SUPREME COURT OF QUEENSLAND

CITATION:	*Delaney v AAMI Insurance Ltd* [2007] QSC 174
PARTIES:	**DAVID MASSINGHAM as Litigation Guardian for SUSAN DELANEY** (applicant) **v** **AAMI INSURANCE LIMITED ACN 92 004 791 744** (respondent)
FILE NO:	BS4395 of 2007
DIVISION:	Trial Division
PROCEEDING:	Application
DELIVERED ON:	17 July 2007
DELIVERED AT:	Supreme Court, Brisbane
HEARING DATE:	26 June 2007
JUDGE:	Wilson J

ORDER:

1. Declare that in the circumstances of this case it would be reasonable and appropriate to make the following rehabilitation services available to the applicant –

(a) consultant neurologist: Dr Alison Reid or Dr Michael Walsh

(b) physiotherapist: Ms Jennie McCorkell

(c) speech pathologist: Ms Vicki Byatt

(d) occupational therapist: Ms Beth Dermer

(e) dietician: Ms Aloysa Houran

(f) case manager: a person nominated by CRS Australia other than Ms Karen Pery-Johnston

2. Order that the respondent pay the applicant's costs of and incidental to the application on the standard basis, fixed at $8,000.

CATCHWORDS: INSURANCE – THIRD-PARTY LIABILITY INSURANCE – MOTOR VEHICLES – COMPULSORY INSURANCE LEGISLATION – GENERALLY – QUEENSLAND – the applicant was seriously injured in a motor vehicle accident – the compulsory third party insurer of the motorcycle on which she had been a passenger agreed to fund reasonable

and appropriate rehabilitation but refused to admit liability – the solicitors for the applicant and respondent could not agree on the professionals to provide rehabilitation services – whether the applicant has the right to choose service providers – which service providers should be appointed by the Court

Motor Accident Insurance Act 1994 (Qld) s 51, 65
Motor Accident Insurance Regulation 2004 (Qld) sch 5

Re Walker (1995) 22 MVR 245, cited

COUNSEL: M Grant-Taylor SC and G J Cross for the applicant
R B Dickson for the respondent

SOLICITORS: Colin Patino & Company for the applicant
Jensen McConaghy for the respondent

[1] **Wilson J**: The applicant sustained serious brain injury and other injuries when the motorcycle on which she was a pillion passenger was involved in an accident on 16 June 2006. She has been in a persistent vegetative state ever since. The motorcycle driver was killed in the accident.

The application

[2] On 14 July 2006 a motor accident claim document was lodged on her behalf with the respondent, which was the compulsory third party insurer of the motorcycle. On 20 July 2006 the respondent wrote that it would "fund the cost of reasonable and appropriate rehabilitation".[1] It has refused to admit liability in full or in part.

[3] The respondent and those acting on behalf of the applicant agree that the applicant requires rehabilitation services provided by a neurologist, a dietician, an occupational therapist, a physiotherapist and a speech pathologist – but they do not agree upon the identities of the service providers or upon who should be the case manager.

[4] The applicant's solicitors twice suggested mediation to help resolve issues between the parties[2] (on 5 February 2007 and on 22 March 2007). On the first occasion they received no response, and on the second they were expressly rebuffed.

[5] To resolve this regrettable impasse, which has delayed the commencement of rehabilitation by almost a year, the applicant (by her litigation guardian) has brought this application pursuant to s 51(5)(b) of the *MAI Act* asking the Court to determine what rehabilitation services are reasonable and appropriate in the circumstances of the case –

> "… and, more particularly, a declaration or decision that it is both reasonable and appropriate, in terms of Standard C Criteria [sic] 3 of the *Rehabilitation Standards for CTP Insurers* published by the Motor Accident Insurance Commission in January 2007 pursuant to s 4 of the *Motor Accident Insurance Regulation 2004*, that the applicant be at liberty to exercise choice in the selection of certain

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1 *Motor Accident Insurance Act 1994* (Qld) (*MAI Act)* s 51(1).
2 *MAI Act* s 51(5)(d).

appropriately qualified and experienced rehabilitation providers, namely:

(a) Dr Don Todman, Consultant Neurologist;
(b) Ms Jennie McCorkell, Physiotherapist;
(c) Ms Heather-Anne Briker-Bell, Speech Pathologist;
(d) Ms Beth Dermer, Occupational Therapist;
(e) Ms Aloysa Houran, Dietician;
(f) Mr Stephen Hoey, Case Manager;
(g) Ms Debbie Anderson, Clinical Neuropsychologist."

