own decision for that of the Insurer (see TAL Life Ltd v Shuetrim; Metlife Insurance Ltd v Shuetrim (2016) 91 NSWLR 439; [2016] NSWCA 68 at [168]-[188] (Leeming JA, Beazley P and Emmett AJA agreeing)), his Honour determined that Mr Jones satisfied both limbs of the definition of Total and Permanent Disablement.

The first limb – unable to follow usual occupation for six months

In relation to the first limb of the definition of TPD ("unable to follow their usual occupation by reason of accident or illness for six consecutive months"), the court found that the claimant was on any view unable to follow his usual occupation of roof plumber for a period of six months from 10 October 2011. It did not matter that his employer had ceased to trade (at [89]-[90]).

This finding was not challenged on appeal.

The second limb

In relation to the second limb, the court relevantly held that:

- the claimant was fitted by his education, training and employment for work as a labourer, and for no other employment. As at April 2012 (being the end of the six month qualifying period), he was not able, and never likely to become able, to perform the duties of a labourer (at [97]);
- with the possible exception of courier/delivery driver, all the suggested occupations involved customer contact and service. The claimant's education, training and experience revealed no experience in or aptitude for customer service and had not prepared or fitted him for customer service positions (at [78] and [100]);
- As for work as a courier or delivery driver, even if it could be said that, as he had a driving licence and could carry light goods, his education, training and experience fitted him for such work, he was unlikely ever to be able to engage in regular remunerative work as a courier or delivery driver given that such work would involve getting into and out of a vehicle, lifting and carrying parcels, and walking up and down stairs which his medical restrictions excluded; and his fear-avoidance syndrome provided a real, if psychological, obstacle to his undertaking such employment (at [103] – [104]).

Each of these findings was challenged on appeal.

DECISION ON APPEAL IN HANNOVER LIFE RE OF AUSTRALASIA LTD V JONES [2017] NSWCA 233

The appeal before the Court covered two substantive issues for consideration:

- whether the primary judge erred in finding that the insurer breached its contractual obligation to act reasonably in forming its "opinion" that Mr Jones is not incapacitated within the meaning of the definition of Total and Permanent Disablement. This ground concerned:
    - the task of the court when reviewing the decision of the insurer; and
    - whether the Court erred in its construction of the ETE clause (grounds 4, 5 and 6 on appeal); and
- whether the primary judge erred in his determination that Mr Jones satisfied the policy definition of Total and Permanent Disablement (grounds 3, 4, 7 and 8).

RELEVANT DEFINITIONS UNDER THE POLICY

TPD was defined in the insurance policy in the following terms (emphasis added):

> What is Total and Permanent Disablement?
>
> 1.3 Total and Permanent Disablement in respect of an Insured Person who was gainfully employed within the six months prior to the Date of Disablement is where:
>
> 1.3.1 the Insured Person is unable to follow their usual occupation by reason of accident or illness for six consecutive months and in our opinion, after consideration of medical evidence satisfactory to us, is unlikely ever to be able to engage in any Regular Remunerative Work for which the Insured Person is reasonably fitted by education, training or experience; or ...

The Policy contained the following definitions of "Date of Disablement" and "Regular Remuneration Work" [sic]:

> Date of Disablement
>
> Total Permanent Disablement is treated as having occurred on the Date of Disablement which is the earlier of:
>
> (a) the date on which the six (6) months consecutive inability to work that results in Total and Permanent Disablement began; or ...
>
> Regular Remuneration Work
>
> An Insured Person is engaged in regular remunerative work if they are doing work in any employment, business or occupation. They must be doing it for reward – or the hope of reward – of any type.

The definition of TPD in the policy also determined the meaning of TPD in the trust deed of the fund.

WHETHER THE INSURER BREACHED THE POLICY

The task of the Court in reviewing the decision of the insurer

In relation to the first two grounds of appeal, the Court turned its mind to three questions (at [81]):

- Did the trial judge mis-state the relevant principles concerning an insurer's obligation to a claimant?
- What criterion or standard of review should be adopted by the court when determining whether an insurer has breached its obligation to act reasonably?
- Third, did his Honour (incorrectly) undertake a review of the merits of the Insurer's decision?

First, the Court held (at [82] to [85]) that the trial judge had not mis-stated the relevant principles. In particular in relation to the statement made by his Honour at [55(3)] of his reasons (see above), the Court said that:

> Second, there is no error in his Honour's statement in [55(3)] of his reasons. That statement is consistent with well-established authority: see Edwards at 77,536; Hannover Life Re v Sayseng at [36]; Hannover Life Re v Colella at [73]; and TAL Life Ltd v Shuetrim at [61]. The complaint by the Insurer that his Honour's reasons did not go far enough to explicate what that proposition meant in the context of the present case is unfair when the Insurer did not direct submissions at trial as to the criterion or standard of review by the court of an insurer's decision.

Secondly, in relation to the standard of review to be applied the Court considered whether the assessment of the reasonableness of the Insurer's "opinion" should be undertaken in the Wednesbury sense or as a review of the merits of the insurer's decision or by some other standard.

The Court characterised the "merits review" argument as being "tantamount to saying that the implied reasonableness term in insurance contracts such as the policy, involves a duty to form a fair and reasonable opinion, or even a duty to form a correct opinion" (at [89]). That submission was rejected by the Full Court.

Rather, the Full Court considered authorities that followed the decision in Edwards as being inconsistent with a merits review and endorsed the criterion of reasonableness stated in Hannover Life Re v Colella namely that the decision of the insurer "was not one open to an insurer acting reasonably and fairly in the consideration of the respondent's claim".