[6] The objects of the *MAI Act* include the promotion and encouragement, as far as practicable, of rehabilitation of claimants who sustain personal injury because of motor vehicle accidents.[3] One of the functions of the Motor Accident Insurance Commission[4] is to –

"**10 Commission's functions**

(1) The commission's functions are to —

…

(e) monitor the availability, adequacy and use of rehabilitation services for claimants who suffer personal injury in motor vehicle accidents and develop programs, resources and guidelines to overcome deficiencies in the services".

[7] Section 51 of the *MAI Act* provides (so far as relevant) –

"**51 Obligation to provide rehabilitation services**

(1) An insurer may make rehabilitation services available to a claimant on the insurer's own initiative or at the claimant's request.

(2) An insurer that makes rehabilitation services available to a claimant before admitting or denying liability on the claim must not be taken, for that reason, to have admitted liability.

(3) Once liability has been admitted on a claim, or the insurer has agreed to fund rehabilitation services without making an admission of liability, the insurer must, at the claimant's request, ensure that reasonable and appropriate rehabilitation services are made available to the claimant.

…

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3 *MAI Act* s 3(d).
4 which is established by *MAI Act* s 6.

(5) The claimant may, if not satisfied that the rehabilitation services made available under this section are reasonable and appropriate —

(a) apply to the commission to appoint a mediator to help resolve the questions between the claimant and the insurer; or

(b) apply to the court to decide what rehabilitation services are, in the circumstances of the case, reasonable and appropriate.

…

(5C) An application may be made to the court under subsection (5)(b) whether or not there has been an earlier attempt to resolve the questions between the claimant and the insurer by mediation.

(5D) On an application under subsection (5)(b), the court may decide what rehabilitation services are, in the circumstances of the case, reasonable and appropriate and make consequential orders and directions."

[8] In *Re Walker*[5] Moynihan J said –

"It may be accepted that the Act, and particularly s 51(5), is to be construed beneficially from the perspective of claimants.

…

As I read the legislation, the plaintiff's remedy remains damages designed to restore him, so far as money is able, to his pre-accident condition and to satisfy, again in so far as money can, needs caused by his injury; see for example *Van Gurven v Fenton* (1992) 175 CLR 327; 17 MVR 29. The present case is concerned with interim measures with the overall consequences of the applicant's injuries to be assessed later.

Section 51 (5) provides a test in broad terms. The elements would seem to be 'the circumstances of the case', 'reasonable' and 'appropriate'. 'Reasonable' would appear to connote no more than its usual meaning as founded on reason as distinct from arbitrary or capricious. 'Appropriate' would appear to connote 'suitable or fitting for a particular purpose' in this case 'rehabilitation' as defined.

Subsection (5) appears to require the court to form its own opinion. Although there may be a role for expert opinion in some aspects of applications under subs (5), that should be limited by the nature of the jurisdiction and to evidence of expert opinion properly defined.

5 (1995) 22 MVR 245.

> The court must make up its own mind at an interim stage in a broad rather than refined way."[6]

[9] A licensed insurer is bound by the provisions of the "industry deed"[7], which is –

> "an agreement, in the form approved by regulation, between the commission, transport administration, the Nominal Defendant and licensed insurers regulating the conduct of CTP insurance business and matters incidental to —
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> (a) the conduct of the business; or
> (b) the statutory insurance scheme."[8]

By s 65(2) of the *MAI Act* –

> "(2) The industry deed may –
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> …
>
> (e) provide direction and guidance for licensed insurers about initiating, managing, monitoring, and measuring the effectiveness of, the provision of rehabilitation services for injured claimants".

[10] The *Motor Accident Insurance Regulation 2004* (Qld) (*MAI Regulation*) provides the approved form of the industry deed.[9] Section 4 of the industry deed is in these terms –

> "**4 Rehabilitation**
>
> The commission may issue rehabilitation standards and guidelines for insurers to—
>
> (a) provide for the assessment of the nature and extent of an injured claimant's need for rehabilitation; and
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> (b) ensure that injured claimants are properly informed about their obligations to undertake appropriate medical treatment and rehabilitation programs; and
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> (c) facilitate access to appropriate rehabilitation services for injured claimants; and
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> (d) provide guidance to help insurers decide what rehabilitation services and costs of the services are reasonable and appropriate; and

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6 (1995) 22 MVR 245, 247-248.
7 *MAI Act* s 65(1).
8 *MAI Act* s 4.
9 *MAI Regulation* s 32, schedule 5.

(e) ensure the rehabilitation process for an injured claimant is appropriately managed; and

(f) monitor the effectiveness of rehabilitation services and the providers of rehabilitation services."

[11] In January 2007 the Commission published *Rehabilitation Standards for CTP Insurers*. The claimant's obligation to cooperate with the insurer to determine rehabilitation needs and the insurer's obligation to ensure that reasonable and appropriate rehabilitation services are made available to the claimant are stated expressly. The insurer's role is to facilitate the rehabilitation process, not to develop treatment and rehabilitation plans.[10] Rehabilitation Standards A to F were developed in consultation with stakeholders "in order to review the performance of insurers in terms of compliance with Section 51 of the [*MAI Act*], and to ensure insurers' processes are aligned with the provision of the [*MAI Regulation*]."[11] Sections C, D, E and F of the Rehabilitation Standards are as follows –

"**Section C:**	**Facilitate access to appropriate rehabilitation services for injured claimants.**
STANDARD C	*Following the screening and identification of possible rehabilitation needs, and where the CTP insurer has indicated its preparedness to meet the reasonable and appropriate cost of rehabilitation, the insurer undertakes appropriate action to facilitate access to services for claimants. This may include the assignment of staff by the insurer to facilitate the provision and coordination of treatment and rehabilitation. Claimants identified as requiring services are advised who to contact at the insurer and how to contact them.*

Standard C Criteria	
Criteria 1	Within 14 days of identifying rehabilitation needs, the insurer undertakes appropriate action to facilitate access to services for claimants. - Appropriate action for **non-complex** injuries may include reviewing and responding to the treatment recommendations outlined in the medical certificate. - Appropriate action for **complex** injuries may include the insurer: • gathering further information from treatment providers to clarify rehabilitation needs; • referring the file to an internal or contracted health professional for review; or • making a reasonable attempt to facilitate the

[10] *Rehabilitation Standards for CTP Insurers* part 3 p 7.

[11] *Rehabilitation Standards for CTP Insurers* part 1 p 4.

	claimant's referral to a provider in cases where unmet needs are identified and referral would be potentially beneficial.
Criteria 2	(2.1) The insurer assigns staff to take responsibility for meeting the insurer's rehabilitation obligations including acting as a point of contact for all rehabilitation requests and monitoring the rehabilitation process. (2.2) Information is sent to claimants who have been identified as requiring rehabilitation services on the role of the assigned staff in relation to rehabilitation and how to contact them. (2.3) The insurer takes reasonable steps to ensure their staff have access to a health professional who has current knowledge of best practice rehabilitation processes whenever necessary
Criteria 3	Claimants are informed of their ability to exercise choice in the selection of an appropriately qualified and experienced service provider whose intervention is supported by the medical evidence.
Criteria 4	Potential conflicts of interest, such as a formal relationship between the service provider and the insurer or insurer's contracted staff, are identified and disclosed to the claimant.

Section D:	**Provide guidance to help insurers decide what rehabilitation services and costs of the services are reasonable and appropriate.**
STANDARD D	*To assist in the determination of rehabilitation requests, the CTP insurer has in place guidelines which are based on objective criteria and which are consistently applied.*

Standard D Criteria

Criteria 1	(1.1) A system is in place to assist insurer's staff in assessing reasonable and appropriate aspects of rehabilitation requests. (1.2) Reasonable steps are taken by the insurer to ensure training is provided to claims staff regarding their role in relation to meeting the insurer's rehabilitation obligations as well as the application of guidelines. (1.3) The decision-making process is based on objective information and medical evidence and is

	adequately documented on file. (1.4) There is demonstrated consistency in decision-making across all the insurer's CTP claims.
Criteria 2	(2.1) Where disputes or complaints about rehabilitation arise, insurers will endeavour to resolve these issues internally. (2.2) Where the dispute is unable to be resolved, claimants are informed of alternative courses of action such as the appointment by MAIC of a mediator to help resolve the dispute or an application to the court.