Furthermore, the Court rejected the notion that there was some special rule for the standard of review in relation to insurance cases. At [99] it said:

> The task for the court is not to assess what it thinks is reasonable and thereby conclude that any other view displays error. That would be contrary to the decisions of three intermediate appellate courts: Hannover Life Re v Sayseng at [36], and TAL Life Ltd v Shuetrim at [175] and [188] in New South Wales; Beverley v Tyndall Life Insurance at [36] in Western Australia; and Hannover Life Re v Colella at [73] in Victoria.

In relation to the concept of Wednesbury unreasonableness the insurer contended that there were authorities involving contractual disputes where the court has assessed the contracting party's obligation to act reasonably by analogy to unreasonableness in a Wednesbury sense (as that test is understood for judicial review of administration discretion). Briefly, the Court formed the view that:

- a reasonableness term is implied in contracts of insurance where the formation of the insurer's opinion is a condition of its liability, because it is necessary to do so for the reasonable and effective operation of the contract. That is implied as a matter of fact based on the presumed intention of the parties (at [115]). The Court went on to say at [116]:

  > While courts are conscious of not exceeding their supervisory role in cases of judicial review (Li at [66]), just as they are conscious of not exceeding their reviewing function in cases involving reasonableness terms in contractual disputes (see [89] - [99] above), it does not follow that the considerations that mandate the assessment of "unreasonableness" in the Wednesbury sense in judicial review cases equally apply in contractual disputes involving reasonableness terms.

- there are fundamental differences between the factual circumstances in which judicial review cases (which apply the Wednesbury standard) arise that provide a sound basis for distinguishing that standard from that required in the present case (see the discussion at [117] to [120]).

The Court concluded (at [121]) by stating that:

> As I have said, the task for the court in the present case is not to assess what it thinks is reasonable and thereby conclude that any other view displays error. It may also be accepted that there can be a range of opinions available to an insurer acting reasonably and fairly on the material before it. However, the suggested analogy with judicial review is not so close as to require the adoption of the stringent test of unreasonableness in the Wednesbury sense. Rather, the criterion of reasonableness of an insurer's decision is whether the opinion formed by the insurer was not open to an insurer acting reasonably and fairly in the consideration of the claim.

Thirdly, on the question of a merits review the Court held that (at [122]):

> Contrary to the Insurer's submissions, I do not read his Honour's reasons as undertaking a review of the merits of the Insurer's decisions. His Honour did not assess the reasonableness of the Insurer's opinion by reference to entirely objective criteria. It seems to me that his Honour's approach was consistent with the criterion of reasonableness identified at [121] above. That this is how his Honour approached the matter can be seen from the way in which he addressed the material that was before the Insurer concerning Mr Jones' psychological makeup.

In particular the Full Court considered his Honour's approach to the evidence concerning Mr Jones' psychological makeup (at [123] to [133]) and held that:

> Contrary to the Insurer's submissions, his Honour did not disregard that there may be a range of opinions open generally to an insurer acting reasonably on the material then before it. Nor did his Honour assess the reasonableness of the Insurer's decisions by reference to the only reasonable conclusion available to an insurer acting reasonably. Here the Insurer failed to take into account a significant component of Mr Jones' incapacity. That failure by the Insurer was a failure to take into account a relevant consideration. Plainly, the failure by the Insurer to take into account a relevant consideration was a failure to act reasonably and fairly in undertaking the task of forming the opinion as to Mr Jones' disablement because an insurer acting reasonably and fairly on the material before it would not have omitted to take that matter into account. There was no error in his Honour's finding that the Insurer had breached its obligation to act reasonably in forming its opinion as to Mr Jones' disablement.

Did the primary judge err in the construction of the ETE clause of the policy?

On appeal the insurer challenged the finding of the primary judge that the sentence emphasised in the passage below disclosed error because the construction read the ETE clause as though it was limited to unfitness for a person's "usual occupation" and overlooked the import of the phrase "any employment, business or occupation" in the definition of Regular Remuneration Work. The relevant passage of the primary judge's reasons stated:

[71] .... It is not necessary, in order to satisfy the TPD definition, that the insured must be incapable of any regular remunerative work, but only that he or she be incapable of regular remunerative work for which he or she is reasonably fitted by education, training or experience. The ETE clause confines the scope of the "regular remunerative work" from which the insured is disabled to that for which the insured is reasonably fitted by education, training or experience. In that phrase, the word "by" is important – it postulates a connection between the suggested future work, and the insured's past education, training and experience. The concept of an occupation or work "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. It refers not to any work for which the insured might have physical and mental capacity without further training, but to work for which the insured has been prepared and shaped by education, training and/or experience. The purpose of the provision is to provide a benefit for those who are disabled from following the vocations for which their past education, training and experience has prepared them – not any occupation which may be conceived, however far removed from his or her vocational history, which can be performed without further education, training or experience. The policy insures the capacity of an insured to perform regular remunerative work, not simpliciter, but in an occupation for which the insured's education, training and experience has prepared him or her. **In that way, it insures against loss of the ability to pursue those employments or careers for which the insured has been prepared and shaped by his or her past vocational history.** The point is illustrated by the reverse of the current type of situation: a surgeon whose tertiary education was in medicine and whose entire vocational history was in surgery, who lost the fine motor skills required for surgery, but was otherwise physically fit, would not be reasonably fitted by education, training or experience for work as a manual labourer, even though he or she might be perfectly capable of performing it without further training.

The Full Court disagreed finding that the reference to "prepared and shaped" must be read in the context of the whole passage. At [148] the Full Court held that:

> His Honour is to be taken as emphasising that the concept of an occupation or work "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, that is, to the link or connection between the suggested job or jobs and the claimant's past education, training or experience.

Accordingly, the Court found that the ETE clause requires the Insurer to examine the occupations for which the claimant is "fitted" in the sense of the occupations for which his education, training and experience has prepared him (at [150]).

THE RESULT

In relation to each of the issues before the Court, it concluded that:

- in relation to the question of whether the primary judge erred in his approach to the task of the Court in reviewing the Insurer's opinion that Mr Jones was not Totally and Permanently Disabled:
    - The relevant inquiry for the Court is neither a "merits review" of the Insurer's decision based on entirely objective criteria (as Mr Jones submitted), nor is it an inquiry into whether the Insurer's decision is unreasonable in the Wednesbury sense, that is, so unreasonable that no reasonable insurer could have so decided (as the Insurer submitted).
    - Rather, the relevant inquiry is whether the opinion formed by the insurer was not open to the insurer acting reasonably and fairly in considering and determining the claim. Edwards v The Hunter Valley Co-Op Dairy Co Ltd (1992) 7 ANZ Ins Cas 61-113 and Hannover Life Re of Australasia v Sayseng (2005) 13 ANZ Ins Cas 90-123; [2005] NSWCA 214 applied; Braganza v BP Shipping Ltd [2015]4 All ER 639 and Bartlett v ANZ Banking Group Ltd (2016) 92 NSWLR 639; [2016] NSWCA 30 referred to.
    - Per Macfarlan JA, the concept of legal reasonableness is not amenable to minute and rigidly defined categorisation, and application of the two different formulations referred to above, that is, unreasonableness in the Wednesbury sense and determination of whether the opinion formed was open to an insurer acting reasonably and fairly, would lead to different results in few, if any, cases.
    - The primary judge did not undertake a review on the merits of the Insurer's decision and there was no error in his Honour's conclusion that the Insurer had failed to take into account Mr Jones' psychological make-up in forming its opinion.
- there was no error on the part of the primary judge in his construction of the ETE clause;
- there was no error in the primary judge's conclusion that the only work for which Mr Jones was reasonably fitted was manual labour;
- his Honour did not err in dealing with the medical evidence before him, or fail to take account of the possibility that Mr Jones' condition would improve with further treatment.

THE RESULT

The Court ordered that the appeal be dismissed and that insurer pay the costs of the member.

7. TPD claim –NSW whether the insurer validly rejected the member's claim; whether the insurer breached its duty of utmost good faith; whether the insurer constructively denied the member's claim – Hellessey v MetLife Insurance Limited [2017] NSWSC 1284

The NSW Supreme Court has delivered a judgment against a superannuation group life insurer determining that the insurer's rejection of the member's claim for a Total and Permanent Disablement benefit was not valid and effective and that the member had established that, at the assessment date, she was incapacitated by her psychological injury in a manner that satisfied the TPD definition in the policies. The case is Hellessey v MetLife Insurance Limited [2017] NSWSC 1284.

BACKGROUND

Ms Hellessey was formerly a member of the New South Wales Police Force. Ms Hellessey retired from the police force by reason of her suffering Post Traumatic Stress Disorder (**PTSD**) and Major Depressive Disorder as a result of events that occurred in the course of her duties as a police officer. The member ceased all work on 30 August 2010.

The member was, by reason of her membership in the NSW Police Force entitled to a benefit if by reason of illness or injury she satisfied the definition of Total and Permanent Disablement (**TPD**) under separate policies of insurance with MetLife known as the "Blue Ribbon" and "MetLife Insurance" policies respectively.

The member's experiences whilst she was a member of the police force were largely uncontested.

Briefly, the member had been a member of the Police Force since 4 May 2001. During the course of her employment with the police force she attended numerous traumatic incidents including fatal motor vehicle accidents, cases of death and abuse of children, murders, suicides, violent crime scenes and assaults, drug and alcohol abuse, aggressive behaviour from criminals, and other traumatic incidents.

Particular traumatic events included attending at the scene of a car accident in which her highway patrol partner was killed on duty in 13 April 2002 and then a few weeks later having to protect the unlicensed, drink driver who killed her partner from the media when he was attending court.

The most notable incident occurred on 16 November 2004 when the member, whilst sitting at her desk at the police station was approached by a colleague, a Senior Constable, who came up behind her and removed her service pistol from its holster, proceeded to waive the gun around in the air and then pointed it at her. The police officer removed the magazine from the gun and gradually emptied the magazine by throwing bullets at her. The member was fearful that the gun was going to be discharged and thought she was going to die.

The member claimed that her psychological symptoms started after the November 2004 incident.

Following that incident, Ms Hellessey continued to attend numerous traumatic incidents in the course of her duty as a police officer. On 6 December 2004, Ms Hellessey was diagnosed with anxiety and conversion reaction and certified unfit to work from 30 November 2004 to 13 December 2004 .

Ms Hellessey was certified as fit for normal duties from 11 January 2005 and was transferred to Hay to get away from the police officer who had threatened her in 2004. She was on full duties between July 2005 and January 2008.

In January 2008, she was assaulted by a drug affected man and subsequently placed on restricted duties.

In July 2006, Ms Hellessey gave evidence at the criminal trial of the police officer who had threatened her; an experience which she found horrific.

On 7 February 2008, Ms Hellessey returned to work at the Hay police station after returning from maternity leave. She attended an incident where the man she attended on (who was known to her) threatened her life and the life of her children. The following day the member had a panic attack and was taken to hospital. She was placed on restricted duties permanently and placed under medical treatment.