Section E: **Ensure the rehabilitation process for an injured claimant is appropriately managed; and**

Section F: **Monitor the effectiveness of rehabilitation services and the providers of rehabilitation services**

STANDARD EF *The insurer has a system in place whereby the rehabilitation process is managed appropriately and effectively by the insurer to deliver outcomes for claimants.*

Standard E & F Criteria

Criteria 1	A system is established whereby service providers are required to outline specific goals to be achieved during the rehabilitation program within specified timeframes and costs. The system should also include regular updates of progress towards the specified goals using objective measures as well as documenting barriers to progress.
Criteria 2	The insurer reviews treatment and rehabilitation plans, progress reports, accounts which have not been pre-approved, and other requests for rehabilitation, and evaluates them considering the reasonable and appropriate guidelines in making funding decisions
Criteria 3	The insurer responds in writing to the claimant and provider regarding rehabilitation requests* within 10 days of receipt, stating whether they are approved, not approved, partially approved or further information is required to consider the requests. *for home modification requests see criteria #6
Criteria 4	If the insurer declines the plan in full or part, an explanation is provided to the provider and claimant in writing and the reasons are documented on file.

Criteria 5	If an insurer decides to discontinue funding for pre-approved services for reasons other than claim settlement, the insurer must provide prior notice in writing to the provider and claimant including an explanation as to why the insurer has terminated payment. The insurer must also liaise with the provider in situations where cessation of funding for services could place the claimant at significant risk, to ensure that sufficient time is allowed for alternate arrangements to be made (for example, when ceasing funding for attendant care or psychological treatment).
Criteria 6	Home modification requests are acknowledged in writing within 10 days to the claimant and provider. The insurer must advise the claimant and provider in writing within 3 months of the request whether the request is approved in principle or rejected.
Criteria 7	There is a system in place to review at appropriate intervals, the rehabilitation needs of: (7.1) Claimants who have sustained serious injury such as spinal cord injury, acquired brain injury or serious multi-trauma, during the life of the claim, such as when there has been a change in circumstance or in association with reaching certain milestones, and (7.2) claimants with other injuries who have been identified as having complex needs or who are at risk of a poor outcome (for example return to work issues, psychosocial issues, or multiple service providers).
Criteria 8	Accounts for pre-approved rehabilitation services are processed within 21 days of receipt of valid invoices.
Criteria 9	Following admission of liability, reimbursement of the claimant's rehabilitation costs must be processed within 21 days: • of the insurer determining they were reasonably and appropriately incurred, and • if the total amount is $200 or greater, or • if the total amount is less than $200 and the claimant does not expect to make further requests for reimbursement.”

The competing assessments

[12] The applicant's solicitors retained Mr Stephen Hoey, an occupational therapist, to assess her needs. He produced a report in October 2006, which her solicitors sent to the respondent. The respondent then arranged an assessment by another occupational therapist, Ms Karen Pery-Johnston, who is a consultant to CRS Australia (a Commonwealth Government rehabilitation agency). The results of her assessment were available in early December 2006. There was no substantial disagreement between them as to the specialist fields in which rehabilitation services should be provided.

[13] The applicant's solicitors nominated service providers in late January 2007, but the respondent rejected every one of the nominees. The applicant's solicitors then arranged a review by Ms Joanne Siketa, an occupational therapist practising in Melbourne with 13 years experience in neurological rehabilitation, 9 of them specialising in acquired brain injury rehabilitation. On 20 April 2007 she made quite detailed recommendations for rehabilitation, including nominating some service providers, and then made some observations on the reports of Mr Hoey and Mr Pery-Johnston. She said –

> "Most important (and with which I offer complete agreement) is Mr Hoey's comments that recovery from severe brain injury is a long term process. In my experience, intensive inpatient rehabilitation programs specialising in acquired brain injury are beneficial for up to 18 months, followed by a tailored outpatient or community based program that may continue for years based upon the progress and goals of the individual."[12]

[14] The respondent then proposed that there be another assessment – this time by a geriatrician, Dr Glenda Powell. The applicant's solicitors have not agreed to this.

[15] Ms Pery-Johnston commented on Ms Siketa's report on 28 May 2007.

Comment

[16] The applicant's rehabilitation needs seem to have been overshadowed by the respondent's intransigent attitude that it will meet the costs only if the rehabilitation services are provided by persons it selects. This dictatorial attitude is inconsistent with the Legislature's expressed intention to promote and encourage rehabilitation of injured persons and with the express provision in the Rehabilitation Standards which are binding on it that claimants be informed of their ability to exercise choice in the selection of an appropriately qualified and experienced service provider whose intervention is supported by the medical evidence. Ultimately it is in the mutual interests of the applicant and the respondent that these issues be dealt with calmly and dispassionately, in a spirit of co-operation and goodwill.

Outcome

[17] Turning to the practitioners nominated in the application before the Court, the following can be said:

(a) *consultant neurologist* It is agreed that it would be reasonable and appropriate to engage a consultant neurologist. The applicant proposes Dr Don Todman,

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12 Exhibit CJP-18 to the affidavit of Colin James Patino, filed 10 June 2007, [91].

who examined the applicant at the behest of her solicitors and wrote a medico-legal report dated 26 February 2007 in which he agreed with the initial recommendations of Mr Hoey. The respondent, at the suggestion of Ms Pery-Johnston, proposes Dr Alison Reid or Dr Michael Walsh, both of whom have apparently been recommended by Dr Ron Hazelton, the Director of the Brain Injury Rehabilitation Unit at the Princess Alexandra Hospital. There is nothing in the material to discredit Dr Todman, but having regard to Dr Hazelton's input, I have concluded that whoever of Dr Reid or Dr Walsh is willing and first able to carry out the assessment should be retained.

(b) *physiotherapist* Ms Jennie McCorkell was recommended by Ms Siketa. She meets with Ms Pery-Johnston's approval, and should be retained.

(c) *speech pathologist* Ms Heather-Anne Briker-Bell was recommended by Ms Siketa, and Ms Vicki Byatt was recommended by Ms Pery-Johnston. Ms Byatt apparently has 20 years experience in neurological speech pathology assessment and treatment. There are no details of Ms Briker-Bell's experience, but there is nothing to discredit her. On the available material I think Ms Byatt should be retained.

(d) *occupational therapist* Ms Siketa nominated Ms Beth Dermer, who is not known to Ms Pery-Johnston. There is no reason why Ms Dermer should not be appointed.

(e) *dietician* Ms Aloysa Houran has been nominated by those acting for the applicant. There is no reason why she should not be appointed.

(f) *case manager* It would not be in the applicant's interests to appoint as case manager someone to whom her representatives or the respondent is antipathetic. For this reason I have concluded that neither Mr Hoey nor Mr Pery-Johnston should assume this role. Instead it should be someone nominated by CRS other than Ms Pery-Johnston.

(g) *clinical neuropsychologist* The parties are not agreed on the need for the services of a neuropsychologist. It is a matter raised by Ms Siketa who said –

> "Neuropsychologist – to assist with formal cognitive assessment and behavioural management strategies once Susan's rehabilitation program is established and gains continue to be made".

I think it would be premature to include a neuropsychologist in the team at this stage. The need for such services should be reviewed by the parties in due course.

[18] I declare that in the circumstances of this case it would be reasonable and appropriate to make the following rehabilitation services available to the applicant –

(a) consultant neurologist: Dr Alison Reid or Dr Michael Walsh

(b) physiotherapist: Ms Jennie McCorkell

(c) speech pathologist: Ms Vicki Byatt

(d) occupational therapist: Ms Beth Dermer

(e) dietician: Ms Aloysa Houran

(f) case manager: a person nominated by CRS Australia other than Ms Karen Pery-Johnston

[19] I order the respondent to pay the applicant's costs of and incidental to the application on the standard basis.