Between October 2008 and 31 August 2010, Ms Hellessey worked at the Goulburn Academy on permanent restricted duties in a clerical type role investigating matters within the police college. She was subject ot psychological treatment during this time.

On 31 August 2010 she thought she saw the officer who had threatened her sitting at her desk. She suffered a subsequent panic attack and was put off work by her general practitioner. She has not returned to work since.

In January 2012 the Trustee made a claim for TPD benefits on behalf of the member to MetLife.

On 17 April 2014, MetLife sent the member its first procedural fairness letter.

The first declination

On 21 July 2014 the member's solicitors responded to the first procedural fairness letter, relying upon a number of medical reports of the member's treating practitioners.

On 4 September 2014 a claims assessor of MetLife sent an email summarising the contents of the various medical reports that had been provided and concluded that:

> Based on the above medical evidence there is a strong support for TPD.
>
> The TPD medical evidence on file outweighs the Non TPD.
>
> ...
>
> I feel if the case was to go to court it would rule in favour of TPD claim as Dr Durrell is the main treater who has known the patient from date of injury.
>
> Dr Durrell strongly supports TPD.

By letter to the Trustee dated 22 December 2014 MetLife declined the member's claim. The basis for MetLife's declination was that the member was active in her activities of daily living and was able to actively attend social events (mostly related to horse activities) which was contrary to that reported to the treating doctors. Notably the letter contained a list of evidence relevant to the first decision, which did not include 6 medical reports from Dr Durrell, the members treating psychiatrist since 2010. The letter also did not summarise any aspect of Dr Durrell's reports.

The only reference to Dr Durrell's reports were made in the context of stating the member's submissions that:

Dr Durrell, the Member's treating psychiatrist, is supportive of the Member's claim and has provided numerous reports, all of which state the Member cannot return to work within her education, training and education (sic).

MetLife's response to Dr Durrell's reports was as follows:

Having reviewed the available evidence, MetLife has determined that the prevailing medical opinion is that the Member will likely return to employment. The only contrary view to this is Dr Durrell whose opinion as at the assessment date is that the Member was unlikely to return to employment.

MetLife concluded:

> Having considered the above medical opinions, vocational assessment, the surveillance, and the Facebook posts and status updates, MetLife considers that the Member is active in her activities of daily living and is able to actively attend social events contrary to that reported to the treating doctors.
>
> For the reasons set out variously above, MetLife does not consider that the Member has discharged the burden of demonstrating that she meets the policy definitions of Total and Permanent Disablement in either the Basic Cover policy or of the Police Blue Ribbon policy. Accordingly, MetLife declines payment of benefit for this claim.

Reconsideration of first declination

On 24 February 2015 the Trustee asked MetLife to reconsider its first declination. In so doing the Trustee noted in particular the alternative medical opinion expressed by Dr Durrell. MetLife agreed to do so but commented that:

> MetLife notes your concerns regarding the alternative medical opinions which have been expressed, particularly by Dr Durrell, treating psychiatrist. MetLife confirms that it has considered Dr Durrell's report of 16 February 2013. The extent to which Dr Durrell's report of 16 February 2013, and his later reports which MetLife has also considered, informs upon the Member's prognosis at and around the date for assessment is questionable. In this respect, MetLife notes that in his 3 December 2010 report, although Dr Durrell said he was not prepared to put a timeframe on when the Member may return to work, he believed at that point in time that a "return to work within her premorbid [pre-injury] role is possible...

> In any event, in view of the issues you have raised on behalf of the Fund, and in accordance with your request, MetLife agrees to conduct in good faith a detailed review of its determination. As part of that review, MetLife may conduct some further enquiries with a view to obtaining further evidence which is contemporaneous with the assessment date.
>
> We will revert to you again once our detailed review is complete and aim to finalise our review within 35 days

Additional evidence was obtained by MetLife including copies of the member's medical discharge file, workers compensation file and a supplementary report of Dr Bertucen. Notably, in obtaining a further medical report from Dr Bertucen MetLife did not ask Dr Bertucen to express an opinion as to whether having regard to the evidence available up to 17 August 2015, Ms Hellessey's incapacity as at the assessment date was in fact such as to satisfy the TPD definition. Rather, it asked whether at or around the assessment date "it would have been reasonable to conclude that the member" satisfied the TPD definition.

On 18 August 2015 proceedings were commenced by the member in the NSW Supreme Court.

On 10 September 2015 MetLife sent the member its second procedural fairness letter.

The second declination

On 19 October 2015 MetLife declined the claim for a second time as follows:

> Based on our review and assessment of all of the material including the material listed in the Information Summary enclosed with our letter dated 10 September 2015 and the letter from the member's solicitors dated 21 July 2014, MetLife has concluded that the medical and other evidence, particularly the evidence around the date for assessment of the member's claim (on or around 1 March 2011), does not support a view that the member satisfies the relevant TPD definitions.
>
> The most contemporaneous medical opinion to the date for assessment was expressed by the member's treating GP (Dr Paul Falk) in a questionnaire dated 10 March 2011. Dr Falk was asked specifically whether the member was fit for work external to the New South Wales Police Force (NSWPF). Dr Falk expressed his belief that the member was fit for such work.
>
> A short time later, the member's treating psychologist (Mr Rodney Ward), provided a medical report dated 18 May 2011 setting out his opinion regarding her condition and prognosis. As Dr Falk had done, Mr Ward supported the member's application for medical discharge from the NSWPF. That being said, Mr Ward said he was supportive of the member participating in a vocational assessment and that she may be fit for work external to the NSWPF as long as such work was 'far removed' from policing.
>
> A similar opinion was expressed by Dr Jeff Bertucen, consultant psychiatrist, who assessed the member on behalf of the NSWPF on 30 August 2011. Dr Bertucen believed that the member's condition may recover to a point where she would be fit to work external to the NSWPF in a position which was unrelated to police work. Dr Bertucen offered a time frame of between six to twelve months after the member's medical discharge from the NSWPF as to when such a recovery may occur.
>
> Leading up to the member's medical discharge on 8 December 2011, Mr Ward said he had begun to notice an improvement in the member's 'base line anxiety' in a report dated 4 October 2011. Following her medical discharge, Dr Falk reported in January 2012 that the member's long term goal should be a return to suitable work external to the NSWPF.
>
> MetLife notes that prior to joining the NSWPF, the member gained various education, training and experience in vocations which are 'far removed' from policing. [The letter then discusses this employment, together with the results of the vocational assessment report].
>
> As he had independently assessed the member relatively close to the date of assessment, MetLife asked Dr Bertucen to review the vocational options identified above and the vocational assessment report, along with the other medical evidence relating to the member's claim, and to provide his opinion as to the likelihood of the member being able to return to work in each of the positions, at or around the date of assessment. In his supplementary report dated 17 August 2015, Dr Bertucen concluded, based on his initial assessment of the member in August 2011, it was likely she could have engaged in each of the vocational options identified on either a part-time or full-time basis at some point prior to the member reaching retirement age.
>
> Further to the above, MetLife notes that the member was 34 years old at the date for assessment and, therefore, had a further 31 years (at that time) prior to reaching retirement age in order for her to regain a capacity for suitable employment.
>
> In addition to the opinions expressed above, the member was independently assessed on behalf of MetLife by Dr Barbara Hodgson, consultant psychiatrist, on 10 September 2012. In her report dated 20 September 2012, Dr Hodgson believed that, although the member would be considered unfit for work at the time of her assessment, with time and ongoing support from her treating

> practitioners, the member may be fit to return to work within her education, training and experience prior to reaching retirement age. Dr Hodgson reiterated her opinion in a supplementary report dated 3 May 2013.
>
> Finally, MetLife notes that the member's treating psychiatrist, Dr Durrell, has consistently been of the opinion that she will not return to work in any capacity at any point in the future. MetLife has considered Dr Durrell's opinion and the reports which he has provided. MetLife does not accept Dr Durrell's opinion, noting its inconsistency with the views offered by not only the member's other treating practitioners (Dr Falk and Mr Ward) but also the other independent specialists who have assessed the member including Dr Bertucen and Dr Hodgson.

On 18 December 2015, the Trustee wrote to Ms Hellessey's solicitors to inform them that the Trustee did not agree with MetLife's decision and that it would refer the matter to the Claims Review Committee. The referral to the Claims Review Committee was adjourned by agreement pending the outcome of the subsequent review of MetLife's declination.

On 18 December 2015, the member's solicitors provided a report of Dr Westmore, a forensic psychiatrist, dated 9 December 2015 and sought a further review of MetLife's declination. Dr Westmore concluded that:

> On the balance of probability, I do believe that Ms Hellessey was, on 28 February 2011, being six months after she ceased work, unlikely ever to engage in any gainful profession, trade or occupation for which she is reasonably qualified by reason of education, training and experience. That situation is unlikely ever to alter in my view, regardless of her previous education, training and experience. She is socially isolated and withdrawn, depressed in mood, irritable and intolerant. Her capacity to deal with clients, co-workers and supervisors would all be significantly impaired because of her psychiatric illnesses and the associated symptoms. Even if she could obtain employment, her ability to maintain employment is virtually non-existent in my view and she certainly could net obtain employment on the open market, regardless of what "transferable skills" may have been identified from her past work history.

MetLife agreed to review the claim and on 11 May 2016 MetLife sent the member's solicitors a third procedural fairness letter to advise Ms Hellessey of the information available to MetLife, and some preliminary considerations that were available, and to give her an opportunity to respond, before MetLife made its third determination of the claim.

The third procedural fairness letter largely repeated the contents of the second procedural fairness letter as well as further consideration of the factual circumstances surrounding the member's social interactions. MetLife formed the view (without seeking any further expert medical opinion) that:

> The level of activity is inconsistent with someone who was experiencing a "high level of social phobia", "avoidance" and "isolation" as Dr Durrell had recorded in June 2011.

MetLife concluded that the medical evidence created at about the assessment date and the other evidence referred to did not provide proof to its satisfaction that Ms Hellessey was unlikely ever to return to any work in the future within her education, training or experience.

In response to Dr Westmore's report MetLife concluded that

> Further it appears that Dr Westmore failed to record, or you failed to report to him, activities which MetLife considers were relevant to considering your functioning around the Date for Assessment and also subsequently. These include, most notably, your participation in the 2011 Royal Easter Show and your subsequent role as secretary with the Association. If you did disclose these matters to Dr Westmore and Dr Westmore did not consider them to be relevant to his opinion, this ought to have been explained in his report. If you did provide Dr Westmore with a history regarding the matters identified above, please advise us accordingly.
>
> Importantly Dr Westmore examined you on 19 November 2015, that is, over four years after the Date for Assessment. This being the case, and especially in the circumstances where it appears Dr Westmore was not provided with significant medical evidence from your treating practitioners MetLife cannot give any significant weight to his retrospective prognosis.

was treated as a declination of the claim for the purposes of commencing proceedings in the NSW Supreme Court.

On 31 October 2016 MetLife wrote a fourth procedural fairness letter. On 30 November 2016 MetLife declined the member's claim for the third time. The third declination was two business days before the commencement of the hearing in the NSW Supreme Court. By reason of the timing of the third declination (and the fact that the parties had agreed to waive the implied undertaking in Hearne v Street (2008) 235 CLR 125; [2008] HCA 36) in order for MetLife to undertake the final review of the member's claim and to reject the member's claim it had to give consideration to all of the evidence and information it received during the course the Supreme Court proceedings.

Relevantly, the ultimate basis upon which MetLife treated the medical experts for the purposes of declining the member's claim was as follows:

MetLife acknowledges that Dr Durrell, Dr Westmore and Mr Rawling have reached a different view and those opinions have not been disregarded by MetLife. MetLife has however identified its concerns about the weight to be given to those opinions. This is because MetLife considers the practitioners have not been provided with full or accurate accounts of the extent of the member's activities.

In so doing, MetLife dismissed the evidence of the member's lay witnesses and discounted the evidence of the medical experts in support of the member's claim.

THE COURT'S DECISION

Definition of TPD under the policies

The definition of TPD as found in clause 6 of the First Schedule to the Blue Ribbon policy was set out at [8] of the Court's reasons as follows:

> TOTAL AND PERMANENT DISABLEMENT:
>
> While covered under this Policy Total and Permanent Disablement shall mean:
>
> (a) The Insured Member suffering the loss of use of two limbs or the sight of both eyes or the loss of use of one limb and the sight of one eye (where limb is defined as the whole hand or the whole foot), or
>
> (b) In the case of an Insured Member whose Normal Hours are 15 hours each week or more at the time of the Insured Event giving rise to the claim:
>
> 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.
>
> (c) In the case of an Insured Member whose Normal Hours are less than 15 hours each week at the time of the Insured Event giving rise to the claim:
>
> The Insured Member, because of injury or illness becomes permanently unable to perform the basic activities normally undertaken as part of everyday life. This will be evidenced by being unable to undertake any two of the activities listed below:
>
> (i) Bathing - to shower or bathe
>
> (ii) Dressing - to dress or undress
>
> (iii) Toileting - to use the toilet including getting on and off
>
> (iv) Feeding - to eat & drink
>
> (v) Mobility - to get in or out of their wheelchair
>
> (vi) Continence - to control bladder and bowel function
>
> If the Insured Member can perform the activity on their own by using special equipment the Insured Member will not be considered unable to perform the activity.
>
> As stated above, the MetLife Insurance policy definition of TPD was identical (save for an additional provision not material to this case).

PRIMARY ISSUES IN DISPUTE

By reason of the lengthy decision-making process and complex pleadings in this case the Court summarised the primary issues between the parties as follows:

- Was it open to the member to claim that MetLife constructively rejected her claim before she filed her statement of claim on 18 August 2015, and if it is, did a constructive rejection occur so that Ms Hellessey's entitlement to the TPD benefits may be decided by the court?
- Did the circumstances in which the member requested and MetLife agreed to review its determinations that led to the first rejection and the second rejection have the effect that the only rejection that is operative is the third rejection?
- If not, was either of the first rejection or the second rejection invalid?
- In particular, was the first rejection invalid because MetLife rejected the claim after it decided that it was probable that a court would find that the member was entitled to the TPD benefits?
- Did MetLife constructively reject the member's claim in the circumstances where, having agreed to review the second rejection, it did not make the third rejection until 30 November 2016?
- If MetLife was not precluded from determining the member's claim a third time, was the third rejection invalid?
- If MetLife's determination of the member's claim was invalid by reason of any or all of the rejections being invalid, is the member entitled to be paid the TPD benefits that she has claimed?

THE COURT'S REASONS

Preliminary question of construction of the TPD definition

MetLife argued that on a proper construction of the definition of TPD under the policies, the meaning of sub-paragraph (b) of the definition should be influenced by the terms of the other paragraphs of the definition. Briefly, MetLife contended that paragraph (b) would only be satisfied in the most serious of cases drawing a comparison between the serious of the injuries and illnesses described in different paragraphs of the TPD definition (at [81] – [82]).

The Court rejected this argument. It held (at [85] – [86]) that:

> ... the three or four paragraphs of the TPD definition (as the case may be in the different policies) are not drafted in a manner that suggests that they were intended to form a genus, and the separate paragraphs do not contain general words that may be read down so that their effect is consistent with the other paragraphs. Each paragraph is a separate description of a risk covered by the policy. Far from treating the separate paragraphs as forming a genus, it is more likely that the TPD definition has evolved over a period of time by the accretion of essentially different risks.
>
> The result is that each paragraph should be construed according to its own terms by applying the received principles of contractual construction.

Notably, the Court expressed concern that the submission had been made by MetLife at all. It was considered that the making of the submissions suggested that MetLife may have acted on the basis of this construction when assessing the member's claim. Such an approach would amount to MetLife asking itself the wrong question in the course of determining whether it should be satisfied that the TPD definition was established. Ultimately, the Court did not have to determine the point (see [81] – [94] of the reasons).

Findings in relation to the first declination

In relation to the first declination the Court held that:

- (at [318], [319]) it was not reasonable for MetLife to reach its own conclusion that the member was active in her activities of daily living. The evidence relied upon by MetLife in the form of surveillance reports and Facebook posts did not justify MetLife's conclusion because it ignored the opinions of medical experts who had assessed and explained the therapeutic basis behind the member's social interations (see paragraph [318] of the reasons referring to paragraphs [194], [197], [198], [202], [205], [217], [227], [228], [231] – [233]). To the extent that the medical evidence supported MetLife's conclusion it was on the basis that the member should be reassessed – which MetLife elected not to do.
- (at [320]) in forming its conclusion MetLife had only had regard to the member's current activities. It had not formed conclusions about her possible capacities in the future.
- (at [321]) the conclusion formed by MetLife that the member's activities were "contrary to that reported to the treating doctors" was false. MetLife had ignored the direct responses given by Mr Ward and Dr Durrell in relation to the member's horse-related activities and Facebook posts. This lead the Court to the conclusion that:

This is a significant finding, because in the absence of any explanation from MetLife, it justifies a conclusion that MetLife had acted upon a false belief, which it had formed internally on the basis of its own understanding of the Facebook posts and the surveillance report, contrary to the weight of the available evidence, that Ms Hellessey had made a false claim based upon her current circumstances.

- (at 325) the basis upon which MetLife rejected Ms Hellessey's claim was unreasonable because MetLife acted upon the vocational assessment report without obtaining any medical opinion that Ms Hellessey's psychological injury was consistent with her being able to engage in the forms of employment identified in the future.

Findings in relation to the second declination

In relation to the second declination the Court held that:

- (at [372]) MetLife's declination was "infected by its continuing belief ... that is the medical evidence that was produced broadly contemporaneously with the assessment date that is the most probative of the issue as to whether Ms Hellessey satisfied the TPD definition"
- (at [373]) MetLife was "not alive to the possibility that longitudinal experience of Ms Hellessey's psychological injuries and her symptoms might provide the more sound evidence as to what the likely consequences of her incapacity in fact were as at the assessment date"
- (at [374]) MetLife continued to devalue the significance of Dr Durrell's series of reasoned reports but did not require any medical experts who expressed contrary views to explain why he was wrong, and how it was likely to occur given the persistent requirement for medication from which Ms Hellessey suffered that she would actually recover sufficiently so that she would be able to gain and undertake relevant employment.
- each of the reports relied upon by MetLife was not reasons and was a "bare statement of optimism concerning Ms Hellessey's prognosis".
- the questions that MetLife posed to Dr Bertucen, who provided the only additional report

- relied upon by MetLife, misstated the test required for satisfaction of the TPD definition. In acting upon Dr Bertucen's report, MetLife in principle determined the wrong question.

Findings in relation to the third procedural fairness letter

In relation to the third procedural fairness letter the Court held that:

- it does not necessarily follow that a person suffering from PTSD and Major Depression could not engage in the activities described by MetLife in its letter, or that a person capable of engaging in these activities would in a real way be capable of obtaining and sustaining the relevant type of employment for the purposes of the TPD definition.
- (at 424) MetLife's letter contained bare assertions that were not supported by any reasoning and without the assistance of any expert medical evidence.
- (at [415]) MetLife was concerned with the member's prognosis at the date of assessment rather than whether she in fact suffered from an incapacity that rendered her unlikely ever to engage in any relevant employment.
- (at [420]) MetLife proceeded upon the wrong question concerning the evidence that was relevant to the question of whether the member satisfied the TPD definition as at the assessment date. It also decided that it should not "give any significant weight to [Dr Westmore's] retrospective prognosis" based upon "a seriously mistaken view as to the information of which Dr Westmore was aware when he prepared his report".

Alleged first constructive rejection

The Court held that it was no longer open to the member on the pleadings to claim that MetLife constructively rejected her claim before she filed her statement of claim on 18 August 2015. In any event, the Court held that the delay in making a determination in the first declination did not involve so serious a breach of MetLife's duty as to constituted a constructive rejection of the member's claim ([771], [780]). Some weight was given to expert medical evidence that recommended the member's claim be deferred for 12 months for further assessment.

Entitlement to contest the validity of the first and second declinations

In relation to the member's entitlement to contest the validity of the first and second declinations the Court held that:

- In circumstances where the Trustee sought a review of MetLife's decision and, on that basis MetLife went to the trouble and expense of issuing the second procedural fairness letter and making the determination that led to the second rejection MetLife's response was not unreasonable and neither the Trustee nor the member could in good faith ignore the second declination and attack the validity of the first declination.
- In relation to the second declination, the member not only requested MetLife to reconsider the second declination but invited MetLife to go to the trouble and expense of considering all of the material received during the course of the proceedings – including fresh evidence.

On this question of validity the Court observed that:

> In the present context, this principle is likely to have the effect that, where the Trustee or Ms Hellessey requests MetLife to review a determination to reject Ms Hellessey's claim, and MetLife agrees and is put to the expense and trouble of going through another process of determination, the Trustee and Ms Hellessey have by implication agreed to abandon any right they may have had to challenge the validity of the determination that is to be reviewed.

Whilst this may appear to have more wide-ranging impact in similar matters the Court did say that:

> Each case will depend upon its own facts, and the issue will be whether MetLife has conducted the review in a manner consistent with its duty of utmost good faith and fair dealing, and whether conversely it is a breach of the Trustee's duty of utmost good faith and fair dealing (perhaps exercised through Ms Hellessey as the Trustee's proxy) for the Trustee and Ms Hellessey to continue to challenge the determination that is reviewed.

Ultimately, the Court held that the member was not entitled to challenge the validity of the first and second declinations but that had she been entitled to do so his Honour would have held both of those rejections invalid.

Findings on MetLife's internal report that TPD was probable

At [810] the Court observed that:

> The court must allow that different officers within the decision-making process instituted by MetLife could take different views about the likelihood that Ms Hellessey's circumstances satisfied that TPD definition. Given the complexity of the issue, it would not be surprising that an individual officer charged with the duty to analyse part of the evidence available to MetLife might form a view that favoured Ms Hellessey satisfying the TPD definition. The formation of such a view internally within MetLife would not necessarily oblige MetLife

> to decide to accept the claim. MetLife could reasonably reject the conclusions reached by individual officers and determine a different outcome, without being in breach of its duty of utmost good faith and fair dealing, provided that overall it directed its mind to the correct questions in making its determination, and provided its process of reasoning was sufficiently reasonable to make the determination of a proper one.

Findings in relation to the third declination

As a preliminary observation the Court noted that because the parties had agreed to waive the implied undertaking in Hearne v Street (2008) 235 CLR 125; [2008] HCA 36 MetLife had to give proper consideration to the evidence and information received during the course of proceedings when determining whether the member satisfied the definition of TPD.

Accordingly, after considering all of the evidence given in the proceedings – including oral testimony from the member and expert medical witnesses – the Court considered whether MetLife's third declination was invalid.

In relation to MetLife's dismissal of the member's lay evidence, the Court found at [868]:

The course that MetLife took [in dismissing that evidence] was at its heart irrational, because having ignored Ms Hellessey's original, candid disclosure of her interest in horse-related activities, and having apparently formed a firm opinion that Ms Hellessey's activities, as disclosed by the accumulating evidence, were fundamentally inconsistent with her claim that she had social phobia, MetLife simply rejected the contrary sworn evidence of apparently credible, and in some degrees independent, witnesses, without having or expressing any rational or persuasive reasons for having done so.

In relation to MetLife's treatment of the member's independent expert medical witnesses the Court found at [890]:

> These observations serve to illustrate the extremity of the process of reasoning adopted by MetLife. It took the view that it was proper to essentially dismiss the medical reports that supported Ms Hellessey's claim, on the basis that the medical experts had not been given all of the information that MetLife had compiled by the time of the fourth procedural fairness letter. It did that without seeking any confirmation that any omissions of information were material to the opinions formed by the experts.

In relation to MetLife's treatment of the evidence, the Court held variously that:

- Dr Durrell was the only medical expert who was in a real position to express opinions concerning Ms Hellessey's need for medication into the indefinite future [891];
- MetLife gave undue weight to the medical opinions expressed at the assessment date which had the result that, "notwithstanding Dr Durrell's longitudinal experience and many reasoned reports, his was a minority opinion when counted against the greater number of preliminary medical opinions expressed at or around the assessment date" [894];
- It was unreasonable for MetLife to discount Dr Durrell's reports in the manner in which it did – one unreasonable consequence being that MetLife has never given any apparent consideration to the ongoing consequences of Ms Hellessey's medication regime [913];
- MetLife failed to ask the right question (in accordance with TAL v Shuetrim) when applying significance to the report of Dr Westmore who had examined the member over four years after the assessment date [918].
- it was a material flaw in the reasoning adopted by MetLife that it focused exclusively on the component of the symptoms of Ms Hellessey's PTSD and depression that was identified by her treating medical professionals as involving social phobia. In so doing, MetLife effectively ignored the other aspects of Ms Hellessey's disability which had been identified by the medical professionals and repeated in Ms Hellessey's solicitors' letter [926].
- For MetLife's determination to be reasonable, it was required to identify objectively all of the symptoms of, and disabilities caused by, Ms Hellessey's psychological injury has reported by Ms Hellessey and her medical experts, and take all of them into account in determining her capacity to engage in relevant employment [928].
- MetLife's rejection of the member's submission that the vocational assessment report was unreliable was " extremely unbalanced, and slanted to a degree that in [the Court's] view was far outside the ambit of MetLife's entitlement to make its own judgments provided that they were reasonable" [931].
- MetLife's reasoning process demonstrates that "MetLife decided that it, as a lay organisation, should decide for itself what relevant activities the member had engaged in both at and around the assessment date, and subsequently up to the time of the third rejection." [944]
- Whilst it was reasonable for MetLife to be suspicious about the veracity of the member's claims when it became aware of the full extent of her horse-related activities, her comments on Facebook and other evidence demonstrating activities she participated in the problem was that MetLife drew conclusions based upon that information and "consequently adopted a process of reasoning in rejecting Ms Hellessey's claim for

the third time, that was so unreasonable that the court must treat the rejection as invalid" [954]. In particular the Court found that:

- it was unreasonable of MetLife to evaluate Facebook posts in the same way as if they had been made by a person of ordinary psychological health [968];
- MetLife failed to provide the Facebook evidence to any independent medical expert;
- Given the warnings received by MetLife from the medical experts it was unsound and unreasonable for MetLife to rely upon its own lay judgment without obtaining expert medical confirmation.
- It was an unreasonable error to proceed on the basis that its lay interpretation of the Facebook evidence was correct and unassailable and on that basis reject the member's lay and medical evidence in its entirety [976].
- Dr Durrell was the only medical expert who was in a real position to express opinions concerning Ms Hellessey's need for medication into the indefinite future [891];

Accordingly, the Court held that the third declination was invalid.

Having regard to the evidence, his Honour determined that the member was at the assessment date incapacitated by her psychological injury in a manner that satisfied the TPD definition in the policies.

THE RESULT

The Court held that:

- The member had established on the evidence that, at the assessment date, she was incapacitated by her psychological injury in a manner that satisfied the TPD definition in the policies.
- The member was entitled to judgment for the amount of the benefits plus interest and costs.

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